agilus diagnostics

Patient Ref. No. 2000011687796

LABORATORY SERVICES

Cert. No. MC-2010

CLIENT CODE : C000138356
CLIENT'S NAME AND ADDRESS :
M CHINNA RAO

SRL Ltd
PRIME SQUARE BUILDING,PLOT NO 1,GAIWADI INDUSTRIAL ESTATE,S.V. ROAD,GOREGAON (W)
MUMBAI, 400062
MAHARASHTRA, INDIA
Tel : 9111591115, Fax :
CIN - U74899PB1995PLC045956

PATIENT NAME : M CHINNA RAO PATIENT ID : **MCHIM1405822**

ACCESSION NO : **0002WC050131** AGE : 40 Years SEX : Male

DRAWN : 25/03/2023 07:55 RECEIVED : 25/03/2023 07:56 REPORTED : 27/03/2023 15:21

REFERRING DOCTOR : SELF CLIENT PATIENT ID :

Test Report Status **Final**	Results		Biological Reference Interval	Units
MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE				
BLOOD COUNTS,EDTA WHOLE BLOOD				
HEMOGLOBIN (HB)	14.5		13.0 - 17.0	g/dL
METHOD : PHOTOMETRIC MEASUREMENT				
RED BLOOD CELL (RBC) COUNT	5.39		4.5 - 5.5	mil/µL
METHOD : COULTER PRINCIPLE				
WHITE BLOOD CELL (WBC) COUNT	5.80		4.0 - 10.0	thou/µL
METHOD : COULTER PRINCIPLE				
PLATELET COUNT	202		150 - 410	thou/µL
METHOD : ELECTRONIC IMPEDENCE & MICROSCOPY				
RBC AND PLATELET INDICES				
HEMATOCRIT (PCV)	42.6		40.0 - 50.0	%
METHOD : CALCULATED PARAMETER				
MEAN CORPUSCULAR VOLUME (MCV)	**79.0**	**Low**	83.0 - 101.0	fL
METHOD : DERIVED PARAMETER FROM RBC HISTOGRAM				
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	**26.9**	**Low**	27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER				
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)	34.1		31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER				
RED CELL DISTRIBUTION WIDTH (RDW)	**14.8**	**High**	11.6 - 14.0	%
METHOD : DERIVED PARAMETER FROM RBC HISTOGRAM				
MENTZER INDEX	14.7			
MEAN PLATELET VOLUME (MPV)	9.1		6.8 - 10.9	fL
METHOD : DERIVED PARAMETER FROM PLATELET HISTOGRAM				
WBC DIFFERENTIAL COUNT				
NEUTROPHILS	42		40 - 80	%
METHOD : VCSN TECHNOLOGY/ MICROSCOPY				
LYMPHOCYTES	**44**	**High**	20 - 40	%
METHOD : VCSN TECHNOLOGY/ MICROSCOPY				
MONOCYTES	**11**	**High**	2.0 - 10.0	%
METHOD : VCSN TECHNOLOGY/ MICROSCOPY				
EOSINOPHILS	2		1.0 - 6.0	%
METHOD : VCSN TECHNOLOGY/ MICROSCOPY				
BASOPHILS	1		0 - 1	%
METHOD : VCSN TECHNOLOGY/ MICROSCOPY				

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ABSOLUTE NEUTROPHIL COUNT	2.50	2.0 - 7.0	thou/µL
METHOD : CALCULATED PARAMETER			
ABSOLUTE LYMPHOCYTE COUNT	2.60	1.0 - 3.0	thou/µL
METHOD : CALCULATED PARAMETER			
ABSOLUTE MONOCYTE COUNT	0.64	0.2 - 1.0	thou/µL
METHOD : CALCULATED PARAMETER			
ABSOLUTE EOSINOPHIL COUNT	0.12	0.02 - 0.50	thou/µL
METHOD : CALCULATED PARAMETER			
ABSOLUTE BASOPHIL COUNT	0.06	0.02 - 0.10	thou/µL
METHOD : CALCULATED PARAMETER			
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	1.0		
METHOD : CALCULATED			
ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD			
E.S.R	5	0 - 14	mm at 1 hr
METHOD : AUTOMATED (PHOTOMETRICAL CAPILLARY STOPPED FLOW KINETIC ANALYSIS)			
GLUCOSE FASTING,FLUORIDE PLASMA			
FBS (FASTING BLOOD SUGAR)	92	Normal <100 Impaired fasting glucose:100 to 125 Diabetes mellitus: > = 126 (on more than 1 occassion) (ADA guidelines 2021)	mg/dL
METHOD : SPECTROPHOTOMETRY HEXOKINASE			
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD			
HBA1C	5.4	Non-diabetic Adult < 5.7 Pre-diabetes 5.7 - 6.4 Diabetes diagnosis: > or = 6.5 Therapeutic goals: < 7.0 Action suggested : > 8.0 (ADA Guideline 2021)	%
METHOD : ION- EXCHANGE HPLC			
ESTIMATED AVERAGE GLUCOSE(EAG)	108.3	< 116	mg/dL
GLUCOSE, POST-PRANDIAL, PLASMA			
PPBS(POST PRANDIAL BLOOD SUGAR)	96	Normal <140 Impaired glucose tolerance:140 to 199 Diabetes mellitus : > = 200 (on more than 1 occassion) ADA guideline 2021	mg/dL
METHOD : SPECTROPHOTOMETRY HEXOKINASE			

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LIPID PROFILE, SERUM				
CHOLESTEROL, TOTAL	180		Desirable : < 200 Borderline : 200 - 239 High : > / = 240	mg/dL
METHOD : SPECTROPHOTOMETRY, ENZYMATIC COLORIMETRIC - CHOLETSEROL OXIDASE, ESTERASE, PEROXIDASE				
TRIGLYCERIDES	138		Normal: < 150 Borderline high: 150 - 199 High: 200 - 499 Very High: >/= 500	mg/dL
METHOD : SPECTROPHOTOMETRY, ENZYMATIC ENDPOINT WITH GLYCEROL BLANK				
HDL CHOLESTEROL	51		At Risk: < 40 Desirable: > or = 60	mg/dL
METHOD : SPECTROPHOTOMETRY, HOMOGENEOUS DIRECT ENZYMATIC COLORIMETRIC				
CHOLESTEROL LDL	**101**	**High**	Optimal : < 100 Near optimal/above optimal : 100-129 Borderline high : 130-159 High : 160-189 Very high : = 190	mg/dL
METHOD : CALCULATED PARAMETER				
NON HDL CHOLESTEROL	129		Desirable : < 130 Above Desirable : 130 -159 Borderline High : 160 - 189 High : 190 - 219 Very high : > / = 220	mg/dL
METHOD : CALCULATED PARAMETER				
VERY LOW DENSITY LIPOPROTEIN	28.0		< or = 30.0	mg/dL
METHOD : CALCULATED PARAMETER				
CHOL/HDL RATIO	3.5		Low Risk : 3.3 - 4.4 Average Risk : 4.5 - 7.0 Moderate Risk : 7.1 - 11.0 High Risk : > 11.0	
METHOD : CALCULATED PARAMETER				
LDL/HDL RATIO	2.6		Desirable/Low Risk : 0.5 - 3.0 Borderline/Moderate Risk : 3.1 - 6.0 High Risk : > 6.0	
METHOD : CALCULATED PARAMETER				
LIVER FUNCTION PROFILE, SERUM				
BILIRUBIN, TOTAL	0.42		Upto 1.2	mg/dL
METHOD : SPECTROPHOTOMETRY, COLORIMETRIC -DIAZO METHOD				
BILIRUBIN, DIRECT	0.20		< or = 0.3	mg/dL
METHOD : SPECTROPHOTOMETRY, JENDRASSIK & GROFF - DIAZOTIZATION				
BILIRUBIN, INDIRECT	0.22		0.0 - 0.9	mg/dL

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METHOD : CALCULATED PARAMETER			
TOTAL PROTEIN	7.5	6.0 - 8.0	g/dL
METHOD : SPECTROPHOTOMETRY, COLORIMETRIC -BIURET, REAGENT BLANK, SERUM BLANK			
ALBUMIN	4.3	3.97 - 4.94	g/dL
METHOD : SPECTROPHOTOMETRY, BROMOCRESOL GREEN(BCG) - DYE BINDING			
GLOBULIN	3.2	2.0 - 3.5	g/dL
METHOD : CALCULATED PARAMETER			
ALBUMIN/GLOBULIN RATIO	1.3	1.0 - 2.1	RATIO
METHOD : CALCULATED PARAMETER			
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	22	Upto 40	U/L
METHOD : SPECTROPHOTOMETRY, WITHOUT PYRIDOXAL PHOSPHATE ACTIVATION(P5P) - IFCC			
ALANINE AMINOTRANSFERASE (ALT/SGPT)	20	Upto 41	U/L
METHOD : SPECTROPHOTOMETRY, WITHOUT PYRIDOXAL PHOSPHATE ACTIVATION(P5P) - IFCC			
ALKALINE PHOSPHATASE	75	40 - 129	U/L
METHOD : SPECTROPHOTOMETRY, PNPP, AMP BUFFER - IFCC			
GAMMA GLUTAMYL TRANSFERASE (GGT)	12	< 60	U/L
METHOD : SPECTROPHOTOMETRY, ENZYMATIC COLORIMETRIC - G-GLUTAMYL-CARBOXY-NITROANILIDE - IFCC			
LACTATE DEHYDROGENASE	182	< 232	U/L
METHOD : SPECTROPHOTOMETRY, LACTATE TO PYRUVATE - UV-IFCC			
BLOOD UREA NITROGEN (BUN), SERUM			
BLOOD UREA NITROGEN	10	6 - 20	mg/dL
METHOD : SPECTROPHOTOMETRY, UREASE -COLORIMETRIC			
CREATININE, SERUM			
CREATININE	0.96	0.90 - 1.30	mg/dL
METHOD : SPECTROPHOTOMETRY, JAFFE'S ALKALINE PICRATE KINETIC - RATE BLANKED - IFCC-IDMS STANDARIZED			
BUN/CREAT RATIO			
BUN/CREAT RATIO	10.20	8 - 15	
METHOD : CALCULATED PARAMETER			
URIC ACID, SERUM			
URIC ACID	4.3	3.4 - 7.0	mg/dL
METHOD : SPECTROPHOTOMETRY, ENZYMATIC COLORIMETRIC- URICASE			
TOTAL PROTEIN, SERUM			
TOTAL PROTEIN	7.5	6.0 - 8.0	g/dL
METHOD : SPECTROPHOTOMETRY, COLORIMETRIC -BIURET, REAGENT BLANK, SERUM BLANK			
ALBUMIN, SERUM			
ALBUMIN	4.3	3.97 - 4.94	g/dL
METHOD : SPECTROPHOTOMETRY, BROMOCRESOL GREEN(BCG) - DYE BINDING			

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GLOBULIN				
GLOBULIN	3.2		2.0 - 3.5	g/dL
METHOD : CALCULATED PARAMETER				
ELECTROLYTES (NA/K/CL), SERUM				
SODIUM, SERUM	**135**	**Low**	136 - 145	mmol/L
METHOD : ISE INDIRECT				
POTASSIUM, SERUM	4.30		3.5 - 5.1	mmol/L
METHOD : ISE INDIRECT				
CHLORIDE, SERUM	100		98 - 106	mmol/L
METHOD : ISE INDIRECT				
PHYSICAL EXAMINATION, URINE				
COLOR	PALE YELLOW			
APPEARANCE	CLEAR			
CHEMICAL EXAMINATION, URINE				
PH	6.0		5.00 - 7.50	
SPECIFIC GRAVITY	1.015		1.010 - 1.030	
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	NOT DETECTED			
NITRITE	NOT DETECTED		NOT DETECTED	
LEUKOCYTE ESTERASE	NOT DETECTED		NOT DETECTED	
MICROSCOPIC EXAMINATION, URINE				
RED BLOOD CELLS	NOT DETECTED		NOT DETECTED	/HPF
PUS CELL (WBC'S)	0-1		0-5	/HPF
EPITHELIAL CELLS	0-1		0-5	/HPF
CASTS	NOT DETECTED			
CRYSTALS	NOT DETECTED			
BACTERIA	NOT DETECTED		NOT DETECTED	
YEAST	NOT DETECTED		NOT DETECTED	
METHOD : URINE ROUTINE & MICROSCOPY EXAMINATION BY INTEGRATED AUTOMATED SYSTEM				
THYROID PANEL, SERUM				
T3	86.1		80.0 - 200.0	ng/dL

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METHOD : COMPETITIVE ELECTROCHEMILUMINESCENCE IMMUNOASSAY			
T4	7.17	5.10 - 14.10	µg/dL
METHOD : COMPETITIVE ELECTROCHEMILUMINESCENCE IMMUNOASSAY			
TSH (ULTRASENSITIVE)	1.570	0.270 - 4.200	µIU/mL
METHOD : SANDWICH ELECTROCHEMILUMINESCENCE IMMUNOASSAY			
PHYSICAL EXAMINATION,STOOL			
COLOUR	BROWN		
CONSISTENCY	SEMI FORMED		
MUCUS	NOT DETECTED	NOT DETECTED	
VISIBLE BLOOD	ABSENT	ABSENT	
ADULT PARASITE	NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION			
CHEMICAL EXAMINATION,STOOL			
STOOL PH	6.0		
OCCULT BLOOD	NOT DETECTED	NOT DETECTED	
METHOD : MODIFIED GUAIAC METHOD			
MICROSCOPIC EXAMINATION,STOOL			
PUS CELLS	1-2		/hpf
RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
METHOD : MICROSCOPIC EXAMINATION			
CYSTS	NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION			
OVA	NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION			
LARVAE	NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION			
TROPHOZOITES	NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION			
FAT	ABSENT		
CHARCOT LEYDEN CRYSTALS	ABSENT		
*** ABO GROUP & RH TYPE, EDTA WHOLE BLOOD**			
ABO GROUP	O		
METHOD : HAEMAGGLUTINATION (AUTOMATED)			
RH TYPE	POSITIVE		
METHOD : HAEMAGGLUTINATION (AUTOMATED)			
*** XRAY-CHEST**			

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IMPRESSION	NO ABNORMALITY DETECTED		
*** TMT OR ECHO**			
TMT OR ECHO	2D ECHO IMPRESSION - GOOD LV SYSTOLIC FUNCTION AT REST. NO RWMA LVEF 60% TRIVIAL MR. TR NO EVIDENCE OF PE/CLOT/VEGETATION		
*** ECG**			
ECG	WITHIN NORMAL LIMITS		
*** MEDICAL HISTORY**			
RELEVANT PRESENT HISTORY	FULLY VACCINATED FOR COVID 19		
RELEVANT PAST HISTORY	NOT SIGNIFICANT		
RELEVANT PERSONAL HISTORY	NOT SIGNIFICANT		
RELEVANT FAMILY HISTORY	HEART DISEASE,DIABETES		
HISTORY OF MEDICATIONS	NOT SIGNIFICANT		
*** ANTHROPOMETRIC DATA & BMI**			
HEIGHT IN METERS	1.72		mts
WEIGHT IN KGS.	76.3		Kgs
BMI	26	BMI & Weight Status as follows: kg/sqmts Below 18.5: Underweight 18.5 - 24.9: Normal 25.0 - 29.9: Overweight 30.0 and Above: Obese	
*** GENERAL EXAMINATION**			
MENTAL / EMOTIONAL STATE	NORMAL		
PHYSICAL ATTITUDE	NORMAL		
GENERAL APPEARANCE / NUTRITIONAL STATUS	OVERWEIGHT		
BUILT / SKELETAL FRAMEWORK	AVERAGE		
FACIAL APPEARANCE	NORMAL		
SKIN	NORMAL		
UPPER LIMB	NORMAL		
LOWER LIMB	NORMAL		
NECK	NORMAL		
NECK LYMPHATICS / SALIVARY GLANDS	NOT ENLARGED OR TENDER		
THYROID GLAND	NOT ENLARGED		
CAROTID PULSATION	NORMAL		
TEMPERATURE	NORMAL		

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PULSE	76/MIN.REGULAR, ALL PERIPHERAL PULSES WELL FELT, NO CAROTID BRUIT		
RESPIRATORY RATE	NORMAL		
*** CARDIOVASCULAR SYSTEM**			
BP	124/90 MM HG (SUPINE)		mm/Hg
PERICARDIUM	NORMAL		
APEX BEAT	NORMAL		
HEART SOUNDS	NORMAL		
MURMURS	ABSENT		
*** RESPIRATORY SYSTEM**			
SIZE AND SHAPE OF CHEST	NORMAL		
MOVEMENTS OF CHEST	SYMMETRICAL		
BREATH SOUNDS INTENSITY	NORMAL		
BREATH SOUNDS QUALITY	VESICULAR (NORMAL)		
ADDED SOUNDS	ABSENT		
*** PER ABDOMEN**			
APPEARANCE	NORMAL		
VENOUS PROMINENCE	ABSENT		
LIVER	NOT PALPABLE		
SPLEEN	NOT PALPABLE		
HERNIA	ABSENT		
*** CENTRAL NERVOUS SYSTEM**			
HIGHER FUNCTIONS	NORMAL		
CRANIAL NERVES	NORMAL		
CEREBELLAR FUNCTIONS	NORMAL		
SENSORY SYSTEM	NORMAL		
MOTOR SYSTEM	NORMAL		
REFLEXES	NORMAL		
*** MUSCULOSKELETAL SYSTEM**			
SPINE	NORMAL		
JOINTS	NORMAL		
*** BASIC EYE EXAMINATION**			
CONJUNCTIVA	NORMAL		
EYELIDS	NORMAL		

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EYE MOVEMENTS	NORMAL		
CORNEA	NORMAL		
DISTANT VISION RIGHT EYE WITHOUT GLASSES	WITHIN NORMAL LIMIT (6/6)		
DISTANT VISION LEFT EYE WITHOUT GLASSES	WITHIN NORMAL LIMIT (6/6)		
NEAR VISION RIGHT EYE WITHOUT GLASSES	WITHIN NORMAL LIMIT (N6)		
NEAR VISION LEFT EYE WITHOUT GLASSES	WITHIN NORMAL LIMIT (N6)		
COLOUR VISION	NORMAL (17/17)		
*** BASIC ENT EXAMINATION**			
EXTERNAL EAR CANAL	NORMAL		
TYMPANIC MEMBRANE	NORMAL		
NOSE	NO ABNORMALITY DETECTED		
SINUSES	CLEAR		
THROAT	NO ABNORMALITY DETECTED		
TONSILS	NOT ENLARGED		
*** BASIC DENTAL EXAMINATION**			
TEETH	NORMAL		
GUMS	HEALTHY		
*** SUMMARY**			
RELEVANT HISTORY	NOT SIGNIFICANT		
RELEVANT GP EXAMINATION FINDINGS	NOT SIGNIFICANT		
RELEVANT LAB INVESTIGATIONS	RAISED LYMPHOCYTES (44)		
RELEVANT NON PATHOLOGY DIAGNOSTICS	USG-NO ABNORMALITIES DETECTED		
REMARKS / RECOMMENDATIONS	RAISED LYMPHOCYTES ADV- MONITOR BLOOD PRESSURE REDUCE SALT INTAKE FOLLOW UP WITH PHYSICIAN FOR 2D ECHO NAD BLOOD PRESSURE		

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

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PRIME SQUARE BUILDING,PLOT NO 1,GAIWADI INDUSTRIAL ESTATE,S.V. ROAD,GOREGAON (W)
MUMBAI, 400062
MAHARASHTRA, INDIA
Tel : 9111591115, Fax :
CIN - U74899PB1995PLC045956

PATIENT NAME : M CHINNA RAO PATIENT ID : **MCHIM1405822**

ACCESSION NO : **0002WC050131** AGE : 40 Years SEX : Male

DRAWN : 25/03/2023 07:55 RECEIVED : 25/03/2023 07:56 REPORTED : 27/03/2023 15:21

REFERRING DOCTOR : SELF CLIENT PATIENT ID :

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

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, Vasculities, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Tissue injury, Pregnancy, Estrogen medication, Aging.
Finding a very accelerated ESR**(>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: Polycythermia 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 sothat 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: 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 & Insulin treatment,Renal Glyosuria,Glycaemic index & response to food consumed,Alimentary Hypoglycemia,Increased insulin response & 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 patients metabolic control has remained continuously within the target range.
1. eAG (Estimated average glucose) converts percentage HbA1c to md/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 :
1. 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.
2.Vitamin C & E are reported to falsely lower test results.(possibly by inhibiting glycation of hemoglobin.
3. 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.
4. 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 paltform (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 Glyosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.Additional test HbA1c
LIVER FUNCTION PROFILE, SERUM-
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** 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

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CLIENT'S NAME AND ADDRESS :
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(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, Pagets disease,Rickets,Sarcoidosis etc. Lower-than-normal ALP levels seen in Hypophosphatasia,Malnutrition,Protein deficiency,Wilsons 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.
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,Waldenstroms 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 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, Muscuophy
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-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,Waldenstroms 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-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.
MEDICAL
HISTORY-**********
THIS REPORT CARRIES THE SIGNATURE OF OUR LABORATORY DIRECTOR. THIS IS AN INVIOLABLE FEATURE OF OUR LAB MANAGEMENT SOFTWARE. HOWEVER, ALL EXAMINATIONS AND INVESTIGATIONS HAVE BEEN CONDUCTED BY OUR PANEL OF DOCTORS.

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Patient Ref. No. 2000011687796

LABORATORY SERVICES

Cert. No. MC-2010

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MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

*** ULTRASOUND ABDOMEN**

ULTRASOUND ABDOMEN

NO ABNORMALITIES DETECTED

****End Of Report****
Please visit www.srlworld.com for related Test Information for this accession
TEST MARKED WITH '*' ARE OUTSIDE THE NABL ACCREDITED SCOPE OF THE LABORATORY.

Dr. Swati Karmarkar, MD,DNB,DMRD
Consultant Radiologist

Dr. Sneha Wadalkar,M.D (Reg.no.MMC2012/06/1868
Junior Biochemist

Dr. Ekta Patil,MD
Microbiologist

Dr. J N Shukla ,MBBS, AFIH
Consultant Physician

CONDITIONS OF LABORATORY TESTING & REPORTING

1. It is presumed that the test sample belongs to the patient named or identified in the test requisition form.
2. All tests are performed and reported as per the turnaround time stated in the SRL Directory of Services.
3. Result delays could occur due to unforeseen circumstances such as non-availability of kits / equipment breakdown / natural calamities / technical downtime or any other unforeseen event.
4. A requested test might not be performed if:
   i. Specimen received is insufficient or inappropriate
   ii. Specimen quality is unsatisfactory
   iii. Incorrect specimen type
   iv. Discrepancy between identification on specimen container label and test requisition form
5. SRL confirms that all tests have been performed or assayed with highest quality standards, clinical safety & technical integrity.
6. Laboratory results should not be interpreted in isolation; it must be correlated with clinical information and be interpreted by registered medical practitioners only to determine final diagnosis.
7. Test results may vary based on time of collection, physiological condition of the patient, current medication or nutritional and dietary changes. Please consult your doctor or call us for any clarification.
8. Test results cannot be used for Medico legal purposes.
9. In case of queries please call customer care (91115 91115) within 48 hours of the report.

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SRL Limited
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Mohali 160062

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