Patient Ref. No. 82000000377235

CLIENT CODE : C000138384

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
30-B, CHOWRINGEE MANSION, JAWAHARLAL NEHRU ROAD,
KOLKATA, 700016
WEST BENGAL, INDIA
Tel : 033-22267333,46019048, Fax : 033-22271324
CIN - U74899PB1995PLC045956

PATIENT NAME : MRS. AMEETA LAV VAIDYA PATIENT ID : **MRSAF26126382**

ACCESSION NO : **0082VC030074** AGE : 58 Years SEX : Female

DRAWN : 29-03-2022 12:50 RECEIVED : 29-03-2022 12:53 REPORTED : 30-03-2022 12:26

REFERRING DOCTOR : DR. ACROFEMI HEALTHCARE LTD (MEDIWHEEL) CLIENT PATIENT ID :

Test Report Status **Preliminary**	Results		Biological Reference Interval	Units
MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40FEMALE				
BLOOD COUNTS,EDTA WHOLE BLOOD				
HEMOGLOBIN	12.1		12.0 - 15.0	g/dL
RED BLOOD CELL COUNT	3.82		3.8 - 4.8	mil/µL
WHITE BLOOD CELL COUNT	**3.52**	**Low**	4.0 - 10.0	thou/µL
PLATELET COUNT	222		150 - 410	thou/µL
RBC AND PLATELET INDICES				
HEMATOCRIT	36.3		36 - 46	%
MEAN CORPUSCULAR VOL	94.9		83 - 101	fL
MEAN CORPUSCULAR HGB.	31.7		27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION	33.3		31.5 - 34.5	g/dL
MENTZER INDEX	24.8			
RED CELL DISTRIBUTION WIDTH	13.9		11.6 - 14.0	%
MEAN PLATELET VOLUME	9.3		6.8 - 10.9	fL
WBC DIFFERENTIAL COUNT - NLR				
SEGMENTED NEUTROPHILS	46		40 - 80	%
ABSOLUTE NEUTROPHIL COUNT	**1.62**	**Low**	2.0 - 7.0	thou/µL
LYMPHOCYTES	33		20 - 40	%
ABSOLUTE LYMPHOCYTE COUNT	1.16		1 - 3	thou/µL
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	1.4			
EOSINOPHILS	**12**	**High**	1 - 6	%
ABSOLUTE EOSINOPHIL COUNT	0.42		0.02 - 0.50	thou/µL
MONOCYTES	9		2 - 10	%
ABSOLUTE MONOCYTE COUNT	0.32		0.20 - 1.00	thou/µL
BASOPHILS	0		0 - 2	%
ABSOLUTE BASOPHIL COUNT	**0**	**Low**	0.02 - 0.10	thou/µL
MORPHOLOGY				
RBC	NORMOCYTIC NORMOCHROMIC			
WBC	NO IMMATURE CELLS SEEN.			
PLATELETS	ADEQUATE			
ERYTHRO SEDIMENTATION RATE, BLOOD				
SEDIMENTATION RATE (ESR)	6		0 - 20	mm at 1 hr

METHOD : AUTOMATED (PHOTOMETRICAL CAPILLARY STOPPED FLOW KINETIC ANALYSIS)"

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Test Report Status **Preliminary**	Results	Biological Reference Interval	Units
GLYCOSYLATED HEMOGLOBIN, EDTA WHOLE BLOOD			
GLYCOSYLATED HEMOGLOBIN (HBA1C)	5.6	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 ADA Target: 7.0 Action suggested: > 8.0	%
METHOD : HPLC			
MEAN PLASMA GLUCOSE	114.0	< 116.0	mg/dL
GLUCOSE, FASTING, PLASMA			
GLUCOSE, FASTING, PLASMA	79	74 - 100	mg/dL
METHOD : ENZYMATIC (HEXOKINASE/G-6-PDH)			
GLUCOSE, POST-PRANDIAL, PLASMA			
GLUCOSE, POST-PRANDIAL, PLASMA	93	140 Normal 140 - 199 Pre-diabetic > or = 200 Diabetic	mg/dL
METHOD : ENZYMATIC (HEXOKINASE/G-6-PDH)			
CORONARY RISK PROFILE (LIPID PROFILE), SERUM.			
CHOLESTEROL	125	< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
METHOD : ENZYMATIC ASSAY			
TRIGLYCERIDES	84	< 150 Normal 150 - 199 Borderline High 200 - 499 High >/=500 Very High	mg/dL
METHOD : GLYCEROL PHOSPHATE OXIDASE			
HDL CHOLESTEROL	47	Low : < 40 High : > / = 60	mg/dL
METHOD : ACCELERATOR SELECTIVE DETERGENT METHODOLOGY			
DIRECT LDL CHOLESTEROL	71	Adult Optimal : < 100 Near optimal : 100 - 129 Borderline high : 130 - 159 High : 160 - 189 Very high : > or = 190	mg/dL
METHOD : MEASURED, LIQUID SELECTIVE DETERGENT			
NON HDL CHOLESTEROL	78	Desirable: Less than 130 Above Desirable: 130-159 Borderline High: 160-189 High: 190 -219 Very High: >or = 220	mg/dL
METHOD : CALCULATED			

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Test Report Status **Preliminary**	Results		Biological Reference Interval	Units
CHOL/HDL RATIO	**2.7**	**Low**	3.3 - 4.4 Low Risk 4.5-7.0 Average Risk 7.1 - 11.0 Moderate Risk > 11.0 High Risk	
METHOD : CALCULATED				
LDL/HDL RATIO	1.5		0.5 - 3.0 Desirable/ Low Risk 3.1-6.0 Borderline /Moderate Risk > 6.0 High Risk	
METHOD : CALCULATED				
VERY LOW DENSITY LIPOPROTEIN	16.8		< or = 30	mg/dL
METHOD : CALCULATED				
LIVER FUNCTION PROFILE, SERUM				
BILIRUBIN, TOTAL	0.49		0.2 - 1.2	mg/dL
METHOD : DIAZONIUM SALT				
BILIRUBIN, DIRECT	0.22		0.0 - 0.5	mg/dL
METHOD : DIAZO REACTION				
BILIRUBIN, INDIRECT	0.27		0.1 - 1.0	mg/dL
METHOD : CALCULATED				
TOTAL PROTEIN	7.2		6.0 - 8.30	g/dL
METHOD : BIURET				
ALBUMIN	3.8		3.5 - 5.2	g/dL
METHOD : COLORIMETRIC (BROMCRESOL GREEN)				
GLOBULIN	3.4		2.0 - 3.5	g/dL
ALBUMIN/GLOBULIN RATIO	1.1		1 - 2.1	RATIO
METHOD : CALCULATED PARAMETER				
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	22		5 - 34	U/L
METHOD : ENZYMATIC (NADH (WITHOUT P-5'-P)				
ALANINE AMINOTRANSFERASE (ALT/SGPT)	16		0 - 55	U/L
METHOD : ENZYMATIC (NADH (WITHOUT P-5'-P)				
ALKALINE PHOSPHATASE	67		40 - 150	U/L
METHOD : PARA-NITROPHENYL PHOSPHATE				
GAMMA GLUTAMYL TRANSFERASE (GGT)	12		8 -33	U/L
METHOD : L-GAMMA-GLUTAMYL-4-NITROANALIDE /GLYCYLGLYCINE KINETIC METHOD				
LACTATE DEHYDROGENASE	216		125 - 220	U/L
METHOD : IFCC LACTATE TO PYRUVATE				
SERUM BLOOD UREA NITROGEN				
BLOOD UREA NITROGEN	**6**	**Low**	9.8 - 20.1	mg/dL
METHOD : UREASE METHOD				
CREATININE, SERUM				

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Test Report Status **Preliminary**	Results	Biological Reference Interval	Units
CREATININE	0.74	0.57 - 1.11	mg/dL
METHOD : KINETIC ALKALINE PICRATE			
BUN/CREAT RATIO			
BUN/CREAT RATIO	8.11	5.0 - 15.0	
URIC ACID, SERUM			
URIC ACID	3.6	2.6 - 6.0	mg/dL
METHOD : URICASE			
TOTAL PROTEIN, SERUM			
TOTAL PROTEIN	7.2	6.0 - 8.3	g/dL
METHOD : BIURET			
ALBUMIN, SERUM			
ALBUMIN	3.8	3.5 - 5.2	g/dL
METHOD : COLORIMETRIC (BROMCRESOL GREEN)			
GLOBULIN			
GLOBULIN	3.4	2.0 - 3.5	g/dL
METHOD : CALCULATED PARAMETER			
ELECTROLYTES (NA/K/CL), SERUM			
SODIUM	139	136 - 145	mmol/L
METHOD : ION SELECTIVE ELECTRODE TECHNOLOGY INDIRECT			
POTASSIUM	4.10	3.5 - 5.1	mmol/L
METHOD : ION SELECTIVE ELECTRODE TECHNOLOGY INDIRECT			
CHLORIDE	104	98 - 107	mmol/L
METHOD : ION SELECTIVE ELECTRODE TECHNOLOGY INDIRECT			
URINALYSIS			
COLOR	PALE YELLOW		
APPEARANCE	CLEAR		
PH	6.5	4.7 - 7.5	
SPECIFIC GRAVITY	1.015	1.003 - 1.035	
METHOD : DIPSTICK			
GLUCOSE	NOT DETECTED	NOT DETECTED	
METHOD : DIPSTICK			
PROTEIN	NOT DETECTED	NOT DETECTED	
METHOD : DIPSTICK			
KETONES	NOT DETECTED	NOT DETECTED	
METHOD : DIPSTICK			
BLOOD	NOT DETECTED	NOT DETECTED	
METHOD : DIPSTICK			

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Test Report Status **Preliminary**	Results		Biological Reference Interval	Units
BILIRUBIN	NOT DETECTED		NOT DETECTED	
METHOD : DIPSTICK				
UROBILINOGEN	NORMAL		NORMAL	
METHOD : DIPSTICK				
NITRITE	NOT DETECTED		NOT DETECTED	
METHOD : DIPSTICK				
PUS CELL (WBC'S)	**8-10**		0-5	/HPF
EPITHELIAL CELLS	2-3		0-5	/HPF
ERYTHROCYTES (RBC'S)	NOT DETECTED		NOT DETECTED	/HPF
CASTS	NOT DETECTED			
CRYSTALS	NOT DETECTED			
BACTERIA	NOT DETECTED		NOT DETECTED	

Comments

URINALYSIS: MICROSCOPIC EXAMINATION IS CARRIED OUT ON CENTRIFUGED URINARY SEDIMENT.

TSH 3RD GENERATION ULTRA(TSH3 - UL), SERUM

TSH 3RD GENERATION	**7.385**	**High**	0.350 - 4.940	µIU/mL
METHOD : TWO-STEP CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY				

25 - HYDROXYVITAMIN D, SERUM

25 - HYDROXYVITAMIN D	**20.6**	**Low**	Deficieny < 20 Insufficiency: 20- 30 Sufficiency: 30 - 100 Toxicity > 100	ng/mL
METHOD : ONE STEP DIRECT CHEMILUMINESCENCE IMMUNOASSAY				

THYROID PANEL, SERUM

T3	104.2		58 - 193	ng/dL
METHOD : TWO-STEP CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY				
T4	8.75		4.87 - 11.71	µg/dL
METHOD : TWO-STEP CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY				

CALCIUM, SERUM

CALCIUM	8.7		8.4 - 10.2	mg/dL
METHOD : ARSENAZO III				

PAPANICOLAOU SMEAR RESULT PENDING

RHEUMATOID FACTOR, SERUM RESULT PENDING

LETTER RESULT PENDING

STOOL: OVA & PARASITE RESULT PENDING

VITAMIN B12 LEVEL, SERUM

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Test Report Status **Preliminary**	Results	Biological Reference Interval	Units
VITAMIN B12	229	187 - 883	pg/mL
FOLIC ACID, SERUM			
FOLIC ACID	4.0	3.1 - 20.5	ng/mL
ABO GROUP & RH TYPE, EDTA WHOLE BLOOD			
ABO GROUP	TYPE O		
RH TYPE	POSITIVE		
XRAY-CHEST			
IMPRESSION	NO ABNORMALITY DETECTED		
ULTRASOUND ABDOMEN			
ULTRASOUND ABDOMEN	NO ABNORMALITIES DETECTED		
TMT OR ECHO			
TMT OR ECHO	ECHO DONE INSTEAD OF TMT; ECHO - NORMAL STUDY EXCEPT MILD AV SCLEROSIS WITH MILD AR		
HIGH SENSITIVITY C-REACTIVE PROTEIN, SERUM			
HIGH SENSITIVITY CRP	1.00	< 5.0	mg/L
ECG			
ECG	LOW VOLTAGE		
MEDICAL HISTORY			
RELEVANT PRESENT HISTORY	HYPOTHYROID		
RELEVANT PAST HISTORY	APPENDICECTOMY; SPINAL SURGERY		
RELEVANT PERSONAL HISTORY	NOT SIGNIFICANT		
RELEVANT FAMILY HISTORY	MOTHER : DIABETIC; FATHER : BRONCHIAL ASTHMA		
OCCUPATIONAL HISTORY	NOT SIGNIFICANT		
HISTORY OF MEDICATIONS	NOT SIGNIFICANT		
ANTHROPOMETRIC DATA & BMI			
HEIGHT IN METERS	1.65		mts
WEIGHT IN KGS.	62		Kgs
BMI	23	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		

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Test Report Status **Preliminary**	Results	Biological Reference Interval	Units
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	79/MINS		
RESPIRATORY RATE	NORMAL		
CARDIOVASCULAR SYSTEM			
BP	110/63		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			
CONJUNCTIVA	NORMAL		
EYELIDS	NORMAL		
EYE MOVEMENTS	NORMAL		
DISTANT VISION RIGHT EYE WITH GLASSES	6/6		
DISTANT VISION LEFT EYE WITH GLASSES	6/6		
NEAR VISION RIGHT EYE WITH GLASSES	N9		
NEAR VISION LEFT EYE WITH GLASSES	N9		
COLOUR VISION	NORMAL		
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			

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

REMARKS / RECOMMENDATIONS

Mrs. VAIDYA CAME FOR ANNUAL HEALTH CHECK-UP. ON EXAMINATION AND INVESTIGATIONS SHE IS FOUND TO HAVE RAISED TSH(7.385) & LOW VIT D LEVEL(20.6);OTHERWISE SHE IS IN GOOD HEALTH.
ADVISED-
1.DIET MODIFICATION AS DISCUSSED.
2.REGULAR PHYSICAL EXERCISE & WALKING.
3.DRINK PLENTY OF WATER.
4.CONSULT COMPANY MEDICAL OFFICER/FAMILY PHYSICIAN

Comments

MEDICAL EXAMINATION DONE BY:
DR. B. N. JANA, MBBS, DCH
CONSULTANT
WELLNESS CLINIC
PARK STREET, KOLKATA

Interpretation(s)
BLOOD COUNTS-
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.
ERYTHRO SEDIMENTATION RATE, BLOOD-
Erythrocyte sedimentation rate (ESR) is a non - specific phenomena and is clinically useful in the diagnosis and monitoring of disorders associated with an increased production of acute phase reactants. The ESR is increased in pregnancy from about the 3rd month and returns to normal by the 4th week post partum. ESR is influenced by age, sex, menstrual cycle and drugs (eg. corticosteroids, contraceptives). It is especially low (0 -1mm) in polycythaemia, hypofibrinogenemia or congestive cardiac failure and when there are abnormalities of the red cells such as poikilocytosis, spherocytosis or sickle cells.

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

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CIN - U74899PB1995PLC045956

PATIENT NAME : MRS. AMEETA LAV VAIDYA PATIENT ID : **MRSAF26126382**

ACCESSION NO : **0082VC030074** AGE : 58 Years SEX : Female

DRAWN : 29-03-2022 12:50 RECEIVED : 29-03-2022 12:53 REPORTED : 30-03-2022 12:26

REFERRING DOCTOR : DR. ACROFEMI HEALTHCARE LTD (MEDIWHEEL) CLIENT PATIENT ID :

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

3. The reference for the adult reference range is "Practical Haematology by Dacie and Lewis, 10th Edition"
GLYCOSYLATED HEMOGLOBIN, EDTA WHOLE BLOOD-
Glycosylated hemoglobin (GHb) has been firmly established as an index of long-term blood glucose concentrations and as a measure of the risk for the development of complications in patients with diabetes mellitus. Formation of GHb is essentially irreversible, and the concentration in the blood depends on both the life span of the red blood cell (average 120 days) and the blood glucose concentration. Because the rate of formation of GHb is directly proportional to the concentration of glucose in the blood, the GHb concentration represents the integrated values for glucose over the preceding 6-8 weeks.
Any condition that alters the life span of the red blood cells has the potential to alter the GHb level. Samples from patients with hemolytic anemias will exhibit decreased glycated hemoglobin values due to the shortened life span of the red cells. This effect will depend upon the severity of the anemia. Samples from patients with polycythemia or post-splenectomy may exhibit increased glycated hemoglobin values due to a somewhat longer life span of the red cells.
Glycosylated hemoglobins results from patients with HbSS, HbCC, and HbSC and HbD must be interpreted with caution, given the pathological processes, including anemia, increased red cell turnover, transfusion requirements, that adversely impact HbA1c as a marker of long-term glycemic control. In these conditions, alternative forms of testing such as glycated serum protein (fructosamine) should be considered.
"Targets should be individualized; More or less stringent glycemic goals may be appropriate for individual patients. Goals should be individualized based on duration of diabetes, age/life expectancy, comorbid conditions, known CVD or advanced microvascular complications, hypoglycemia unawareness, and individual patient considerations.''

References
1. Tietz Textbook of Clinical Chemistry and Molecular Diagnostics, edited by Carl A Burtis, Edward R.Ashwood, David E Bruns, 4th Edition, Elsevier publication, 2006, 879-884.
2. Forsham PH. Diabetes Mellitus:A rational plan for management. Postgrad Med 1982, 71,139-154.
3. Mayer TK, Freedman ZR: Protein glycosylation in Diabetes Mellitus: A review of laboratory measurements and their clinical utility. Clin Chim Acta 1983, 127, 147-184.
GLUCOSE, FASTING, PLASMA-
ADA 2021 guidelines for adults, after 8 hrs fasting is as follows:
Pre-diabetics: 100 - 125 mg/dL
Diabetic: > or = 126 mg/dL
GLUCOSE, POST-PRANDIAL, PLASMA-ADA Guidelines for 2hr post prandial glucose levels is only after ingestion of 75grams of glucose in 300 ml water,over a period of 5 minutes.
CORONARY RISK PROFILE (LIPID PROFILE), SERUM.-
Serum cholesterol is a blood test that can provide valuable information for the risk of coronary artery disease This test can help determine your risk of the build up of plaques in your arteries that can lead to narrowed or blocked arteries throughout your body (atherosclerosis). High cholesterol levels usually don't cause any signs or symptoms, so a cholesterol test is an important tool. High cholesterol levels often are a significant risk factor for heart disease and important for diagnosis of hyperlipoproteinemia, atherosclerosis, hepatic and thyroid diseases.

Serum Triglyceride are a type of fat in the blood. When you eat, your body converts any calories it doesn't need into triglycerides, which are stored in fat cells. High triglyceride levels are associated with several factors, including being overweight, eating too many sweets or drinking too much alcohol, smoking, being sedentary, or having diabetes with elevated blood sugar levels. Analysis has proven useful in the diagnosis and treatment of patients with diabetes mellitus, nephrosis, liver obstruction, other diseases involving lipid metabolism, and various endocrine disorders. In conjunction with high density lipoprotein and total serum cholesterol, a triglyceride determination provides valuable information for the assessment of coronary heart disease risk.It is done in fasting state.

High-density lipoprotein (HDL) cholesterol. This is sometimes called the ""good"" cholesterol because it helps carry away LDL cholesterol, thus keeping arteries open and blood flowing more freely.HDL cholesterol is inversely related to the risk for cardiovascular disease. It increases following regular exercise, moderate alcohol consumption and with oral estrogen therapy. Decreased levels are associated with obesity, stress, cigarette smoking and diabetes mellitus.

SERUM LDL The small dense LDL test can be used to determine cardiovascular risk in individuals with metabolic syndrome or established/progressing coronary artery disease, individuals with triglyceride levels between 70 and 140 mg/dL, as well as individuals with a diet high in trans-fat or carbohydrates. Elevated sdLDL levels are associated with metabolic syndrome and an 'atherogenic lipoprotein profile', and are a strong, independent predictor of cardiovascular disease.
Elevated levels of LDL arise from multiple sources. A major factor is sedentary lifestyle with a diet high in saturated fat. Insulin-resistance and pre-diabetes have also been implicated, as has genetic predisposition. Measurement of sdLDL allows the clinician to get a more comprehensive picture of lipid risk factors and tailor treatment accordingly. Reducing LDL levels will reduce the risk of CVD and MI.

Recommendations:
Results of Lipids should always be interpreted in conjunction with the patient's medical history, clinical presentation and other findings.

NON FASTING LIPID PROFILE includes Total Cholesterol, HDL Cholesterol and calculated non-HDL Cholesterol. It does not include triglycerides and may be best used in patients for whom fasting is difficult.
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

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

Causes of decreased levels
• 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's
• Multiple Sclerosis

Nutritional tips to manage increased Uric acid levels
• Drink plenty of fluids
• Limit animal proteins
• High Fibre foods
• Vit C Intake
• Antioxidant rich foods
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-

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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.
ELECTROLYTES (NA/K/CL), SERUM-
Sodium levels are Increased in dehydration, cushing's syndrome, aldosteronism & decreased in Addison's disease, hypopituitarism,liver disease. Hypokalemia (low K) is common in vomiting, diarrhea, alcoholism, folic acid deficiency and primary aldosteronism. Hyperkalemia may be seen in end-stage renal failure, hemolysis, trauma, Addison's disease, metabolic acidosis, acute starvation, dehydration, and with rapid K infusion.Chloride is increased in dehydration, renal tubular acidosis (hyperchloremia metabolic acidosis), acute renal failure, metabolic acidosis associated with prolonged diarrhea and loss of sodium bicarbonate, diabetes insipidus, adrenocortical hyperfuction, salicylate intoxication and with excessive infusion of isotonic saline or extremely high dietary intake of salt.Chloride is decreased in overhydration, chronic respiratory acidosis, salt-losing nephritis, metabolic alkalosis, congestive heart failure, Addisonian crisis, certain types of metabolic acidosis, persistent gastric secretion and prolonged vomiting,
URINALYSIS-Routine urine analysis assists in screening and diagnosis of various metabolic, urological, kidney and liver disorders
Protein: Elevated proteins can be an early sign of kidney disease. Urinary protein excretion can also be temporarily elevated by strenuous exercise, orthostatic proteinuria, dehydration, urinary tract infections and acute illness with fever
Glucose: Uncontrolled diabetes mellitus can lead to presence of glucose in urine. Other causes include pregnancy, hormonal disturbances, liver disease and certain medications.
Ketones: Uncontrolled diabetes mellitus can lead to presence of ketones in urine. Ketones can also be seen in starvation, frequent vomiting, pregnancy and strenuous exercise.
Blood: Occult blood can occur in urine as intact erythrocytes or haemoglobin, which can occur in various urological, nephrological and bleeding disorders.
Leukocytes: An increase in leukocytes is an indication of inflammation in urinary tract or kidneys. Most common cause is bacterial urinary tract infection.
Nitrite: Many bacteria give positive results when their number is high. Nitrite concentration during infection increases with length of time the urine specimen is retained in bladder prior to collection.
pH: The kidneys play an important role in maintaining acid base balance of the body. Conditions of the body producing acidosis/ alkalosis or ingestion of certain type of food can affect the pH of urine.
Specific gravity: Specific gravity gives an indication of how concentrated the urine is. Increased specific gravity is seen in conditions like dehydration, glycosuria and proteinuria while decreased specific gravity is seen in excessive fluid intake, renal failure and diabetes insipidus.
Bilirubin: In certain liver diseases such as biliary obstruction or hepatitis, bilirubin gets excreted in urine.
Urobilinogen: Positive results are seen in liver diseases like hepatitis and cirrhosis and in cases of hemolytic anemia
TSH 3RD GENERATION ULTRA(TSH3 - UL), SERUM-
Below mentioned are the guidelines for Pregnancy related reference ranges for TSH.

Levels in Pregnancy	TSH (µIU/mL)
First Trimester	0.1 - 2.5
2nd Trimester	0.2 – 3.0
3rd Trimester	0.3 – 3.0

NOTE: TSH concentrations in apparently normal euthyroid subjects are known to be highly skewed, with a strong tailed distribution towards higher TSH values. This is well documented in the pediatric population including the infant age group.
25 - HYDROXYVITAMIN D, SERUM-Note: Our Vitamin D assays is standardized to be in alignment with the ID-LC/MS/MS 25(OH)vitamin D Reference Method Procedure (RMP), the reference procedure for the Vitamin D Standardization Program (VDSP). The VDSP, a collaboration of the National Institutes of Health Office of Dietary Supplements, National Institute of Technology and Standards, Centers for Disease Control and Ghent University, is an initiative to standardize 25(OH)vitamin D measurement across methods
THYROID PANEL, SERUM-
Triiodothyronine T3 , is a thyroid hormone. It affects 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.
Thyroxine T4, Thyroxine's principal function is to stimulate the metabolism of all cells and tissues in the body. Excessive secretion of thyroxine in the body is hyperthyroidism, and deficient secretion is called 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.
In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hypothyroidism, TSH levels are low.
Below mentioned are the guidelines for Pregnancy related reference ranges for Total T4, TSH & Total T3

Levels in Pregnancy	TOTAL T4 (µg/dL)	TSH3G (µIU/mL)	TOTAL T3 (ng/dL)
First Trimester	6.6 - 12.4	0.1 - 2.5	81 - 190
2nd Trimester	6.6 - 15.5	0.2 - 3.0	100 - 260
3rd Trimester	6.6 - 15.5	0.3 - 3.0	100 - 260

Below mentioned are the guidelines for age related reference ranges for T3 and T4.

T3 (ng/dL)	T4 (µg/dL)
New Born: 75 - 260	1-3 day: 8.2 - 19.9
.	1 Week: 6.0 - 15.9

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NOTE: TSH concentrations in apparently normal euthyroid subjects are known to be highly skewed, with a strong tailed distribution towards higher TSH values. This is well documented in the pediatric population including the infant age group.
Kindly note: Method specific reference ranges are appearing on the report under biological reference range.

Reference:
1. Burtis C.A., Ashwood E. R. Bruns D.E. Teitz textbook of Clinical Chemistry and Molecular Diagnostics, 4th Edition.
2. Gowenlock A.H. Varley's Practical Clinical Biochemistry, 6th Edition.
3. Behrman R.E. Kilegman R.M., Jenson H. B. Nelson Text Book of Pediatrics, 17th Edition
CALCIUM, SERUM-
Commom causes of decreased value of calcium (hypocalcemia) are chronic renal failure, hypomagnesemia and hypoalbuminemia.

Hypercalcemia (increased value of calcium) can be caused by increased intestinal absorbtion (vitamin d intoxication), increased skeletal reasorption (immobilization), or a combination of mechanisms (primary hyperparathyroidism). Primary hyperparathyroidism and malignancy accounts for 90-95% of all cases of hypercalcemia.

Values of total calcium is affected by serum proteins, particularly albumin thus, latter's value should be taken into account when interpreting serum calcium levels. The following regression equation may be helpful.
Corrected total calcium (mg/dl)= total calcium (mg/dl) + 0.8 (4- albumin [g/dl])*
because regression equations vary among group of patients in different physiological and pathological conditions, mathematical corrections are only approximations. The possible mathematical corrections should be replaced by direct determination of free calcium by ISE (available with srl) a common and important source of preanalytical error in the measurement of calcium is prolonged torniquet application during sampling. Thus, this along with fist clenching should be avoided before phlebotomy.
FOLIC ACID, SERUM-
Folates are compounds of pteroylglutamic acid (PGA) that function as coenzymes in metabolic reactions involving the transfer of single-carbon units from a donor to a recipient compound. Folate, with vitamin B12, is essential for DNA synthesis, which is required for normal red blood cell maturation. Human obtain folate from dietary sources including fruits, green and leafy vegetables, yeast, and organ meats. Folate is absorbed through the small intestine and stored in the liver.

Low folate intake, malabsorption as result of gastrointestinal diseases, pregnancy, and drugs such as phenytoin are causes of folate deficiency. Folate deficiency is also associated with chronic alcoholism. Folate and vitamin B12 deficiency impair DNA synthesis, causing macrocytic anemias. These anemias are characterized by abnormal maturation of red blood cell precursors in the bone marrow, the presence of megaloblasts, and decreased red blood cell survival.

Since both folate and vitamin B12 deficiency can cause macrocytic anemia, appropriate treatment depends on the differential diagnosis of the deficiency. Serum folate measurement provides an early index of folate status. However, folate is much more concentrated in red blood cells than in serum so the red blood cell folate measurement more closely reflects tissue stores. Red blood cell folate concentration is considered the most reliable indicator of folate status.

Methotrexate and Leucovorin interfere with folate measurement because these drugs cross-react with folate binding proteins.
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.
HIGH SENSITIVITY C-REACTIVE PROTEIN, SERUM-
High sensitivity CRP measurements may be used as an independent risk marker for the identification of individuals at risk for future cardiovascular disease. Measurement of hs- CRP, when used in conjunction with traditional clinical laboratory evaluation of acute coronary syndromes, may be useful as an independent marker of prognosis for recurrent events, in patients with stable coronary disease or acute coronary syndromes.
When using this assay for risk assessment, patients with persistently unexplained, marked elevation of hs- CRP (> 10mg/l) after repeated testing should be evaluated for non cardiovascular etiologies. In Rheumatic and other inflammatory diseases, value of CRP less than 10 mg/l is considered satisfactory. More than 10 mg/l suggests disease activity. Patients with evidence of active infection, systemic inflammatory processes or trauma should not be tested for cardiovascular disease risk assessment until these conditions have abated
Hs- CRP levels should not be substituted for assessment of traditional cardiovascular risk factors.
Turbidity and particles in the sample may interfere with the determination. Patient samples which contain heterophilic antibodies could react in immunoassays to give a falsely elevated or depressed result.
Results of this test should always be interpreted in conjunction with the patient's medical history, clinical presentation and other findings.

References:

1. Teitz textbook of clinical chemistry and Molecular diagnostics, edited by Carl A Burtis, Edward R. Ashrwood, David E Bruns, 4th edition, Elseiver publication, 2006,962-966
2. Parson TA, Mensah GA, et al. Marker of inflammation and cardiovascular disease: application to clinical and public health practice. Circulation 2003,107,499-511
3. Rheumatoid arthritis disease activity measures: American College of Rheumatology recommendations for use in clinical practice: Jacyln Anderson, Liron Caplin et al, Wiley online, 2012.
MEDICAL
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