DDRC SRL Diagnostic Services
INDIA'S LEADING DIAGNOSTICS NET WORK

Patient Ref. No. 666000000934175

LABORATORY SERVICES

CLIENT CODE : CA00010147
CLIENT'S NAME AND ADDRESS :
MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED
F701A, LADO SARAI, NEW DELHI,
SOUTH DELHI, DELHI,
SOUTH DELHI 110030
DELHI INDIA
8800465156

DDRC SRL DIAGNOSTICS
Palmland Building(6/260/2),Temple Road,Bank Junction
ALUVA, 683101
KERALA, INDIA
Tel : 93334 93334
Email : customercare.ddrc@srl.in

PATIENT NAME : SANDEEP B PATIENT ID : **SANDM1807904006**

ACCESSION NO : **4006VG003213** AGE : 32 Years SEX : Male

DRAWN : RECEIVED : 18/07/2022 10:43 REPORTED : 18/07/2022 16:23

REFERRING DOCTOR : DR. MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED CLIENT PATIENT ID :

Test Report Status	Results	Biological Reference Interval	Units
MEDIWHEEL HEALTH CHEKUP BELOW 40(M)TMT	RESULT PENDING		
OPTHAL	RESULT PENDING		

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MEDIWHEEL HEALTH CHEKUP BELOW 40(M)TMT	RESULT PENDING			
LIVER PROFILE - EXTENDED	RESULT PENDING			
BUN/CREAT RATIO				
BUN/CREAT RATIO	9.6		5.00 - 15.00	
CREATININE, SERUM				
CREATININE	**0.62**	**Low**	0.7 - 1.2	mg/dL
GLUCOSE, POST-PRANDIAL, PLASMA				
GLUCOSE, POST-PRANDIAL, PLASMA	**335**	**High**	70 - 140	mg/dL
GLUCOSE, FASTING, PLASMA				
GLUCOSE, FASTING, PLASMA	**205**	**High**	74 - 106	mg/dL
GLYCOSYLATED HEMOGLOBIN, EDTA WHOLE BLOOD				
GLYCOSYLATED HEMOGLOBIN (HBA1C)	**10.9**	**High**	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 ADA Target: 7.0 Action suggested: > 8.0	%
MEAN PLASMA GLUCOSE	**266.1**	**High**	< 116.0	mg/dL
CORONARY RISK PROFILE (LIPID PROFILE), SERUM				
CHOLESTEROL	192		< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
TRIGLYCERIDES	76		< 150 Normal 150 - 199 Borderline High 200 - 499 High >/=500 Very High	mg/dL
HDL CHOLESTEROL	47		< 40 Low >/=60 High	mg/dL
DIRECT LDL CHOLESTEROL	**130**	**High**	< 100 Optimal 100 - 129 Near or above optimal 130 - 159 Borderline High 160 - 189 High >/= 190 Very High	mg/dL
NON HDL CHOLESTEROL	**145**	**High**	Desirable-Less than 130 Above Desirable-130-159 Borderline High-160-189 High-190-219 Very High- >or =220	mg/dL
CHOL/HDL RATIO	4.1		3.3 - 4.4 Low Risk 4.5 - 7.0 Average Risk 7.1 - 11.0 Moderate Risk > 11.0 High Risk	

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LDL/HDL RATIO	2.8		0.5-3 Desirable/Low risk 3.1-6 Borderline/Moderate risk >6.0 High Risk	
VERY LOW DENSITY LIPOPROTEIN	15.2		</= 30	mg/dL
LIVER FUNCTION TEST WITH GGT				
BILIRUBIN, TOTAL	0.57		Upto 1.2	mg/dL
BILIRUBIN, DIRECT	0.20		Upto 0.2	mg/dL
BILIRUBIN, INDIRECT	0.37		0.00 - 0.60	mg/dL
GAMMA GLUTAMYL TRANSFERASE (GGT)	33		8 - 61	U/L
URIC ACID, SERUM				
URIC ACID	**3.3**	**Low**	3.4 - 7.0	mg/dL
ABO GROUP & RH TYPE, EDTA WHOLE BLOOD				
ABO GROUP	TYPE AB			
RH TYPE	POSITIVE			
BLOOD COUNTS				
HEMOGLOBIN	14.9		13.0 - 17.0	g/dL
RED BLOOD CELL COUNT	5.02		4.5 - 5.5	mil/µL
WHITE BLOOD CELL COUNT	5.10		4.0 - 10.0	thou/µL
PLATELET COUNT	344		150 - 410	thou/µL
RBC AND PLATELET INDICES				
HEMATOCRIT	43.9		40 - 50	%
MEAN CORPUSCULAR VOL	88.0		83 - 101	fL
MEAN CORPUSCULAR HGB.	29.7		27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION	34.0		31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH	**15.8**	**High**	11.6 - 14.0	%
MEAN PLATELET VOLUME	7.9		6.8 - 10.9	fL
WBC DIFFERENTIAL COUNT - NLR				
SEGMENTED NEUTROPHILS	53		40 - 80	%
ABSOLUTE NEUTROPHIL COUNT	2.70		2.0 - 7.0	thou/µL
LYMPHOCYTES	**42**	**High**	20 - 40	%
ABSOLUTE LYMPHOCYTE COUNT	2.14		1.0 - 3.0	thou/µL
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	1.3			
EOSINOPHILS	04		1 - 6	%
ABSOLUTE EOSINOPHIL COUNT	0.20		0.02 - 0.50	thou/µL

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MONOCYTES	**01**	**Low**	2 - 10	%
ABSOLUTE MONOCYTE COUNT	**0.05**	**Low**	0.2 - 1.0	thou/µL
BASOPHILS	00		0 - 2	%
ERYTHRO SEDIMENTATION RATE, BLOOD				
SEDIMENTATION RATE (ESR)	07		0 - 14	mm at 1 hr
STOOL: OVA & PARASITE	RESULT PENDING			
SUGAR URINE - POST PRANDIAL				
SUGAR URINE - POST PRANDIAL	**DETECTED (++++)**		NOT DETECTED	
URINALYSIS				
COLOR	PALE YELLOW			
APPEARANCE	CLEAR			
PH	5.0		4.8 - 7.4	
SPECIFIC GRAVITY	1.015		1.015 - 1.030	
GLUCOSE	**DETECTED (++)**		NOT DETECTED	
PROTEIN	NOT DETECTED		NOT DETECTED	
KETONES	NOT DETECTED		NOT DETECTED	
BLOOD	NOT DETECTED		NOT DETECTED	
BILIRUBIN	NOT DETECTED		NOT DETECTED	
UROBILINOGEN	NORMAL		NORMAL	
NITRITE	NOT DETECTED		NOT DETECTED	
WBC	2-3		0-5	/HPF
EPITHELIAL CELLS	**DETECTED (OCCASIONAL)**		NOT DETECTED	/HPF
RED BLOOD CELLS	NOT DETECTED		NOT DETECTED	/HPF
CASTS	NIL			
CRYSTALS	NIL			
BACTERIA	NOT DETECTED		NOT DETECTED	
THYROID PANEL, SERUM				
T3	108.83		60 - 181	ng/dL
T4	12.0		3.2 - 12.6	µg/dl
TSH 3RD GENERATION	2.75		0.35 - 5.50	µIU/mL

Interpretation(s)
CREATININE, SERUM-

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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
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.
GLUCOSE, FASTING, PLASMA-
ADA 2012 guidelines for adults as follows:
Pre-diabetics: 100 - 125 mg/dL
Diabetic: > or = 126 mg/dL

(Ref: Tietz 4th Edition & ADA 2012 Guidelines)
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.
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.

Non HDL Cholesterol - Adult treatment panel ATP III suggested the addition of Non-HDL Cholesterol as an indicator of all atherogenic lipoproteins (mainly LDL and VLDL). NICE guidelines recommend Non-HDL Cholesterol measurement before initiating lipid lowering therapy. It has also been shown to be a better marker of risk in both primary and secondary prevention studies.

Recommendations:

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Test Report Status	Results	Units

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.
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
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.
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-
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.
WBC DIFFERENTIAL COUNT - NLR-
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
3. The reference for the adult reference range is "Practical Haematology by Dacie and Lewis, 10th Edition"
SUGAR URINE - POST PRANDIAL-METHOD: DIPSTICK/BENEDICT'S TEST
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.

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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
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

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

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ECG WITH REPORT	RESULT PENDING	
USG ABDOMEN AND PELVIS	RESULT PENDING	
CHEST X-RAY WITH REPORT	RESULT PENDING	

****End Of Report****
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SOUMYA C R
Senior Technician

JIJI SHIBU
LAB TECHNICIAN

LIJI BENNY
LAB TECHNICIAN

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SOUTH DELHI, DELHI,
SOUTH DELHI 110030
DELHI INDIA
8800465156

DDRC SRL DIAGNOSTICS
Palmland Building(6/260/2),Temple Road,Bank Junction
ALUVA, 683101
KERALA, INDIA
Tel : 93334 93334
Email : customercare.ddrc@srl.in

PATIENT NAME : SANDEEP B PATIENT ID : **SANDM1807904006**

ACCESSION NO : **4006VG003213** AGE : 32 Years SEX : Male

DRAWN : RECEIVED : 18/07/2022 10:43 REPORTED : 18/07/2022 16:23

REFERRING DOCTOR : DR. MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED CLIENT PATIENT ID :

Test Report Status	Results			Units
MEDIWHEEL HEALTH CHEKUP BELOW 40(M)TMT	RESULT PENDING			
LIVER PROFILE - EXTENDED	RESULT PENDING			
BUN/CREAT RATIO				
BUN/CREAT RATIO	9.6		5.00 - 15.00	
CREATININE, SERUM				
CREATININE	**0.62**	**Low**	0.7 - 1.2	mg/dL
GLUCOSE, POST-PRANDIAL, PLASMA				
GLUCOSE, POST-PRANDIAL, PLASMA	**335**	**High**	70 - 140	mg/dL
GLUCOSE, FASTING, PLASMA				
GLUCOSE, FASTING, PLASMA	**205**	**High**	74 - 106	mg/dL
GLYCOSYLATED HEMOGLOBIN, EDTA WHOLE BLOOD				
GLYCOSYLATED HEMOGLOBIN (HBA1C)	**10.9**	**High**	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 ADA Target: 7.0 Action suggested: > 8.0	%
MEAN PLASMA GLUCOSE	**266.1**	**High**	< 116.0	mg/dL
CORONARY RISK PROFILE (LIPID PROFILE), SERUM				
CHOLESTEROL	192		< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
TRIGLYCERIDES	76		< 150 Normal 150 - 199 Borderline High 200 - 499 High >/=500 Very High	mg/dL
HDL CHOLESTEROL	47		< 40 Low >/=60 High	mg/dL
DIRECT LDL CHOLESTEROL	**130**	**High**	< 100 Optimal 100 - 129 Near or above optimal 130 - 159 Borderline High 160 - 189 High >/= 190 Very High	mg/dL
NON HDL CHOLESTEROL	**145**	**High**	Desirable-Less than 130 Above Desirable-130-159 Borderline High-160-189 High-190-219 Very High- >or =220	mg/dL
CHOL/HDL RATIO	4.1		3.3 - 4.4 Low Risk 4.5 - 7.0 Average Risk 7.1 - 11.0 Moderate Risk > 11.0 High Risk	

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LDL/HDL RATIO	2.8		0.5-3 Desirable/Low risk 3.1-6 Borderline/Moderate risk >6.0 High Risk	
VERY LOW DENSITY LIPOPROTEIN	15.2		</= 30	mg/dL
LIVER FUNCTION TEST WITH GGT				
BILIRUBIN, TOTAL	0.57		Upto 1.2	mg/dL
BILIRUBIN, DIRECT	0.20		Upto 0.2	mg/dL
BILIRUBIN, INDIRECT	0.37		0.00 - 0.60	mg/dL
GAMMA GLUTAMYL TRANSFERASE (GGT)	33		8 - 61	U/L
URIC ACID, SERUM				
URIC ACID	**3.3**	**Low**	3.4 - 7.0	mg/dL
ABO GROUP & RH TYPE, EDTA WHOLE BLOOD				
ABO GROUP	TYPE AB			
RH TYPE	POSITIVE			
BLOOD COUNTS				
HEMOGLOBIN	14.9		13.0 - 17.0	g/dL
RED BLOOD CELL COUNT	5.02		4.5 - 5.5	mil/µL
WHITE BLOOD CELL COUNT	5.10		4.0 - 10.0	thou/µL
PLATELET COUNT	344		150 - 410	thou/µL
RBC AND PLATELET INDICES				
HEMATOCRIT	43.9		40 - 50	%
MEAN CORPUSCULAR VOL	88.0		83 - 101	fL
MEAN CORPUSCULAR HGB.	29.7		27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION	34.0		31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH	**15.8**	**High**	11.6 - 14.0	%
MEAN PLATELET VOLUME	7.9		6.8 - 10.9	fL
WBC DIFFERENTIAL COUNT - NLR				
SEGMENTED NEUTROPHILS	53		40 - 80	%
ABSOLUTE NEUTROPHIL COUNT	2.70		2.0 - 7.0	thou/µL
LYMPHOCYTES	**42**	**High**	20 - 40	%
ABSOLUTE LYMPHOCYTE COUNT	2.14		1.0 - 3.0	thou/µL
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	1.3			
EOSINOPHILS	04		1 - 6	%
ABSOLUTE EOSINOPHIL COUNT	0.20		0.02 - 0.50	thou/µL

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MONOCYTES	**01**	**Low**	2 - 10	%
ABSOLUTE MONOCYTE COUNT	**0.05**	**Low**	0.2 - 1.0	thou/µL
BASOPHILS	00		0 - 2	%
ERYTHRO SEDIMENTATION RATE, BLOOD				
SEDIMENTATION RATE (ESR)	07		0 - 14	mm at 1 hr
STOOL: OVA & PARASITE	RESULT PENDING			
SUGAR URINE - POST PRANDIAL				
SUGAR URINE - POST PRANDIAL	**DETECTED (++++)**		NOT DETECTED	
URINALYSIS				
COLOR	PALE YELLOW			
APPEARANCE	CLEAR			
PH	5.0		4.8 - 7.4	
SPECIFIC GRAVITY	1.015		1.015 - 1.030	
GLUCOSE	**DETECTED (++)**		NOT DETECTED	
PROTEIN	NOT DETECTED		NOT DETECTED	
KETONES	NOT DETECTED		NOT DETECTED	
BLOOD	NOT DETECTED		NOT DETECTED	
BILIRUBIN	NOT DETECTED		NOT DETECTED	
UROBILINOGEN	NORMAL		NORMAL	
NITRITE	NOT DETECTED		NOT DETECTED	
WBC	2-3		0-5	/HPF
EPITHELIAL CELLS	**DETECTED (OCCASIONAL)**		NOT DETECTED	/HPF
RED BLOOD CELLS	NOT DETECTED		NOT DETECTED	/HPF
CASTS	NIL			
CRYSTALS	NIL			
BACTERIA	NOT DETECTED		NOT DETECTED	
THYROID PANEL, SERUM				
T3	108.83		60 - 181	ng/dL
T4	12.0		3.2 - 12.6	µg/dl
TSH 3RD GENERATION	2.75		0.35 - 5.50	µIU/mL

Interpretation(s)
CREATININE, SERUM-

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Test Report Status	Results	Units

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
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.
GLUCOSE, FASTING, PLASMA-
ADA 2012 guidelines for adults as follows:
Pre-diabetics: 100 - 125 mg/dL
Diabetic: > or = 126 mg/dL

(Ref: Tietz 4th Edition & ADA 2012 Guidelines)
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.
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.

Non HDL Cholesterol - Adult treatment panel ATP III suggested the addition of Non-HDL Cholesterol as an indicator of all atherogenic lipoproteins (mainly LDL and VLDL). NICE guidelines recommend Non-HDL Cholesterol measurement before initiating lipid lowering therapy. It has also been shown to be a better marker of risk in both primary and secondary prevention studies.

Recommendations:

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SOUTH DELHI 110030
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8800465156

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Test Report Status	Results	Units

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.
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
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.
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-
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.
WBC DIFFERENTIAL COUNT - NLR-
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
3. The reference for the adult reference range is "Practical Haematology by Dacie and Lewis, 10th Edition"
SUGAR URINE - POST PRANDIAL-METHOD: DIPSTICK/BENEDICT'S TEST
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.

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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
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

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

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ECG WITH REPORT	RESULT PENDING	
USG ABDOMEN AND PELVIS	RESULT PENDING	
CHEST X-RAY WITH REPORT	RESULT PENDING	

****End Of Report****
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SOUMYA C R
Senior Technician

JIJI SHIBU
LAB TECHNICIAN

LIJI BENNY
LAB TECHNICIAN

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