agilus diagnostics

Patient Ref. No. 775000002565363

LABORATORY SERVICES

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
8800465156

SRL Ltd
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THANE, 400602
MAHARASHTRA, INDIA
Tel : 9111591115, Fax : CIN - U74899PB1995PLC045956
Email : customercare.thane@srl.in

PATIENT NAME : SNEHAL SONEKAR PATIENT ID : **SNEHF231088181**

ACCESSION NO : **0181WC000542** AGE : 34 Years SEX : Male

DRAWN : RECEIVED : 11/03/2023 08:11 REPORTED : 15/03/2023 11:54

REFERRING DOCTOR : SELF CLIENT PATIENT ID :

Test Report Status **Final**	Results		Biological Reference Interval	Units
MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE				
BLOOD COUNTS,EDTA WHOLE BLOOD				
HEMOGLOBIN (HB)	13.6		13.0 - 17.0	g/dL
METHOD : SLS- HEMOGLOBIN DETECTION METHOD				
RED BLOOD CELL (RBC) COUNT	5.49		4.5 - 5.5	mil/µL
METHOD : HYDRODYNAMIC FOCUSING BY DC DETECTION				
WHITE BLOOD CELL (WBC) COUNT	6.88		4.0 - 10.0	thou/µL
METHOD : FLUORESCENCE FLOW CYTOMETRY				
PLATELET COUNT	215		150 - 410	thou/µL
METHOD : HYDRODYNAMIC FOCUSING BY DC DETECTION				
RBC AND PLATELET INDICES				
HEMATOCRIT (PCV)	43.3		40.0 - 50.0	%
METHOD : CUMULATIVE PULSE HEIGHT DETECTION METHOD				
MEAN CORPUSCULAR VOLUME (MCV)	**78.9**	**Low**	83.0 - 101.0	fL
METHOD : CALCULATED FROM RBC & HCT				
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	**24.8**	**Low**	27.0 - 32.0	pg
METHOD : CALCULATED FROM THE RBC & HGB				
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)	**31.4**	**Low**	31.5 - 34.5	g/dL
METHOD : CALCULATED FROM THE HGB & HCT				
RED CELL DISTRIBUTION WIDTH (RDW)	13.5		11.6 - 14.0	%
METHOD : CALCULATED FROM RBC SIZE DISTRIBUTION CURVE				
MENTZER INDEX	14.4			
MEAN PLATELET VOLUME (MPV)	**12.4**	**High**	6.8 - 10.9	fL
METHOD : CALCULATED FROM PLATELET COUNT & PLATELET HEMATOCRIT				
WBC DIFFERENTIAL COUNT				
NEUTROPHILS	52		40 - 80	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
LYMPHOCYTES	39		20 - 40	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
MONOCYTES	5		2 - 10	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
EOSINOPHILS	4		1 - 6	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
ABSOLUTE NEUTROPHIL COUNT	3.55		2.0 - 7.0	thou/µL
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				

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ABSOLUTE LYMPHOCYTE COUNT	2.68		1.0 - 3.0	thou/µL
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
ABSOLUTE MONOCYTE COUNT	0.32		0.2 - 1.0	thou/µL
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
ABSOLUTE EOSINOPHIL COUNT	0.28		0.02 - 0.50	thou/µL
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	1.3			
MORPHOLOGY				
RBC	NORMOCYTIC NORMOCHROMIC			
WBC	NORMAL MORPHOLOGY			
METHOD : MICROSCOPIC EXAMINATION				
PLATELETS	ADEQUATE			
ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD				
E.S.R	2		< 15	mm at 1 hr
GLUCOSE FASTING,FLUORIDE PLASMA				
FBS (FASTING BLOOD SUGAR)	91		Normal 75 - 99 Pre-diabetics: 100 – 125 Diabetic: > or = 126	mg/dL
METHOD : ENZYMATIC REFERENCE METHOD WITH HEXOKINASE				
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD				
HBA1C	**5.9**	**High**	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)	**122.6**	**High**	< 116.0	mg/dL
METHOD : CALCULATED PARAMETER				
GLUCOSE, POST-PRANDIAL, PLASMA				
PPBS(POST PRANDIAL BLOOD SUGAR)	89		70 - 139	mg/dL
METHOD : ENZYMATIC REFERENCE METHOD WITH HEXOKINASE				
LIPID PROFILE, SERUM				
CHOLESTEROL, TOTAL	163		Desirable cholesterol level < 200 Borderline high cholesterol 200 - 239 High cholesterol > / = 240	mg/dL

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METHOD : ENZYMATIC COLORIMETRIC ASSAY				
TRIGLYCERIDES	99		Normal: < 150 Borderline high: 150 - 199 High: 200 - 499 Very High: >/= 500	mg/dL
METHOD : ENZYMATIC COLORIMETRIC ASSAY				
HDL CHOLESTEROL	**38**	**Low**	Low HDL Cholesterol <40 High HDL Cholesterol >/= 60	mg/dL
METHOD : ENZYMATIC, COLORIMETRIC				
CHOLESTEROL LDL	**105**	**High**	Adult levels: Optimal < 100 Near optimal/above optimal: 100-129 Borderline high : 130-159 High : 160-189 Very high : = 190	mg/dL
METHOD : ENZYMATIC COLORIMETRIC ASSAY				
NON HDL CHOLESTEROL	125		Desirable : < 130 Above Desirable : 130 -159 Borderline High : 160 - 189 High : 190 - 219 Very high : > / = 220	mg/dL
VERY LOW DENSITY LIPOPROTEIN	19.8		< OR = 30.0	mg/dL
CHOL/HDL RATIO	4.3		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	2.8		0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
LIVER FUNCTION PROFILE, SERUM				
BILIRUBIN, TOTAL	0.53		Upto 1.2	mg/dL
METHOD : COLORIMETRIC DIAZO				
BILIRUBIN, DIRECT	0.26		< 0.30	mg/dL
BILIRUBIN, INDIRECT	0.27		0.1 - 1.0	mg/dL
TOTAL PROTEIN	7.0		6.0 - 8.0	g/dL
METHOD : COLORIMETRIC				
ALBUMIN	4.4		3.97 - 4.94	g/dL
METHOD : COLORIMETRIC				
GLOBULIN	2.6		2.0 - 3.5	g/dL
ALBUMIN/GLOBULIN RATIO	1.7		1.0 - 2.1	RATIO

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ASPARTATE AMINOTRANSFERASE (AST/SGOT)	19	< OR = 50	U/L
METHOD : UV ABSORBANCE			
ALANINE AMINOTRANSFERASE (ALT/SGPT)	21	< OR = 50	U/L
METHOD : UV ABSORBANCE			
ALKALINE PHOSPHATASE	65	40 - 129	U/L
METHOD : COLORIMETRIC			
GAMMA GLUTAMYL TRANSFERASE (GGT)	15	0 - 60	U/L
METHOD : ENZYMATIC, COLORIMETRIC			
LACTATE DEHYDROGENASE	154	125 - 220	U/L
METHOD : UV ABSORBANCE			
BLOOD UREA NITROGEN (BUN), SERUM			
BLOOD UREA NITROGEN	11	6 - 20	mg/dL
METHOD : ENZYMATIC ASSAY			
CREATININE, SERUM			
CREATININE	0.84	0.7 - 1.2	mg/dL
METHOD : COLORIMETRIC			
BUN/CREAT RATIO			
BUN/CREAT RATIO	13.10	8.0 - 15.0	
URIC ACID, SERUM			
URIC ACID	4.6	3.4 - 7.0	mg/dL
METHOD : ENZYMATIC COLORIMETRIC ASSAY			
TOTAL PROTEIN, SERUM			
TOTAL PROTEIN	7.0	6.0 - 8.0	g/dL
METHOD : COLORIMETRIC			
ALBUMIN, SERUM			
ALBUMIN	4.4	3.97 - 4.94	g/dL
METHOD : COLORIMETRIC			
GLOBULIN			
GLOBULIN	2.6	2.0 - 3.5	g/dL
ELECTROLYTES (NA/K/CL), SERUM			
SODIUM, SERUM	140	136 - 145	mmol/L
POTASSIUM, SERUM	4.68	3.5 - 5.1	mmol/L
CHLORIDE, SERUM	105	98 - 107	mmol/L
PHYSICAL EXAMINATION, URINE			
COLOR	PALE YELLOW		
APPEARANCE	CLEAR		

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CHEMICAL EXAMINATION, URINE			
PH	6.0	5.00 - 7.50	
SPECIFIC GRAVITY	1.015	1.010 - 1.030	
PROTEIN	NOT DETECTED	NOT DETECTED	
GLUCOSE	NOT DETECTED	NOT DETECTED	
KETONES	NOT DETECTED	NOT DETECTED	
BLOOD	NOT DETECTED	NOT DETECTED	
UROBILINOGEN	NORMAL	NORMAL	
NITRITE	NOT DETECTED	NOT DETECTED	
LEUKOCYTE ESTERASE	NOT DETECTED	NOT DETECTED	
MICROSCOPIC EXAMINATION, URINE			
RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
PUS CELL (WBC'S)	0-1	0-5	/HPF
EPITHELIAL CELLS	3-5	0-5	/HPF
CASTS	NOT DETECTED		
CRYSTALS	NOT DETECTED		
BACTERIA	NOT DETECTED	NOT DETECTED	
YEAST	NOT DETECTED	NOT DETECTED	
THYROID PANEL, SERUM			
T3	121.0	80 - 200	ng/dL
METHOD : ELECTROCHEMILUMINESCENCE			
T4	9.83	5.1 - 14.1	µg/dL
METHOD : ELECTROCHEMILUMINESCENCE			
TSH (ULTRASENSITIVE)	1.360	0.27 - 4.2	µIU/mL
METHOD : ELECTROCHEMILUMINESCENCE			
PHYSICAL EXAMINATION,STOOL			
COLOUR	BROWN		
METHOD : VISUAL			
CONSISTENCY	WELL FORMED		
METHOD : VISUAL			
MUCUS	ABSENT	NOT DETECTED	
METHOD : VISUAL			
VISIBLE BLOOD	ABSENT	ABSENT	
METHOD : VISUAL			
CHEMICAL EXAMINATION,STOOL			

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OCCULT BLOOD	NOT DETECTED	NOT DETECTED	
METHOD : HEMOSPOT			
MICROSCOPIC EXAMINATION,STOOL			
PUS CELLS	0-1		/hpf
RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
METHOD : MICROSCOPIC EXAMINATION			
CYSTS	NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION			
OVA	NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION			
LARVAE	NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION			
TROPHOZOITES	NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION			
FAT	ABSENT		
VEGETABLE CELLS	**PRESENT**		
CONCENTRATION METHOD	NO OVA CYST SEEN AFTER PERFORMING CONCENTRATION TECHNIQUE FOR STOOL SAMPLE		
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			
TMT OR ECHO	NEGATIVE		
ECG			
ECG	WITHIN NORMAL LIMITS		
MEDICAL HISTORY			
RELEVANT PRESENT HISTORY	NOT SIGNIFICANT		
RELEVANT PAST HISTORY	NOT SIGNIFICANT		
RELEVANT PERSONAL HISTORY	MARRIED / MIXED DIET / NO ALLERGIES / NO SMOKING / NO ALCOHOL.		
RELEVANT FAMILY HISTORY	NOT SIGNIFICANT		
OCCUPATIONAL HISTORY	NOT SIGNIFICANT		

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HISTORY OF MEDICATIONS	NOT SIGNIFICANT		
ANTHROPOMETRIC DATA & BMI			
HEIGHT IN METERS	1.74		mts
WEIGHT IN KGS.	63		Kgs
BMI	21	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	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		
BREAST (FOR FEMALES)	NORMAL		
TEMPERATURE	NORMAL		
PULSE	60/MIN.REGULAR, ALL PERIPHERAL PULSES WELL FELT, NO CAROTID BRUIT		
RESPIRATORY RATE	NORMAL		
CARDIOVASCULAR SYSTEM			
BP	113/74 MM HG (SUPINE)		mm/Hg
PERICARDIUM	NORMAL		
APEX BEAT	NORMAL		
HEART SOUNDS	NORMAL		
MURMURS	ABSENT		
RESPIRATORY SYSTEM			
SIZE AND SHAPE OF CHEST	NORMAL		

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MOVEMENTS OF CHEST	SYMMETRICAL		
BREATH SOUNDS INTENSITY	NORMAL		
BREATH SOUNDS QUALITY	VESICULAR (NORMAL)		
ADDED SOUNDS	ABSENT		
PER ABDOMEN			
APPEARANCE	NORMAL		
VENOUS PROMINENCE	ABSENT		
LIVER	NOT PALPABLE		
SPLEEN	NOT PALPABLE		
HERNIA	ABSENT		
CENTRAL NERVOUS SYSTEM			
HIGHER FUNCTIONS	NORMAL		
CRANIAL NERVES	NORMAL		
CEREBELLAR FUNCTIONS	NORMAL		
SENSORY SYSTEM	NORMAL		
MOTOR SYSTEM	NORMAL		
REFLEXES	NORMAL		
MUSCULOSKELETAL SYSTEM			
SPINE	NORMAL		
JOINTS	NORMAL		
BASIC EYE EXAMINATION			
CONJUNCTIVA	NORMAL		
EYELIDS	NORMAL		
EYE MOVEMENTS	NORMAL		
CORNEA	NORMAL		
DISTANT VISION RIGHT EYE WITHOUT GLASSES	REDUCED VISUAL ACUITY 6/24		
DISTANT VISION LEFT EYE WITHOUT GLASSES	REDUCED VISUAL ACUITY 6/24		
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		

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REMARKS / RECOMMENDATIONS

WEIGHT LOSS -LOW FAT, LOW CARBOHYDRATE, HIGH FIBRE DIET.
REGULAR EXERCISE,REGULAR WALK FOR 30-40 MIN DAILY.
REPEAT BLOOD SUGAR AFTER 3 MONTHS OF DIET AND EXERCISE.
OPHTHALMOLOGY CONSULT FOR REDUCED VISUAL ACUITY.
DRINK 3-4 LIT WATER DAILY.
UROLOGY CONSULT FOR RENAL CALCULI

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, Vasculities, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Tissue injury, Pregnancy, Estrogen medication, Aging.
Finding a very accelerated ESR**(>100 mm/hour)** in patients with ill-defined symptoms directs the physician to search for a systemic disease (Paraproteinemias, Disseminated malignancies, connective tissue disease, severe infections such as bacterial endocarditis).
In pregnancy BRI in first trimester is 0-48 mm/hr(62 if anemic) and in second trimester (0-70 mm /hr(95 if anemic). ESR returns to normal 4th week post partum.
Decreased in: Polycythermia vera, Sickle cell anemia

LIMITATIONS

False elevated ESR : Increased fibrinogen, Drugs(Vitamin A, Dextran etc), Hypercholesterolemia
False Decreased : Poikilocytosis,(SickleCells,spherocytes),Microcytosis, Low fibrinogen, Very high WBC counts, Drugs(Quinine,

salicylates)

REFERENCE :
1. Nathan and Oski's Haematology of Infancy and Childhood, 5th edition 2. Paediatric reference intervals. AACC Press, 7th edition. Edited by S. Soldin 3. The reference for the adult reference range is "Practical Haematology by Dacie and Lewis,10th edition.
GLUCOSE FASTING,FLUORIDE PLASMA-**TEST DESCRIPTION**
Normally, the glucose concentration in extracellular fluid is closely regulated so that a source of energy is readily available to tissues and sothat no glucose is excreted in the urine.
Increased in:Diabetes mellitus, Cushing' s syndrome (10 – 15%), chronic pancreatitis (30%). Drugs:corticosteroids,phenytoin, estrogen, thiazides.
Decreased in :Pancreatic islet cell disease with increased insulin,insulinoma,adrenocortical insufficiency,hypopituitarism,diffuse liver disease, malignancy(adrenocortical,stomach,fibrosarcoma),infant of a diabetic mother,enzyme deficiency diseases(e.g.galactosemia),Drugs-insulin,ethanol,propranolol sulfonylureas,tolbutamide,and other oral hypoglycemic agents.
NOTE: While random serum glucose levels correlate with home glucose monitoring results (weekly mean capillary glucose values),there is wide fluctuation within individuals.Thus, glycosylated hemoglobin(HbA1c) levels are favored to monitor glycemic control.
High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment,Renal Glyosuria,Glycaemic index & response to food consumed,Alimentary Hypoglycemia,Increased insulin response & sensitivity etc.
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD-**Used For**:

1. Evaluating the long-term control of blood glucose concentrations in diabetic patients.

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CLIENT CODE : C000138394
CLIENT'S NAME AND ADDRESS :
ACROFEMI HEALTHCARE LTD (MEDIWHEEL)
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PATIENT NAME : SNEHAL SONEKAR PATIENT ID : **SNEHF231088181**

ACCESSION NO : **0181WC000542** AGE : 34 Years SEX : Male

DRAWN : RECEIVED : 11/03/2023 08:11 REPORTED : 15/03/2023 11:54

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2. Diagnosing diabetes.
3. Identifying patients at increased risk for diabetes (prediabetes).
The ADA recommends measurement of HbA1c (typically 3-4 times per year for type 1 and poorly controlled type 2 diabetic patients, and 2 times per year for well-controlled type 2 diabetic patients) to determine whether a patients metabolic control has remained continuously within the target range.
1. eAG (Estimated average glucose) converts percentage HbA1c to md/dl, to compare blood glucose levels.
2. eAG gives an evaluation of blood glucose levels for the last couple of months.
3. eAG is calculated as eAG (mg/dl) = 28.7 * HbA1c - 46.7

HbA1c Estimation can get affected due to :
1. Shortened Erythrocyte survival : Any condition that shortens erythrocyte survival or decreases mean erythrocyte age (e.g. recovery from acute blood loss,hemolytic anemia) will falsely lower HbA1c test results.Fructosamine is recommended in these patients which indicates diabetes control over 15 days.
2.Vitamin C & E are reported to falsely lower test results.(possibly by inhibiting glycation of hemoglobin.
3. Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia,uremia, hyperbilirubinemia, chronic alcoholism,chronic ingestion of salicylates & opiates addiction are reported to interfere with some assay methods,falsely increasing results.
4. Interference of hemoglobinopathies in HbA1c estimation is seen in

a) Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.
b) Heterozygous state detected (D10 is corrected for HbS & HbC trait.)
c) HbF > 25% on alternate paltform (Boronate affinity chromatography) is recommended for testing of HbA1c.Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy
GLUCOSE, POST-PRANDIAL, PLASMA-High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glyosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.Additional test HbA1c
LIVER FUNCTION PROFILE, SERUM-
Bilirubin is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. Bilirubin is excreted in bile and urine, and elevated levels may give yellow discoloration in jaundice.**Elevated levels** results from increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Conjugated (direct) bilirubin is elevated more than unconjugated (indirect) bilirubin in Viral hepatitis, Drug reactions, Alcoholic liver disease Conjugated (direct) bilirubin is also elevated more than unconjugated (indirect) bilirubin when there is some kind of blockage of the bile ducts like in Gallstones getting into the bile ducts, tumors &Scarring of the bile ducts. Increased unconjugated (indirect) bilirubin may be a result of Hemolytic or pernicious anemia, Transfusion reaction & a common metabolic condition termed Gilbert syndrome, due to low levels of the enzyme that attaches sugar molecules to bilirubin.
AST is an enzyme found in various parts of the body. AST is found in the liver, heart, skeletal muscle, kidneys, brain, and red blood cells, and it is commonly measured clinically as a marker for liver health. AST levels increase during chronic viral hepatitis, blockage of the bile duct, cirrhosis of the liver,liver cancer,kidney failure,hemolytic anemia,pancreatitis,hemochromatosis. AST levels may also increase after a heart attack or strenuous activity.ALT test measures the amount of this enzyme in the blood.ALT is found mainly in the liver, but also in smaller amounts in the kidneys,heart,muscles, and pancreas.It is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health.AST levels increase during acute hepatitis,sometimes due to a viral infection,ischemia to the liver,chronic hepatitis,obstruction of bile ducts,cirrhosis.
ALP is a protein found in almost all body tissues.Tissues with higher amounts of ALP include the liver,bile ducts and bone.Elevated ALP levels are seen in Biliary obstruction, Osteoblastic bone tumors, osteomalacia, hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, Pagets disease,Rickets,Sarcoidosis etc. Lower-than-normal ALP levels seen in Hypophosphatasia,Malnutrition,Protein deficiency,Wilsons disease.
GGT is an enzyme found in cell membranes of many tissues mainly in the liver,kidney and pancreas.It is also found in other tissues including intestine,spleen,heart, brain and seminal vesicles.The highest concentration is in the kidney,but the liver is considered the source of normal enzyme activity.Serum GGT has been widely used as an index of liver dysfunction.Elevated serum GGT activity can be found in diseases of the liver,biliary system and pancreas.Conditions that increase serum GGT are obstructive liver disease,high alcohol consumption and use of enzyme-inducing drugs etc.
Total Protein also known as total protein,is a biochemical test for measuring the total amount of protein in serum.Protein in the plasma is made up of albumin and globulin.Higher-than-normal levels may be due to:Chronic inflammation or infection,including HIV and hepatitis B or C,Multiple myeloma,Waldenstroms disease.Lower-than-normal levels may be due to: Agammaglobulinemia,Bleeding (hemorrhage),Burns,Glomerulonephritis,Liver disease, Malabsorption,Malnutrition,Nephrotic syndrome,Protein-losing enteropathy etc.
Albumin is the most abundant protein in human blood plasma.It is produced in the liver.Albumin constitutes about half of the blood serum protein.Low blood albumin levels (hypoalbuminemia) can be caused by:Liver disease like cirrhosis of the liver, nephrotic syndrome,protein-losing enteropathy,Burns,hemodilution,increased vascular permeability or decreased lymphatic clearance,malnutrition and wasting etc
BLOOD UREA NITROGEN (BUN), SERUM-**Causes of Increased** levels include Pre renal (High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal), Renal Failure, Post Renal (Malignancy, Nephrolithiasis, Prostatism)
Causes of decreased level include Liver disease, SIADH.
CREATININE, SERUM-**Higher than normal level may be due to:**
• Blockage in the urinary tract, Kidney problems, such as kidney damage or failure, infection, or reduced blood flow, Loss of body fluid (dehydration), Muscle problems, such as breakdown of muscle fibers, Problems during pregnancy, such as seizures (eclampsia)), or high blood pressure caused by pregnancy (preeclampsia)
Lower than normal level may be due to:• Myasthenia Gravis, Muscuophy
URIC ACID, SERUM-**Causes of Increased levels:**-Dietary(High Protein Intake,Prolonged Fasting,Rapid weight loss),Gout,Lesch nyhan syndrome,Type 2 DM,Metabolic syndrome **Causes of decreased levels**-Low Zinc intake,OCP,Multiple Sclerosis
TOTAL PROTEIN, SERUM-is a biochemical test for measuring the total amount of protein in serum.Protein in the plasma is made up of albumin and globulin.
Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma,Waldenstroms disease.
Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage),Burns,Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome,Protein-losing enteropathy etc.
ALBUMIN, SERUM-
Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. **Low blood albumin levels (hypoalbuminemia) can be caused by:** Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns,

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hemodilution, increased vascular permeability or decreased lymphatic clearance,malnutrition and wasting etc.
ABO GROUP & RH TYPE, EDTA WHOLE BLOOD-Blood group is identified by antigens and antibodies present in the blood. Antigens are protein molecules found on the surface of red blood cells. Antibodies are found in plasma. To determine blood group, red cells are mixed with different antibody solutions to give A,B,O or AB.

Disclaimer: "Please note, as the results of previous ABO and Rh group (Blood Group) for pregnant women are not available, please check with the patient records for availability of the same."

The test is performed by both forward as well as reverse grouping methods.
MEDICAL
HISTORY-**********
THIS REPORT CARRIES THE SIGNATURE OF OUR LABORATORY DIRECTOR. THIS IS AN INVIOLABLE FEATURE OF OUR LAB MANAGEMENT SOFTWARE. HOWEVER, ALL EXAMINATIONS AND INVESTIGATIONS HAVE BEEN CONDUCTED BY OUR PANEL OF DOCTORS.

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MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

ULTRASOUND ABDOMEN

ULTRASOUND ABDOMEN

Bilateral renal non obstructive calculi.

****End Of Report****
Please visit www.srlworld.com for related Test Information for this accession

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CONDITIONS OF LABORATORY TESTING & REPORTING

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

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SRL Limited
Fortis Hospital, Sector 62, Phase VIII,
Mohali 160062

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