MC-5333

**PATIENT NAME : BABITA SHARMA** | **REF. DOCTOR :** SELF

| | | |
|---|---|---|
| **CODE/NAME & ADDRESS :** C000049066<br>SRL JAIPUR WELLNESS CORPORATE WALK IN<br>AAKRITI LABS PVT LTD. A-430, AGRASEN MARG<br>JAIPUR 302017<br>9314660100 | ACCESSION NO : **0251WF000270**<br>PATIENT ID : BABIF040690251<br>CLIENT PATIENT ID: 012306040027<br>ABHA NO : | AGE/SEX :33 Years Female<br>DRAWN :04/06/2023 10:24:00<br>RECEIVED :04/06/2023 10:56:48<br>REPORTED :04/06/2023 15:40:35 |

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## HAEMATOLOGY - CBC

**MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE**

**BLOOD COUNTS,EDTA WHOLE BLOOD**

| | | | |
|---|---|---|---|
| HEMOGLOBIN (HB)<br>METHOD : CYANIDE FREE DETERMINATION | 12.1 | 12.0 - 15.0 | g/dL |
| RED BLOOD CELL (RBC) COUNT<br>METHOD : ELECTRICAL IMPEDANCE | 4.07 | 3.8 - 4.8 | mil/µL |
| WHITE BLOOD CELL (WBC) COUNT<br>METHOD : ELECTRICAL IMPEDANCE | 4.50 | 4.0 - 10.0 | thou/µL |
| PLATELET COUNT<br>METHOD : ELECTRONIC IMPEDANCE | 211 | 150 - 410 | thou/µL |

**RBC AND PLATELET INDICES**

| | | | |
|---|---|---|---|
| HEMATOCRIT (PCV)<br>METHOD : CALCULATED PARAMETER | 36.4 | 36 - 46 | % |
| MEAN CORPUSCULAR VOLUME (MCV)<br>METHOD : CALCULATED PARAMETER | 89.0 | 83 - 101 | fL |
| MEAN CORPUSCULAR HEMOGLOBIN (MCH)<br>METHOD : CALCULATED PARAMETER | 29.7 | 27.0 - 32.0 | pg |
| MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)<br>METHOD : CALCULATED PARAMETER | 33.2 | 31.5 - 34.5 | g/dL |
| RED CELL DISTRIBUTION WIDTH (RDW)<br>METHOD : CALCULATED PARAMETER | **14.3 High** | 11.6 - 14.0 | % |
| MENTZER INDEX | 21.9 | | |
| MEAN PLATELET VOLUME (MPV)<br>METHOD : CALCULATED PARAMETER | **11.0 High** | 6.8 - 10.9 | fL |

**WBC DIFFERENTIAL COUNT**

| | | | |
|---|---|---|---|
| NEUTROPHILS<br>METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY | 57 | 40 - 80 | % |
| LYMPHOCYTES<br>METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY | 37 | 20 - 40 | % |
| MONOCYTES | 05 | 2 - 10 | % |

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Rajasthan, India

**Patient Ref. No. 775000003445691**

**PATIENT NAME : BABITA SHARMA** | **REF. DOCTOR :** SELF

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|---|---|---|
| **CODE/NAME & ADDRESS :** C000049066<br>SRL JAIPUR WELLNESS CORPORATE WALK IN<br>AAKRITI LABS PVT LTD. A-430, AGRASEN MARG<br>JAIPUR 302017<br>9314660100 | ACCESSION NO : **0251WF000270**<br>PATIENT ID : BABIF040690251<br>CLIENT PATIENT ID: 012306040027<br>ABHA NO : | AGE/SEX :33 Years Female<br>DRAWN :04/06/2023 10:24:00<br>RECEIVED :04/06/2023 10:56:48<br>REPORTED :04/06/2023 15:40:35 |

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| METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY<br>EOSINOPHILS | 01 | 1 - 6 | % |
| METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY<br>BASOPHILS | 00 | 0 - 2 | % |
| METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY<br>ABSOLUTE NEUTROPHIL COUNT | 2.56 | 2.0 - 7.0 | thou/µL |
| METHOD : CALCULATED PARAMETER<br>ABSOLUTE LYMPHOCYTE COUNT | 1.66 | 1.0 - 3.0 | thou/µL |
| METHOD : CALCULATED PARAMETER<br>ABSOLUTE MONOCYTE COUNT | 0.22 | 0.2 - 1.0 | thou/µL |
| METHOD : CALCULATED PARAMETER<br>ABSOLUTE EOSINOPHIL COUNT | 0.04 | 0.02 - 0.50 | thou/µL |
| METHOD : CALCULATED PARAMETER<br>ABSOLUTE BASOPHIL COUNT | **0 Low** | 0.02 - 0.10 | thou/µL |
| NEUTROPHIL LYMPHOCYTE RATIO (NLR) | 1.5 | | |

**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),WHOLE BLOOD** | | | |
|---|---|---|---|
| E.S.R | 15 | 0 - 20 | mm at 1 hr |

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

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

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

REFERENCE :
1. Nathan and Oski's Haematology of Infancy and Childhood, 5th edition;2. Paediatric reference intervals. AACC Press, 7th edition. Edited by S. Soldin;3. The reference for the adult reference range is "Practical Haematology by Dacie and Lewis,10th edition.

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**IMMUNOHAEMATOLOGY**

**MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE**

**ABO GROUP & RH TYPE, EDTA WHOLE BLOOD**

| | | | |
|---|---|---|---|
| ABO GROUP | TYPE O | | |
| 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) | 81 | 74 - 99 | mg/dL |

METHOD : GLUCOSE OXIDASE

**GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD**

| | | | |
|---|---|---|---|
| HBA1C | 4.5 | Non-diabetic: < 5.7<br>Pre-diabetics: 5.7 - 6.4<br>Diabetics: > or = 6.5<br>Therapeutic goals: < 7.0<br>Action suggested : > 8.0<br>(ADA Guideline 2021) | % |

METHOD : HIGH PERFORMANCE LIQUID CHROMATOGRAPHY (HPLC)

| | | | |
|---|---|---|---|
| ESTIMATED AVERAGE GLUCOSE(EAG) | 82.5 | < 116.0 | mg/dL |

METHOD : CALCULATED PARAMETER

**GLUCOSE, POST-PRANDIAL, PLASMA**

| | | | |
|---|---|---|---|
| PPBS(POST PRANDIAL BLOOD SUGAR) | 104 | 70 - 140 | mg/dL |

METHOD : GLUCOSE OXIDASE

**LIPID PROFILE, SERUM**

| | | | |
|---|---|---|---|
| CHOLESTEROL, TOTAL | **257 High** | < 200 Desirable<br>200 - 239 Borderline High<br>>/= 240 High | mg/dL |

METHOD : CHOLESTEROL OXIDASE

| | | | |
|---|---|---|---|
| TRIGLYCERIDES | 107 | < 150 Normal<br>150 - 199 Borderline High<br>200 - 499 High<br>>/=500 Very High | mg/dL |

METHOD : LIPASE/GPO-PAP NO CORRECTION

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| HDL CHOLESTEROL | 41 | < 40 Low<br>>/=60 High | mg/dL |
| METHOD : DIRECT CLEARANCE METHOD | | | |
| CHOLESTEROL LDL | **195 High** | < 100 Optimal<br>100 - 129<br>Near optimal/ above optimal<br>130 - 159<br>Borderline High<br>160 - 189 High<br>>/= 190 Very High | mg/dL |
| NON HDL CHOLESTEROL | **216 High** | Desirable: Less than 130<br>Above Desirable: 130 - 159<br>Borderline High: 160 - 189<br>High: 190 - 219<br>Very high: > or = 220 | mg/dL |
| METHOD : CALCULATED PARAMETER | | | |
| VERY LOW DENSITY LIPOPROTEIN | 21.4 | </= 30.0 | mg/dL |
| CHOL/HDL RATIO | **6.3 High** | 3.3 - 4.4<br>Low Risk<br>4.5 - 7.0<br>Average Risk<br>7.1 - 11.0<br>Moderate Risk<br>> 11.0<br>High Risk | |
| LDL/HDL RATIO | **4.8 High** | 0.5 - 3.0 Desirable/Low Risk<br>3.1 - 6.0 Borderline/Moderate Risk<br>>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 |

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| | |
|---|---|
| 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.

**LIVER FUNCTION PROFILE, SERUM**

| | | | |
|---|---|---|---|
| BILIRUBIN, TOTAL<br>METHOD : DIAZO WITH SULPHANILIC ACID | 0.66 | 0 - 1 | mg/dL |
| BILIRUBIN, DIRECT<br>METHOD : DIAZO WITH SULPHANILIC ACID | 0.18 | 0.00 - 0.25 | mg/dL |
| BILIRUBIN, INDIRECT<br>METHOD : CALCULATED PARAMETER | 0.48 | 0.1 - 1.0 | mg/dL |
| TOTAL PROTEIN<br>METHOD : BIURET REACTION, END POINT | 8.1 | 6.4 - 8.2 | g/dL |
| ALBUMIN<br>METHOD : BROMOCRESOL GREEN | **4.6 High** | 3.8 - 4.4 | g/dL |
| GLOBULIN<br>METHOD : CALCULATED PARAMETER | 3.5 | 2.0 - 4.1 | g/dL |
| ALBUMIN/GLOBULIN RATIO<br>METHOD : CALCULATED PARAMETER | 1.3 | 1.0 - 2.1 | RATIO |
| ASPARTATE AMINOTRANSFERASE(AST/SGOT)<br>METHOD : TRIS BUFFER NO P5P IFCC / SFBC 37° C | **39 High** | 0 - 31 | U/L |



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| ALANINE AMINOTRANSFERASE (ALT/SGPT)<br>METHOD : TRIS BUFFER NO P5P IFCC / SFBC 37° C | **49 High** | 0 - 31 | U/L |
| ALKALINE PHOSPHATASE<br>METHOD : AMP OPTIMISED TO IFCC 37° C | 100 | 39 - 117 | U/L |
| GAMMA GLUTAMYL TRANSFERASE (GGT)<br>METHOD : GAMMA GLUTAMYL-3 CARBOXY-4 NITROANILIDE (IFCC) 37° C | **45 High** | 7 - 32 | U/L |
| LACTATE DEHYDROGENASE | 318 | 230 - 460 | U/L |
| **BLOOD UREA NITROGEN (BUN), SERUM** | | | |
| BLOOD UREA NITROGEN<br>METHOD : UREASE KINETIC | 8 | 5.0 - 18.0 | mg/dL |
| **CREATININE, SERUM** | | | |
| CREATININE<br>METHOD : ALKALINE PICRATE NO DEPROTEINIZATION | 0.92 | 0.6 - 1.2 | mg/dL |
| **BUN/CREAT RATIO** | | | |
| BUN/CREAT RATIO<br>METHOD : CALCULATED PARAMETER | 8.70 | | |
| **URIC ACID, SERUM** | | | |
| URIC ACID<br>METHOD : URICASE PEROXIDASE WITH ASCORBATE OXIDASE | 5.1 | 2.4 - 5.7 | mg/dL |
| **TOTAL PROTEIN, SERUM** | | | |
| TOTAL PROTEIN<br>METHOD : BIURET REACTION, END POINT | 8.1 | 6.4 - 8.3 | g/dL |

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| **ALBUMIN, SERUM** | | | |
| ALBUMIN<br>METHOD : BROMOCRESOL GREEN | **4.6 High** | 3.8 - 4.4 | g/dL |
| **GLOBULIN** | | | |
| GLOBULIN | 3.5 | 2.0 - 4.1 | g/dL |
| **ELECTROLYTES (NA/K/CL), SERUM** | | | |
| SODIUM, SERUM<br>METHOD : ION-SELECTIVE ELECTRODE | 145.0 | 137 - 145 | mmol/L |
| POTASSIUM, SERUM<br>METHOD : ION-SELECTIVE ELECTRODE | 4.32 | 3.6 - 5.0 | mmol/L |
| CHLORIDE, SERUM<br>METHOD : ION-SELECTIVE ELECTRODE | 106.5 | 98 - 107 | mmol/L |

**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. |

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Rajasthan, India

Patient Ref. No. 775000003445691

| | | |
|---|---|---|
| **PATIENT NAME : BABITA SHARMA** | **REF. DOCTOR :** SELF | |
| **CODE/NAME & ADDRESS :** C000049066<br>SRL JAIPUR WELLNESS CORPORATE WALK IN<br>AAKRITI LABS PVT LTD. A-430, AGRASEN MARG<br>JAIPUR 302017<br>9314660100 | ACCESSION NO : **0251WF000270**<br>PATIENT ID : BABIF040690251<br>CLIENT PATIENT ID: 012306040027<br>ABHA NO : | AGE/SEX :33 Years Female<br>DRAWN :04/06/2023 10:24:00<br>RECEIVED :04/06/2023 10:56:48<br>REPORTED :04/06/2023 15:40:35 |

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| | | |
|---|---|---|
| **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. |
| **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) |

**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 sothat no glucose is excreted in the urine.
**Increased in**:Diabetes mellitus, Cushing' s syndrome (10 – 15%), chronic pancreatitis (30%). Drugs:corticosteroids,phenytoin, estrogen, thiazides.
**Decreased in** :Pancreatic islet cell disease with increased insulin,insulinoma,adrenocortical insufficiency,hypopituitarism,diffuse liver disease, malignancy(adrenocortical,stomach,fibrosarcoma),infant of a diabetic mother,enzyme deficiency diseases(e.g.galactosemia),Drugs-insulin,ethanol,propranolol;sulfonylureas,tolbutamide,and other oral hypoglycemic agents.
**NOTE:** While random serum glucose levels correlate with home glucose monitoring results (weekly mean capillary glucose values),there is wide fluctuation within individuals.Thus, glycosylated hemoglobin(HbA1c) levels are favored to monitor glycemic control.
High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment,Renal Glyosuria,Glycaemic index & response to food consumed,Alimentary Hypoglycemia,Increased insulin response & sensitivity etc.
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD-**Used For**:

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

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

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

a) Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.
b) Heterozygous state detected (D10 is corrected for HbS & HbC trait.)
c) HbF > 25% on alternate paltform (Boronate affinity chromatography) is recommended for testing of HbA1c.Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy
GLUCOSE, POST-PRANDIAL, PLASMA-High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glyosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.Additional test HbA1c
LIVER FUNCTION PROFILE, SERUM-
**Bilirubin** is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. Bilirubin is excreted in bile and urine, and elevated levels may give yellow discoloration in jaundice.**Elevated levels** results from increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Conjugated (direct) bilirubin is elevated more than unconjugated

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(indirect) bilirubin in Viral hepatitis, Drug reactions, Alcoholic liver disease Conjugated (direct) bilirubin is also elevated more than unconjugated (indirect) bilirubin when there is some kind of blockage of the bile ducts like in Gallstones getting into the bile ducts, tumors &Scarring of the bile ducts. Increased unconjugated (indirect) bilirubin may be a result of Hemolytic or pernicious anemia, Transfusion reaction & a common metabolic condition termed Gilbert syndrome, due to low levels of the enzyme that attaches sugar molecules to bilirubin.

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

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

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

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

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

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

**Causes of decreased** level include Liver disease, SIADH.

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

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

**Lower than normal level may be due to:**• Myasthenia Gravis, Muscuophy

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

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

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

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

ALBUMIN, SERUM-

Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. **Low blood albumin levels (hypoalbuminemia) can be caused by:** Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, 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<br>METHOD : GROSS EXAMINATION | PALE YELLOW | |
| APPEARANCE<br>METHOD : GROSS EXAMINATION | **SLIGHTLY HAZY** | |

### CHEMICAL EXAMINATION, URINE

| | | | |
|---|---|---|---|
| PH<br>METHOD : DOUBLE INDICATOR PRINCIPLE | 5.0 | 4.7 - 7.5 | |
| SPECIFIC GRAVITY<br>METHOD : IONIC CONCENTRATION METHOD | 1.020 | 1.003 - 1.035 | |
| PROTEIN<br>METHOD : PROTEIN ERROR OF INDICATORS WITH REFLECTANCE | NOT DETECTED | NEGATIVE | |
| GLUCOSE<br>METHOD : GLUCOSE OXIDASE PEROXIDASE / BENEDICTS | NOT DETECTED | NEGATIVE | |
| KETONES<br>METHOD : SODIUM NITROPRUSSIDE REACTION | NOT DETECTED | NOT DETECTED | |
| BLOOD<br>METHOD : PEROCIDASE ANTI PEROXIDASE | **DETECTED (+)** | NOT DETECTED | |
| BILIRUBIN<br>METHOD : DIPSTICK | NOT DETECTED | NOT DETECTED | |
| UROBILINOGEN<br>METHOD : EHRLICH REACTION REFLECTANCE | NORMAL | NORMAL | |
| NITRITE<br>METHOD : NITRATE TO NITRITE CONVERSION METHOD | NOT DETECTED | NOT DETECTED | |
| LEUKOCYTE ESTERASE | **DETECTED (+)** | NOT DETECTED | |

### MICROSCOPIC EXAMINATION, URINE

| | | | |
|---|---|---|---|
| RED BLOOD CELLS<br>METHOD : MICROSCOPIC EXAMINATION | **5 - 7** | NOT DETECTED | /HPF |
| PUS CELL (WBC'S)<br>METHOD : DIPSTICK, MICROSCOPY | **8-10** | 0-5 | /HPF |

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| EPITHELIAL CELLS<br>METHOD : MICROSCOPIC EXAMINATION | **10-15** | 0-5 | /HPF |
| CASTS<br>METHOD : MICROSCOPIC EXAMINATION | NOT DETECTED | | |
| CRYSTALS<br>METHOD : MICROSCOPIC EXAMINATION | NOT DETECTED | | |
| BACTERIA<br>METHOD : MICROSCOPIC EXAMINATION | **DETECTED (FEW)** | NOT DETECTED | |
| YEAST | NOT DETECTED | NOT DETECTED | |

**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 |
| Pus (White Blood Cells) | Urinary tract infection, urinary tract or kidney stone, tumors or any kind of kidney impairment |
| Glucose | Diabetes or kidney disease |
| Ketones | Diabetic ketoacidosis (DKA), starvation or thirst |
| Urobilinogen | Liver disease such as hepatitis or cirrhosis |
| Blood | Renal or genital disorders/trauma |
| Bilirubin | Liver disease |
| Erythrocytes | Urological diseases (e.g. kidney and bladder cancer, urolithiasis), urinary tract infection and glomerular diseases |
| Leukocytes | Urinary tract infection, glomerulonephritis, interstitial nephritis either acute or chronic, polycystic kidney disease, urolithiasis, contamination by genital secretions |
| Epithelial cells | Urolithiasis, bladder carcinoma or hydronephrosis, ureteric stents or bladder catheters for prolonged periods of time |
| | |
| Granular Casts | Low intratubular pH, high urine osmolality and sodium concentration, interaction with Bence-Jones protein |
| Hyaline casts | Physical stress, fever, dehydration, acute congestive heart failure, renal diseases |

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|---|---|
| Calcium oxalate | Metabolic stone disease, primary or secondary hyperoxaluria, intravenous infusion of large doses of vitamin C, the use of vasodilator naftidrofuryl oxalate or the gastrointestinal lipase inhibitor orlistat, ingestion of ethylene glycol or of star fruit (Averrhoa carambola) or its juice |
| Uric acid | arthritis |
| Bacteria | Urinary infectionwhen present in significant numbers & with pus cells. |
| Trichomonas vaginalis | Vaginitis, cervicitis or salpingitis |

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**CYTOLOGY**

**MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE**

**PAPANICOLAOU SMEAR**

| | |
|---|---|
| TEST METHOD | SAMPLE NOT RECEIVED |

**Dr. Akansha Jain**
**Consultant Pathologist**



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**CLINICAL PATH - STOOL ANALYSIS**

**MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE**

**PHYSICAL EXAMINATION,STOOL**

| | | | |
|---|---|---|---|
| COLOUR | SAMPLE NOT RECEIVED | | |

METHOD : GROSS EXAMINATION



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**SPECIALISED CHEMISTRY - HORMONE**

**MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE**

**THYROID PANEL, SERUM**

| | | | |
|---|---|---|---|
| T3 | 96.68 | 60.0 - 181.0 | ng/dL |
| METHOD : CHEMILUMINESCENCE | | | |
| T4 | **12.40 High** | 4.5 - 10.9 | µg/dL |
| METHOD : CHEMILUMINESCENCE | | | |
| TSH (ULTRASENSITIVE) | 1.122 | 0.550 - 4.780 | µIU/mL |
| METHOD : CHEMILUMINESCENCE | | | |

**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 autoimmunc 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 |

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| | | |
|---|---|---|
| **CODE/NAME & ADDRESS :** C000049066<br>SRL JAIPUR WELLNESS CORPORATE WALK IN<br>AAKRITI LABS PVT LTD. A-430, AGRASEN MARG<br>JAIPUR 302017<br>9314660100 | ACCESSION NO : **0251WF000270**<br>PATIENT ID : BABIF040690251<br>CLIENT PATIENT ID: 012306040027<br>ABHA NO : | AGE/SEX :33 Years Female<br>DRAWN :04/06/2023 10:24:00<br>RECEIVED :04/06/2023 10:56:48<br>REPORTED :04/06/2023 15:40:35 |

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

| | | | | | |
|---|---|---|---|---|---|
| 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 duriing 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.srlworld.com for related Test Information for this accession**

**Dr. Akansha Jain**
**Consultant Pathologist**



View Details View Report

**PERFORMED AT :**
Agilus Diagnostics Ltd (Formerly SRL Ltd)
C/O Aakriti Labs Pvt Ltd, 3, Mahatma Gandhi Marg,Gandhi Nagar Mod, Tonk Road
Jaipur, 302015
Rajasthan, India

Patient Ref. No. 775000003445691

wellness partner

# Aakriti Labs

3 Mahatma Gandhi Marg, Gandhi Nagar Mod
Tonk Road, Jaipur (Raj.) Ph.: 0141-2710661
www.aakritilabs.com
CIN NO.: U85195RJ2004PTC019563

| | | | |
|---|---|---|---|
| Name | : **Mrs. BABITA SHARMA** | Registration No: | 59148 |
| Age/Gender: | 33 Y/Female | Registered | : 04/Jun/2023 10:24AM |
| Patient ID | : 012306040027 | Analysed | : 05/Jun/2023 10:36AM |
| BarcodeNo | : 10087656 | Reported | : 05/Jun/2023 10:36AM |
| Referred By | : Self | Panel | : MEDI WHEEL (ARCOFEMI HEALTHCARE LTD) |

## DIGITAL X-RAY CHEST PA VIEW

Soft tissue shadow and bony cages are normal.

Trachea is central.

Bilateral lung field and both CP angle are clear.

Domes of diaphragm are normally placed.

Transverse diameter of heart appears with normal limits.

**IMPRESSION:- NO OBVIOUS ABNORMALITY DETECTED.**



*** End Of Report ***



Dr. Neera Mehta
M.B.B.S.,D.M.R.D.
RMCNO.005807/14853

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5

NAME BABITA JI

Mob - 9785082577

Age - 33/F

RATINA CHECK

UN < 6/12
6/12

PD glass. < 6/6
6/6

Ref < S
-1.00
-1.00

Colour < normal
normal

Fam. < unmarried. BE >

Dr. RAKESH SHARMA
M.S. OPTH. B. OPTH
FICLLP

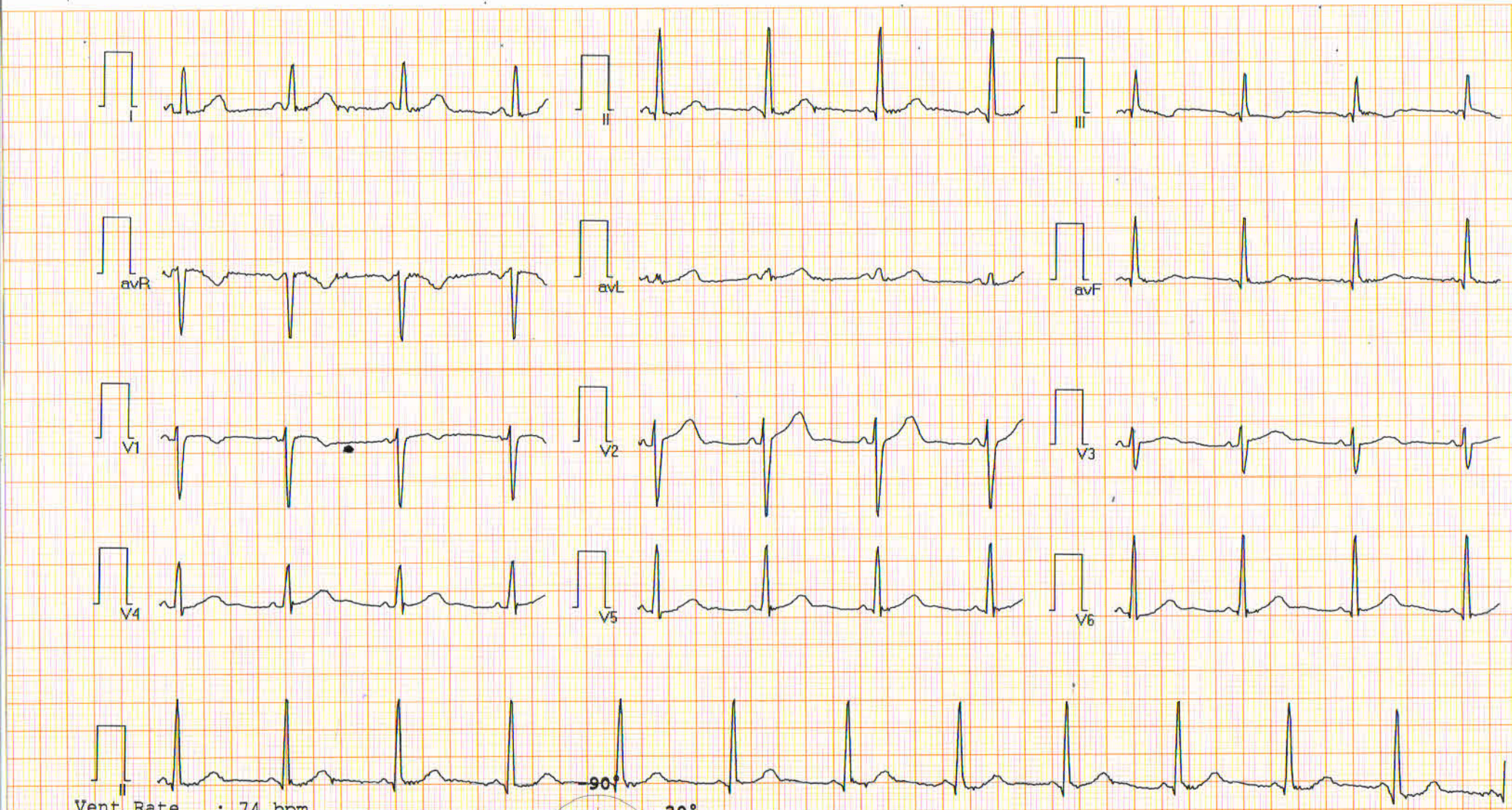
# Aakriti Labs

56350 / MRS BABITA SHARMA / 33 Yrs / F/ Non Smoker

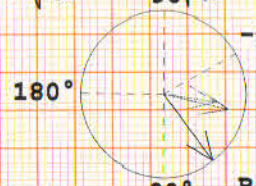
Heart Rate : 74 bpm / Tested On : 04-Jun-23 12.06.30 / HF 0.05 Hz - LF 100 Hz / Notch 50 Hz / Sn 1.00 Cm/mV / Sw 25 mm/s / Refd By.: MEDIWHEEL

ECG

ACHPL




Vent Rate : 74 bpm
PR Interval : 100 ms
QRS Duration: 78 ms
QT/QTc Int : 388/413 ms
P-QRS-T axis: 8.00° 53.00° 13.00°




Axis R 53.00° T 13.00° P 8.00°

Dr. NITIZ GOYAL
M.B.B.S. M.D.
Reported By:DR NITIZ GOYAL

Allengers ECG (Pisces)(PIS218210312)

wellness partner

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Tonk Road, Jaipur (Raj.) Ph.: 0141-2710661
www.aakritilabs.com
CIN NO.: U85195RJ2004PTC019563

| NAME | MS BABITA SHARMA | AGE | 33YRS | SEX | FEMALE |
|---|---|---|---|---|---|
| REF BY | MEDI WHEEL | DATE | 04/06/2023 | REG NO | |

## ECHOCARDIOGRAM REPORT

**WINDOW-** POOR/ADEQUATE/GOODVALVE

| | | | |
|---|---|---|---|
| MITRAL | NORMAL | TRICUSPID | NORMAL |
| AORTIC | NORMAL | PULMONARY | NORMAL |

**2D/M-MOD**

| | | | | | |
|---|---|---|---|---|---|
| IVSD mm | 8.5 | IVSS mm | 12.9 | AORTA mm | 20.6 |
| LVID mm | 41.6 | LVIS mm | 25.7 | LA mm | 28.1 |
| LVPWD mm | 9.1 | LVPWS mm | 12.2 | EF% | 60% |

**CHAMBERS**

| | | | |
|---|---|---|---|
| LA | NORMAL | RA | NORMAL |
| LV | NORMAL | RV | NORMAL |
| PERICARDIUM | NORMAL | | |

**DOPPLER STUDY MITRAL**

| | | | |
|---|---|---|---|
| PEAK VELOCITY m/s E/A | 1.17/0.79 | PEAK GRADIANT MmHg | |
| MEAN VELOCITY m/s | | MEAN GRADIANT MmHg | |
| MVA cm2 (PLANITMETERY) | | MVA cm2 (PHT) | |
| **MR** | **TRACE** | | |

**AORTIC**

| | | | |
|---|---|---|---|
| PEAK VELOCITY m/s | 1.48 | PEAK GRADIANT MmHg | |
| MEAN VELOCITY m/s | | MEAN GRADIANT MmHg | |
| AR | | | |

**TRICUSPID**

| | | | |
|---|---|---|---|
| PEAK VELOCITY m/s | 0.60 | PEAK GRADIANT MmHg | |
| MEAN VELOCITY m/s | | MEAN GRADIANT MmHg | |
| TR | | PASP mmHg | |

**PULMONARY**

| | | | |
|---|---|---|---|
| PEAK VELOCITY m/s | 1.55 | PEAK GRADIANT MmHg | |
| MEAN VELOCITY m/s | | MEAN GRADIANT MmHg | |
| **PR** | **MILD** | RVEDP mmHg | |

## IMPRESSION

- **NORMAL LV SYSTOLIC & DIASTOLIC FUNCTION**
- **NO RWMA LVEF 60%**
- **NORMAL RV FUNCTION**
- **TRACE MR**
- **MILD PR**
- **NORMAL CHAMBER DIMENSIONS**
- **NORMAL VALVULAR ECHO**
- **INTACT IAS / IVS**
- **NO THROMBUS, NO VEGETATION, NORMAL PERICARDIUM.**
- **IVC NORMAL**

- **CONCLUSION : MILD PR, FAIR LV FUNCTION.**

Cardiologist