

PATIENT NAME : KARTARNATH

REF. DOCTOR : SELF

CODE/NAME & ADDRESS : C000138361

ACROFEMI HEALTHCARE LTD (MEDIWHEEL)
F-703, LADO SARAI, MEHRAULISOUTH WEST
DELHINEW DELHI 110030
8800465156

ACCESSION NO : 0028WD000367

PATIENT ID : KARTM01036828

CLIENT PATIENT ID:

ABHA NO :

AGE/SEX : 55 Years Male

DRAWN :

RECEIVED : 12/04/2023 09:43:46

REPORTED : 13/04/2023 11:58:03

Test Report Status **Final**

Results

Biological Reference Interval Units

HAEMATOLOGY - CBC

MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE

BLOOD COUNTS, EDTA WHOLE BLOOD

Parameter	Result	Reference Interval	Units
HEMOGLOBIN (HB) METHOD : SPECTROPHOTOMETRY	13.7	13.0 - 17.0	g/dL
RED BLOOD CELL (RBC) COUNT METHOD : ELECTRICAL IMPEDANCE	5.05	4.5 - 5.5	mil/ μ L
WHITE BLOOD CELL (WBC) COUNT METHOD : ELECTRICAL IMPEDANCE	8.70	4.0 - 10.0	thou/ μ L
PLATELET COUNT METHOD : ELECTRICAL IMPEDANCE	175	150 - 410	thou/ μ L

RBC AND PLATELET INDICES

HEMATOCRIT (PCV) METHOD : CALCULATED PARAMETER	42.5	40.0 - 50.0	%
MEAN CORPUSCULAR VOLUME (MCV) METHOD : DERIVED/COULTER PRINCIPLE	84.3	83.0 - 101.0	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH) METHOD : CALCULATED PARAMETER	27.1	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC) METHOD : CALCULATED PARAMETER	32.2	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW) METHOD : DERIVED/COULTER PRINCIPLE	14.5 High	11.6 - 14.0	%
MENTZER INDEX METHOD : CALCULATED PARAMETER	16.7		
MEAN PLATELET VOLUME (MPV) METHOD : DERIVED/COULTER PRINCIPLE	12.3 High	6.8 - 10.9	fL

WBC DIFFERENTIAL COUNT

NEUTROPHILS METHOD : VCS TECHNOLOGY/ MICROSCOPY	63	40 - 80	%
LYMPHOCYTES METHOD : VCS TECHNOLOGY/ MICROSCOPY	27	20 - 40	%
MONOCYTES METHOD : VCS TECHNOLOGY/ MICROSCOPY	8	2.0 - 10.0	%
EOSINOPHILS	2	1.0 - 6.0	%


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Sr. Pathologist

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CIN - U74899PB1995PLC045956
Email : customercare.noida@srl.in

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 DELHI
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METHOD : VCS TECHNOLOGY/ MICROSCOPY				
BASOPHILS		0	0 - 1	%
METHOD : VCS TECHNOLOGY/ MICROSCOPY				
ABSOLUTE NEUTROPHIL COUNT		5.50	2.0 - 7.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE LYMPHOCYTE COUNT		2.40	1.0 - 3.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE MONOCYTE COUNT		0.70	0.2 - 1.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE EOSINOPHIL COUNT		0.17	0.02 - 0.50	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE BASOPHIL COUNT		0.00 Low	0.02 - 0.10	thou/ μ L
METHOD : CALCULATED PARAMETER				
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		2.3		
METHOD : CALCULATED PARAMETER				

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.

Dr. Shyla Goel,M.B.B.S ,DCP
Sr.Pathologist



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HAEMATOLOGY

MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE**ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD**

E.S.R 6 < 15 mm at 1 hr

METHOD : MODIFIED WESTERGREIN METHOD BY AUTOMATED ANALYSER

Interpretation(s)**ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD-TEST DESCRIPTION :-**

Erythrocyte sedimentation rate (ESR) is a test that indirectly measures the degree of inflammation present in the body. The test actually measures the rate of fall (sedimentation) of erythrocytes in a sample of blood that has been placed into a tall, thin, vertical tube. Results are reported as the millimetres of clear fluid (plasma) that are present at the top portion of the tube after one hour. Nowadays fully automated instruments are available to measure ESR.

ESR is not diagnostic; it is a non-specific test that may be elevated in a number of different conditions. It provides general information about the presence of an inflammatory condition. CRP is superior to ESR because it is more sensitive and reflects a more rapid change.

TEST INTERPRETATION

Increase in: Infections, Vasculitides, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Tissue injury, Pregnancy, Estrogen medication, Aging.

Finding a very accelerated ESR (>100 mm/hour) in patients with ill-defined symptoms directs the physician to search for a systemic disease (Paraproteinemias, Disseminated malignancies, connective tissue disease, severe infections such as bacterial endocarditis).

In pregnancy BRI in first trimester is 0-48 mm/hr(62 if anemic) and in second trimester (0-70 mm /hr(95 if anemic). ESR returns to normal 4th week post partum.

Decreased in: Polycythemia vera, Sickle cell anemia

LIMITATIONS

False elevated ESR : Increased fibrinogen, Drugs(Vitamin A, Dextran etc), Hypercholesterolemia

False Decreased : Poikilocytosis,(SickleCells,spherocytes),Microcytosis, Low fibrinogen, Very high WBC counts, Drugs(Quinine, 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.



Dr. Shyla Goel, M.B.B.S ,DCP
Sr.Pathologist

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Results

Biological Reference Interval Units

IMMUNOHAEMATOLOGY

MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE**ABO GROUP & RH TYPE, EDTA WHOLE BLOOD**

ABO GROUP

TYPE A

METHOD : COLUMN AGGLUTINATION TECHNOLOGY

RH TYPE

POSITIVE

METHOD : COLUMN AGGLUTINATION TECHNOLOGY

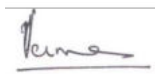
Interpretation(s)

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD-

Blood group is identified by antigens and antibodies present in the blood. Antigens are protein molecules found on the surface of red blood cells. Antibodies are found in plasma. To determine blood group, red cells are mixed with different antibody solutions to give A,B,O or AB.

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

The test is performed by both forward as well as reverse grouping methods.



Dr. Neena Verma
Senior Pathologist

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BIOCHEMISTRY

MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE

GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

HBA1C	6.1 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)
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METHOD : HPLC

ESTIMATED AVERAGE GLUCOSE(EAG)	128.4 High	< 116.0	mg/dL
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GLUCOSE FASTING,FLUORIDE PLASMA

FBS (FASTING BLOOD SUGAR)	107 High	74 - 106	mg/dL
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METHOD : HEXOKINASE

GLUCOSE, POST-PRANDIAL, PLASMA

PPBS(POST PRANDIAL BLOOD SUGAR)	118	Non-Diabetes 70 - 140	mg/dL
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METHOD : HEXOKINASE

LIPID PROFILE, SERUM

CHOLESTEROL, TOTAL	180	< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
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METHOD : CHOLESTEROL OXIDASE, ESTERASE,PEROXIDASE

TRIGLYCERIDES	291 High	< 150 Normal 150 - 199 Borderline High 200 - 499 High >/= 500 Very High	mg/dL
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METHOD : ENZYMATIC, END POINT

HDL CHOLESTEROL	37 Low	< 40 Low >/=60 High	mg/dL
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METHOD : DIRECT MEASURE POLYMER-POLYANION

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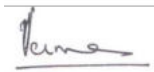
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CHOLESTEROL LDL	85	< 100 Optimal 100 - 129 Near or above optimal 130 - 159 Borderline High 160 - 189 High >/= 190 Very High	mg/dL
NON HDL CHOLESTEROL	143 High	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
METHOD : CALCULATED PARAMETER			
VERY LOW DENSITY LIPOPROTEIN	58.2 High	Desirable value :	mg/dL
CHOL/HDL RATIO	4.9 High	10 - 35 3.3-4.4 Low Risk 4.5-7.0 Average Risk 7.1-11.0 Moderate Risk > 11.0 High Risk	
LDL/HDL RATIO	2.3	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	

Interpretation(s)

LIVER FUNCTION PROFILE, SERUM

BILIRUBIN, TOTAL	0.45	UPTO 1.2	mg/dL
METHOD : DIAZONIUM ION, BLANKED (ROCHE)			
BILIRUBIN, DIRECT	0.18	0.00 - 0.30	mg/dL
METHOD : DIAZOTIZATION			
BILIRUBIN, INDIRECT	0.27	0.00 - 0.60	mg/dL
METHOD : CALCULATED PARAMETER			
TOTAL PROTEIN	7.2	6.6 - 8.7	g/dL
METHOD : BIURET,SERUM BLANK,ENDPOINT			
ALBUMIN	4.6	3.97 - 4.94	g/dL
METHOD : BROMOCRESOL GREEN			



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GLOBULIN	2.6	2.0 - 4.0	g/dL
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		Neonates - Pre Mature: 0.29 - 1.04	
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METHOD : CALCULATED PARAMETER

ALBUMIN/GLOBULIN RATIO	1.8	1.0 - 2.0	RATIO
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METHOD : CALCULATED PARAMETER

ASPARTATE AMINOTRANSFERASE(AST/SGOT)	19	0 - 40	U/L
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METHOD : UV WITHOUT P5P

ALANINE AMINOTRANSFERASE (ALT/SGPT)	25	0 - 41	U/L
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METHOD : UV WITHOUT P5P

ALKALINE PHOSPHATASE	63	40 - 129	U/L
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METHOD : PNPP, AMP BUFFER-IFCC

GAMMA GLUTAMYL TRANSFERASE (GGT)	27	8 - 61	U/L
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METHOD : G-GLUTAMYL-CARBOXY-NITROANILIDE-IFCC

LACTATE DEHYDROGENASE	142	135 - 225	U/L
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METHOD : L TO P, IFCC

BLOOD UREA NITROGEN (BUN), SERUM

BLOOD UREA NITROGEN	8	6 - 20	mg/dL
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METHOD : UREASE - UV

CREATININE, SERUM

CREATININE	1.09	0.70 - 1.20	mg/dL
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METHOD : ALKALINE PICRATE-KINETIC

BUN/CREAT RATIO

BUN/CREAT RATIO	7.34	5.00 - 15.00	
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METHOD : CALCULATED PARAMETER

URIC ACID, SERUM

URIC ACID	7.4 High	3.4 - 7.0	mg/dL
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METHOD : URICASE, COLORIMETRIC

TOTAL PROTEIN, SERUM

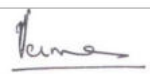
TOTAL PROTEIN	7.2	6.6 - 8.7	g/dL
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METHOD : BIURET,SERUM BLANK,ENDPOINT

ALBUMIN, SERUM

ALBUMIN	4.6	3.97 - 4.94	g/dL
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METHOD : BROMOCRESOL GREEN

GLOBULIN

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GLOBULIN	2.6	2.0 - 4.0 Neonates - Pre Mature: 0.29 - 1.04	g/dL
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METHOD : CALCULATED PARAMETER

ELECTROLYTES (NA/K/CL), SERUM

SODIUM, SERUM	138	136 - 145	mmol/L
METHOD : ISE INDIRECT			
POTASSIUM, SERUM	4.11	3.5 - 5.1	mmol/L
METHOD : ISE INDIRECT			
CHLORIDE, SERUM	100	98 - 107	mmol/L
METHOD : ISE INDIRECT			

Interpretation(s)

Sodium	Potassium	Chloride
Decreased in: CCF, cirrhosis, vomiting, diarrhea, excessive sweating, salt-losing nephropathy, adrenal insufficiency, nephrotic syndrome, water intoxication, SIADH. Drugs: thiazides, diuretics, ACE inhibitors, chlorpropamide, carbamazepine, anti depressants (SSRI), antipsychotics.	Decreased in: Low potassium intake, prolonged vomiting or diarrhea, RTA types I and II, hyperaldosteronism, Cushing's syndrome, osmotic diuresis (e.g., hyperglycemia), alkalosis, familial periodic paralysis, trauma (transient). Drugs: Adrenergic agents, diuretics.	Decreased in: Vomiting, diarrhea, renal failure combined with salt deprivation, over-treatment with diuretics, chronic respiratory acidosis, diabetic ketoacidosis, excessive sweating, SIADH, salt-losing nephropathy, porphyria, expansion of extracellular fluid volume, adrenal insufficiency, hyperaldosteronism, metabolic alkalosis. Drugs: chronic laxative, corticosteroids, diuretics.
Increased in: Dehydration (excessive sweating, severe vomiting or diarrhea), diabetes mellitus, diabetes insipidus, hyperaldosteronism, inadequate water intake. Drugs: steroids, licorice, oral contraceptives.	Increased in: Massive hemolysis, severe tissue damage, rhabdomyolysis, acidosis, dehydration, renal failure, Addison's disease, RTA type IV, hyperkalemic familial periodic paralysis. Drugs: potassium salts, potassium-sparing diuretics, NSAIDs, beta-blockers, ACE inhibitors, high-dose trimethoprim-sulfamethoxazole.	Increased in: Renal failure, nephrotic syndrome, RTA, dehydration, overtreatment with saline, hyperparathyroidism, diabetes insipidus, metabolic acidosis from diarrhea (Loss of HCO ₃ ⁻), respiratory alkalosis, hyperadrenocorticism. Drugs: acetazolamide, androgens, hydrochlorothiazide, salicylates.
Interferences: Severe lipemia or hyperproteinemi, if sodium analysis involves a dilution step can cause spurious results. The serum sodium falls about 1.6 mEq/L for each 100 mg/dL increase in blood glucose.	Interferences: Hemolysis of sample, delayed separation of serum, prolonged fist clenching during blood drawing, and prolonged tourniquet placement. Very high WBC/PLT counts may cause spurious. Plasma potassium levels are normal.	Interferences: Test is helpful in assessing normal and increased anion gap metabolic acidosis and in distinguishing hypercalcemia due to hyperparathyroidism (high serum chloride) from that due to malignancy (Normal serum chloride)

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Interpretation(s)

GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD-Used For:

- Evaluating the long-term control of blood glucose concentrations in diabetic patients.
- Diagnosing diabetes.
- Identifying patients at increased risk for diabetes (prediabetes).

The ADA recommends measurement of HbA1c (typically 3-4 times per year for type 1 and poorly controlled type 2 diabetic patients, and 2 times per year for well-controlled type 2 diabetic patients) to determine whether a patients metabolic control has remained continuously within the target range.

- eAG (Estimated average glucose) converts percentage HbA1c to md/dl, to compare blood glucose levels.
- eAG gives an evaluation of blood glucose levels for the last couple of months.
- eAG is calculated as $eAG (mg/dl) = 28.7 * HbA1c - 46.7$

HbA1c Estimation can get affected due to :

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

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 platform (Boronate affinity chromatography) is recommended for testing of HbA1c.Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy

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 Glycosuria,Glycaemic index & response to food consumed,Alimentary Hypoglycemia,Increased insulin response & sensitivity etc.

GLUCOSE, POST-PRANDIAL, PLASMA-High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glycosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.Additional test HbA1c LIVER FUNCTION PROFILE, SERUM-

Bilirubin is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. Bilirubin is excreted in bile and urine, and elevated levels may give yellow discoloration in jaundice.**Elevated levels** results from increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Conjugated (direct) bilirubin is elevated more than unconjugated (indirect) bilirubin in Viral hepatitis, Drug reactions, Alcoholic liver disease Conjugated (direct) bilirubin is also elevated more than unconjugated (indirect) bilirubin when there is some kind of blockage of the bile ducts like in Gallstones getting into the bile ducts, tumors & Scarring of the bile ducts. Increased unconjugated (indirect) bilirubin may be a result of Hemolytic or pernicious anemia, Transfusion reaction & a common metabolic condition termed Gilbert syndrome, due to low levels of the enzyme that attaches sugar molecules to bilirubin.

AST is an enzyme found in various parts of the body. AST is found in the liver, heart, skeletal muscle, kidneys, brain, and red blood cells, and it is commonly measured clinically as a marker for liver health. AST levels increase during chronic viral hepatitis, blockage of the bile duct, cirrhosis of the liver,liver cancer,kidney failure,hemolytic anemia,pancreatitis,hemochromatosis. AST levels may also increase after a heart attack or strenuous activity.ALT test measures the amount of this enzyme in the blood.ALT is found mainly in the liver, but also in smaller amounts in the kidneys,heart,muscles, and pancreas.It is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health.AST levels increase during acute hepatitis,sometimes due to a viral infection,ischemia to the liver,chronic hepatitis,obstruction of bile ducts,cirrhosis.

ALP is a protein found in almost all body tissues.Tissues with higher amounts of ALP include the liver,bile ducts and bone.Elevated ALP levels are seen in Biliary obstruction, Osteoblastic bone tumors, osteomalacia, hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, Pagets disease,Rickets,Sarcoidosis etc. Lower-than-normal ALP levels seen in Hypophosphatasia,Malnutrition,Protein deficiency,Wilsons disease.

GGT is an enzyme found in cell membranes of many tissues mainly in the liver,kidney and pancreas.It is also found in other tissues including intestine,spleen,heart, brain and seminal vesicles.The highest concentration is in the kidney,but the liver is considered the source of normal enzyme activity.Serum GGT has been widely used as an index of liver dysfunction.Elevated serum GGT activity can be found in diseases of the liver,biliary system and pancreas.Conditions that increase serum GGT are obstructive liver disease,high alcohol consumption and use of enzyme-inducing drugs etc.

Total Protein also known as total protein,is a biochemical test for measuring the total amount of protein in serum.Protein in the plasma is made up of albumin and globulin.Higher-than-normal levels may be due to:Chronic inflammation or infection,including HIV and hepatitis B or C,Multiple myeloma,Waldenstroms disease.Lower-than-normal levels may be due to: Agammaglobulinemia,Bleeding (hemorrhage),Burns,Glomerulonephritis,Liver disease, Malabsorption,Malnutrition,Nephrotic 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

Dr. Neena Verma
Senior Pathologist



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NOIDA, 201301
UTTAR PRADESH, INDIA
Tel : 0120-2403338, Fax :
CIN - U74899PB1995PLC045956
Email : customercare.noida@srl.in



Patient Ref. No. 77500002885133

PATIENT NAME : KARTARNATH

REF. DOCTOR : SELF

CODE/NAME & ADDRESS : C000138361

ACROFEMI HEALTHCARE LTD (MEDIWHEEL)
F-703, LADO SARAI, MEHRAULISOUTH WEST
DELHI
NEW DELHI 110030
8800465156

ACCESSION NO : 0028WD000367

PATIENT ID : KARTM01036828

CLIENT PATIENT ID:

ABHA NO :

AGE/SEX : 55 Years Male

DRAWN :

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REPORTED : 13/04/2023 11:58:03

Test Report Status	Final	Results	Biological Reference Interval	Units
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(hypoalbuminemia) can be caused by: Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance, malnutrition and wasting etc

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

Causes of decreased level include Liver disease, SIADH.

CREATININE, SERUM- Higher than normal level may be due to:

- Blockage in the urinary tract, Kidney problems, such as kidney damage or failure, infection, or reduced blood flow, Loss of body fluid (dehydration), Muscle problems, such as breakdown of muscle fibers, Problems during pregnancy, such as seizures (eclampsia)), or high blood pressure caused by pregnancy (preeclampsia)

Lower than normal level may be due to:

- Myasthenia Gravis, Muscuophy

URIC ACID, SERUM- Causes of Increased levels:- Dietary (High Protein Intake, Prolonged Fasting, Rapid weight loss), Gout, Lesch nyhan syndrome, Type 2 DM, Metabolic syndrome **Causes of decreased levels-** Low Zinc intake, OCP, Multiple Sclerosis

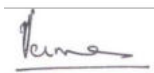
TOTAL PROTEIN, SERUM- is a biochemical test for measuring the total amount of protein in serum. Protein in the plasma is made up of albumin and globulin.

Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma, Waldenstroms disease.

Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage), Burns, Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome, Protein-losing enteropathy etc.

ALBUMIN, SERUM-

Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. **Low blood albumin levels (hypoalbuminemia) can be caused by:** Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance, malnutrition and wasting etc.



Dr. Neena Verma
Senior Pathologist



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Email : customercare.noida@srl.in



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 ACROFEMI HEALTHCARE LTD (MEDIWHEEL)
 F-703, LADO SARAI, MEHRAULISOUTH WEST
 DELHI
 NEW DELHI 110030
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CLINICAL PATH - URINALYSIS

MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE

PHYSICAL EXAMINATION, URINE

COLOR PALE YELLOW
METHOD : VISUAL

APPEARANCE CLEAR
METHOD : VISUAL

CHEMICAL EXAMINATION, URINE

PH 6.0 4.7 - 7.5
METHOD : DOUBLE INDICATOR PRINCIPLE

SPECIFIC GRAVITY 1.015 1.003 - 1.035
METHOD : PKA CHANGE OF PRETREATED POLYELECTROLYTES

PROTEIN NOT DETECTED NOT DETECTED
METHOD : PROTEIN- ERROR INDICATOR

GLUCOSE NOT DETECTED NOT DETECTED
METHOD : OXIDASE-PEROXIDASE REACTION

KETONES NOT DETECTED NOT DETECTED
METHOD : ACETOACETIC REACTION WITH NITROPRUSSIDE

BLOOD NOT DETECTED NOT DETECTED
METHOD : PEROXIDASE-LIKE ACTIVITY OF HEMOGLOBIN

BILIRUBIN NOT DETECTED NOT DETECTED
METHOD : DIAZOTIZATION

UROBILINOGEN NORMAL NORMAL
METHOD : MODIFIED EHRlich REACTION

NITRITE NOT DETECTED NOT DETECTED
METHOD : CONVERSION OF NITRATE TO NITRITE

LEUKOCYTE ESTERASE NOT DETECTED NOT DETECTED
METHOD : ESTERASE HYDROLYSIS ACTIVITY

MICROSCOPIC EXAMINATION, URINE

RED BLOOD CELLS NOT DETECTED NOT DETECTED /HPF
METHOD : MICROSCOPIC EXAMINATION

PUS CELL (WBC'S) 1-2 0-5 /HPF
METHOD : MICROSCOPIC EXAMINATION

EPITHELIAL CELLS 0-1 0-5 /HPF
METHOD : MICROSCOPIC EXAMINATION

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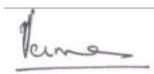
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CASTS METHOD : MICROSCOPIC EXAMINATION		NOT DETECTED		
CRYSTALS METHOD : MICROSCOPIC EXAMINATION		NOT DETECTED		
BACTERIA METHOD : MICROSCOPIC EXAMINATION		NOT DETECTED	NOT DETECTED	
YEAST		NOT DETECTED	NOT DETECTED	

Interpretation(s)



Dr. Neena Verma
Senior Pathologist



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SPECIALISED CHEMISTRY - HORMONE

MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE

THYROID PANEL, SERUM

T3 METHOD : ECLIA	123.1	80.00 - 200.00	ng/dL
T4 METHOD : ECLIA	12.47	5.10 - 14.10	µg/dL
TSH (ULTRASENSITIVE) METHOD : ECLIA	3.520	0.270 - 4.200	µIU/mL

Interpretation(s)

Triiodothyronine T3 , Thyroxine T4, and Thyroid Stimulating Hormone TSH are thyroid hormones which affect almost every physiological process in the body, including growth, development, metabolism, body temperature, and heart rate.

Production of T3 and its prohormone thyroxine (T4) is activated by thyroid-stimulating hormone (TSH), which is released from the pituitary gland. Elevated concentrations of T3, and T4 in the blood inhibit the production of TSH.

Excessive secretion of thyroxine in the body is hyperthyroidism, and deficient secretion is called hypothyroidism.

In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hyperthyroidism, TSH levels are low. Below mentioned are the guidelines for Pregnancy related reference ranges for Total T4, TSH & Total T3. Measurement of the serum TT3 level is a more sensitive test for the diagnosis of hyperthyroidism, and measurement of TT4 is more useful in the diagnosis of hypothyroidism. Most of the thyroid hormone in blood is bound to transport proteins. Only a very small fraction of the circulating hormone is free and biologically active. It is advisable to detect Free T3, FreeT4 along with TSH, instead of testing for albumin bound Total T3, Total T4.

Sr. No.	TSH	Total T4	FT4	Total T3	Possible Conditions
1	High	Low	Low	Low	(1) Primary Hypothyroidism (2) Chronic autoimmune Thyroiditis (3) Post Thyroidectomy (4) Post Radio-Iodine treatment
2	High	Normal	Normal	Normal	(1) Subclinical Hypothyroidism (2) Patient with insufficient thyroid hormone replacement therapy (3) In cases of Autoimmune/Hashimoto thyroiditis (4). Isolated increase in TSH levels can be due to Subclinical inflammation, drugs like amphetamines, Iodine containing drug and dopamine antagonist e.g. domperidone and other physiological reasons.
3	Normal/Low	Low	Low	Low	(1) Secondary and Tertiary Hypothyroidism
4	Low	High	High	High	(1) Primary Hyperthyroidism (Graves Disease) (2) Multinodular Goitre (3) Toxic Nodular Goitre (4) Thyroiditis (5) Over treatment of thyroid hormone (6) Drug effect e.g. Glucocorticoids, dopamine, T4 replacement therapy (7) First trimester of Pregnancy
5	Low	Normal	Normal	Normal	(1) Subclinical Hyperthyroidism
6	High	High	High	High	(1) TSH secreting pituitary adenoma (2) TRH secreting tumor
7	Low	Low	Low	Low	(1) Central Hypothyroidism (2) Euthyroid sick syndrome (3) Recent treatment for Hyperthyroidism

Dr. Shyla Goel, M.B.B.S ,DCP
Sr.Pathologist



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F-703, LADO SARAI, MEHRAULISOUTH WEST
DELHI
NEW DELHI 110030
8800465156

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8	Normal/Low	Normal	Normal	High	(1) T3 thyrotoxicosis (2) Non-Thyroidal illness
9	Low	High	High	Normal	(1) T4 Ingestion (2) Thyroiditis (3) Interfering Anti TPO antibodies

REF: 1. TIETZ Fundamentals of Clinical chemistry 2.Guidlines of the American Thyroid association during pregnancy and Postpartum, 2011.

NOTE: It is advisable to detect Free T3,FreeT4 along with TSH, instead of testing for albumin bound Total T3, Total T4.TSH is not affected by variation in thyroid - binding protein. TSH has a diurnal rhythm, with peaks at 2:00 - 4:00 a.m. And troughs at 5:00 - 6:00 p.m. With ultradian variations.



**Dr. Shyla Goel, M.B.B.S ,DCP
Sr.Pathologist**

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MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE

XRAY-CHEST

>>>	BOTH THE LUNG FIELDS ARE CLEAR
>>>	BOTH THE COSTOPHRENIC AND CARIOPHRENIC ANGELS ARE CLEAR
>>>	BOTH THE HILA ARE NORMAL
>>>	CARDIAC AND AORTIC SHADOWS APPEAR NORMAL
>>>	BOTH THE DOMES OF THE DIAPHRAM ARE NORMAL
>>>	VISUALIZED BONY THORAX IS NORMAL

IMPRESSION

NORMAL

TMT OR ECHO

TMT OR ECHO

TMT DONE

ECG

ECG

WITHIN NORMAL LIMITS

MEDICAL HISTORY

RELEVANT PRESENT HISTORY	NOT SIGNIFICANT
RELEVANT PAST HISTORY	NOT SIGNIFICANT
RELEVANT PERSONAL HISTORY	married 2 child non veg
RELEVANT FAMILY HISTORY	NOT SIGNIFICANT
OCCUPATIONAL HISTORY	job
HISTORY OF MEDICATIONS	NOT SIGNIFICANT

ANTHROPOMETRIC DATA & BMI

HEIGHT IN METERS	1.84	mts
WEIGHT IN KGS.	92.1	Kgs
BMI	27	kg/sqmts

BMI & Weight Status as follows
 Below 18.5: Underweight
 18.5 - 24.9: Normal
 25.0 - 29.9: Overweight
 30.0 and Above: Obese

GENERAL EXAMINATION

MENTAL / EMOTIONAL STATE	NORMAL
PHYSICAL ATTITUDE	NORMAL
GENERAL APPEARANCE / NUTRITIONAL STATUS	HEALTHY
BUILT / SKELETAL FRAMEWORK	AVERAGE



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NEW DELHI, 110092
NEW DELHI, INDIA
Tel : 9111591115, Fax :
CIN - U74899PB1995PLC045956
Email : wellness.eastdelhi@srl.in



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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		95/MINUTE REGULAR, ALL PERIPHERAL PULSES WELL FELT, NO CAROTID BRUIT		
RESPIRATORY RATE		NORMAL		
CARDIOVASCULAR SYSTEM				
BP		138/77		mm/Hg
PERICARDIUM		NORMAL		
APEX BEAT		NORMAL		
HEART SOUNDS		NORMAL		
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		
CORNEA		NORMAL		
DISTANT VISION RIGHT EYE WITHOUT GLASSES		NORMAL		
DISTANT VISION LEFT EYE WITHOUT GLASSES		NORMAL		
NEAR VISION RIGHT EYE WITHOUT GLASSES		NORMAL		
NEAR VISION LEFT EYE WITHOUT GLASSES		NORMAL		
COLOUR VISION		NORMAL		
BASIC ENT EXAMINATION				
EXTERNAL EAR CANAL		NORMAL		
TYMPANIC MEMBRANE		NORMAL		
NOSE		NO ABNORMALITY DETECTED		
SINUSES		NORMAL		
THROAT		NO ABNORMALITY DETECTED		
TONSILS		NOT ENLARGED		
SUMMARY				
RELEVANT HISTORY		NOT SIGNIFICANT		
RELEVANT GP EXAMINATION FINDINGS		NOT SIGNIFICANT		
RELEVANT LAB INVESTIGATIONS		HIGH TRIGLYCERIDE		
RELEVANT NON PATHOLOGY DIAGNOSTICS		NO ABNORMALITIES DETECTED		
REMARKS / RECOMMENDATIONS		PLEASE CORRELATE CLINICALLY		



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MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE

ULTRASOUND ABDOMEN

ULTRASOUND ABDOMEN

BORDERLINE PROSTATOMEGALY WITH LEFT RENAL CALCULUS

Interpretation(s)

MEDICAL HISTORY_*****
THIS REPORT CARRIES THE SIGNATURE OF OUR LABORATORY DIRECTOR. THIS IS AN INVIOABLE FEATURE OF OUR LAB MANAGEMENT SOFTWARE. HOWEVER, ALL EXAMINATIONS AND INVESTIGATIONS HAVE BEEN CONDUCTED BY OUR PANEL OF DOCTORS.

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- | | |
|---|---|
| <ol style="list-style-type: none"> 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: <ol style="list-style-type: none"> 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 | <ol style="list-style-type: none"> 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



View Details



View Report

PERFORMED AT :

SRL Ltd
E-368, LGF, Nirman Vihar, Near Nirman Vihar Metro
NEW DELHI, 110092
NEW DELHI, INDIA
Tel : 9111591115, Fax :
CIN - U74899PB1995PLC045956
Email : wellness.eastdelhi@srl.in



Patient Ref. No. 77500002885133