

**CLIENT CODE :** C000138394  
**CLIENT'S NAME AND ADDRESS :**  
 ACROFEMI HEALTHCARE LTD ( MEDIWHEEL )  
 F-703, F-703, LADO SARAI, MEHRAULI  
 SOUTH WEST DELHI  
 NEW DELHI 110030  
 DELHI INDIA  
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SRL Ltd  
 S.K. Tower, Hari Niwas, LBS Marg  
 THANE, 400602  
 MAHARASHTRA, INDIA  
 Tel : 9111591115, Fax : CIN - U74899PB1995PLC045956  
 Email : customercare.thane@srl.in

**PATIENT NAME : MADHURI VARSHIKAR** PATIENT ID : **MADHF020787181**

ACCESSION NO : **0181WC001632** AGE : 35 Years SEX : Female

DRAWN : RECEIVED : 25/03/2023 09:01 REPORTED : 29/03/2023 15:37

REFERRING DOCTOR : SELF CLIENT PATIENT ID :

Test Report Status	Results	Biological Reference Interval	Units
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**MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE**

**BLOOD COUNTS, EDTA WHOLE BLOOD**

HEMOGLOBIN (HB)	<b>10.3</b>	<b>Low</b> 12.0 - 15.0	g/dL
METHOD : SLS- HEMOGLOBIN DETECTION METHOD			
RED BLOOD CELL (RBC) COUNT	<b>5.09</b>	<b>High</b> 3.8 - 4.8	mil/ $\mu$ L
METHOD : HYDRODYNAMIC FOCUSING BY DC DETECTION			
WHITE BLOOD CELL (WBC) COUNT	5.50	4.0 - 10.0	thou/ $\mu$ L
METHOD : FLUORESCENCE FLOW CYTOMETRY			
PLATELET COUNT	336	150 - 410	thou/ $\mu$ L
METHOD : HYDRODYNAMIC FOCUSING BY DC DETECTION			

**RBC AND PLATELET INDICES**

HEMATOCRIT (PCV)	<b>35.0</b>	<b>Low</b> 36.0 - 46.0	%
METHOD : CUMULATIVE PULSE HEIGHT DETECTION METHOD			
MEAN CORPUSCULAR VOLUME (MCV)	<b>68.8</b>	<b>Low</b> 83.0 - 101.0	fL
METHOD : CALCULATED FROM RBC & HCT			
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	<b>20.2</b>	<b>Low</b> 27.0 - 32.0	pg
METHOD : CALCULATED FROM THE RBC & HGB			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)	<b>29.4</b>	<b>Low</b> 31.5 - 34.5	g/dL
METHOD : CALCULATED FROM THE HGB & HCT			
RED CELL DISTRIBUTION WIDTH (RDW)	<b>15.8</b>	<b>High</b> 11.6 - 14.0	%
METHOD : CALCULATED FROM RBC SIZE DISTRIBUTION CURVE			
MENTZER INDEX	13.5		
MEAN PLATELET VOLUME (MPV)	<b>12.0</b>	<b>High</b> 6.8 - 10.9	fL
METHOD : CALCULATED FROM PLATELET COUNT & PLATELET HEMATOCRIT			

**WBC DIFFERENTIAL COUNT**

NEUTROPHILS	65	40 - 80	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
LYMPHOCYTES	28	20 - 40	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
MONOCYTES	5	2 - 10	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
EOSINOPHILS	2	1 - 6	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
ABSOLUTE NEUTROPHIL COUNT	3.58	2.0 - 7.0	thou/ $\mu$ L
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			



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ABSOLUTE LYMPHOCYTE COUNT		1.54	1.0 - 3.0	thou/ $\mu$ L
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
ABSOLUTE MONOCYTE COUNT		0.29	0.2 - 1.0	thou/ $\mu$ L
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
ABSOLUTE EOSINOPHIL COUNT		0.08	0.02 - 0.50	thou/ $\mu$ L
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		2.3		
<b>MORPHOLOGY</b>				
RBC		MICROCYTOSIS		
WBC		NORMAL MORPHOLOGY		
METHOD : MICROSCOPIC EXAMINATION				
PLATELETS		ADEQUATE		
<b>ERYTHROCYTE SEDIMENTATION RATE (ESR), WHOLE BLOOD</b>				
E.S.R		19	< 20	mm at 1 hr
METHOD : MODIFIED WESTERGREN				
<b>GLUCOSE FASTING, FLUORIDE PLASMA</b>				
FBS (FASTING BLOOD SUGAR)		75	Normal 75 - 99 Pre-diabetics: 100 - 125 Diabetic: > or = 126	mg/dL
METHOD : ENZYMATIC REFERENCE METHOD WITH HEXOKINASE				
<b>GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD</b>				
HBA1C		5.1	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 : HPLC				
ESTIMATED AVERAGE GLUCOSE(EAG)		99.7	< 116.0	mg/dL
METHOD : CALCULATED PARAMETER				
<b>GLUCOSE, POST-PRANDIAL, PLASMA</b>				
PPBS(POST PRANDIAL BLOOD SUGAR)		90	70 - 139	mg/dL
METHOD : ENZYMATIC REFERENCE METHOD WITH HEXOKINASE				
<b>LIPID PROFILE, SERUM</b>				



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**ACCESSION NO : 0181WC001632** AGE : 35 Years SEX : Female

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**CHOLESTEROL, TOTAL** 193 Desirable cholesterol level < 200 mg/dL  
 Borderline high cholesterol 200 - 239  
 High cholesterol > / = 240  
 METHOD : ENZYMATIC COLORIMETRIC ASSAY

**TRIGLYCERIDES** 257 **High** Normal: < 150 mg/dL  
 Borderline high: 150 - 199  
 High: 200 - 499  
 Very High: >/= 500  
 METHOD : ENZYMATIC COLORIMETRIC ASSAY

**HDL CHOLESTEROL** 32 **Low** Low HDL Cholesterol <40 mg/dL  
 High HDL Cholesterol >/= 60  
 METHOD : ENZYMATIC, COLORIMETRIC

**CHOLESTEROL LDL** 110 **High** Adult levels: mg/dL  
 Optimal < 100  
 Near optimal/above optimal: 100-129  
 Borderline high : 130-159  
 High : 160-189  
 Very high : = 190  
 METHOD : ENZYMATIC COLORIMETRIC ASSAY

**NON HDL CHOLESTEROL** 161 **High** Desirable : < 130 mg/dL  
 Above Desirable : 130 -159  
 Borderline High : 160 - 189  
 High : 190 - 219  
 Very high : > / = 220

**VERY LOW DENSITY LIPOPROTEIN CHOL/HDL RATIO** 51.4 **High** < OR = 30.0 mg/dL  
 6.0 **High** 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** 3.4 **High** 0.5 - 3.0 Desirable/Low Risk  
 3.1 - 6.0 Borderline/Moderate Risk  
 >6.0 High Risk

**LIVER FUNCTION PROFILE, SERUM**

**BILIRUBIN, TOTAL** 0.47 Upto 1.2 mg/dL  
 METHOD : COLORIMETRIC DIAZO

**BILIRUBIN, DIRECT** 0.23 < 0.30 mg/dL

**BILIRUBIN, INDIRECT** 0.24 0.1 - 1.0 mg/dL

**TOTAL PROTEIN** 7.1 6.0 - 8.0 g/dL  
 METHOD : COLORIMETRIC



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ALBUMIN		4.3	3.97 - 4.94	g/dL
METHOD : COLORIMETRIC				
GLOBULIN		2.8	2.0 - 3.5	g/dL
ALBUMIN/GLOBULIN RATIO		1.5	1.0 - 2.1	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT)		19	< OR = 35	U/L
METHOD : UV ABSORBANCE				
ALANINE AMINOTRANSFERASE (ALT/SGPT)		15	< OR = 35	U/L
METHOD : UV ABSORBANCE				
ALKALINE PHOSPHATASE		71	35 - 104	U/L
METHOD : COLORIMETRIC				
GAMMA GLUTAMYL TRANSFERASE (GGT)		15	0 - 40	U/L
METHOD : ENZYMATIC, COLORIMETRIC				
LACTATE DEHYDROGENASE		181	125 - 220	U/L
METHOD : UV ABSORBANCE				
<b>BLOOD UREA NITROGEN (BUN), SERUM</b>				
BLOOD UREA NITROGEN		7	6 - 20	mg/dL
METHOD : ENZYMATIC ASSAY				
<b>CREATININE, SERUM</b>				
CREATININE		<b>0.47</b>	<b>Low</b> 0.5 - 0.9	mg/dL
METHOD : COLORIMETRIC				
<b>BUN/CREAT RATIO</b>				
BUN/CREAT RATIO		14.89	8.0 - 15.0	
<b>URIC ACID, SERUM</b>				
URIC ACID		4.8	2.4 - 5.7	mg/dL
METHOD : ENZYMATIC COLORIMETRIC ASSAY				
<b>TOTAL PROTEIN, SERUM</b>				
TOTAL PROTEIN		7.1	6.0 - 8.0	g/dL
METHOD : COLORIMETRIC				
<b>ALBUMIN, SERUM</b>				
ALBUMIN		4.3	3.97 - 4.94	g/dL
METHOD : COLORIMETRIC				
<b>GLOBULIN</b>				
GLOBULIN		2.8	2.0 - 3.5	g/dL
<b>ELECTROLYTES (NA/K/CL), SERUM</b>				
SODIUM, SERUM		139	136 - 145	mmol/L
POTASSIUM, SERUM		4.57	3.5 - 5.1	mmol/L



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CHLORIDE, SERUM		103	98 - 107	mmol/L
<b>PHYSICAL EXAMINATION, URINE</b>				
COLOR		PALE YELLOW		
APPEARANCE		<b>SLIGHTLY HAZY</b>		
<b>CHEMICAL EXAMINATION, URINE</b>				
PH		6.5	5.00 - 7.50	
SPECIFIC GRAVITY		1.010	1.010 - 1.030	
METHOD : URINE ROUTINE & MICROSCOPY EXAMINATION BY INTEGRATED AUTOMATED SYSTEM				
PROTEIN		NOT DETECTED	NOT DETECTED	
GLUCOSE		NOT DETECTED	NOT DETECTED	
KETONES		NOT DETECTED	NOT DETECTED	
BLOOD		<b>DETECTED (TRACE)</b>	NOT DETECTED	
UROBILINOGEN		NORMAL	NORMAL	
NITRITE		NOT DETECTED	NOT DETECTED	
LEUKOCYTE ESTERASE		NOT DETECTED	NOT DETECTED	
<b>MICROSCOPIC EXAMINATION, URINE</b>				
RED BLOOD CELLS		<b>0 - 1</b>	NOT DETECTED	/HPF
PUS CELL (WBC'S)		3-5	0-5	/HPF
EPITHELIAL CELLS		<b>8-10</b>	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				
<b>THYROID PANEL, SERUM</b>				
T3		122.0	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				
T4		9.92	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



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METHOD : ELECTROCHEMILUMINESCENCE TSH (ULTRASENSITIVE)	3.150	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
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METHOD : ELECTROCHEMILUMINESCENCE <b>PAPANICOLAOU SMEAR</b> TEST METHOD METHOD : MICROSCOPIC EXAMINATION SPECIMEN TYPE METHOD : MICROSCOPIC EXAMINATION REPORTING SYSTEM SPECIMEN ADEQUACY METHOD : PAP STAIN & MICROSCOPIC EXAMINATION MICROSCOPY METHOD : PAP STAIN INTERPRETATION / RESULT METHOD : PAP STAIN & MICROSCOPIC EXAMINATION	CONVENTIONAL GYNEC CYTOLOGY  P-432/23  TWO UNSTAINED CERVICAL SMEARS RECEIVED  2014 BETHESDA SYSTEM FOR REPORTING CERVICAL CYTOLOGY SATISFACTORY  THE SMEARS SHOW MAINLY SUPERFICIAL SQUAMOUS CELLS, FEW INTERMEDIATE SQUAMOUS CELLS, MANY CLUSTERS OF ENDOCERVICAL CELLS IN THE BACKGROUND OF MODERATE POLYMORPHS & RBC'S.  NEGATIVE FOR INTRAEPITHELIAL LESION OR MALIGNANCY
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**Comments**

PLEASE NOTE PAPANICOLAOU SMEAR STUDY IS A SCREENING PROCEDURE FOR CERVICAL CANCER WITH INHERENT FALSE NEGATIVE RESULTS HENCE SHOULD BE INTERPRETED WITH CAUTION. NO CYTOLOGICAL EVIDENCE OF HPV INFECTION IN THE SMEARS STUDIED. SMEARS WILL BE PRESERVED FOR 5 YEARS ONLY.

**MICROSCOPIC EXAMINATION, STOOL**

REMARK SAMPLE NOT RECEIVED

**ABO GROUP & RH TYPE, EDTA WHOLE BLOOD**

ABO GROUP TYPE O

METHOD : GEL COLUMN AGGLUTINATION METHOD.

RH TYPE POSITIVE

METHOD : GEL COLUMN AGGLUTINATION METHOD.

**XRAY-CHEST**

IMPRESSION NO ABNORMALITY DETECTED

**TMT OR ECHO**



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TMT OR ECHO		NEGATIVE		
<b>ECG</b>				
ECG		WITHIN NORMAL LIMITS		
<b>MEDICAL HISTORY</b>				
RELEVANT PRESENT HISTORY		NOT SIGNIFICANT		
RELEVANT PAST HISTORY		K/H/O PCOD.		
RELEVANT PERSONAL HISTORY		MARRIED / VEG DIET / NO ALLERGIES / NO SMOKING / NO ALCOHOL.		
LMP (FOR FEMALES)		20/3/2023.		
RELEVANT FAMILY HISTORY		NOT SIGNIFICANT		
HISTORY OF MEDICATIONS		NOT SIGNIFICANT		
<b>ANTHROPOMETRIC DATA &amp; BMI</b>				
HEIGHT IN METERS	1.53			mts
WEIGHT IN KGS.	64			Kgs
BMI	27			
			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	HEALTHY
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	83/MIN.REGULAR, ALL PERIPHERAL PULSES WELL FELT, NO CAROTID BRUIT
RESPIRATORY RATE	NORMAL

**CARDIOVASCULAR SYSTEM**



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BP		130/90 MM HG (SUPINE)		mm/Hg
PERICARDIUM		NORMAL		
APEX BEAT		NORMAL		
HEART SOUNDS		NORMAL		
MURMURS		ABSENT		
<b>RESPIRATORY SYSTEM</b>				
SIZE AND SHAPE OF CHEST		NORMAL		
MOVEMENTS OF CHEST		SYMMETRICAL		
BREATH SOUNDS INTENSITY		NORMAL		
BREATH SOUNDS QUALITY		VESICULAR (NORMAL)		
ADDED SOUNDS		ABSENT		
<b>PER ABDOMEN</b>				
APPEARANCE		NORMAL		
VENOUS PROMINENCE		ABSENT		
LIVER		NOT PALPABLE		
SPLEEN		NOT PALPABLE		
HERNIA		ABSENT		
<b>CENTRAL NERVOUS SYSTEM</b>				
HIGHER FUNCTIONS		NORMAL		
CRANIAL NERVES		NORMAL		
CEREBELLAR FUNCTIONS		NORMAL		
SENSORY SYSTEM		NORMAL		
MOTOR SYSTEM		NORMAL		
REFLEXES		NORMAL		
<b>MUSCULOSKELETAL SYSTEM</b>				
SPINE		NORMAL		
JOINTS		NORMAL		
<b>BASIC EYE EXAMINATION</b>				
CONJUNCTIVA		NORMAL		
EYELIDS		NORMAL		
EYE MOVEMENTS		NORMAL		
CORNEA		NORMAL		
DISTANT VISION RIGHT EYE WITHOUT GLASSES		WITHIN NORMAL LIMIT		



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DISTANT VISION LEFT EYE WITHOUT GLASSES	WITHIN NORMAL LIMIT
NEAR VISION RIGHT EYE WITHOUT GLASSES	WITHIN NORMAL LIMIT
NEAR VISION LEFT EYE WITHOUT GLASSES	WITHIN NORMAL LIMIT
COLOUR VISION	NORMAL

**SUMMARY**

RELEVANT HISTORY	NOT SIGNIFICANT
RELEVANT GP EXAMINATION FINDINGS	NOT SIGNIFICANT
REMARKS / RECOMMENDATIONS	FOLLOW UP WITH GYNAEC FOR PCOD. SURGICAL GASTROENTEROLOGIST CONSULT FOR CHOLELITHIASIS. TO DO S,IRON STUDIES. IRON RICH DIET ADVISED. ADD GREEN LEAFY VEGETABLES,TO THE DAILY DIET. DRINK 2-3 LITRE WATER DAILY. REPEAT URINE ROUTINE AFTER 15 DAYS AND FOLLOW-UP WITH REPORTS. LOW FAT, LOW CARBOHYDRATE, HIGH FIBRE DIET. REGULAR EXERCISE.REGULAR WALK FOR 30-40 MIN DAILY. REPEAT LIPID PROFILE AFTER 3 MONTHS OF DIET AND EXERCISE.

**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, 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,



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**PATIENT NAME : MADHURI VARSHIKAR** PATIENT ID : **MADHF020787181**

ACCESSION NO : **0181WC001632** AGE : 35 Years SEX : Female

DRAWN : RECEIVED : 25/03/2023 09:01 REPORTED : 29/03/2023 15:37

REFERRING DOCTOR : SELF CLIENT PATIENT ID :

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

- Evaluating the long-term control of blood glucose concentrations in diabetic patients.
  - Diagnosing diabetes.
  - 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.
- eAG (Estimated average glucose) converts percentage HbA1c to mg/dl, to compare blood glucose levels.
  - eAG gives an evaluation of blood glucose levels for the last couple of months.
  - eAG is calculated as  $eAG (mg/dl) = 28.7 * HbA1c - 46.7$

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

- 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.
- Vitamin C & E are reported to falsely lower test results. (possibly by inhibiting glycation of hemoglobin).
- Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia, uremia, hyperbilirubinemia, chronic alcoholism, chronic ingestion of salicylates & opiates addition are reported to interfere with some assay methods, falsely increasing results.
- Interference of hemoglobinopathies in HbA1c estimation is seen in

- Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.
  - Heterozygous state detected (D10 is corrected for HbS & HbC trait.)
  - 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-

**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, 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



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

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**MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE**

**ULTRASOUND ABDOMEN**

**ULTRASOUND ABDOMEN**

GRADE I FATTY LIVER.

CHOLELITHIASIS.

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

Please visit [www.srlworld.com](http://www.srlworld.com) for related Test Information for this accession

**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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