DIAGNOSTIC REPORT

SRL Diagnostics

NAME:-MR. ANMOL RATAN	Age/ Sex/56/Years/M
ACC:- 0071VG000391	Date :- 14/07/2022

X-RAY CHEST PA VIEW

- Both lung fields are normal.
- Both costophrenic angles are normal.
- Both domes of diaphragm are normal.
- Both hilar shadow are normal.
- Cardiac size is normal.
- Visualized soft tissues & thoracic cage are normal.
- **IMPRESSION :**

Please Correlate Clinically.

Dr. D.R. CHUGH
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Tel.: 0129-4179184/85

Dr. D.R CHUGH
(RADIOLOGIST)

Disclaimer:
The science of radiology is based upon interpretation of shadows of normal and abnormal tissue. This is neither complete nor accurate, hence findings should always be interpreted in to the light of clinico-pathological correlation. This a professional opinion, not a diagnosis. Not meant for medico l7egal purpose.

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ELECTROCARDIOGRAM

Result	Values	Nomal Rate
Rate	78	60-100b/m
Rhythm	Sinus	Sinus
P Wave	0.10	Width<0.11Sec.Height<3mm
QRS complex	0.10	<0.10sec in duration
T Wave	Upright	Upright
U Wave	absent	
P R Interval	0.15	0.12 - 0.20sec
S T segment	NAD	Isoelectric

IMPRESSION : Lt axix dev.
Correlate clinically
Otherwise normal.

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Dr. MUKUL GOSWAMI
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Dr. MUKUL GOSWAMI
CONSULTANT PHYSICIAN

Disclaimer:

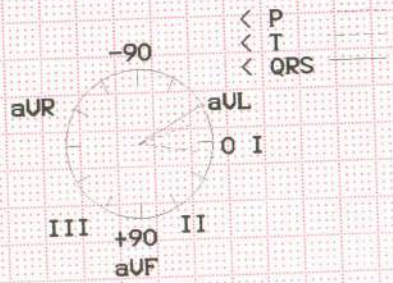
The science of cardiology is based upon interpretation of normal and abnormal ECG graph. This is neither complete or accurate, hence findings should always be interpreted in to the light of clinico-pathological correlation. This a professional opinion, not a diagnosis. Not meant for medico legal purpose.

CARDIOPRINT

GE MAC1200 ST ANMOL, RATAN 000000056, SRLLIMITEDSEC 16 FARIDABAD HR 78bpm
Male

Measurement Results:

QRS	:	102	ms
QT/QTcB	: 394 /	451	ms
PR	:	152	ms
P	:	126	ms
RR/PP	: 764 /	770	ms
P/QRS/T	: -20/ -30/	10	degrees
QTD/QTcBD	: 60 /	69	ms
Sokolow	:	1.4	mV
NK	:	10	

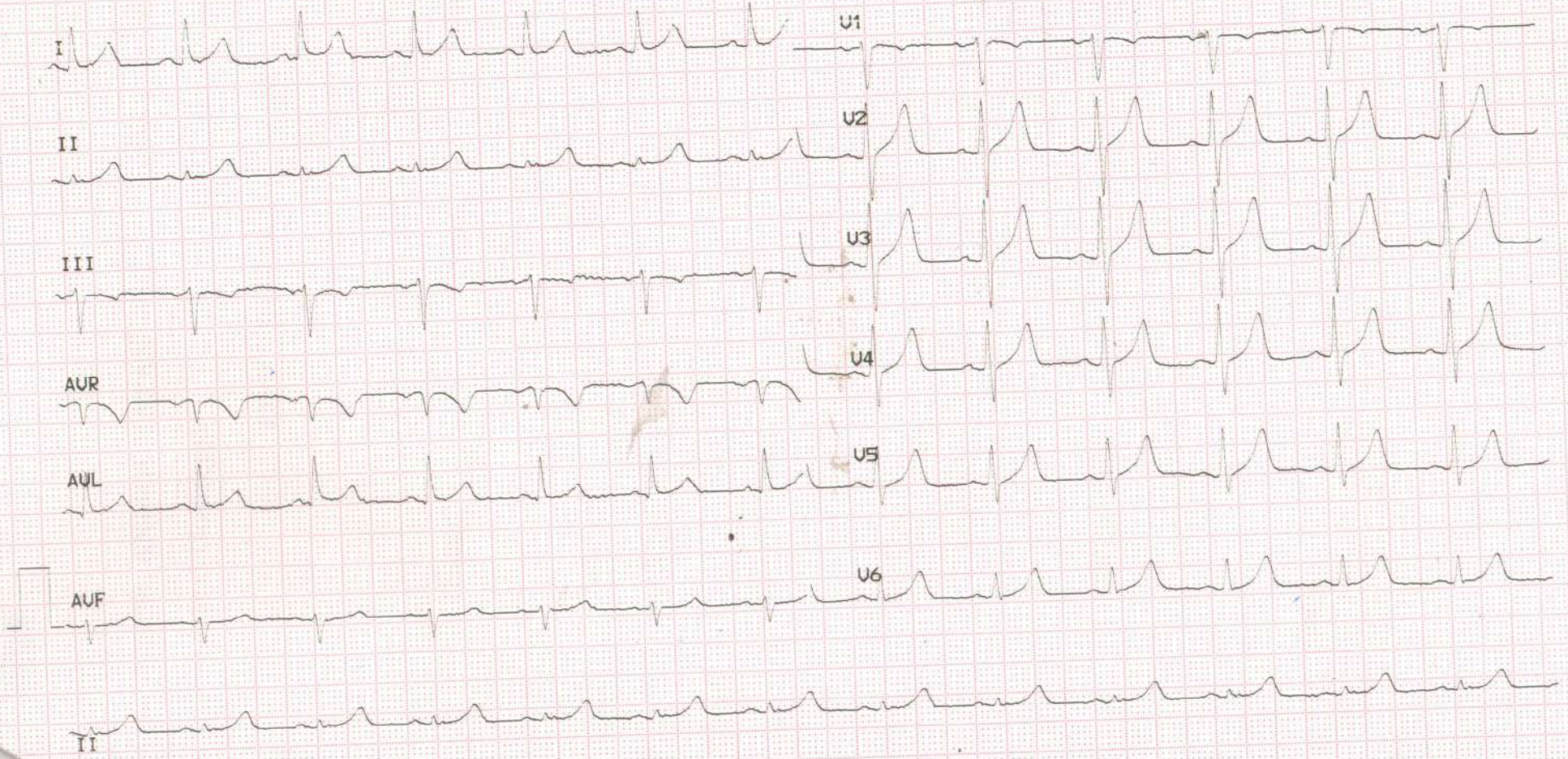


< P
< T
< QRS

Interpretation:

left axis deviation
R/S inversion area between U1 and U2
borderline ECG

Unconfirmed report.



1 Jan 2001 01:22:48 AM 25mm/s 10mm/mV ADS 50Hz 0.08 - 20Hz 6_F1_R Automatic V6.2 12i (1)

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ULTRA SOUND SCAN OF WHOLE ABDOMEN

Liver: Normal in size, and shows homogeneous echotexture. No obvious focal or diffuse pathology is noted in either of the lobes.Fatty changes present in the liver of grade I
Hepatic veins appear normal.

Gall bladder: Well distended with echofree lumen and normal wall thicknes
CBD AND PORTALVEIN : normal in caliber

Pancreas : Normal in size shape and echotexture no e/o focal lesion /calcification.Pancreatic duct appears normal.
Spleen: Normal in size, shape and Echotexture. No e/o focal lesion

Both Kidneys: Both kidneys are normal in size and echotexture.
There is cyst of 15.8x14.3mm in RT kidney
No e/o hydronephrosis/focal lesion

Urinary bladder: Well distended.No e/o calculi/internal echoes.Wall thickness appears normal.

Prostate: Normal in size, in Shape and echotexture.No e/o focal lesion
No free fluid noted.
No obvious lymphadenopathy noted.

IMPRESSION:- WHOLE ABDOMEN REVEALS FATTY CHANGES IN THE LIVER. AND CYST IN THE RT KIDNEY

Correlate with clinically findings.

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DIAGNOSTIC REPORT

Patient Ref. No. 71000000302564

CLIENT CODE : C000138381

CLIENT'S NAME AND ADDRESS :
ACROFEMI HEALTHCARE LTD (MEDIWHEEL)
F-703, LADO SARAI, MEHRAULI
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Haryana, INDIA
Tel : 9111591115,
CIN - U74899PB1995PLC045956

PATIENT NAME : ANMOL RATAN PATIENT ID : **ANMOM25116771**

ACCESSION NO : **0071VG000391** AGE : 54 Years SEX : Male ABHA NO :

DRAWN : RECEIVED : 14/07/2022 08:58 REPORTED : 15/07/2022 16:29

REFERRING DOCTOR : SELF CLIENT PATIENT ID :

Test Report Status **Preliminary**	Results		Biological Reference Interval	Units
MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE				
BLOOD COUNTS,EDTA WHOLE BLOOD				
HEMOGLOBIN METHOD : SPECTROPHOTOMETRY	13.1		13.0 - 17.0	g/dL
RED BLOOD CELL COUNT METHOD : IMPEDANCE	4.57		4.5 - 5.5	mil/µL
WHITE BLOOD CELL COUNT METHOD : IMPEDANCE	5.97		4.0 - 10.0	thou/µL
PLATELET COUNT METHOD : IMPEDANCE	165		150 - 410	thou/µL
RBC AND PLATELET INDICES				
HEMATOCRIT METHOD : CALCULATED	43.4		40 - 50	%
MEAN CORPUSCULAR VOL METHOD : DERIVED FROM IMPEDANCE MEASURE	95.0		83 - 101	fL
MEAN CORPUSCULAR HGB. METHOD : CALCULATED PARAMETER	28.7		27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION METHOD : CALCULATED PARAMETER	**30.2**	**Low**	31.5 - 34.5	g/dL
MENTZER INDEX	20.8			
RED CELL DISTRIBUTION WIDTH METHOD : DERIVED FROM IMPEDANCE MEASURE	**16.1**	**High**	11.6 - 14.0	%
MEAN PLATELET VOLUME METHOD : DERIVED FROM IMPEDANCE MEASURE	**12.5**	**High**	6.8 - 10.9	fL
WBC DIFFERENTIAL COUNT - NLR				
SEGMENTED NEUTROPHILS METHOD : DHSS FLOWCYTOMETRY	56		40 - 80	%
ABSOLUTE NEUTROPHIL COUNT METHOD : DHSS FLOWCYTOMETRY, CALCULATED	3.35		2.0 - 7.0	thou/µL
LYMPHOCYTES METHOD : DHSS FLOWCYTOMETRY	33		20 - 40	%
ABSOLUTE LYMPHOCYTE COUNT METHOD : DHSS FLOWCYTOMETRY, CALCULATED	1.95		1 - 3	thou/µL
NEUTROPHIL LYMPHOCYTE RATIO (NLR) METHOD : CALCULATED	1.7			
EOSINOPHILS	4		1 - 6	%

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METHOD : DHSS FLOWCYTOMETRY				
ABSOLUTE EOSINOPHIL COUNT	0.25		0.02 - 0.50	thou/µL
METHOD : DHSS FLOWCYTOMETRY, CALCULATED				
MONOCYTES	6		2 - 10	%
METHOD : DHSS FLOWCYTOMETRY				
ABSOLUTE MONOCYTE COUNT	0.36		0.20 - 1.00	thou/µL
METHOD : DHSS FLOWCYTOMETRY, CALCULATED				
BASOPHILS	1		0 - 2	%
METHOD : IMPEDANCE				
ABSOLUTE BASOPHIL COUNT	0.04		0.02 - 0.10	thou/µL
METHOD : DHSS FLOWCYTOMETRY, CALCULATED				
ERYTHRO SEDIMENTATION RATE, BLOOD				
SEDIMENTATION RATE (ESR)	**24**	**High**	0 - 14	mm at 1 hr
METHOD : AUTOMATED (PHOTOMETRICAL CAPILLARY STOPPED FLOW KINETIC ANALYSIS)				
GLYCOSYLATED HEMOGLOBIN, EDTA WHOLE BLOOD				
GLYCOSYLATED HEMOGLOBIN (HBA1C)	**6.1**	**High**	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 ADA Target: 7.0 Action suggested: > 8.0	%
METHOD : CAPILLARY ELECTROPHORESIS				
MEAN PLASMA GLUCOSE	**128.4**	**High**	< 116	mg/dL
METHOD : CALCULATED PARAMETER				
GLUCOSE, FASTING, PLASMA				
GLUCOSE, FASTING, PLASMA	99		Normal 75 - 99 Pre-diabetics: 100 – 125 Diabetic: > or = 126	mg/dL
METHOD : SPECTROPHOTOMETRY HEXOKINASE				
GLUCOSE, POST-PRANDIAL, PLASMA	RESULT PENDING			
CORONARY RISK PROFILE (LIPID PROFILE), SERUM.				
CHOLESTEROL	136		Desirable cholesterol level < 200 Borderline high cholesterol 200 - 239 High cholesterol > / = 240	mg/dL
TRIGLYCERIDES	74		Normal: < 150 Borderline high: 150 - 199 High: 200 - 499 Very High: >/= 500	mg/dL
HDL CHOLESTEROL	**38**	**Low**	<40 = 60	mg/dL

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DIRECT LDL CHOLESTEROL	97.00		Optimal : < 100 Near optimal/above optimal : 100 - 129 Borderline high : 130 - 159 High : 160 - 189 Very high : > / = 190	mg/dL
NON HDL CHOLESTEROL	99		Desirable : < 130 Above Desirable : 130 -159 Borderline High : 160 - 189 High : 190 - 219 Very high : > / = 220	mg/dL
CHOL/HDL RATIO	4.0		Low Risk : 3.3 - 4.4 Average Risk : 4.5 - 7.0 Moderate Risk : 7.1 - 11.0 High Risk : > 11.0	
LDL/HDL RATIO	2.6		Desirable/Low Risk - 0.5-3 Borderline/Moderate Risk- 3.1-6 High Risk- >6.0	
VERY LOW DENSITY LIPOPROTEIN	14.7		</= 30.0	mg/dL
LIVER FUNCTION PROFILE, SERUM				
BILIRUBIN, TOTAL	0.3		Upto 1.2	mg/dL
BILIRUBIN, DIRECT	0.2		< 0.30	mg/dL
BILIRUBIN, INDIRECT	0.10		0.1 - 1.0	mg/dL
TOTAL PROTEIN	7.0		6.0 - 8.0	g/dL
ALBUMIN	4.5		3.97 - 4.94	g/dL
GLOBULIN	2.5		2.0 - 3.5	g/dL
ALBUMIN/GLOBULIN RATIO	1.8		1.0 - 2.1	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	**59**	**High**	< OR = 50	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)	**59**	**High**	< OR = 50	U/L
ALKALINE PHOSPHATASE	70		35 - 104	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)	40		0 - 60	U/L
LACTATE DEHYDROGENASE	194		125 - 220	U/L
SERUM BLOOD UREA NITROGEN				
BLOOD UREA NITROGEN	9.5		6 - 20	mg/dL
CREATININE, SERUM				
CREATININE	0.80		0.7 - 1.2	mg/dL
BUN/CREAT RATIO				
BUN/CREAT RATIO	11.90		8.0 - 15.0	
URIC ACID, SERUM				
URIC ACID	6.3		3.4 - 7.0	mg/dL

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Test Report Status **Preliminary**	Results	Biological Reference Interval	Units
TOTAL PROTEIN, SERUM			
TOTAL PROTEIN	7.0	6.0 - 8.0	g/dL
ALBUMIN, SERUM			
ALBUMIN	4.5	3.97 - 4.94	g/dL
GLOBULIN			
GLOBULIN	2.5	2.0 - 3.5	g/dL
ELECTROLYTES (NA/K/CL), SERUM			
SODIUM	141	136 - 145	mmol/L
POTASSIUM	4.4	3.5 - 4.5	mmol/L
CHLORIDE	105		mmol/L
PHYSICAL EXAMINATION, URINE			
COLOR	PALE YELLOW		
APPEARANCE	CLEAR		
SPECIFIC GRAVITY	1.015	1.003 - 1.035	

Comments

NOTE :MICROSCOPIC EXAMINATION OF URINE IS PERFORMED ON CENTRIFUGED URINARY SEDIMENT.
IN NORMAL URINE SAMPLES CAST AND CRYSTALS ARE NOT DETECTED.

CHEMICAL EXAMINATION, URINE			
PH	6.0	4.7 - 7.5	
PROTEIN	NOT DETECTED	NOT DETECTED	
GLUCOSE	NOT DETECTED	NOT DETECTED	
KETONES	NOT DETECTED	NOT DETECTED	
BLOOD	NOT DETECTED	NOT DETECTED	
BILIRUBIN	NOT DETECTED	NOT DETECTED	
UROBILINOGEN	NORMAL	NORMAL	
NITRITE	NOT DETECTED	NOT DETECTED	
MICROSCOPIC EXAMINATION, URINE			
PUS CELL (WBC'S)	1-2	0-5	/HPF
EPITHELIAL CELLS	0-1	0-5	/HPF
ERYTHROCYTES (RBC'S)	NOT DETECTED	NOT DETECTED	/HPF
CASTS	NOT DETECTED		
CRYSTALS	NOT DETECTED		
BACTERIA	NOT DETECTED	NOT DETECTED	

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THYROID PANEL, SERUM			
T3	125.0	80 - 200	ng/dL
T4	6.90	5.1 - 14.1	µg/dL
TSH 3RD GENERATION	3.180	0.27 - 4.2	µIU/mL
STOOL: OVA & PARASITE	RESULT PENDING		
ABO GROUP & RH TYPE, EDTA WHOLE BLOOD			
ABO GROUP	B		
RH TYPE	RH+		
XRAY-CHEST	RESULT PENDING		
TMT OR ECHO	RESULT PENDING		
ECG	RESULT PENDING		
MEDICAL HISTORY	RESULT PENDING		
ANTHROPOMETRIC DATA & BMI	RESULT PENDING		
GENERAL EXAMINATION	RESULT PENDING		
CARDIOVASCULAR SYSTEM	RESULT PENDING		
RESPIRATORY SYSTEM	RESULT PENDING		
PER ABDOMEN	RESULT PENDING		
CENTRAL NERVOUS SYSTEM	RESULT PENDING		
MUSCULOSKELETAL SYSTEM	RESULT PENDING		
BASIC EYE EXAMINATION	RESULT PENDING		
BASIC ENT EXAMINATION	RESULT PENDING		
SUMMARY	RESULT PENDING		
FITNESS STATUS	RESULT PENDING		

Interpretation(s)
BLOOD COUNTS,EDTA WHOLE BLOOD-
The cell morphology is well preserved for 24hrs. However after 24-48 hrs a progressive increase in MCV and HCT is observed leading to a decrease in MCHC. A direct smear is recommended for an accurate differential count and for examination of RBC morphology.
RBC AND PLATELET INDICES-
Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia(>13) from Beta thalassaemia trait (<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.
WBC DIFFERENTIAL COUNT - NLR-
The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR < 3.3, COVID-19 patients tend to show mild disease.
(Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients ; A.-P. Yang, et al.; International Immunopharmacology 84 (2020) 106504
This ratio element is a calculated parameter and out of NABL scope.
ERYTHRO SEDIMENTATION RATE, BLOOD-
Erythrocyte sedimentation rate (ESR) is a non - specific phenomena and is clinically useful in the diagnosis and monitoring of disorders associated with an increased

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Test Report Status **Preliminary**	Results	Biological Reference Interval	Units

production of acute phase reactants. The ESR is increased in pregnancy from about the 3rd month and returns to normal by the 4th week post partum. ESR is influenced by age, sex, menstrual cycle and drugs (eg. corticosteroids, contraceptives). It is especially low (0 -1mm) in polycythaemia, hypofibrinogenemia or congestive cardiac failure and when there are abnormalities of the red cells such as poikilocytosis, spherocytosis or sickle cells.

Reference :
1. Nathan and Oski's Haematology of Infancy and Childhood, 5th edition
2. Paediatric reference intervals. AACC Press, 7th edition. Edited by S. Soldin
3. The reference for the adult reference range is "Practical Haematology by Dacie and Lewis, 10th Edition"

GLYCOSYLATED HEMOGLOBIN, EDTA WHOLE BLOOD-
Glycosylated hemoglobin (GHb) has been firmly established as an index of long-term blood glucose concentrations and as a measure of the risk for the development of complications in patients with diabetes mellitus. Formation of GHb is essentially irreversible, and the concentration in the blood depends on both the life span of the red blood cell (average 120 days) and the blood glucose concentration. Because the rate of formation of GHb is directly proportional to the concentration of glucose in the blood, the GHb concentration represents the integrated values for glucose over the preceding 6-8 weeks.
Any condition that alters the life span of the red blood cells has the potential to alter the GHb level. Samples from patients with hemolytic anemias will exhibit decreased glycated hemoglobin values due to the shortened life span of the red cells. This effect will depend upon the severity of the anemia. Samples from patients with polycythemia or post-splenectomy may exhibit increased glycated hemoglobin values due to a somewhat longer life span of the red cells.
Glycosylated hemoglobins results from patients with HbSS, HbCC, and HbSC and HbD must be interpreted with caution, given the pathological processes, including anemia, increased red cell turnover, transfusion requirements, that adversely impact HbA1c as a marker of long-term glycemic control. In these conditions, alternative forms of testing such as glycated serum protein (fructosamine) should be considered.
"Targets should be individualized; More or less stringent glycemic goals may be appropriate for individual patients. Goals should be individualized based on duration of diabetes, age/life expectancy, comorbid conditions, known CVD or advanced microvascular complications, hypoglycemia unawareness, and individual patient considerations.''

References
1. Tietz Textbook of Clinical Chemistry and Molecular Diagnostics, edited by Carl A Burtis, Edward R.Ashwood, David E Bruns, 4th Edition, Elsevier publication, 2006, 879-884.
2. Forsham PH. Diabetes Mellitus:A rational plan for management. Postgrad Med 1982, 71,139-154.
3. Mayer TK, Freedman ZR: Protein glycosylation in Diabetes Mellitus: A review of laboratory measurements and their clinical utility. Clin Chim Acta 1983, 127, 147-184.

GLUCOSE, FASTING, PLASMA-
ADA 2021 guidelines for adults, after 8 hrs fasting is as follows:
Pre-diabetics: 100 - 125 mg/dL
Diabetic: > or = 126 mg/dL

CORONARY RISK PROFILE (LIPID PROFILE), SERUM-
Serum cholesterol is a blood test that can provide valuable information for the risk of coronary artery disease This test can help determine your risk of the build up of plaques in your arteries that can lead to narrowed or blocked arteries throughout your body (atherosclerosis). High cholesterol levels usually don't cause any signs or symptoms, so a cholesterol test is an important tool. High cholesterol levels often are a significant risk factor for heart disease and important for diagnosis of hyperlipoproteinemia, atherosclerosis, hepatic and thyroid diseases.

Serum Triglyceride are a type of fat in the blood. When you eat, your body converts any calories it doesn't need into triglycerides, which are stored in fat cells. High triglyceride levels are associated with several factors, including being overweight, eating too many sweets or drinking too much alcohol, smoking, being sedentary, or having diabetes with elevated blood sugar levels. Analysis has proven useful in the diagnosis and treatment of patients with diabetes mellitus, nephrosis, liver obstruction, other diseases involving lipid metabolism, and various endocrine disorders. In conjunction with high density lipoprotein and total serum cholesterol, a triglyceride determination provides valuable information for the assessment of coronary heart disease risk.It is done in fasting state.

High-density lipoprotein (HDL) cholesterol. This is sometimes called the ""good"" cholesterol because it helps carry away LDL cholesterol, thus keeping arteries open and blood flowing more freely.HDL cholesterol is inversely related to the risk for cardiovascular disease. It increases following regular exercise, moderate alcohol consumption and with oral estrogen therapy. Decreased levels are associated with obesity, stress, cigarette smoking and diabetes mellitus.

SERUM LDL The small dense LDL test can be used to determine cardiovascular risk in individuals with metabolic syndrome or established/progressing coronary artery disease, individuals with triglyceride levels between 70 and 140 mg/dL, as well as individuals with a diet high in trans-fat or carbohydrates. Elevated sdLDL levels are associated with metabolic syndrome and an 'atherogenic lipoprotein profile', and are a strong, independent predictor of cardiovascular disease.
Elevated levels of LDL arise from multiple sources. A major factor is sedentary lifestyle with a diet high in saturated fat. Insulin-resistance and pre-diabetes have also been implicated, as has genetic predisposition. Measurement of sdLDL allows the clinician to get a more comprehensive picture of lipid risk factors and tailor treatment accordingly. Reducing LDL levels will reduce the risk of CVD and MI.

Non HDL Cholesterol - Adult treatment panel ATP III suggested the addition of Non-HDL Cholesterol as an indicator of all atherogenic lipoproteins (mainly LDL and VLDL). NICE guidelines recommend Non-HDL Cholesterol measurement before initiating lipid lowering therapy. It has also been shown to be a better marker of risk in both primary and secondary prevention studies.

Recommendations:
Results of Lipids should always be interpreted in conjunction with the patient's medical history, clinical presentation and other findings.

NON FASTING LIPID PROFILE includes Total Cholesterol, HDL Cholesterol and calculated non-HDL Cholesterol. It does not include triglycerides and may be best used in patients for whom fasting is difficult.

LIVER FUNCTION PROFILE, SERUM-
LIVER FUNCTION PROFILE
Bilirubin is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. Bilirubin is excreted in bile and urine, and elevated levels may give

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Tel : 9111591115,
CIN - U74899PB1995PLC045956

PATIENT NAME : ANMOL RATAN PATIENT ID : **ANMOM25116771**

ACCESSION NO : **0071VG000391** AGE : 54 Years SEX : Male ABHA NO :

DRAWN : RECEIVED : 14/07/2022 08:58 REPORTED : 15/07/2022 16:29

REFERRING DOCTOR : SELF CLIENT PATIENT ID :

Test Report Status **Preliminary**	Results	Biological Reference Interval	Units

yellow discoloration in jaundice.Elevated levels results from increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Conjugated (direct) bilirubin is elevated more than unconjugated (indirect) bilirubin in Viral hepatitis, Drug reactions, Alcoholic liver disease Conjugated (direct) bilirubin is also elevated more than unconjugated (indirect) bilirubin when there is some kind of blockage of the bile ducts like in Gallstones getting into the bile ducts, tumors &Scarring of the bile ducts. Increased unconjugated (indirect) bilirubin may be a result of Hemolytic or pernicious anemia, Transfusion reaction & a common metabolic condition termed Gilbert syndrome, due to low levels of the enzyme that attaches sugar molecules to bilirubin.
AST is an enzyme found in various parts of the body. AST is found in the liver, heart, skeletal muscle, kidneys, brain, and red blood cells, and it is commonly measured clinically as a marker for liver health. AST levels increase during chronic viral hepatitis, blockage of the bile duct, cirrhosis of the liver,liver cancer,kidney failure,hemolytic anemia,pancreatitis,hemochromatosis. AST levels may also increase after a heart attack or strenuous activity.ALT test measures the amount of this enzyme in the blood.ALT is found mainly in the liver, but also in smaller amounts in the kidneys,heart,muscles, and pancreas.It is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health.AST levels increase during acute hepatitis,sometimes due to a viral infection,ischemia to the liver,chronic hepatitis,obstruction of bile ducts,cirrhosis.
ALP is a protein found in almost all body tissues.Tissues with higher amounts of ALP include the liver,bile ducts and bone.Elevated ALP levels are seen in Biliary obstruction, Osteoblastic bone tumors, osteomalacia, hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, Paget's disease,Rickets,Sarcoidosis etc. Lower-than-normal ALP levels seen in Hypophosphatasia,Malnutrition,Protein deficiency,Wilson's disease.GGT is an enzyme found in cell membranes of many tissues mainly in the liver,kidney and pancreas.It is also found in other tissues including intestine,spleen,heart, brain and seminal vesicles.The highest concentration is in the kidney,but the liver is considered the source of normal enzyme activity.Serum GGT has been widely used as an index of liver dysfunction.Elevated serum GGT activity can be found in diseases of the liver,biliary system and pancreas.Conditions that increase serum GGT are obstructive liver disease,high alcohol consumption and use of enzyme-inducing drugs etc.Serum total protein,also known as total protein,is a biochemical test for measuring the total amount of protein in serum.Protein in the plasma is made up of albumin and globulin.Higher-than-normal levels may be due to:Chronic inflammation or infection,including HIV and hepatitis B or C,Multiple myeloma,Waldenstrom's disease.Lower-than-normal levels may be due to: Agammaglobulinemia,Bleeding (hemorrhage),Burns,Glomerulonephritis,Liver disease, Malabsorption,Malnutrition,Nephrotic syndrome,Protein-losing enteropathy etc.Human serum albumin is the most abundant protein in human blood plasma.It is produced in the liver.Albumin constitutes about half of the blood serum protein.Low blood albumin levels (hypoalbuminemia) can be caused by:Liver disease like cirrhosis of the liver, nephrotic syndrome,protein-losing enteropathy,Burns,hemodilution,increased vascular permeability or decreased lymphatic clearance,malnutrition and wasting etc
SERUM BLOOD UREA NITROGEN-
Causes of Increased levels
Pre renal
• High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal
• Renal Failure
Post Renal
• Malignancy, Nephrolithiasis, Prostatism

Causes of decreased levels
• Liver disease
• SIADH.
CREATININE, SERUM-
Higher than normal level may be due to:
• Blockage in the urinary tract
• Kidney problems, such as kidney damage or failure, infection, or reduced blood flow
• Loss of body fluid (dehydration)
• Muscle problems, such as breakdown of muscle fibers
• Problems during pregnancy, such as seizures (eclampsia)), or high blood pressure caused by pregnancy (preeclampsia)

Lower than normal level may be due to:
• Myasthenia Gravis
• Muscular dystrophy
URIC ACID, SERUM-
Causes of Increased levels
Dietary
• High Protein Intake.
• Prolonged Fasting,
• Rapid weight loss.
Gout
Lesch nyhan syndrome.
Type 2 DM.
Metabolic syndrome.

Causes of decreased levels
• Low Zinc Intake
• OCP's
• Multiple Sclerosis

Nutritional tips to manage increased Uric acid levels
• Drink plenty of fluids
• Limit animal proteins
• High Fibre foods
• Vit C Intake

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• Antioxidant rich foods
TOTAL PROTEIN, SERUM-
Serum total protein,also known as total protein, is a biochemical test for measuring the total amount of protein in serum..Protein in the plasma is made up of albumin and globulin

Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma, Waldenstrom's disease
Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage),Burns,Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome,Protein-losing enteropathy etc.
ALBUMIN, SERUM-
Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. Low blood albumin levels (hypoalbuminemia) can be caused by: Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance,malnutrition and wasting etc.
ELECTROLYTES (NA/K/CL), SERUM-
Sodium levels are Increased in dehydration, cushing's syndrome, aldosteronism & decreased in Addison's disease, hypopituitarism,liver disease. Hypokalemia (low K) is common in vomiting, diarrhea, alcoholism, folic acid deficiency and primary aldosteronism. Hyperkalemia may be seen in end-stage renal failure, hemolysis, trauma, Addison's disease, metabolic acidosis, acute starvation, dehydration, and with rapid K infusion.Chloride is increased in dehydration, renal tubular acidosis (hyperchloremia metabolic acidosis), acute renal failure, metabolic acidosis associated with prolonged diarrhea and loss of sodium bicarbonate, diabetes insipidus, adrenocortical hyperfuction, salicylate intoxication and with excessive infusion of isotonic saline or extremely high dietary intake of salt.Chloride is decreased in overhydration, chronic respiratory acidosis, salt-losing nephritis, metabolic alkalosis, congestive heart failure, Addisonian crisis, certain types of metabolic acidosis, persistent gastric secretion and prolonged vomiting,
MICROSCOPIC EXAMINATION, URINE-
Routine urine analysis assists in screening and diagnosis of various metabolic, urological, kidney and liver disorders
Protein: Elevated proteins can be an early sign of kidney disease. Urinary protein excretion can also be temporarily elevated by strenuous exercise, orthostatic proteinuria, dehydration, urinary tract infections and acute illness with fever
Glucose: Uncontrolled diabetes mellitus can lead to presence of glucose in urine. Other causes include pregnancy, hormonal disturbances, liver disease and certain medications.
Ketones: Uncontrolled diabetes mellitus can lead to presence of ketones in urine. Ketones can also be seen in starvation, frequent vomiting, pregnancy and strenuous exercise.
Blood: Occult blood can occur in urine as intact erythrocytes or haemoglobin, which can occur in various urological, nephrological and bleeding disorders.
Leukocytes: An increase in leukocytes is an indication of inflammation in urinary tract or kidneys. Most common cause is bacterial urinary tract infection.
Nitrite: Many bacteria give positive results when their number is high. Nitrite concentration during infection increases with length of time the urine specimen is retained in bladder prior to collection.
pH: The kidneys play an important role in maintaining acid base balance of the body. Conditions of the body producing acidosis/ alkalosis or ingestion of certain type of food can affect the pH of urine.
Specific gravity: Specific gravity gives an indication of how concentrated the urine is. Increased specific gravity is seen in conditions like dehydration, glycosuria and proteinuria while decreased specific gravity is seen in excessive fluid intake, renal failure and diabetes insipidus.
Bilirubin: In certain liver diseases such as biliary obstruction or hepatitis, bilirubin gets excreted in urine.
Urobilinogen: Positive results are seen in liver diseases like hepatitis and cirrhosis and in cases of hemolytic anemia
THYROID PANEL, SERUM-
Triiodothyronine T3 , is a thyroid hormone. It affects almost every physiological process in the body, including growth, development, metabolism, body temperature, and heart rate. Production of T3 and its prohormone thyroxine (T4) is activated by thyroid-stimulating hormone (TSH), which is released from the pituitary gland. Elevated concentrations of T3, and T4 in the blood inhibit the production of TSH.
Thyroxine T4, Thyroxine's principal function is to stimulate the metabolism of all cells and tissues in the body. Excessive secretion of thyroxine in the body is hyperthyroidism, and deficient secretion is called hypothyroidism. Most of the thyroid hormone in blood is bound to transport proteins. Only a very small fraction of the circulating hormone is free and biologically active.
In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hypothyroidism, TSH levels are low.
Below mentioned are the guidelines for Pregnancy related reference ranges for Total T4, TSH & Total T3

Levels in Pregnancy	TOTAL T4 (µg/dL)	TSH3G (µIU/mL)	TOTAL T3 (ng/dL)
First Trimester	6.6 - 12.4	0.1 - 2.5	81 - 190
2nd Trimester	6.6 - 15.5	0.2 - 3.0	100 - 260
3rd Trimester	6.6 - 15.5	0.3 - 3.0	100 - 260

Below mentioned are the guidelines for age related reference ranges for T3 and T4.

	T3 (ng/dL)	T4 (µg/dL)
New Born:	75 - 260	1-3 day: 8.2 - 19.9
.		1 Week: 6.0 - 15.9

NOTE: TSH concentrations in apparently normal euthyroid subjects are known to be highly skewed, with a strong tailed distribution towards higher TSH values. This is well documented in the pediatric population including the infant age group.
Kindly note: Method specific reference ranges are appearing on the report under biological reference range.

Reference:
1. Burtis C.A., Ashwood E. R. Bruns D.E. Teitz textbook of Clinical Chemistry and Molecular Diagnostics, 4th Edition.
2. Gowenlock A.H. Varley's Practical Clinical Biochemistry, 6th Edition.
3. Behrman R.E. Kilegman R.M., Jenson H. B. Nelson Text Book of Pediatrics, 17th Edition
ABO GROUP & RH TYPE, EDTA WHOLE BLOOD-

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Blood group is identified by antigens and antibodies present in the blood. Antigens are protein molecules found on the surface of red blood cells. Antibodies are found in plasma. To determine blood group, red cells are mixed with different antibody solutions to give A,B,O or AB.

Disclaimer: "Please note, as the results of previous ABO and Rh group (Blood Group) for pregnant women are not available, please check with the patient records for availability of the same."

The test is performed by both forward as well as reverse grouping methods.

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MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 50 MALE	RESULT PENDING	
ULTRASOUND ABDOMEN	RESULT PENDING	

****End Of Report****
Please visit www.srlworld.com for related Test Information for this accession

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