DIAGNOSTIC REPORT

SRL Diagnostics

PATIENT NAME : NIRMAL AGARWAL		**REF. DOCTOR :** SELF
CODE/NAME & ADDRESS : C000138364 ACROFEMI HEALTHCARE LTD (MEDIWHEEL) F-703, LADO SARAI, MEHRAULISOUTH WEST DELHI NEW DELHI 110030 8800465156	ACCESSION NO : **0321WA002528** PATIENT ID : NIRMM29108799 CLIENT PATIENT ID: ABHA NO :	AGE/SEX : 35 Years Male DRAWN : RECEIVED : 28/01/2023 10:34:26 REPORTED : 03/02/2023 12:15:33

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

MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

XRAY-CHEST

IMPRESSION	PROMINENT BRONCHO VASCULAR MARKINGS NOTED		

TMT OR ECHO

TMT OR ECHO	TMT:- NORMAL		

ECG

ECG	NORMAL SINUS RHYTHM		

MEDICAL HISTORY

RELEVANT PRESENT HISTORY	C/O RENAL STONE 3 YEARS		
RELEVANT PAST HISTORY	P/H/O SKIN INFECTION IN 2002		
RELEVANT PERSONAL HISTORY	NOT SIGNIFICANT		
RELEVANT FAMILY HISTORY	NOT SIGNIFICANT		
OCCUPATIONAL HISTORY	NOT SIGNIFICANT		
HISTORY OF MEDICATIONS	NOT SIGNIFICANT		

ANTHROPOMETRIC DATA & BMI

HEIGHT IN METERS	1.67		mts
WEIGHT IN KGS.	72.7		Kgs
BMI	26	BMI & Weight Status as follows: Below 18.5: Underweight 18.5 - 24.9: Normal 25.0 - 29.9: Overweight 30.0 and Above: Obese	kg/sqmts

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

Dr.Sahil .N.Shah
Consultant Radiologist

Dr.Priyank Kapadia
Physician

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Patient Ref. No. 775000002221651

SRL Diagnostics

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THYROID GLAND	NOT ENLARGED		
TEMPERATURE	NORMAL		
PULSE	70/MIN		
RESPIRATORY RATE	NORMAL		
CARDIOVASCULAR SYSTEM			
BP	130/84 MM HG (SITTING)		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		
LIVER	NOT PALPABLE		
SPLEEN	NOT PALPABLE		
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			
DISTANT VISION RIGHT EYE WITH GLASSES	WITH GLASSES NORMAL		

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DISTANT VISION LEFT EYE WITH GLASSES	WITH GLASSES NORMAL		
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		
RELEVANT LAB INVESTIGATIONS	EOSINOPHILS:- HIGH		
	LDL:- HIGH		
	URINE:- BLOOD DETECTED (+), RBC:- HIGH, WBC:- HIGH		
RELEVANT NON PATHOLOGY DIAGNOSTICS	CHEST X-RAY:- PROMINENT BRONCHO VASCULAR MARKINGS NOTED		
REMARKS / RECOMMENDATIONS	1) LDL:- HIGH		
	ADV:- LOW FAT DIET, REGULAR PHYSICAL EXERCISE		
	2) URINE:- BLOOD DETECTED (+), RBC:- HIGH, WBC:- HIGH		
	ADV:- DRINK PLENTY OF WATER, REPEAT URINE ANALYSIS AFTER 10 DAYS AND PHYSICIAN OPINION SOS		
	3) EOSINOPHILS:- HIGH		
	ADV:- S. IGE LEVEL		

Comments

OUR PANEL DOCTORS FOR NON-PATHOLOGY TESTS:-

CHECK UP DONE BY:– DR. NAMRATA AGRAWAL (M.B.B.S)

REPORT REVIEWED BY:- DR. PRIYANK KAPADIYA (M.B.B.S DNB MEDICINE)

RADIOLOGIST:– DR. KALPANA MODI (M.D.RADIOLOGY) // DR. SAHIL N SHAH (M.D.RADIOLOGY)

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MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

ULTRASOUND ABDOMEN

ULTRASOUND ABDOMEN

MILD HYDRONEPHROSIS NOTED IN RIGHT KIDNEY WITH DILATED UPPER URETER DISTALLY OBSCURED WITH BOWEL GAS. NEED FURTHER WORK - UP.

Interpretation(s)
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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Consultant Radiologist

P. V. Kapadia

Dr.Priyank Kapadia
Physician

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8800465156

ACCESSION NO : **0321WA002528**
PATIENT ID : NIRMM29108799
CLIENT PATIENT ID:
ABHA NO :

AGE/SEX : 35 Years Male
DRAWN :
RECEIVED : 28/01/2023 10:34:26
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Test Report Status **Final**	Results	Biological Reference Interval	Units

HAEMATOLOGY - CBC

MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

BLOOD COUNTS,EDTA WHOLE BLOOD			
HEMOGLOBIN (HB)	13.9	13.0 - 17.0	g/dL
RED BLOOD CELL (RBC) COUNT	**4.49 Low**	4.5 - 5.5	mil/µL
WHITE BLOOD CELL (WBC) COUNT	5.28	4.0 - 10.0	thou/µL
PLATELET COUNT	262	150 - 410	thou/µL
RBC AND PLATELET INDICES			
HEMATOCRIT (PCV)	40.5	40.0 - 50.0	%
MEAN CORPUSCULAR VOLUME (MCV)	90.1	83.0 - 101.0	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	31.0	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)	34.3	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW)	**14.3 High**	11.6 - 14.0	%
MENTZER INDEX	20.1		
MEAN PLATELET VOLUME (MPV)	8.0	6.8 - 10.9	fL
WBC DIFFERENTIAL COUNT			
NEUTROPHILS	**37 Low**	40 - 80	%
LYMPHOCYTES	**47 High**	20 - 40	%
MONOCYTES	8	2.0 - 10.0	%
EOSINOPHILS	**8 High**	1.0 - 6.0	%
BASOPHILS	0	0 - 1	%
ABSOLUTE NEUTROPHIL COUNT	**1.95 Low**	2.0 - 7.0	thou/µL
ABSOLUTE LYMPHOCYTE COUNT	2.48	1.0 - 3.0	thou/µL
ABSOLUTE MONOCYTE COUNT	0.42	0.2 - 1.0	thou/µL
ABSOLUTE EOSINOPHIL COUNT	0.42	0.02 - 0.50	thou/µL
ABSOLUTE BASOPHIL COUNT	**0.00 Low**	0.02 - 0.10	thou/µL
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	0.8		
MORPHOLOGY			
RBC	NORMOCYTIC NORMOCHROMIC		
WBC	RELATIVE LYMPHOCYTOSIS		
PLATELETS	ADEQUATE		

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REMARKS	NO PREMATURE CELLS ARE SEEN. MALARIAL PARASITES ARE NOT DETECTED.		

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.

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HAEMATOLOGY

MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD

E.S.R	10	0 - 14	mm at 1 hr

Interpretation(s)
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, 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.

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IMMUNOHAEMATOLOGY

MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP	TYPE B		
RH TYPE	POSITIVE		

Interpretation(s)
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.

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BIOCHEMISTRY

MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

GLUCOSE FASTING,FLUORIDE PLASMA			
FBS (FASTING BLOOD SUGAR)	96	74 - 99	mg/dL
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD			
HBA1C	4.5	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 Therapeutic goals: < 7.0 Action suggested : > 8.0 (ADA Guideline 2021)	%
ESTIMATED AVERAGE GLUCOSE(EAG)	82.5	< 116.0	mg/dL
GLUCOSE, POST-PRANDIAL, PLASMA			
PPBS(POST PRANDIAL BLOOD SUGAR)	99	70 - 140	mg/dL
LIPID PROFILE, SERUM			
CHOLESTEROL, TOTAL	176	Desirable: < 200 BorderlineHigh: 200 - 239 High: > or = 240	mg/dL
TRIGLYCERIDES	62	Desirable: < 150 BorderlineHigh: 150 - 199 High: 200 - 499 Very High: > or = 500	mg/dL
HDL CHOLESTEROL	42	< 40 Low > or = 60 High	mg/dL
CHOLESTEROL LDL	**122 High**	Adult levels: Optimal < 100 Near optimal/above optimal: 100-129 Borderline high : 130-159 High : 160-189 Very high : = 190	mg/dL
NON HDL CHOLESTEROL	**134 High**	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
VERY LOW DENSITY LIPOPROTEIN	12.4		mg/dL

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CHOL/HDL RATIO	4.2		
LDL/HDL RATIO	2.9	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
Interpretation(s)			
LIVER FUNCTION PROFILE, SERUM			
BILIRUBIN, TOTAL	0.40	Upto 1.2	mg/dL
BILIRUBIN, DIRECT	0.16	Upto 0.2	mg/dL
BILIRUBIN, INDIRECT	0.24	0.00 - 1.00	mg/dL
TOTAL PROTEIN	7.4	6.4 - 8.3	g/dL
ALBUMIN	5.1	3.5 - 5.2	g/dL
GLOBULIN	2.3	2.0 - 4.1	g/dL
ALBUMIN/GLOBULIN RATIO	**2.2 High**	1.0 - 2.0	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	19	0 - 40	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)	17	0 - 41	U/L
ALKALINE PHOSPHATASE	68	40 - 129	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)	19	8 - 61	U/L
LACTATE DEHYDROGENASE	180	135 - 225	U/L
BLOOD UREA NITROGEN (BUN), SERUM			
BLOOD UREA NITROGEN	9	6 - 20	mg/dL
CREATININE, SERUM			
CREATININE	0.81	0.70 - 1.30	mg/dL
BUN/CREAT RATIO			
BUN/CREAT RATIO	11.11	5.0 - 15.0	
URIC ACID, SERUM			
URIC ACID	5.9	3.4 - 7.0	mg/dL
TOTAL PROTEIN, SERUM			
TOTAL PROTEIN	7.4	6.4 - 8.3	g/dL
ALBUMIN, SERUM			
ALBUMIN	5.1	3.5 - 5.2	g/dL

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GLOBULIN			
GLOBULIN	2.3	2.0 - 4.1	g/dL
ELECTROLYTES (NA/K/CL), SERUM			
SODIUM, SERUM	143.1	136- 145	mmol/L
POTASSIUM, SERUM	**5.11 High**	3.50- 5.10	mmol/L
CHLORIDE, SERUM	**110 High**	98 - 107	mmol/L

Interpretation(s)

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

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

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Patient Ref. No. 775000002221651

DIAGNOSTIC REPORT

SRL Diagnostics

PATIENT NAME : NIRMAL AGARWAL **REF. DOCTOR :** SELF

CODE/NAME & ADDRESS : C000138364 ACROFEMI HEALTHCARE LTD (MEDIWHEEL) F-703, LADO SARAI, MEHRAULISOUTH WEST DELHI NEW DELHI 110030 8800465156	ACCESSION NO : **0321WA002528** PATIENT ID : NIRMM29108799 CLIENT PATIENT ID: ABHA NO :	AGE/SEX : 35 Years Male DRAWN : RECEIVED : 28/01/2023 10:34:26 REPORTED : 03/02/2023 12:15:33

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CLINICAL PATH - URINALYSIS

MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

PHYSICAL EXAMINATION, URINE			
COLOR	Yellow		
APPEARANCE	Clear		
CHEMICAL EXAMINATION, URINE			
PH	5.5	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	**2 - 3**	NOT DETECTED	/HPF
PUS CELL (WBC'S)	**8-10**	0-5	/HPF
EPITHELIAL CELLS	NOT DETECTED	0-5	/HPF
CASTS	NOT DETECTED		
CRYSTALS	NOT DETECTED		
BACTERIA	NOT DETECTED	NOT DETECTED	
YEAST	NOT DETECTED	NOT DETECTED	
REMARKS	MICROSCOPIC EXAMINATION OF URINE IS CARRIED OUT ON CENTRIFUGED URINARY SEDIMENT.		

Interpretation(s)

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CLINICAL PATH - STOOL ANALYSIS

MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

PHYSICAL EXAMINATION,STOOL			
COLOUR	BROWN		
CONSISTENCY	WELL FORMED		
MUCUS	ABSENT	NOT DETECTED	
VISIBLE BLOOD	ABSENT	ABSENT	
ADULT PARASITE	NOT DETECTED		
CHEMICAL EXAMINATION,STOOL			
STOOL PH	NEGATIVE		
OCCULT BLOOD	NOT DETECTED	NOT DETECTED	
MICROSCOPIC EXAMINATION,STOOL			
PUS CELLS	0-1		/hpf
RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
CYSTS	NOT DETECTED	NOT DETECTED	
OVA	NOT DETECTED		
LARVAE	NOT DETECTED	NOT DETECTED	
TROPHOZOITES	NOT DETECTED	NOT DETECTED	
FAT	ABSENT		
VEGETABLE CELLS	ABSENT		
CHARCOT LEYDEN CRYSTALS	ABSENT		
CONCENTRATION METHOD	OVA OR CYSTS NOT SEEN		

Interpretation(s)

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SPECIALISED CHEMISTRY - HORMONE

MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

THYROID PANEL, SERUM

T3	**71.55 Low**	80.00 - 200.00	ng/dL
T4	**5.03 Low**	5.10 - 14.10	µg/dL
TSH (ULTRASENSITIVE)	2.300	0.270 - 4.200	µIU/mL

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.
owidctlparowidctlparBelow 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, FreeT4 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.Guidlines of the American Thyroid association duriing pregnancy and Postpartum, 2011.

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NOTE: It is advisable to detect Free T3,FreeT4 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.

****End Of Report****
Please visit 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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