



CLIENT CODE : C000138354

CLIENT'S NAME AND ADDRESS :

ACROFEMI HEALTHCARE LTD (MEDIWHEEL)
F-703, LADO SARAI, MEHRAULI
SOUTH WEST DELHI
NEW DELHI 110030
DELHI INDIA
8800465156

SRL Ltd
Shop CG 017, PALM SPRINGS PLAZA
GURUGRAM, 122001
HARYANA, INDIA
Tel : 9111591115

PATIENT NAME : GARMILA CHAUHAN

PATIENT ID : GARMF010983282

ACCESSION NO : 0282WA00072 AGE : 39 Years SEX : Female

ABHA NO :

DRAWN :

RECEIVED : 21/01/2023 09:34

REPORTED : 23/01/2023 11:25

REFERRING DOCTOR : SELF

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

HEMOGLOBIN (HB)	11.7	Low	12.0 - 15.0	g/dL
METHOD : SPECTROPHOTOMETRY				
RED BLOOD CELL (RBC) COUNT	4.03		3.8 - 4.8	mil/ μ L
METHOD : IMPEDANCE				
WHITE BLOOD CELL (WBC) COUNT	5.34		4.0 - 10.0	thou/ μ L
METHOD : IMPEDANCE				
PLATELET COUNT	185		150 - 410	thou/ μ L
METHOD : IMPEDANCE				

RBC AND PLATELET INDICES

HEMATOCRIT (PCV)	35.9	Low	36 - 46	%
METHOD : CALCULATED				
MEAN CORPUSCULAR VOLUME (MCV)	89.0		83 - 101	fL
METHOD : DERIVED FROM IMPEDANCE MEASURE				
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	29.0		27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER				
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)	32.6		31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER				
RED CELL DISTRIBUTION WIDTH (RDW)	16.1	High	11.6 - 14.0	%
METHOD : DERIVED FROM IMPEDANCE MEASURE				
MENTZER INDEX	22.1			
MEAN PLATELET VOLUME (MPV)	10.7		6.8 - 10.9	fL
METHOD : DERIVED FROM IMPEDANCE MEASURE				

WBC DIFFERENTIAL COUNT

NEUTROPHILS	55		40 - 80	%
METHOD : DHSS FLOWCYTOMETRY				
LYMPHOCYTES	36		20 - 40	%
METHOD : DHSS FLOWCYTOMETRY				
MONOCYTES	6		2 - 10	%
METHOD : DHSS FLOWCYTOMETRY				
EOSINOPHILS	2		1 - 6	%
METHOD : DHSS FLOWCYTOMETRY				
BASOPHILS	1		0 - 2	%
METHOD : IMPEDANCE				
ABSOLUTE NEUTROPHIL COUNT	2.96		2.0 - 7.0	thou/ μ L



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METHOD : DHSS FLOWCYTOMETRY, CALCULATED				
ABSOLUTE LYMPHOCYTE COUNT		1.90	1 - 3	thou/ μ L
METHOD : DHSS FLOWCYTOMETRY, CALCULATED				
ABSOLUTE MONOCYTE COUNT		0.32	0.20 - 1.00	thou/ μ L
METHOD : DHSS FLOWCYTOMETRY, CALCULATED				
ABSOLUTE EOSINOPHIL COUNT		0.08	0.02 - 0.50	thou/ μ L
METHOD : DHSS FLOWCYTOMETRY, CALCULATED				
ABSOLUTE BASOPHIL COUNT		0.04	0.02 - 0.10	thou/ μ L
METHOD : DHSS FLOWCYTOMETRY, CALCULATED				
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		1.6		
METHOD : CALCULATED				
ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD				
E.S.R		17	0 - 20	mm at 1 hr
METHOD : AUTOMATED (PHOTOMETRICAL CAPILLARY STOPPED FLOW KINETIC ANALYSIS)				
GLUCOSE FASTING,FLUORIDE PLASMA				
FBS (FASTING BLOOD SUGAR)		92	Normal 75 - 99 Pre-diabetics: 100 - 125 Diabetic: > or = 126	mg/dL
METHOD : SPECTROPHOTOMETRY HEXOKINASE				
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD				
HBA1C		5.4	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				
ESTIMATED AVERAGE GLUCOSE(EAG)		108.3	< 116	mg/dL
METHOD : CALCULATED PARAMETER				



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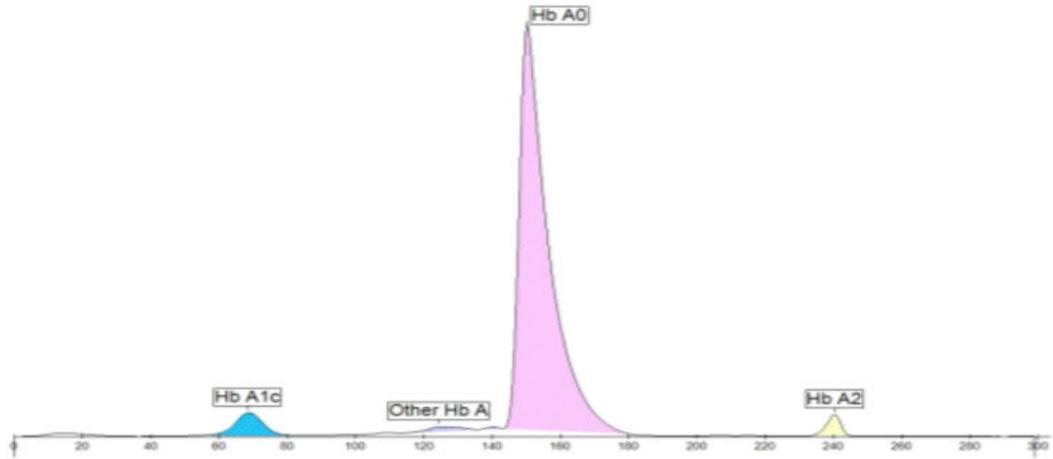
PLOT NO.31,ELECTRONIC CITY,SECTOR 18, GURUGRAM

ID : 28213177781

Sample Date: 1/22/2023

Name :

Sample num.: 31



A1c Haemoglobin Electrophoresis

Fractions	%	mmol/mol	Cal. %
Hb A1c	-	36	5.4
Other Hb A	1.4		
Hb A0	91.3		
Hb A2	2.4		

HbA1c % cal : 5.4 %

Comments :

GLUCOSE, POST-PRANDIAL, PLASMA

PPBS(POST PRANDIAL BLOOD SUGAR) 97 70 - 139 mg/dL





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METHOD : SPECTROPHOTOMETRY, HEXOKINASE

LIPID PROFILE, SERUM

CHOLESTEROL, TOTAL	141	Desirable cholesterol level < 200 Borderline high cholesterol 200 - 239 High cholesterol > / = 240	mg/dL
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METHOD : ENZYMATIC COLORIMETRIC ASSAY

TRIGLYCERIDES	96	Normal: < 150 Borderline high: 150 - 199 High: 200 - 499 Very High: >/= 500	mg/dL
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METHOD : ENZYMATIC COLORIMETRIC ASSAY

HDL CHOLESTEROL	44	Low HDL Cholesterol <40 High HDL Cholesterol >/= 60	mg/dL
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METHOD : HOMOGENEOUS ENZYMATIC COLORIMETRIC ASSAY

CHOLESTEROL LDL	82	Adult levels: Optimal < 100 Near optimal/above optimal: 100-129 Borderline high : 130-159 High : 160-189 Very high : = 190	mg/dL
-----------------	----	---	-------

METHOD : HOMOGENEOUS ENZYMATIC COLORIMETRIC ASSAY

NON HDL CHOLESTEROL	97	Desirable : < 130 Above Desirable : 130 -159 Borderline High : 160 - 189 High : 190 - 219 Very high : > / = 220	mg/dL
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METHOD : CALCULATED PARAMETER

VERY LOW DENSITY LIPOPROTEIN	19.0	< OR = 30.0	mg/dL
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METHOD : CALCULATED PARAMETER

CHOL/HDL RATIO	3.2	Low Low Risk : 3.3 - 4.4 Average Risk : 4.5 - 7.0 Moderate Risk : 7.1 - 11.0 High Risk : > 11.0
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METHOD : CALCULATED PARAMETER

LDL/HDL RATIO	1.9	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk
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METHOD : CALCULATED PARAMETER

Interpretation(s)**LIVER FUNCTION PROFILE, SERUM**

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Patient Ref. No. 775000002179039

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BILIRUBIN, TOTAL		0.9	Upto 1.2	mg/dL
METHOD : COLORIMETRIC DIAZO METHOD				
BILIRUBIN, DIRECT		0.5	High < 0.30	mg/dL
METHOD : COLORIMETRIC DIAZO METHOD				
BILIRUBIN, INDIRECT		0.40	0.1 - 1.0	mg/dL
METHOD : CALCULATED PARAMETER				
TOTAL PROTEIN		7.7	6.0 - 8.0	g/dL
METHOD : SPECTROPHOTOMETRY, BIURET				
ALBUMIN		4.6	3.97 - 4.94	g/dL
METHOD : SPECTROPHOTOMETRY, BROMOCRESOL GREEN(BCG) - DYE BINDING				
GLOBULIN		3.1	2.0 - 3.5	g/dL
METHOD : CALCULATED PARAMETER				
ALBUMIN/GLOBULIN RATIO		1.5	1.0 - 2.1	RATIO
METHOD : CALCULATED PARAMETER				
ASPARTATE AMINOTRANSFERASE (AST/SGOT)		21	< OR = 35	U/L
METHOD : SPECTROPHOTOMETRY, WITH PYRIDOXAL PHOSPHATE ACTIVATION-IFCC				
ALANINE AMINOTRANSFERASE (ALT/SGPT)		21	< OR = 35	U/L
METHOD : SPECTROPHOTOMETRY, WITH PYRIDOXAL PHOSPHATE ACTIVATION-IFCC				
ALKALINE PHOSPHATASE		85	35 - 104	U/L
METHOD : SPECTROPHOTOMETRY, PNPP, AMP BUFFER - IFCC				
GAMMA GLUTAMYL TRANSFERASE (GGT)		7	0 - 40	U/L
METHOD : ENZYMATIC COLORIMETRIC ASSAY STANDARDIZED AGAINST IFCC / SZASZ				
LACTATE DEHYDROGENASE		161	125 - 220	U/L
METHOD : SPECTROPHOTOMETRY, LACTATE TO PYRUVATE - UV-IFCC				
BLOOD UREA NITROGEN (BUN), SERUM				
BLOOD UREA NITROGEN		8.0	6 - 20	mg/dL
METHOD : SPECTROPHOTOMETRY, KINETIC TEST WITH UREASE AND GLUTAMATE DEHYDROGENASE				
CREATININE, SERUM				
CREATININE		0.60	0.5 - 0.9	mg/dL
METHOD : SPECTROPHOTOMETRIC, JAFFE'S KINETICS				
BUN/CREAT RATIO				
BUN/CREAT RATIO		13.00	8.0 - 15.0	
METHOD : CALCULATED PARAMETER				
URIC ACID, SERUM				
URIC ACID		4.0	2.4 - 5.7	mg/dL
METHOD : SPECTROPHOTOMETRY, URICASE				
TOTAL PROTEIN, SERUM				
TOTAL PROTEIN		7.7	6.0 - 8.0	g/dL



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METHOD : SPECTROPHOTOMETRY, BIURET

ALBUMIN, SERUM

ALBUMIN	4.6	3.97 - 4.94	g/dL
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METHOD : SPECTROPHOTOMETRY, BROMOCRESOL GREEN(BCG) - DYE BINDING

GLOBULIN

GLOBULIN	3.1	2.0 - 3.5	g/dL
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METHOD : CALCULATED PARAMETER

ELECTROLYTES (NA/K/CL), SERUM

SODIUM, SERUM	139	136 - 145	mmol/L
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METHOD : ISE INDIRECT

POTASSIUM, SERUM	3.9	3.5 - 5.1	mmol/L
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METHOD : ISE INDIRECT

CHLORIDE, SERUM	104	98 - 107	mmol/L
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METHOD : ISE INDIRECT

Interpretation(s)**PHYSICAL EXAMINATION, URINE**

COLOR	PALE YELLOW
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APPEARANCE	CLEAR
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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	6.5	4.7 - 7.5
SPECIFIC GRAVITY	<=1.005	1.003 - 1.035
PROTEIN	NOT DETECTED	NOT DETECTED
GLUCOSE	NOT DETECTED	NOT DETECTED
KETONES	NOT DETECTED	NOT DETECTED
BLOOD	DETECTED (+)	NOT DETECTED
BILIRUBIN	NOT DETECTED	NOT DETECTED
UROBILINOGEN	NORMAL	NORMAL
NITRITE	NOT DETECTED	NOT DETECTED
LEUKOCYTE ESTERASE	NOT DETECTED	NOT DETECTED

MICROSCOPIC EXAMINATION, URINE

RED BLOOD CELLS	3 - 5	NOT DETECTED	/HPF
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PUS CELL (WBC'S)	1-2	0-5	/HPF
EPITHELIAL CELLS	3-5	0-5	/HPF
CASTS	NOT DETECTED		
CRYSTALS	NOT DETECTED		
BACTERIA	NOT DETECTED	NOT DETECTED	

METHOD : DIP STICK/MICRO SCOPY/REFLECTANCE SPECTROPHOTOMETRY

Interpretation(s)

THYROID PANEL, SERUM

T3	139.0	Non-Pregnant Women 80.0 - 200.0 Pregnant Women 1st Trimester:105.0 - 230.0 2nd Trimester:129.0 - 262.0 3rd Trimester:135.0 - 262.0	ng/dL
METHOD : ELECTROCHEMILUMINESCENCE IMMUNO ASSAY			
T4	9.50	Non-Pregnant Women 5.10 - 14.10 Pregnant Women 1st Trimester: 7.33 - 14.80 2nd Trimester: 7.93 - 16.10 3rd Trimester: 6.95 - 15.70	µg/dL
METHOD : ELECTROCHEMILUMINESCENCE IMMUNO ASSAY			
TSH (ULTRASENSITIVE)	4.410	High Non Pregnant Women 0.27 - 4.20 Pregnant Women 1st Trimester: 0.33 - 4.59 2nd Trimester: 0.35 - 4.10 3rd Trimester: 0.21 - 3.15	µIU/mL
METHOD : ELECTROCHEMILUMINESCENCE IMMUNO ASSAY			



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Interpretation(s)

Triiodothyronine T3, **Thyroxine T4**, and **Thyroid Stimulating Hormone TSH** are thyroid hormones which affect 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.

Excessive secretion of thyroxine in the body is hyperthyroidism, and deficient secretion is called hypothyroidism.

In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hyperthyroidism, TSH levels are low.

Below mentioned are the guidelines for Pregnancy related reference ranges for Total T4, TSH & Total T3. Measurement of the serum TT3 level is a more sensitive test for the diagnosis of hyperthyroidism, and measurement of TT4 is more useful in the diagnosis of 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. It is advisable to detect Free T3, Free T4 along with TSH, instead of testing for albumin bound Total T3, Total T4.

Sr. No.	TSH	Total T4	FT4	Total T3	Possible Conditions
1	High	Low	Low	Low	(1) Primary Hypothyroidism (2) Chronic autoimmune Thyroiditis (3) Post Thyroidectomy (4) Post Radio-Iodine treatment
2	High	Normal	Normal	Normal	(1) Subclinical Hypothyroidism (2) Patient with insufficient thyroid hormone replacement therapy (3) In cases of Autoimmune/Hashimoto thyroiditis (4). Isolated increase in TSH levels can be due to Subclinical inflammation, drugs like amphetamines, Iodine containing drug and dopamine antagonist e.g. domperidone and other physiological reasons.
3	Normal/Low	Low	Low	Low	(1) Secondary and Tertiary Hypothyroidism
4	Low	High	High	High	(1) Primary Hyperthyroidism (Graves Disease) (2) Multinodular Goitre (3) Toxic Nodular Goitre (4) Thyroiditis (5) Over treatment of thyroid hormone (6) Drug effect e.g. Glucocorticoids, dopamine, T4 replacement therapy (7) First trimester of Pregnancy
5	Low	Normal	Normal	Normal	(1) Subclinical Hyperthyroidism
6	High	High	High	High	(1) TSH secreting pituitary adenoma (2) TRH secreting tumor
7	Low	Low	Low	Low	(1) Central Hypothyroidism (2) Euthyroid sick syndrome (3) Recent treatment for Hyperthyroidism
8	Normal/Low	Normal	Normal	High	(1) T3 thyrotoxicosis (2) Non-Thyroidal illness
9	Low	High	High	Normal	(1) T4 Ingestion (2) Thyroiditis (3) Interfering Anti TPO antibodies

REF: 1. TIETZ Fundamentals of Clinical chemistry 2. Guidelines of the American Thyroid association during pregnancy and Postpartum, 2011.

NOTE: It is advisable to detect Free T3, Free T4 along with TSH, instead of testing for albumin bound Total T3, Total T4. TSH is not affected by variation in thyroid-binding protein. TSH has a diurnal rhythm, with peaks at 2:00 - 4:00 a.m. and troughs at 5:00 - 6:00 p.m. With ultradian variations.

PAPANICOLAOU SMEAR



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SPECIMEN TYPE

Serial no : C/1249/23

CLASSIFICATION
 Bethesda 2014

SPECIMEN SITE
 Cervix

SPECIMEN TYPE
 Conventional PAP smear - Cervix
 Received two unstained smears in a slides mailer labelled with two identifiers.

Processing and evaluation - Manual

SPECIMEN ADEQUACY
 Satisfactory for evaluation
 Endocervical component - Absent

GENERAL CATEGORIZATION
 Negative for intraepithelial lesion or malignancy

FINDINGS
 Superficial and intermediate squamous epithelial cells along with metaplastic epithelial cells seen in background of minimal acute inflammation.

INTERPRETATION/RESULTS
 Negative for intraepithelial lesion or malignancy

DISCLAIMER
 Gynaecological cytology is a screening procedure subject to both false negative and false positive results. It is most reliable when a satisfactory sample is obtained on a regular and repetitive basis. Results must be interpreted in context of the historic and current clinical information. Corroboration of cytopathologic findings with colposcopic/ local examination and ancillary findings is recommended.

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP O

METHOD : HEMAGGLUTINATION REACTION ON SOLID PHASE

RH TYPE RH+

METHOD : HEMAGGLUTINATION REACTION ON SOLID PHASE

XRAY-CHEST

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>>> BOTH THE LUNG FIELDS ARE CLEAR
>>> BOTH THE COSTOPHRENIC AND CARDIOPHRENIC ANGLES ARE CLEAR
>>> BOTH THE HILA ARE NORMAL
>>> CARDIAC AND AORTIC SHADOWS APPEAR NORMAL
>>> BOTH THE DOMES OF THE DIAPHRAGM ARE NORMAL
>>> VISUALIZED BONY THORAX IS NORMAL
IMPRESSION NO ABNORMALITY DETECTED

TMT OR ECHO

TMT OR ECHO

ECHO REPORT

- Normal sized cardiac chambers and normal valves
- No RWMA
- Trivial TR
- Normal LV systolic function LVEF ~ 60 %
- Normal LV diastolic function, E>A
- No Clot/Vegetation/Pericardial Effusion
- IVS/IAS intact,no flow seen across.

ECG

ECG

WITHIN NORMAL LIMITS

MEDICAL HISTORY

RELEVANT PRESENT HISTORY HYPOTHYROID - 10 YRS
RELEVANT PAST HISTORY LSCS TWICE
RELEVANT PERSONAL HISTORY MARRIED, TWO CHILDREN
LMP (FOR FEMALES) 1 JAN 2023
RELEVANT FAMILY HISTORY NOT SIGNIFICANT
OCCUPATIONAL HISTORY SERVICE
HISTORY OF MEDICATIONS TAB THYRONORM 50MCG OD

ANTHROPOMETRIC DATA & BMI

HEIGHT IN METERS	1.51	mts
WEIGHT IN KGS.	64.1	Kgs
BMI	28	

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



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ACROFEMI HEALTHCARE LTD (MEDIWHEEL)
F-703, LADO SARAI, MEHRAULI
SOUTH WEST DELHI
NEW DELHI 110030
DELHI INDIA
8800465156

SRL Ltd
Shop CG 017, PALM SPRINGS PLAZA
GURUGRAM, 122001
HARYANA, INDIA
Tel : 9111591115

PATIENT NAME : GARMILA CHAUHAN

PATIENT ID : GARMF010983282

ACCESSION NO : 0282WA00072 AGE : 39 Years SEX : Female ABHA NO :

DRAWN : RECEIVED : 21/01/2023 09:34 REPORTED : 23/01/2023 11:25

REFERRING DOCTOR : SELF

CLIENT PATIENT ID :

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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			
PULSE	88 / MIN REGULAR, ALL PERIPHERAL PULSES WELL FELT			
RESPIRATORY RATE	NORMAL			
CARDIOVASCULAR SYSTEM				
BP	106/68 MMHG (SUPINE)			mm/Hg
PERICARDIUM	NORMAL			
APEX BEAT	NORMAL			
HEART SOUNDS	S1, S2 HEARD NORMALLY			
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			
CENTRAL NERVOUS SYSTEM				
HIGHER FUNCTIONS	NORMAL			
CRANIAL NERVES	NORMAL			
CEREBELLAR FUNCTIONS	NORMAL			



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SENSORY SYSTEM	NORMAL
MOTOR SYSTEM	NORMAL
REFLEXES	NORMAL

MUSCULOSKELETAL SYSTEM

SPINE	NORMAL
JOINTS	NORMAL

BASIC EYE EXAMINATION

DISTANT VISION RIGHT EYE WITHOUT GLASSES	6/6
DISTANT VISION LEFT EYE WITHOUT GLASSES	6/6
NEAR VISION RIGHT EYE WITHOUT GLASSES	N/6
NEAR VISION LEFT EYE WITHOUT GLASSES	N/6
COLOUR VISION	17/17

SUMMARY

REMARKS / RECOMMENDATIONS

ADVISED
LIFESTYLE CHANGES
IRON RICH DIET
REPEAT URINE RE AFTER PLENTY OF ORAL FLUIDS,

FOLLOW UP WITH PHYSICIAN
& EYE SPECIALIST.
REVIEW WITH PAP,USG REPORTS.

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 :-

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(>100 mm/hour) in patients with ill-defined symptoms directs the physician to search for a systemic disease (Paraproteinemias,



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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; sulfonyleureas,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 Glycosuria, 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 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 & E are reported to falsely lower test results.(possibly by inhibiting glycation of hemoglobin.

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 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



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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

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, 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.

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 INVIOABLE FEATURE OF OUR LAB MANAGEMENT SOFTWARE. HOWEVER, ALL EXAMINATIONS AND INVESTIGATIONS HAVE BEEN CONDUCTED BY OUR PANEL OF DOCTORS.





Patient Ref. No. 775000002179039

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MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE**ULTRASOUND ABDOMEN****ULTRASOUND ABDOMEN****U.S.G Scan S/o Small hepatic cyst.****No other significant abnormality seen.******End Of Report****Please visit www.srlworld.com for related Test Information for this accession

Dr. Arpita Roy, MD
Pathologist

Dr. Deblina Naithani
Consultant Physician

Dr. Gargy Gupta, DNB
Pathology, (Reg.No. HMC-
012332)
Senior Resident

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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