



# Aakriti Labs

3 Mahatma Gandhi Marg, Gandhi Nagar Mod  
Tonk Road, Jaipur (Raj.) Ph.: 0141-2710661  
www.aakritilabs.com  
CIN NO.: U85195RJ2004PTC019563



Name : Mr. YOGESH KUMAR MEENA  
Age/Gender: 33 Y/Male  
Patient ID : 012211120021  
BarcodeNo : 10067071  
Referred By : Self

Registration No: 46090  
Registered : 12/Nov/2022 09:19AM  
Analysed : 13/Nov/2022 09:53AM  
Reported : 13/Nov/2022 09:53AM  
Panel : Medi Wheel (ArcoFemi  
Healthcare Ltd)

## DIGITAL X-RAY CHEST PA VIEW

**Right dome of diaphragm is raised.**

Soft tissue shadow and bony cages are normal.

Trachea is central.

Bilateral lung field and both CP angle are clear.


Transverse diameter of heart appears with normal limits.

**IMPRESSION:- RAISED RIGHT HEMI DIAPHRAGM.**

\*\*\* End Of Report \*\*\*

Page 1 of 1



  
Dr. Neera Mehta  
M.B.B.S., D.M.R.D.  
RMCNO.005807/14853



Name : Mr. YOGESH KUMAR MEENA

Registration No: 46090

Age/Gender: 33 Y/Male

Registered : 12/Nov/2022 09:19AM

Patient ID : 012211120021

Analysed : 12/Nov/2022 12:15PM

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## USG: WHOLE ABDOMEN (Male)

**LIVER** : Is normal in size and shape with **bright** echogenicity.  
The IHBR and hepatic radicals are not dilated.  
No evidence of focal echopoor/echorich lesion seen.  
Portal vein diameter and common bile duct appear normal.

**GALL** : Is normal in size, shape and echotexture. Walls are smooth and  
**BLADDER** regular with normal thickness. There is no evidence of cholelithiasis.

**PANCREAS** : Is normal in size, shape and echotexture. Pancreatic duct is not dilated.

**SPLEEN** : Is normal in size, shape and echogenicity. Splenic hilum is not dilated.

**KIDNEYS** : Right Kidney:-Size: 98 x 42 mm, Left Kidney:-Size: 101 x 47 mm.  
Bilateral Kidneys are normal in size, shape and echotexture,  
corticomedullary differentiation is fair and ratio appears normal.  
Pelvi calyceal system is normal. No evidence of hydronephrosis/ nephrolithiasis.

**URINARY** : Bladder walls are smooth, regular and normal thickness.

**BLADDER** : No evidence of mass or stone in bladder lumen.

**PROSTATE**: Is normal in size, shape and echotexture,  
measures: 28 x 28 x 25 mm, wt: 10 gms.  
Its capsule is intact and no evidence of focal lesion.


**SPECIFIC** : No evidence of retroperitoneal mass or free fluid seen in peritoneal cavity.  
No evidence of lymphadenopathy or mass lesion in retroperitoneum.  
Visualized bowel loop appear normal. Great vessels appear normal.

**IMPRESSION** :- Fatty liver

\*\*\* End Of Report \*\*\*

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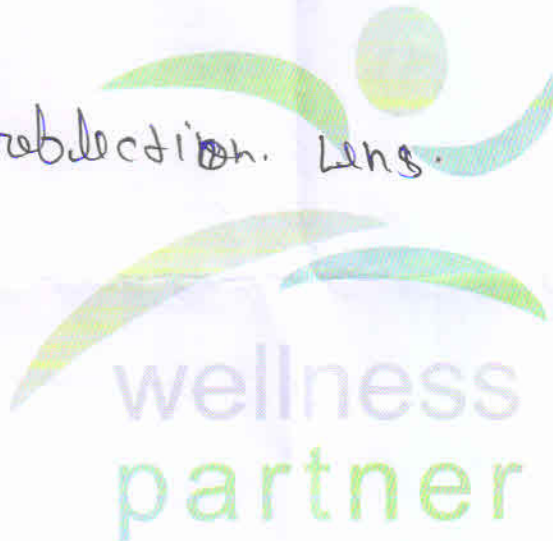
Yogish. Kumar. Mishra. | 33. / 9782177787.

29626. Sway Path. Anaj mandi road. Jaipur.

D.D.

-3.50 / -0.50 x 20  
-4.00 D.Dh.

Adv. Antireflection. Lens.



Dr. RAKESH SHARMA  
M.S. OPHTH. B. OPHTH.  
FICLLP



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NAME	MR YOGESH KUMAR MEENA	AGE	33Y	SEX	MALE
REF BY	MEDIWHEEL	DATE	12/11/2022	REG NO	

## ECHOCARDIOGRAM REPORT

WINDOW- POOR/ADEQUATE/GOODVALVE

MITRAL	NORMAL	TRICUSPID	NORMAL
AORTIC	NORMAL	PULMONARY	NORMAL

### 2D/M-MOD

IVSD mm	10.1	IVSS mm	13.2	AORTA mm	23.0
LVID mm	38.6	LVIS mm	24.4	LA mm	27.7
LVPWD mm	9.5	LVPWS mm	12.2	EF%	60%

### CHAMBERS

LA	NORMAL	RA	NORMAL
LV	NORMAL	RV	NORMAL
PERICARDIUM	NORMAL		

### DOPPLER STUDY MITRAL

PEAK VELOCITY m/s E/A	0.92/0.79	PEAK GRADIANT MmHg	
MEAN VELOCITY m/s		MEAN GRADIANT MmHg	
MVA cm2 (PLANIMETERY)		MVA cm2 (PHT)	
MR			

### AORTIC

PEAK VELOCITY m/s	1.67	PEAK GRADIANT MmHg	
MEAN VELOCITY m/s		MEAN GRADIANT MmHg	
AR			

### TRICUSPID

PEAK VELOCITY m/s	0.60	PEAK GRADIANT MmHg	
MEAN VELOCITY m/s		MEAN GRADIANT MmHg	
TR		PASP mmHg	

### PULMONARY

PEAK VELOCITY m/s	1.48	PEAK GRADIANT MmHg	
MEAN VELOCITY m/s		MEAN GRADIANT MmHg	
PR		RVEDP mmHg	

### IMPRESSION

- NORMAL LV SYSTOLIC & DIASTOLIC FUNCTION
- NO RWMA LVEF 60%
- NORMAL RV FUNCTION
- NORMAL CHAMBER DIMENSIONS
- NORMAL VALVULAR ECHO
- INTACT IAS / IVS
- NO THROMBUS, NO VEGETATION, NORMAL PERICARDIUM.
- IVC NORMAL

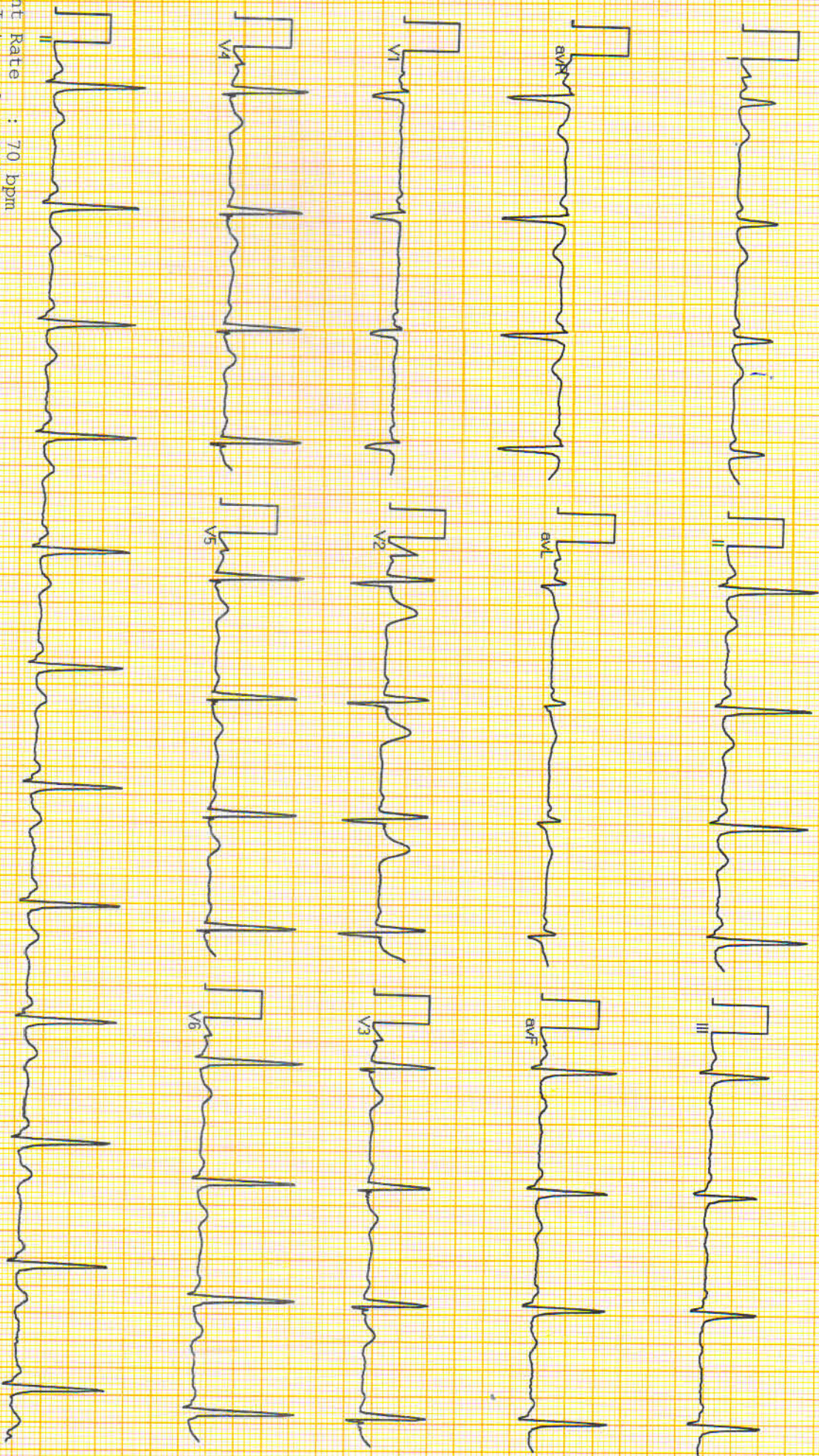
CONCLUSION : FAIR LV FUNCTION.

  
Cardiologist

**AAKRITI LABS PVT.LTD JAIPUR**

19792 / MR. YOGESH KUMAR MEENA / 33 Yrs / M/ Non Smoker  
Heart Rate : 70 bpm / Tested On : 12-Nov-22 10:38:42 / HF 0.05 Hz - LF 100 Hz / Notch 50 Hz / Sn 1.00 Cm/mV / Sw 25 mm/s  
/ Refd By.: MEDI WHEEL

ECG



Vent Rate : 70 bpm  
PR Interval : 138 ms  
QRS Duration: 104 ms  
QT/QTc Int : 370/388 ms  
P-QRS-T axis: 53.00 • 63.00 • 35.00 •  
Allengers ECG (P/soes)(P/IS215190617)

TSNL

**DR. NITIZ GOYAL**

MBBS, MD  
RMC - 023319

Reported By: DR. NITIZ GOYAL



Patient Ref. No. 251000000164762



CLIENT CODE : C000049066

Cert. No. MC-5333

## CLIENT'S NAME AND ADDRESS :

SRL JAIPUR WELLNESS CORPORATE WALK IN (CASH)  
AAKRITI LABS PVT LTD. A-430, AGRASEN MARG

SRL Ltd

C/o Aakriti Labs Pvt Ltd, 3, Mahatma Gandhi Marg, Gandhi Nagar Mod,  
Tonk Road  
JAIPUR, 302015  
Rajasthan, INDIAJAIPUR 302017  
RAJASTHAN INDIA  
9314660100

PATIENT NAME : YOGESH KUMAR MEENA

PATIENT ID : YOGEM121189251

ACCESSION NO : 0251VK001129 AGE : 33 Years SEX : Male

ABHA NO :

DRAWN : 12/11/2022 09:19:00

RECEIVED : 12/11/2022 11:33:19

REPORTED : 12/11/2022 16:08:40

REFERRING DOCTOR : SELF

CLIENT PATIENT ID : 0122111200021

Test Report Status	Final	Results	Biological Reference Interval	Units
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**MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE****BLOOD COUNTS, EDTA WHOLE BLOOD**

HEMOGLOBIN (HB)	14.1	13.0 - 17.0	g/dL
METHOD : CYANIDE FREE DETERMINATION			
RED BLOOD CELL (RBC) COUNT	4.68	4.5 - 5.5	mil/ $\mu$ L
METHOD : ELECTRICAL IMPEDANCE			
WHITE BLOOD CELL (WBC) COUNT	5.60	4.0 - 10.0	thou/ $\mu$ L
METHOD : ELECTRICAL IMPEDANCE			
PLATELET COUNT	363	150 - 410	thou/ $\mu$ L
METHOD : ELECTRONIC IMPEDANCE			

**RBC AND PLATELET INDICES**

HEMATOCRIT (PCV)	43.0	40 - 50	%
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR VOLUME (MCV)	92.0	83 - 101	fL
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	30.2	27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)	32.8	31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER			
RED CELL DISTRIBUTION WIDTH (RDW)	11.9	11.6 - 14.0	%
METHOD : CALCULATED PARAMETER			
MENTZER INDEX	19.7		
MEAN PLATELET VOLUME (MPV)	8.7	6.8 - 10.9	fL
METHOD : CALCULATED PARAMETER			

**WBC DIFFERENTIAL COUNT**

NEUTROPHILS	48	40 - 80	%
METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY			
LYMPHOCYTES	<b>46</b>	<b>High</b> 20 - 40	%
METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY			
MONOCYTES	04	2 - 10	%
METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY			
EOSINOPHILS	02	1 - 6	%
METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY			
BASOPHILS	00	0 - 2	%
METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY			



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ABSOLUTE NEUTROPHIL COUNT		2.69	2.0 - 7.0	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE LYMPHOCYTE COUNT		2.58	1.0 - 3.0	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE MONOCYTE COUNT		0.22	0.2 - 1.0	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE EOSINOPHIL COUNT		0.11	0.02 - 0.50	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE BASOPHIL COUNT		0	Low 0.02 - 0.10	thou/ $\mu$ L
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		1.0		
<b>* ERYTHROCYTE SEDIMENTATION RATE (ESR), WHOLE BLOOD</b>				
E.S.R		07	0 - 14	mm at 1 hr
METHOD : AUTOMATED (PHOTOMETRICAL CAPILLARY STOPPED FLOW KINETIC ANALYSIS)"				
<b>GLUCOSE FASTING, FLUORIDE PLASMA</b>				
FBS (FASTING BLOOD SUGAR)		98	74 - 99	mg/dL
METHOD : GLUCOSE OXIDASE				
<b>GLYCOSYLATED HEMOGLOBIN (HBA1C), EDTA WHOLE BLOOD</b>				
HBA1C		5.5	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 ADA Target: 7.0 Action suggested: > 8.0	%
METHOD : HIGH PERFORMANCE LIQUID CHROMATOGRAPHY (HPLC)				
ESTIMATED AVERAGE GLUCOSE (EAG)		111.2	< 116.0	mg/dL
METHOD : CALCULATED PARAMETER				
<b>GLUCOSE, POST-PRANDIAL, PLASMA</b>				
PPBS (POST PRANDIAL BLOOD SUGAR)		99	70 - 140	mg/dL
METHOD : GLUCOSE OXIDASE				
<b>LIPID PROFILE, SERUM</b>				
CHOLESTEROL, TOTAL		234	High < 200 Desirable 200 - 239 Borderline High >= 240 High	mg/dL
METHOD : CHOLESTEROL OXIDASE				
TRIGLYCERIDES		150	< 150 Normal 150 - 199 Borderline High 200 - 499 High >= 500 Very High	mg/dL



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METHOD : LIPASE/GPO-PAP NO CORRECTION

HDL CHOLESTEROL	44	< 40 Low >/=60 High	mg/dL
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METHOD : DIRECT CLEARANCE METHOD

CHOLESTEROL LDL	160	High < 100 Optimal 100 - 129 Near optimal/ above optimal 130 - 159 Borderline High 160 - 189 High >/= 190 Very High	mg/dL
NON HDL CHOLESTEROL	190	High Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL

METHOD : CALCULATED PARAMETER

CHOL/HDL RATIO	5.3	High 3.3 - 4.4 Low Risk 4.5 - 7.0 Average Risk 7.1 - 11.0 Moderate Risk > 11.0 High Risk	
LDL/HDL RATIO	3.6	High 0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	

VERY LOW DENSITY LIPOPROTEIN	30.0	</= 30.0	mg/dL
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## LIVER FUNCTION PROFILE, SERUM

BILIRUBIN, TOTAL	0.47	0 - 1	mg/dL
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METHOD : DIAZO WITH SULPHANILIC ACID

BILIRUBIN, DIRECT	0.12	0.00 - 0.25	mg/dL
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METHOD : DIAZO WITH SULPHANILIC ACID

BILIRUBIN, INDIRECT	0.35	0.1 - 1.0	mg/dL
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METHOD : CALCULATED PARAMETER

TOTAL PROTEIN	8.6	High 6.4 - 8.2	g/dL
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METHOD : BIURET REACTION, END POINT

ALBUMIN	5.1	High 3.8 - 4.4	g/dL
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METHOD : BROMOCRESOL GREEN

GLOBULIN	3.5	2.0 - 4.1	g/dL
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METHOD : CALCULATED PARAMETER



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ALBUMIN/GLOBULIN RATIO		1.5	1.0 - 2.1	RATIO
METHOD : CALCULATED PARAMETER				
ASPARTATE AMINOTRANSFERASE (AST/SGOT)		39	High 0 - 37	U/L
METHOD : TRIS BUFFER NO P5P IFCC / SFBC 37° C				
ALANINE AMINOTRANSFERASE (ALT/SGPT)		74	High 0 - 40	U/L
METHOD : TRIS BUFFER NO P5P IFCC / SFBC 37° C				
ALKALINE PHOSPHATASE		107	39 - 117	U/L
METHOD : AMP OPTIMISED TO IFCC 37° C				
GAMMA GLUTAMYL TRANSFERASE (GGT)		79	High 11 - 50	U/L
METHOD : GAMMA GLUTAMYL-3 CARBOXY-4 NITROANILIDE (IFCC) 37° C				
LACTATE DEHYDROGENASE		357	230 - 460	U/L
METHOD : GERMAN METHODS 37° C				
<b>BLOOD UREA NITROGEN (BUN), SERUM</b>				
BLOOD UREA NITROGEN		9	5.0 - 18.0	mg/dL
METHOD : UREASE KINETIC				
<b>CREATININE, SERUM</b>				
CREATININE		0.98	0.8 - 1.3	mg/dL
METHOD : ALKALINE PICRATE NO DEPROTEINIZATION				
<b>BUN/CREAT RATIO</b>				
BUN/CREAT RATIO		9.18		
METHOD : CALCULATED PARAMETER				
<b>URIC ACID, SERUM</b>				
URIC ACID		6.4	3.4 - 7.0	mg/dL
METHOD : URICASE PEROXIDASE WITH ASCORBATE OXIDASE				
<b>TOTAL PROTEIN, SERUM</b>				
TOTAL PROTEIN		8.6	High 6.4 - 8.3	g/dL
METHOD : BIURET REACTION, END POINT				
<b>ALBUMIN, SERUM</b>				
ALBUMIN		5.1	High 3.8 - 4.4	g/dL
METHOD : BROMOCRESOL GREEN				
<b>GLOBULIN</b>				
GLOBULIN		3.5	2.0 - 4.1	g/dL
METHOD : CALCULATED PARAMETER				
<b>ELECTROLYTES (NA/K/CL), SERUM</b>				
SODIUM, SERUM		140.0	137 - 145	mmol/L



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METHOD : ION-SELECTIVE ELECTRODE

POTASSIUM, SERUM

5.02

High 3,6 - 5,0

mmol/L

METHOD : ION-SELECTIVE ELECTRODE

CHLORIDE, SERUM

101.5

98 - 107

mmol/L

METHOD : ION-SELECTIVE ELECTRODE

## Interpretation(s)

## PHYSICAL EXAMINATION, URINE

COLOR

PALE YELLOW

METHOD : GROSS EXAMINATION

APPEARANCE

CLEAR

METHOD : GROSS EXAMINATION

## CHEMICAL EXAMINATION, URINE

PH

6.0

4,7 - 7,5

METHOD : DOUBLE INDICATOR PRINCIPLE

SPECIFIC GRAVITY

1.020

1.003 - 1.035

METHOD : IONIC CONCENTRATION METHOD

PROTEIN

NOT DETECTED

NOT DETECTED

METHOD : PROTEIN ERROR OF INDICATORS WITH REFLECTANCE

GLUCOSE

NOT DETECTED

NOT DETECTED

METHOD : GLUCOSE OXIDASE PEROXIDASE / BENEDICTS

KETONES

NOT DETECTED

NOT DETECTED

METHOD : SODIUM NITROPRUSSIDE REACTION

BLOOD

NOT DETECTED

NOT DETECTED

METHOD : PEROXIDASE ANTI PEROXIDASE

BILIRUBIN

NOT DETECTED

NOT DETECTED

METHOD : DIPSTICK

UROBILINOGEN

NORMAL

NORMAL

METHOD : EHRlich REACTION REFLECTANCE

NITRITE

NOT DETECTED

NOT DETECTED

METHOD : NITRATE TO NITRITE CONVERSION METHOD

LEUKOCYTE ESTERASE

NOT DETECTED

NOT DETECTED

## MICROSCOPIC EXAMINATION, URINE

RED BLOOD CELLS

NOT DETECTED

NOT DETECTED

/HPF

METHOD : MICROSCOPIC EXAMINATION

PUS CELL (WBC'S)

1-2

0-5

/HPF



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METHOD : DIPSTICK, MICROSCOPY

EPITHELIAL CELLS

0-1

0-5

/HPF

METHOD : MICROSCOPIC EXAMINATION

CASTS

NOT DETECTED

METHOD : MICROSCOPIC EXAMINATION

CRYSTALS

NOT DETECTED

METHOD : MICROSCOPIC EXAMINATION

BACTERIA

NOT DETECTED

NOT DETECTED

METHOD : MICROSCOPIC EXAMINATION

YEAST

NOT DETECTED

NOT DETECTED

**Interpretation(s)****THYROID PANEL, SERUM**

T3

120.3

60.0 - 181.0

ng/dL

METHOD : CHEMILUMINESCENCE

T4

8.60

4.5 - 10.9

µg/dL

METHOD : CHEMILUMINESCENCE

TSH (ULTRASENSITIVE)

**5.553****High** 0,550 - 4,780

µIU/mL

METHOD : CHEMILUMINESCENCE

**Interpretation(s)****STOOL: OVA & PARASITE**

CONSISTENCY

TEST NOT PERFORMED

METHOD : GROSS EXAMINATION

**Interpretation(s)****\* ABO GROUP & RH TYPE, EDTA WHOLE BLOOD**

ABO GROUP

TYPE A

METHOD : TUBE AGGLUTINATION

RH TYPE

POSITIVE

METHOD : TUBE AGGLUTINATION

**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



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PATIENT NAME : YOGESH KUMAR MEENA

PATIENT ID : YOGEM121189251

ACCESSION NO : 0251VK001129 AGE : 33 Years SEX : Male

ABHA NO :

DRAWN : 12/11/2022 09:19:00

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REFERRING DOCTOR : SELF

CLIENT PATIENT ID : 0122111200021

Test Report Status	Final	Results	Biological Reference Interval	Units
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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(&gt;13) from Beta thalassaemia trait (&lt;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-

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 &lt; 49.5 years old and NLR &lt; 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.

## ERYTHROCYTE SEDIMENTATION RATE (ESR), WHOLE BLOOD-TEST DESCRIPTION :-

Erythrocyte sedimentation rate (ESR) is a test that indirectly measures the degree of inflammation present in the body. The test actually measures the rate of fall (sedimentation) of erythrocytes in a sample of blood that has been placed into a tall, thin, vertical tube. Results are reported as the millimetres of clear fluid (plasma) that are present at the top portion of the tube after one hour. Nowadays fully automated instruments are available to measure ESR.

ESR is not diagnostic; it is a non-specific test that may be elevated in a number of different conditions. It provides general information about the presence of an inflammatory condition. CRP is superior to ESR because it is more sensitive and reflects a more rapid change.

## TEST INTERPRETATION

**Increase** in: Infections, Vasculitides, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Tissue injury, Pregnancy, Estrogen medication, Aging.

Finding a very accelerated ESR(&gt;100 mm/hour) in patients with ill-defined symptoms directs the physician to search for a systemic disease (Paraproteinemias, Disseminated malignancies, connective tissue disease, severe infections such as bacterial endocarditis).

In pregnancy BRI in first trimester is 0-48 mm/hr(62 if anemic) and in second trimester (0-70 mm/hr(95 if anemic). ESR returns to normal 4th week post partum.

**Decreased** in: Polycythemia vera, Sickle cell anemia

## LIMITATIONS

**False elevated** ESR : Increased fibrinogen, Drugs(Vitamin A, Dextran etc), Hypercholesterolemia**False Decreased** : Poikilocytosis,(SickleCells,spherocytes),Microcytosis, Low fibrinogen, Very high WBC counts, Drugs(Quinine, salicylates)

## 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.

## GLUCOSE FASTING, FLUORIDE PLASMA-TEST DESCRIPTION

Normally, the glucose concentration in extracellular fluid is closely regulated so that a source of energy is readily available to tissues and so that no glucose is excreted in the urine.

**Increased in**

Diabetes mellitus, Cushing's syndrome (10 - 15%), chronic pancreatitis (30%). Drugs: corticosteroids, phenytoin, estrogen, thiazides.

**Decreased in**

Pancreatic islet cell disease with increased insulin, insulinoma, adrenocortical insufficiency, hypopituitarism, diffuse liver disease, malignancy (adrenocortical, stomach, fibrosarcoma), infant of a diabetic mother, enzyme deficiency diseases (e.g., galactosemia), Drugs- insulin, ethanol, propranolol, sulfonylureas, tolbutamide, and other oral hypoglycemic agents.

**NOTE:**

Hypoglycemia is defined as a glucose of &lt; 50 mg/dL in men and &lt; 40 mg/dL in women.

While random serum glucose levels correlate with home glucose monitoring results (weekly mean capillary glucose values), there is wide fluctuation within individuals. Thus, glycosylated hemoglobin (HbA1c) levels are favored to monitor glycemic control.

High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics &amp; Insulin treatment, Renal Glycosuria, Glycaemic index &amp; response to food consumed, Alimentary Hypoglycemia, Increased insulin response &amp; sensitivity etc.

GLYCOSYLATED HEMOGLOBIN (HbA1c), EDTA WHOLE BLOOD-Used For:

1. Evaluating the long-term control of blood glucose concentrations in diabetic patients.

2. Diagnosing diabetes.

3. Identifying patients at increased risk for diabetes (prediabetes).

The ADA recommends measurement of HbA1c (typically 3-4 times per year for type 1 and poorly controlled type 2 diabetic patients, and 2 times per year for well-controlled type 2 diabetic patients) to determine whether a patient's metabolic control has remained continuously within the target range.

1. eAG (Estimated average glucose) converts percentage HbA1c to mg/dl, to compare blood glucose levels.

2. eAG gives an evaluation of blood glucose levels for the last couple of months.

3. eAG is calculated as eAG (mg/dl) = 28.7 \* HbA1c - 46.7

**HbA1c Estimation can get affected due to :**

I. Shortened Erythrocyte survival : Any condition that shortens erythrocyte survival or decreases mean erythrocyte age (e.g. recovery from acute blood loss, hemolytic anemia) will falsely lower HbA1c test results. Fructosamine is recommended in these patients which indicates diabetes control over 15 days.

II. Vitamin C &amp; E are reported to falsely lower test results. (possibly by inhibiting glycation of hemoglobin).



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Patient Ref. No. 251000000164762



CLIENT CODE : C000049066

Cert. No. MC-5333

## CLIENT'S NAME AND ADDRESS :

SRL JAIPUR WELLNESS CORPORATE WALK IN (CASH)  
AAKRITI LABS PVT LTD. A-430, AGRASEN MARGSRL Ltd  
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III. Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia, uremia, hyperbilirubinemia, chronic alcoholism, chronic ingestion of salicylates & opiates addiction are reported to interfere with some assay methods, falsely increasing results.

IV. Interference of hemoglobinopathies in HbA1c estimation is seen in  
a. Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.  
b. Heterozygous state detected (D10 is corrected for HbS & HbC trait.)  
c. HbF > 25% on alternate platform (Boronate affinity chromatography) is recommended for testing of HbA1c. Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy

GLUCOSE, POST-PRANDIAL, PLASMA-High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glycosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc. Additional test HbA1c 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 yellow discoloration in jaundice. Elevated levels result 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 are 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, Waldenström'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.

BLOOD UREA NITROGEN (BUN), SERUM-Causes of Increased levels include Pre renal (High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal), Renal Failure, Post Renal (Malignancy, Nephrolithiasis, Prostatism)

Causes of decreased level include 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, Multiple Sclerosis

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, Waldenström'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.

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD-



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AAKRITI LABS PVT LTD. A-430, AGRASEN MARGSRL Ltd  
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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.

**\*\*End Of Report\*\***

Please visit [www.srlworld.com](http://www.srlworld.com) for related Test Information for this accession  
TEST MARKED WITH '\*' ARE OUTSIDE THE NABL ACCREDITED SCOPE OF THE LABORATORY.

**Dr. Abhishek Sharma**  
Consultant Microbiologist

**Dr. Akansha Jain**  
Consultant Pathologist



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