

PATIENT NAME : JYOTI .

REF. DOCTOR : SELF

CODE/NAME & ADDRESS : C000138376

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

ACCESSION NO : 0062WL000005

PATIENT ID : FHL21.15513

CLIENT PATIENT ID:

ABHA NO :

AGE/SEX : 38 Years Female

DRAWN :

RECEIVED : 01/12/2023 08:15:13

REPORTED : 02/12/2023 20:28:13

Test Report Status **Final**

Results

Biological Reference Interval Units

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE**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

ECG

ECG WITHIN NORMAL LIMITS

MEDICAL HISTORY

RELEVANT PRESENT HISTORY NOT SIGNIFICANT
 RELEVANT PAST HISTORY NOT SIGNIFICANT
 RELEVANT PERSONAL HISTORY MARRIED, 2 CHILDREN, VEG.
 MENSTRUAL HISTORY (FOR FEMALES) NOT SIGNIFICANT
 LMP (FOR FEMALES) 18/11/2023
 OBSTETRIC HISTORY (FOR FEMALES) P2D1L3 LSCS
 LCB (FOR FEMALES) 8YRS
 RELEVANT FAMILY HISTORY FATHER- DIABETES
 OCCUPATIONAL HISTORY HOME MAKER
 HISTORY OF MEDICATIONS NOT SIGNIFICANT

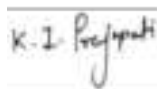
ANTHROPOMETRIC DATA & BMI

HEIGHT IN METERS 1.61 mts
 WEIGHT IN KGS. 57.55 Kgs
 BMI 22 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



Dr. Kamlesh I Prajapati
 Consultant Pathologist

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PERFORMED AT :

Agilus Diagnostics Ltd.
 Plot No.160,Pocket D-11 Sector 8, Rohini

New Delhi, 110085
 New Delhi, India
 Tel : 9111591115, Fax :
 CIN - U74899PB1995PLC045956



Patient Ref. No. 775000005610348

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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

76/MINUTE REGULAR, ALL PERIPHERAL PULSES WELL FELT, NO CAROTID
BRUIT

RESPIRATORY RATE

NORMAL

CARDIOVASCULAR SYSTEM

BP

97/59 MM HG
(SITTING)

mm/Hg

PERICARDIUM

NORMAL

APEX BEAT

NORMAL

HEART SOUNDS

S1, S2 HEARD NORMALLY

MURMURS

ABSENT

RESPIRATORY SYSTEM

SIZE AND SHAPE OF CHEST

NORMAL

MOVEMENTS OF CHEST

SYMMETRICAL

BREATH SOUNDS INTENSITY

NORMAL

BREATH SOUNDS QUALITY

VESICULAR (NORMAL)

ADDED SOUNDS

ABSENT

PER ABDOMEN

APPEARANCE

NORMAL

VENOUS PROMINENCE

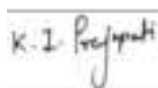
ABSENT

LIVER

NOT PALPABLE

SPLEEN

NOT PALPABLE


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HERNIA ABSENT

ANY OTHER COMMENTS NIL

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 6/6

DISTANT VISION LEFT EYE WITHOUT GLASSES 6/6

NEAR VISION RIGHT EYE WITHOUT GLASSES N/6

NEAR VISION LEFT EYE WITHOUT GLASSES N/6

COLOUR VISION NORMAL

BASIC ENT EXAMINATION

EXTERNAL EAR CANAL NORMAL

TYMPANIC MEMBRANE NORMAL

NOSE NO ABNORMALITY DETECTED

SINUSES NORMAL

THROAT NORMAL

TONSILS NOT ENLARGED

BASIC DENTAL EXAMINATION

TEETH NORMAL

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GUMS

HEALTHY

ANY OTHER COMMENTS

NIL

SUMMARY

RELEVANT HISTORY

NOT SIGNIFICANT

RELEVANT GP EXAMINATION FINDINGS

NOT SIGNIFICANT

RELEVANT LAB INVESTIGATIONS

ESR - ABOVE NORMAL LIMITS

RELEVANT NON PATHOLOGY DIAGNOSTICS

NO ABNORMALITIES DETECTED

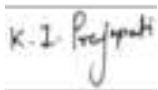
REMARKS / RECOMMENDATIONS

MONITOR ESR

FITNESS STATUS

FITNESS STATUS

FIT (WITH MEDICAL ADVICE) (AS PER REQUESTED PANEL OF TESTS)



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Results

Units

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE**ULTRASOUND ABDOMEN****ULTRASOUND ABDOMEN****ULTRASOUND WHOLE ABDOMEN**

Liver is normal in size, outline & normal echotexture. No obvious focal parenchymal lesion/biliary dilatation is seen. Hepatic veins and portal venous radicals are normal.

Gall bladder is partially distended and appears grossly normal.

Common bile duct is not dilated. Portal vein is normal in course and caliber.

Pancreas

Pancreas is normal in size, outline and echotexture. No evidence of any focal lesion or calcification is seen.

Pancreatic duct is not dilated.

Spleen

Spleen is normal in size, outline and echotexture .No focal lesion/ calcification is seen.

Kidneys

Both kidneys are normal in size, outline and echotexture. Corticomedullary differentiation is well maintained.

Parenchymal thickness is normal. No mass lesion, calculus or hydronephrosis is seen.

No significant retroperitoneal lymphadenopathy/ascites is seen.

Urinary Bladder

Urinary bladder is adequately distended with normal outline.No mass lesion, calculus or diverticulum is noted in the urinary bladder.Urinary bladder wall thickness is normal.

Uterus

Uterus is retroflexed with normal in size outline and echotexture. Endometrial thickness is 8mm. No obvious myometrial/endometrial pathology seen. **Adv- TVS for better evaluation.**

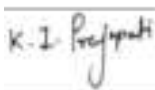
Both adnexae

Both ovaries are normal in size, outline and echotexture. No focal lesion is seen.

No obvious adnexal pathology is seen.

POD is clear.

Correlate clinically



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TMT OR ECHO

CLINICAL PROFILE

NEGATIVE

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.

FITNESS STATUS-Conclusion on an individual's Fitness, which is commented upon mainly for Pre employment cases, is based on multi factorial findings and does not depend on any one single parameter. The final Fitness assigned to a candidate will depend on the Physician's findings and overall judgement on a case to case basis, details of the candidate's past and personal history as well as the comprehensiveness of the diagnostic panel which has been requested for .These are then further correlated with details of the job under consideration to eventually fit the right man to the right job.

Basis the above, Agilus diagnostic classifies a candidate's Fitness Status into one of the following categories:

- Fit (As per requested panel of tests) – AGILUS Limited gives the individual a clean chit to join the organization, on the basis of the General Physical Examination and the specific test panel requested for.
- Fit (with medical advice) (As per requested panel of tests) - This indicates that although the candidate can be declared as FIT to join the job, minimal problems have been detected during the Pre- employment examination. Examples of conditions which could fall in this category could be cases of mild reversible medical abnormalities such as height weight disproportions, borderline raised Blood Pressure readings, mildly raised Blood sugar and Blood Lipid levels, Hematuria, etc. Most of these relate to sedentary lifestyles and come under the broad category of life style disorders. The idea is to caution an individual to bring about certain lifestyle changes as well as seek a Physician's consultation and counseling in order to bring back to normal the mildly deranged parameters. For all purposes the individual is FIT to join the job.
- Fitness on Hold (Temporary Unfit) (As per requested panel of tests) - Candidate's reports are kept on hold when either the diagnostic tests or the physical findings reveal the presence of a medical condition which warrants further tests, counseling and/or specialist opinion, on the basis of which a candidate can either be placed into Fit, Fit (With Medical Advice), or Unfit category. Conditions which may fall into this category could be high blood pressure, abnormal ECG, heart murmurs, abnormal vision, grossly elevated blood sugars, etc.
- Unfit (As per requested panel of tests) - An unfit report by Agilus diagnostic Limited clearly indicates that the individual is not suitable for the respective job profile e.g. total color blindness in color related jobs.

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HAEMATOLOGY - CBC

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

BLOOD COUNTS, EDTA WHOLE BLOOD

| | | | |
|-----------------------------------|------|-------------|---------------|
| HEMOGLOBIN (HB) | 12.8 | 12.0 - 15.0 | g/dL |
| METHOD : CYANMETHEMOGLOBIN METHOD | | | |
| RED BLOOD CELL (RBC) COUNT | 4.01 | 3.8 - 4.8 | mil/ μ L |
| METHOD : IMPEDANCE | | | |
| WHITE BLOOD CELL (WBC) COUNT | 6.99 | 4.0 - 10.0 | thou/ μ L |
| METHOD : IMPEDANCE | | | |
| PLATELET COUNT | 268 | 150 - 410 | thou/ μ L |
| METHOD : IMPEDANCE | | | |

RBC AND PLATELET INDICES

| | | | |
|--|------------------|-------------|------|
| HEMATOCRIT (PCV) | 39.3 | 36 - 46 | % |
| METHOD : CALCULATED | | | |
| MEAN CORPUSCULAR VOLUME (MCV) | 98.1 | 83 - 101 | fL |
| METHOD : CELL COUNTER | | | |
| MEAN CORPUSCULAR HEMOGLOBIN (MCH) | 32.0 | 27.0 - 32.0 | pg |
| METHOD : CALCULATED PARAMETER | | | |
| MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC) | 32.6 | 31.5 - 34.5 | g/dL |
| METHOD : CALCULATED PARAMETER | | | |
| RED CELL DISTRIBUTION WIDTH (RDW) | 13.6 | 11.6 - 14.0 | % |
| METHOD : CALCULATED | | | |
| MENTZER INDEX | 24.5 | | |
| METHOD : CALCULATED PARAMETER | | | |
| MEAN PLATELET VOLUME (MPV) | 11.8 High | 6.8 - 10.9 | fL |
| METHOD : CALCULATED PARAMETER | | | |

WBC DIFFERENTIAL COUNT

| | | | |
|---------------------------------|----|---------|---|
| NEUTROPHILS | 68 | 40 - 80 | % |
| METHOD : IMPEDANCE / MICROSCOPY | | | |
| LYMPHOCYTES | 24 | 20 - 40 | % |
| METHOD : IMPEDANCE / MICROSCOPY | | | |
| MONOCYTES | 5 | 2 - 10 | % |
| METHOD : IMPEDANCE / MICROSCOPY | | | |
| EOSINOPHILS | 3 | 1 - 6 | % |

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| METHOD : IMPEDANCE / MICROSCOPY | | | | |
| BASOPHILS | | 0 | 0 - 2 | % |
| METHOD : MICROSCOPIC EXAMINATION | | | | |
| ABSOLUTE NEUTROPHIL COUNT | | 4.75 | 2.0 - 7.0 | thou/μL |
| METHOD : CALCULATED PARAMETER | | | | |
| ABSOLUTE LYMPHOCYTE COUNT | | 1.68 | 1 - 3 | thou/μL |
| METHOD : CALCULATED PARAMETER | | | | |
| ABSOLUTE MONOCYTE COUNT | | 0.35 | 0.20 - 1.00 | thou/μL |
| METHOD : CALCULATED PARAMETER | | | | |
| ABSOLUTE EOSINOPHIL COUNT | | 0.21 | 0.02 - 0.50 | thou/μL |
| METHOD : CALCULATED PARAMETER | | | | |
| ABSOLUTE BASOPHIL COUNT | | 0 Low | 0.02 - 0.10 | thou/μL |
| METHOD : CALCULATED PARAMETER | | | | |
| NEUTROPHIL LYMPHOCYTE RATIO (NLR) | | 2.8 | | |
| 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.

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HAEMATOLOGY

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

ERYTHROCYTE SEDIMENTATION RATE (ESR),EDTA BLOOD

E.S.R **35 High** 0 - 20 mm at 1 hr

METHOD : WESTERGREN METHOD

GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

HBA1C 5.2 Non-diabetic: < 5.7 %
Pre-diabetics: 5.7 - 6.4
Diabetics: > or = 6.5
Therapeutic goals: < 7.0
Action suggested : > 8.0
(ADA Guideline 2021)

METHOD : HPLC

ESTIMATED AVERAGE GLUCOSE(EAG) 102.5 < 116.0 mg/dL

Interpretation(s)

ERYTHROCYTE SEDIMENTATION RATE (ESR),EDTA 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. AACCC Press, 7th edition. Edited by S. Soldin 3. The reference for the adult reference range is "Practical Haematology by Dacie and Lewis,10th edition.

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).

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

Dr. Kamlesh I Prajapati
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PERFORMED AT :

Agilus Diagnostics Ltd.
Plot No.160, Pocket D-11 Sector 8, Rohini



Patient Ref. No. 775000005610348

PATIENT NAME : JYOTI .

REF. DOCTOR : SELF

CODE/NAME & ADDRESS : C000138376

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

ACCESSION NO : 0062WL000005

PATIENT ID : FHL21.15513

CLIENT PATIENT ID:

ABHA NO :

AGE/SEX : 38 Years Female

DRAWN :

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IMMUNOHAEMATOLOGY

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP

TYPE A

METHOD : TUBE AGGLUTINATION

RH TYPE

POSITIVE

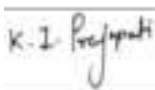
METHOD : TUBE AGGLUTINATION

Interpretation(s)

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

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

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



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BIOCHEMISTRY

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

GLUCOSE FASTING,FLUORIDE PLASMA

| | | |
|---------------------------|-----------------|--|
| FBS (FASTING BLOOD SUGAR) | 101 High | Normal <100 mg/dL Impaired fasting glucose:100 to 125 Diabetes mellitus: > = 126 (on more than 1 occassion) (ADA guidelines 2021) |
|---------------------------|-----------------|--|

METHOD : HEXOKINASE

GLUCOSE, POST-PRANDIAL, PLASMA

| | | |
|---------------------------------|-----|----------------|
| PPBS(POST PRANDIAL BLOOD SUGAR) | 109 | 70 - 140 mg/dL |
|---------------------------------|-----|----------------|

LIPID PROFILE WITH CALCULATED LDL

| | | |
|--------------------|-----|--|
| CHOLESTEROL, TOTAL | 165 | < 200 Desirable mg/dL 200 - 239 Borderline High >/= 240 High |
|--------------------|-----|--|

METHOD : CHOLESTEROL OXIDASE, ESTERASE,PEROXIDASE

| | | |
|---------------|----|---|
| TRIGLYCERIDES | 65 | < 150 Normal mg/dL 150 - 199 Borderline High 200 - 499 High >/=500 Very High |
|---------------|----|---|

METHOD : ENZYMATIC, END POINT

| | | |
|-----------------|----------------|------------------------------|
| HDL CHOLESTEROL | 63 High | < 40 Low mg/dL >/=60 High |
|-----------------|----------------|------------------------------|

METHOD : DIRECT MEASURE POLYMER-POLYANION

| | | |
|-----------------|----|--|
| CHOLESTEROL LDL | 89 | < 100 Optimal mg/dL 100 - 129 Near optimal/ above optimal 130 - 159 Borderline High 160 - 189 High >/= 190 Very High |
|-----------------|----|--|

| | | |
|---------------------|-----|--|
| NON HDL CHOLESTEROL | 102 | Desirable-Less than 130 mg/dL Above Desirable-130-159 Borderline High-160-189 High-190-219 Very High- >or =220 |
|---------------------|-----|--|

METHOD : CALCULATED

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| VERY LOW DENSITY LIPOPROTEIN | | 13 | | mg/dL |
| CHOL/HDL RATIO | | 2.6 Low | 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 | | 1.4 | 0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk | |

Interpretation(s)

Serum lipid profile is measured for cardiovascular risk prediction. Lipid Association of India recommends LDL-C as primary target and Non HDL-C as co-primary treatment target.

Risk Stratification for ASCVD (Atherosclerotic cardiovascular disease) by Lipid Association of India

| Risk Category | |
|---|--|
| Extreme risk group | A. CAD with > 1 feature of high risk group B. CAD with > 1 feature of Very high risk group or recurrent ACS (within 1 year) despite LDL-C < or = 50 mg/dl or polyvascular disease |
| Very High Risk | 1. Established ASCVD 2. Diabetes with 2 major risk factors or evidence of end organ damage 3. Familial Homozygous Hypercholesterolemia |
| High Risk | 1. Three major ASCVD risk factors. 2. Diabetes with 1 major risk factor or no evidence of end organ damage. 3. CKD stage 3B or 4. 4. LDL >190 mg/dl 5. Extreme of a single risk factor. 6. Coronary Artery Calcium - CAC >300 AU. 7. Lipoprotein a >= 50mg/dl 8. Non stenotic carotid plaque |
| Moderate Risk | 2 major ASCVD risk factors |
| Low Risk | 0-1 major ASCVD risk factors |
| Major ASCVD (Atherosclerotic cardiovascular disease) Risk Factors | |
| 1. Age > or = 45 years in males and > or = 55 years in females | 3. Current Cigarette smoking or tobacco use |
| 2. Family history of premature ASCVD | 4. High blood pressure |
| 5. Low HDL | |

Newer treatment goals and statin initiation thresholds based on the risk categories proposed by LAI in 2020.

| Risk Group | Treatment Goals | | Consider Drug Therapy | |
|-------------------------------|--------------------------------|-------------------------------|-----------------------|-----------------|
| | LDL-C (mg/dl) | Non-HDL (mg/dl) | LDL-C (mg/dl) | Non-HDL (mg/dl) |
| Extreme Risk Group Category A | <50 (Optional goal < OR = 30) | < 80 (Optional goal <OR = 60) | >OR = 50 | >OR = 80 |
| Extreme Risk Group Category B | <OR = 30 | <OR = 60 | > 30 | >60 |
| Very High Risk | <50 | <80 | >OR= 50 | >OR= 80 |
| High Risk | <70 | <100 | >OR= 70 | >OR= 100 |
| Moderate Risk | <100 | <130 | >OR= 100 | >OR= 130 |
| Low Risk | <100 | <130 | >OR= 130* | >OR= 160 |

*After an adequate non-pharmacological intervention for at least 3 months.

References: Management of Dyslipidaemia for the Prevention of Stroke: Clinical Practice Recommendations from the Lipid Association of India. Current Vascular Pharmacology, 2022, 20, 134-155.

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LIVER FUNCTION PROFILE, SERUM

| | | | |
|------------------|------|----------|-------|
| BILIRUBIN, TOTAL | 0.54 | Upto 1.2 | mg/dL |
|------------------|------|----------|-------|

METHOD : DIAZONIUM ION, BLANKED (ROCHE)

| | | | |
|-------------------|------|----------|-------|
| BILIRUBIN, DIRECT | 0.19 | Upto 0.2 | mg/dL |
|-------------------|------|----------|-------|

METHOD : DIAZONIUM ION, BLANKED (ROCHE)

| | | | |
|---------------------|------|-------------|-------|
| BILIRUBIN, INDIRECT | 0.35 | 0.00 - 0.90 | mg/dL |
|---------------------|------|-------------|-------|

METHOD : CALCULATED PARAMETER

| | | | |
|---------------|-----|-----------|------|
| TOTAL PROTEIN | 7.6 | 6.4 - 8.3 | g/dL |
|---------------|-----|-----------|------|

| | | | |
|---------|-----|-------------|------|
| ALBUMIN | 4.7 | 3.97 - 4.94 | g/dL |
|---------|-----|-------------|------|

METHOD : BROMOCRESOL PURPLE

| | | | |
|----------|-----|-----------|------|
| GLOBULIN | 2.9 | 2.0 - 4.0 | g/dL |
|----------|-----|-----------|------|

METHOD : CALCULATED PARAMETER

| | | | |
|------------------------|-----|-----------|-------|
| ALBUMIN/GLOBULIN RATIO | 1.6 | 1.0 - 2.0 | RATIO |
|------------------------|-----|-----------|-------|

METHOD : CALCULATED PARAMETER

| | | | |
|--------------------------------------|----|--------|-----|
| ASPARTATE AMINOTRANSFERASE(AST/SGOT) | 21 | 0 - 32 | U/L |
|--------------------------------------|----|--------|-----|

METHOD : IFCC WITH PYRIDOXAL 5 PHOSPHATE

| | | | |
|-------------------------------------|----|--------|-----|
| ALANINE AMINOTRANSFERASE (ALT/SGPT) | 17 | 0 - 33 | U/L |
|-------------------------------------|----|--------|-----|

METHOD : UV WITH P5P-IFCC

| | | | |
|----------------------|----|----------|-----|
| ALKALINE PHOSPHATASE | 59 | 35 - 104 | U/L |
|----------------------|----|----------|-----|

METHOD : PNPP, AMP BUFFER-IFCC

| | | | |
|----------------------------------|----|--------|-----|
| GAMMA GLUTAMYL TRANSFERASE (GGT) | 10 | 5 - 36 | U/L |
|----------------------------------|----|--------|-----|

METHOD : G-GLUTAMYL-CARBOXY-NITROANILIDE-IFCC

| | | | |
|-----------------------|-----|-----------|-----|
| LACTATE DEHYDROGENASE | 173 | 135 - 214 | U/L |
|-----------------------|-----|-----------|-----|

METHOD : L TO P, IFCC

BLOOD UREA NITROGEN (BUN), SERUM

| | | | |
|---------------------|---|--------|-------|
| BLOOD UREA NITROGEN | 7 | 6 - 20 | mg/dL |
|---------------------|---|--------|-------|

METHOD : UREASE - UV

CREATININE, SERUM

| | | | |
|------------|------|-----------|-------|
| CREATININE | 0.63 | 0.5 - 0.9 | mg/dL |
|------------|------|-----------|-------|

METHOD : ALKALINE PICRATE

BUN/CREAT RATIO

| | | | |
|-----------------|-------|--------------|--|
| BUN/CREAT RATIO | 11.11 | 5.00 - 15.00 | |
|-----------------|-------|--------------|--|

URIC ACID, SERUM

| | | | |
|-----------|-----|-----------|-------|
| URIC ACID | 3.2 | 2.4 - 5.7 | mg/dL |
|-----------|-----|-----------|-------|

METHOD : URICASE, COLORIMETRIC

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MC-5733

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TOTAL PROTEIN, SERUM

TOTAL PROTEIN 7.6 6.4 - 8.3 g/dL
METHOD : BIURET

ALBUMIN, SERUM

ALBUMIN 4.7 3.97 - 4.94 g/dL
METHOD : BROMOCRESOL PURPLE (BCP) DYE-BINDING

GLOBULIN

GLOBULIN 2.9 2.0 - 4.0 g/dL
METHOD : CALCULATED PARAMETER

ELECTROLYTES (NA/K/CL), SERUM

SODIUM, SERUM 139 136 - 145 mmol/L
METHOD : ISE INDIRECT

POTASSIUM, SERUM **5.29 High** 3.3 - 5.1 mmol/L
METHOD : ISE DIRECT

CHLORIDE, SERUM 104 98 - 106 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, adrenalinsufficiency, hyperaldosteronism,metabolic alkalosis. Drugs: chronic laxative,corticosteroids, diuretics. |
| Increased in: Dehydration (excessivesweating, severe vomiting or diarrhea),diabetes mellitus, diabetesinsipidus, 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 HCO3-), respiratory alkalosis,hyperadrenocorticism. Drugs: acetazolamide,androgens, hydrochlorothiazide,salicylates. |

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Interferences: Severe lipemia or hyperproteinemia, 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)

Interpretation(s)

GLUCOSE FASTING, FLUORIDE PLASMA-TEST DESCRIPTION

Normally, the glucose concentration in extracellular fluid is closely regulated so that a source of energy is readily available to tissues and so that 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 (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.

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

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|--------------------|-------|---------|-------------------------------|-------|

CLINICAL PATH - URINALYSIS

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

PHYSICAL EXAMINATION, URINE

COLOR PALE YELLOW
APPEARANCE CLEAR

CHEMICAL EXAMINATION, URINE

| | | | |
|--------------------|--------------|---------------|--|
| PH | 6.5 | 4.5 - 7.5 | |
| SPECIFIC GRAVITY | 1.005 | 1.005 - 1.030 | |
| PROTEIN | NOT DETECTED | NEGATIVE | |
| GLUCOSE | NOT DETECTED | NEGATIVE | |
| KETONES | NOT DETECTED | NOT DETECTED | |
| BLOOD | NOT DETECTED | NEGATIVE | |
| BILIRUBIN | NOT DETECTED | NOT DETECTED | |
| UROBILINOGEN | NORMAL | NORMAL | |
| NITRITE | NOT DETECTED | NOT DETECTED | |
| LEUKOCYTE ESTERASE | NOT DETECTED | NOT DETECTED | |

MICROSCOPIC EXAMINATION, URINE

| | | | |
|------------------|--------------|--------------|------|
| RED BLOOD CELLS | NOT DETECTED | NOT DETECTED | /HPF |
| PUS CELL (WBC'S) | 1-2 | 0-5 | /HPF |
| EPITHELIAL CELLS | 8-10 | 0-5 | /HPF |
| CASTS | NOT DETECTED | | |
| CRYSTALS | NOT DETECTED | | |
| BACTERIA | NOT DETECTED | NOT DETECTED | |
| YEAST | NOT DETECTED | NOT DETECTED | |

REMARKS NOTE:- MICROSCOPIC EXAMINATION OF URINE IS PERFORMED BY CENTRIFUGE URINARY SEDIMENT.

Interpretation(s)

The following table describes the probable conditions, in which the analytes are present in urine

| Presence of | Conditions |
|-------------|----------------------------------|
| Proteins | Inflammation or immune illnesses |

Dr. Kamlesh I Prajapati
Consultant Pathologist



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PERFORMED AT :

Agilus Diagnostics Ltd.
Plot No.160,Pocket D-11 Sector 8, Rohini



Patient Ref. No. 77500005610348

PATIENT NAME : JYOTI .

REF. DOCTOR : SELF

CODE/NAME & ADDRESS : C000138376

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

ACCESSION NO : 0062WL000005

PATIENT ID : FHL21.15513

CLIENT PATIENT ID:

ABHA NO :

AGE/SEX : 38 Years Female

DRAWN :

RECEIVED : 01/12/2023 08:15:13

REPORTED : 02/12/2023 20:28:13

| Test Report Status | Final | Results | Biological Reference Interval | Units |
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|--------------------|-------|---------|-------------------------------|-------|

CYTOLOGY

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

PAPANICOLAOU SMEAR

TEST METHOD

PAP stain

Specimen Type : Conventional PAP smear
Received two unstained slides fixed in Alcohol.Reporting system:- 2014 The Bethesda system of reporting cervical
cytology.

Specimen Adequacy : Satisfactory for evaluation

Endocervical component/ Transformation zone - Endocervical cells
present in small clumps

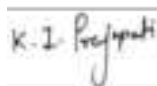
Microscopy :

Smears examined show superficial and intermediate squamous epithelial
cells.

Scattered RBCs present in the background.

Interpretation : Negative for intraepithelial lesion or malignancy (NILM).

Comment : Pap smear cytology is a screening procedure.

Corroboration of cytopathologic findings with
colposcopic/local examination and ancillary findings is recommended.
Test was done by manual method.

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Plot No.160,Pocket D-11 Sector 8, RohiniNew Delhi, 110085
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Tel : 9111591115, Fax :
CIN - U74899PB1995PLC045956

Patient Ref. No. 77500005610348



MC-5733

PATIENT NAME : JYOTI .**REF. DOCTOR : SELF****CODE/NAME & ADDRESS :** C000138376ARCOFEMI HEALTHCARE LTD (MEDIWHEEL
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8800465156**ACCESSION NO :** 0062WL000005**PATIENT ID :** FHL21.15513**CLIENT PATIENT ID:****ABHA NO :****AGE/SEX :** 38 Years Female**DRAWN :****RECEIVED :** 01/12/2023 08:15:13**REPORTED :** 02/12/2023 20:28:13

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CLINICAL PATH - STOOL ANALYSIS**MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE****PHYSICAL EXAMINATION,STOOL**

COLOUR

SAMPLE NOT RECEIVED

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Consultant Pathologist

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PERFORMED AT :Agilus Diagnostics Ltd.
Plot No.160,Pocket D-11 Sector 8, Rohini**Patient Ref. No. 775000005610348**

PATIENT NAME : JYOTI .

REF. DOCTOR : SELF

CODE/NAME & ADDRESS : C000138376

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SPECIALISED CHEMISTRY - HORMONE

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

THYROID PANEL, SERUM

| | | | |
|----------------------|--------|---|--------|
| T3 | 110.90 | Non-Pregnant Women 80.0 - 200.0 Pregnant Women 1st Trimester:105.0 - 230.0 2nd Trimester:129.0 - 262.0 3rd Trimester:135.0 - 262.0 | ng/dL |
| T4 | 8.63 | Non-Pregnant Women 5.10 - 14.10 Pregnant Women 1st Trimester: 7.33 - 14.80 2nd Trimester: 7.93 - 16.10 3rd Trimester: 6.95 - 15.70 | µg/dL |
| TSH (ULTRASENSITIVE) | 3.900 | Non Pregnant Women 0.27 - 4.20 Pregnant Women (As per American Thyroid Association) 1st Trimester 0.100 - 2.500 2nd Trimester 0.200 - 3.000 3rd Trimester 0.300 - 3.000 | 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 |

Dr. Kamlesh I Prajapati
Consultant Pathologist

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Patient Ref. No. 77500005610348

PATIENT NAME : JYOTI .

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DELHI

PATIENT ID : FHL21.15513

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NEW DELHI 110030
8800465156

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| | | | | | |
|---|------------|--------|--------|--------|---|
| 2 | High | Normal | Normal | Normal | (1)Subclinical Hypothyroidism (2) Patient with insufficient thyroid hormone replacement therapy (3) In cases of Autoimmune/Hashimoto thyroiditis (4). Isolated increase in TSH levels can be due to Subclinical inflammation, drugs like amphetamines, Iodine containing drug and dopamine antagonist e.g. domperidone and other physiological reasons. |
| 3 | Normal/Low | Low | Low | Low | (1) Secondary and Tertiary Hypothyroidism |
| 4 | Low | High | High | High | (1) Primary Hyperthyroidism (Graves Disease) (2) Multinodular Goitre (3)Toxic Nodular Goitre (4) Thyroiditis (5) Over treatment of thyroid hormone (6) Drug effect e.g. Glucocorticoids, dopamine, T4 replacement therapy (7) First trimester of Pregnancy |
| 5 | Low | Normal | Normal | Normal | (1) Subclinical Hyperthyroidism |
| 6 | High | High | High | High | (1) TSH secreting pituitary adenoma (2) TRH secreting tumor |
| 7 | Low | Low | Low | Low | (1) Central Hypothyroidism (2) Euthyroid sick syndrome (3) Recent treatment for Hyperthyroidism |
| 8 | Normal/Low | Normal | Normal | High | (1) T3 thyrotoxicosis (2) Non-Thyroidal illness |
| 9 | Low | High | High | Normal | (1) T4 Ingestion (2) Thyroiditis (3) Interfering Anti TPO antibodies |

REF: 1. TIETZ Fundamentals of Clinical chemistry 2.Guidlines of the American Thyroid association 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.

****End Of Report****

Please visit www.agilusdiagnostics.com for related Test Information for this accession

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Patient Ref. No. 77500005610348

PATIENT NAME : JYOTI .

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Test Report Status **Final**

Results

Biological Reference Interval Units

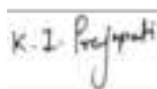
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1. It is presumed that the test sample belongs to the patient named or identified in the test requisition form.
2. All tests are performed and reported as per the turnaround time stated in the AGILUS Directory of Services.
3. Result delays could occur 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. AGILUS Diagnostics 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.
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Agilus Diagnostics Ltd

Fortis Hospital, Sector 62, Phase VIII,
Mohali 160062



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New Delhi, 110085
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Tel : 9111591115, Fax :
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