

**Client****Jeevan Jyoti HLM**

Pathkind Diagnostics Pvt. Ltd.

162, Lowther Road, Bai Ka Bagh, Prayagraj

**Processed By****Pathkind Diagnostics Pvt. Ltd.**

162, Lowther Road, Bai Ka Bagh, Prayagraj

Uttar Pradesh-211003

<b>Name</b> : Mrs. VANDANA REG-313223 OPD	Billing Date	: 19/11/2022 10:18:01
Age : 31 Yrs	Sample Collected on	: 19/11/2022 13:46:16
Sex : Female	Sample Received on	: 19/11/2022 14:52:57
P. ID No. : P1212100006044	Report Released on	: 19/11/2022 15:14:15
<b>Accession No</b> : 121222026063	Barcode No.	: 1201068957
Referring Doctor : SELF	Ref no.	:
Referred By :		

**Report Status - Final**

Test Name	Result	Biological Ref. Interval	Unit
<b>HAEMATOLOGY</b>			
<b>Complete Blood Count (CBC)</b>			
<b>Haemoglobin (Hb)</b> Sample: Whole Blood EDTA Method: Photometric measurement	12.5	12.0 - 15.0	gm/dL
<b>Total WBC Count / TLC</b> Sample: Whole Blood EDTA Method: Impedance	6.1	4.0 - 10.0	thou/ $\mu$ L
<b>RBC Count</b> Sample: Whole Blood EDTA Method: Impedance	4.1	3.8 - 4.8	million/ $\mu$ L
<b>PCV / Hematocrit</b> Sample: Whole Blood EDTA Method: Impedance	39.2	36.0 - 46.0	%
<b>MCV</b> Sample: Whole Blood EDTA Method: Calculated	94.7	83.0 - 101.0	fL
<b>MCH</b> Sample: Whole Blood EDTA Method: Calculated	30.3	27.0 - 32.0	pg
<b>MCHC</b> Sample: Whole Blood EDTA Method: Calculated	32.0	31.5 - 34.5	g/dL
<b>RDW (Red Cell Distribution Width)</b> Sample: Whole Blood EDTA Method: Calculated	12.0	11.9 - 15.5	%
<b>DLC (Differential Leucocyte Count)</b> Method: Flowcytometry/Microscopy			
<b>Neutrophils</b> Sample: Whole Blood EDTA Method: VCS Technology & Microscopy	62	40 - 80	%
<b>Lymphocytes</b> Sample: Whole Blood EDTA Method: VCS Technology & Microscopy	27	20 - 40	%

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<b>Eosinophils</b> <i>Sample: Whole Blood EDTA</i> <i>Method: VCS Technology &amp; Microscopy</i>	<b>07 H</b>	01 - 06	%
<b>Monocytes</b> <i>Sample: Whole Blood EDTA</i> <i>Method: VCS Technology &amp; Microscopy</i>	04	02 - 10	%
<b>Basophils</b> <i>Sample: Whole Blood EDTA</i> <i>Method: VCS Technology &amp; Microscopy</i>	00	00 - 02	%
<b>Absolute Neutrophil Count</b> <i>Sample: Whole Blood EDTA</i>	3782	2000 - 7000	/ $\mu$ L
<b>Absolute Lymphocyte Count</b> <i>Sample: Whole Blood EDTA</i>	1647	1000 - 3000	/ $\mu$ L
<b>Absolute Eosinophil Count</b> <i>Sample: Whole Blood EDTA</i>	427	20 - 500	/ $\mu$ L
<b>Absolute Monocyte Count</b> <i>Sample: Whole Blood EDTA</i>	244	200 - 1000	/ $\mu$ L
<b>Absolute Basophil Count</b> <i>Sample: Whole Blood EDTA</i>	<b>0 L</b>	20 - 100	/ $\mu$ L
<b>DLC Performed By</b> <i>Sample: Whole Blood EDTA</i>	EDTA Smear		
<b>Platelet Count</b> <i>Sample: Whole Blood EDTA</i> <i>Method: Impedance</i>	269	150 - 410	thou/ $\mu$ L
<b>MPV (Mean Platelet Volume)</b> <i>Sample: Whole Blood EDTA</i> <i>Method: Calculated</i>	9.9	6.8 - 10.9	fL
<b>Erythrocyte Sedimentation Rate (ESR)</b> <i>Sample: Whole Blood EDTA</i> <i>Method: Modified Westergren Method</i>	<b>27 H</b>	<12	mm 1st Hour

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<b>BIOCHEMISTRY</b>			
<b>HbA1C (Glycosylated Hemoglobin)</b>			
<b>HbA1c</b> <i>Sample: Whole Blood EDTA</i> <i>Method: Turbidimetric inhibition immunoassay</i>	4.9	Non Diabetic : < 5.7 % Prediabetic Range : 5.7 - 6.4 % Diabetic Range : >= 6.5 % Goal of Therapy : <7.0 % Action suggested : >8.0 %	%
<b>Mean Plasma Glucose</b> <i>Sample: Whole Blood EDTA</i> <i>Method: Calculated</i>	93.9	<116.0	mg/dL
<b>Fasting Plasma Glucose</b> <i>Sample: Fluoride Plasma - F</i>	92	74 - 106	mg/dl
<b>Glucose Post-Prandial</b> <i>Sample: Fluoride Plasma - PP</i> <i>Method: Hexokinase</i>	110	70 - 140	mg/dl

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**CLINICAL PATHOLOGY****Stool Routine & Microscopic Examination****Physical Examination****Colour***Sample: Stool*

Brownish

Yellowish Brown

**Consistency***Sample: Stool*

Semi Solid

Semi Solid

**Mucus***Sample: Stool*

Absent

Absent

**Blood***Sample: Stool*

Absent

Absent

**Odour***Sample: Stool*

Fecal

Fecal

**Microscopic Examination****Cyst***Sample: Stool*

Not Detected

Not Detected

**Trophozoites***Sample: Stool*

Not Detected

Not Detected

**Charcot - Leyden Crystals***Sample: Stool*

Not Detected

Not Detected

**Ova***Sample: Stool*

Not Detected

Not Detected

**Adult Parasite***Sample: Stool*

Not Detected

Not Detected

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Test Name	Result	Biological Ref. Interval	Unit
<b>RBC</b> <i>Sample: Stool</i>	Not Detected	0 - 0	/hpf
<b>Pus Cells</b> <i>Sample: Stool</i>	2 - 4	0 - 5	/HPF

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**BIOCHEMISTRY****Liver Function Test (LFT)****Bilirubin Total**

Sample: Serum

Method: Spectrophotometry

0.5

&lt;1.1

mg/dL

**Bilirubin Direct**

Sample: Serum

Method: Spectrophotometry

0.2

&lt;0.2

mg/dL

**Serum Bilirubin (Indirect)**

Sample: Serum

Method: Calculated

0.3

&lt;0.90

mg/dL

**SGOT / AST**

Sample: Serum

Method: Spectrophotometry

14

&lt;31

U/L

**SGPT / ALT**

Sample: Serum

Method: Spectrophotometry

16

&lt;33

U/L

**AST / ALT Ratio**

Sample: Serum

Method: Calculated

0.88

**Alkaline Phosphatase (ALP)**

Sample: Serum

Method: Spectrophotometry

84

&lt;98

U/L

**Total Protein**

Sample: Serum

Method: Spectrophotometry

6.7

6.4 - 8.3

g/dL

**Albumin**

Sample: Serum

Method: Spectrophotometry

4.6

4.0 - 4.9

g/dL

**Globulin**

Sample: Serum

Method: Calculated

2.1

1.9 - 3.7

g/dL

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Test Name	Result	Biological Ref. Interval	Unit
<b>Albumin/Globulin (A/G) Ratio</b> <i>Sample: Serum</i> <i>Method: Calculated</i>	<b>2.2 H</b>	1.0 - 2.1	g/dL
<b>Lipid Profile</b>			
<b>Total Cholesterol</b> <i>Sample: Serum</i> <i>Method: Spectrophotometry</i>	151	No risk : < 200 Moderate risk : 200-239 High risk : =240	mg/dL
<b>Triglycerides</b> <i>Sample: Serum</i> <i>Method: Spectrophotometry</i>	56	Desirable : < 150 Borderline High : 150 - 199 High : 200 - 499 Very High : >/= 500	mg/dL
<b>LDL Cholesterol (Calculated)</b> <i>Sample: Serum</i> <i>Method: Calculated</i>	83	Optimal : <100 Near Optimal : 100 - 129 Borderline High : 130 - 160 High : 161 - 189 Very High : >/=190	mg/dL
<b>HDL Cholesterol</b> <i>Sample: Serum</i> <i>Method: Spectrophotometry</i>	57	Low : < 40 Optimal : 40 - 60 High : > 60	mg/dL
<b>Non HDL Cholesterol</b> <i>Sample: Serum</i>	94	< 130	mg/dL
<b>VLDL Cholesterol</b> <i>Sample: Serum</i> <i>Method: Calculated</i>	11.2	Desirable 10 - 35	mg/dL
<b>Total Cholesterol / HDL Ratio</b> <i>Sample: Serum</i> <i>Method: Calculated</i>	<b>2.65 L</b>	Low Risk : 3.3 - 4.4 Average Risk : 4.5 - 7.0 Moderate Risk : 7.1 - 11.0 High Risk : > 11.0	
<b>LDL / HDL Ratio</b> <i>Sample: Serum</i> <i>Method: Calculated</i>	1.5	0.5 - 3.0	
		Low Risk : 0.5 - 3.0	

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Test Name	Result	Biological Ref. Interval	Unit
<b>Kidney Profile (KFT)</b>		Moderate Risk : 3.1 - 6.0 High Risk : > 6.0	
<b>Blood Urea</b>			
<b>Blood Urea Nitrogen (BUN)</b> Sample: Serum Method: Spectrophotometry-Urease / GLDH	10.06	7.00 - 18.69	mg/dL
<b>Urea</b> Sample: Serum Method: Spectrophotometry	21.53	17.00 - 43.00	mg/dL
<b>Creatinine</b> Sample: Serum Method: Spectrophotometry	0.63	0.50 - 1.10	mg/dL
<b>BUN Creatinine Ratio</b> Sample: Serum Method: Calculated	16	10 - 20	
<b>Calcium</b> Sample: Serum Method: Spectrophotometry	9.3	8.6 - 10.0	mg/dL
<b>Uric Acid</b> Sample: Serum Method: Spectrophotometry	3.2	2.4 - 5.7	mg/dL
<b>Total Protein</b> Sample: Serum Method: Spectrophotometry	6.7	6.4 - 8.3	g/dL
<b>Albumin</b> Sample: Serum Method: Spectrophotometry	4.6	4.0 - 4.9	g/dL
<b>Globulin</b> Sample: Serum Method: Calculated	2.1	1.9 - 3.7	g/dL
<b>Albumin/Globulin (A/G) Ratio</b> Sample: Serum Method: Calculated	<b>2.2 H</b>	1.0 - 2.1	g/dL

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**CLINICAL PATHOLOGY****Urine Routine & Microscopic Examination**

Method: Reflectance Photometry

**Physical Examination****Colour**

Sample: Urine

Method: Physical Examination

Pale Yellow

Pale Yellow

**Appearance**

Sample: Urine

Method: Physical Examination

Clear

Clear

**Specific Gravity**

Sample: Urine

Method: pKa change of pretreated polyelectrolytes

1.015

1.003 - 1.035

**pH**

Sample: Urine

Method: Double indicator principle

5.0

4.7 - 7.5

**Chemical Examination****Glucose**

Sample: Urine

Method: Glucose oxidase/peroxidase

Not Detected

Not Detected

**Protein**

Sample: Urine

Method: Protein-error-of-indicators principle

Not Detected

Not Detected

**Ketones**

Sample: Urine

Method: Sodium nitroprusside reaction

Not Detected

Not Detected

**Blood**

Sample: Urine

Method: Peroxidase

Not Detected

Not Detected

**Bilirubin**

Sample: Urine

Method: Diazo reaction

Not Detected

Not Detected

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Test Name	Result	Biological Ref. Interval	Unit
<b>Urobilinogen</b> Sample: Urine Method: Ehrlich's reaction	Normal	Normal	
<b>Nitrite</b> Sample: Urine Method: Nitrite Test	Not Detected	Not Detected	
<b>Microscopic Examination</b> Method: Microscopy			
<b>Pus Cells</b> Sample: Urine	2 - 3	0 - 5	/hpf
<b>RBC</b> Sample: Urine	Not Detected	Not Detected	/hpf
<b>Epithelial Cells</b> Sample: Urine	2 - 3	0 - 5	/hpf
<b>Casts</b> Sample: Urine	Not Detected	Not Detected	/hpf
<b>Crystals</b> Sample: Urine	Not Detected	Not Detected	/hpf
<b>Bacteria</b> Sample: Urine	Not Detected	Not Detected	/hpf
<b>Remarks</b> Sample: Urine			

**Remarks** : Microscopic Examination is performed on urine sediment**BIOCHEMISTRY****Electrolytes (Na/K/Cl)**

<b>Sodium</b> Sample: Serum Method: ISE	139	136 - 145	mmol/L
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<b>Potassium</b> <i>Sample: Serum</i> <i>Method: ISE</i>	4.1	3.5 - 5.1	mmol/L
<b>Chloride</b> <i>Sample: Serum</i> <i>Method: ISE</i>	106	97 - 107	mmol/L

**Complete Blood Count (CBC)**Clinical Significance :

CBC comprises of estimation of the cellular components of blood including RBCs, WBCs and Platelets. Mean corpuscular volume (MCV) is a measure of the size of the average RBC, MCH is a measure of the hemoglobin content of the average RBC and MCHC is the hemoglobin concentration per RBC. The red cell distribution width (RDW) is a measure of the degree of variation in RBC size (anisocytosis) and is helpful in distinguishing between some anemias. CBC examination is used as a screening tool to confirm a hematologic disorder, to establish or rule out a diagnosis, to detect an unsuspected hematologic disorder, or to monitor effects of radiation or chemotherapy. Abnormal results may be due to a primary disorder of the cell-producing organs or an underlying disease. Results should be interpreted in conjunction with the patient's clinical picture and appropriate additional testing performed.

**Erythrocyte Sedimentation Rate (ESR)**Clinical Significance :

The erythrocyte sedimentation rate (ESR) is a simple but non-specific test that helps to detect inflammation associated with conditions such as infections, cancers, and autoimmune diseases.

**HbA1C (Glycosylated Hemoglobin)**Clinical Significance :

Hemoglobin A1c (HbA1c) level reflects the mean glucose concentration over the previous period (approximately 8-12 weeks) and provides a much better indication of long-term glycemic control than blood and urinary glucose determinations. American Diabetes Association (ADA) include the use of HbA1c to diagnose diabetes, using a cutpoint of 6.5%. The ADA recommends measurement of HbA1c 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 assess whether a patient's metabolic control has remained continuously within the target range. Falsely low HbA1c results may be seen in conditions that shorten erythrocyte life span. and may



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not reflect glycemc control in these cases accurately.

**Stool Routine & Microscopic Examination**Clinical Significance :

Routine and microscopic examination of stool sample comprises of macroscopic as well as microscopic examination of the sample for presence of parasitic ova and cysts.

**Bilirubin Total**Clinical Significance :

"Total Bilirubin is one of the most commonly used tests to assess liver function. A number of inherited and acquired diseases affect bilirubin production, metabolism, storage and excretion and causes hyperbilirubinemia resulting in jaundice. Hyperbilirubinemia may be due to increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Unconjugated hyperbilirubinemia is seen in newborn and known as physiological jaundice. Elevated unconjugated bilirubin in the neonatal period may result in brain damage (kernicterus). Crigler-Najjar syndromes type I and type II are also associated with elevated levels of indirect bilirubin. Both conjugated and unconjugated bilirubin are increased in hepatitis and space-occupying lesions of the liver; and obstructive lesions such as carcinoma of the head of the pancreas, common bile duct, or ampulla of Vater."

**Bilirubin Direct**Clinical Significance :

"Direct bilirubin is a measurement of conjugated bilirubin. Jaundice can occur as a result of increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Inherited disorders in which direct bilirubin levels are increased are seen in Dubin-Johnson syndrome and Rotor syndrome, idiopathic neonatal hepatitis and biliary atresia. The most commonly occurring form of jaundice of the newborn called physiological jaundice is due to increase in levels of indirect bilirubin. Both conjugated and unconjugated bilirubin are increased in hepatocellular diseases such as hepatitis and space-occupying lesions of the liver, obstructive lesions such as carcinoma of the head of the pancreas, common bile duct, or ampulla of Vater."

**SGOT / AST**Clinical Significance :

"Elevated aspartate aminotransferase (AST) values are seen most commonly in parenchymal liver diseases. Values can be elevated from 10 to 100

121222026063 Mrs. VANDANA REG-313223 C

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**Client****Jeevan Jyoti HLM**

Pathkind Diagnostics Pvt. Ltd.

162, Lowther Road, Bai Ka Bagh, Prayagraj

**Processed By****Pathkind Diagnostics Pvt. Ltd.**

162, Lowther Road, Bai Ka Bagh, Prayagraj

Uttar Pradesh-211003

<b>Name</b> : Mrs. VANDANA REG-313223 OPD	Billing Date	: 19/11/2022 10:18:01
Age : 31 Yrs	Sample Collected on	: 19/11/2022 13:46:16
Sex : Female	Sample Received on	: 19/11/2022 14:52:57
P. ID No. : P1212100006044	Report Released on	: 19/11/2022 15:14:15
<b>Accession No</b> : 121222026063	Barcode No.	: 1201068956, 1201068941, 1201068955, 1201068959, 1201068958, 1201068957
Referring Doctor : SELF	Ref no.	:
Referred By :		

**Report Status - Final**

Test Name	Result	Biological Ref. Interval	Unit
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times the normal range, though commonly 20 to 50 times elevations are seen. AST levels are raised in infectious hepatitis and other inflammatory conditions affecting the liver along with ALT, though ALT levels are higher. The ALT:AST ratio which is normally <1 is reversed in these conditions and becomes >1. AST levels are usually raised before clinical signs and symptoms of disease appear. AST and ALT also rise in primary or metastatic carcinoma of the liver, with AST usually being higher than ALT. Elevated AST values may also be seen in disorders affecting the heart, skeletal muscle and kidney, such as myocardial infarction, muscular dystrophy, dermatomyositis, acute pancreatitis and crushed muscle injuries."

**SGPT / ALT**Clinical Significance :

Elevated alanine aminotransferase (ALT) values are seen in parenchymal liver diseases characterized by a destruction of hepatocytes. Values are at least 10 times higher the normal range and may reach up to 100 times the upper reference limit. Commonly, values are seen to be 20 - 50 times higher than normal. In infectious hepatitis and other inflammatory conditions affecting the liver, ALT levels rise more than aspartate aminotransferase (AST), and the ALT/AST ratio, which is normally <1, is reversed and becomes >1. ALT levels usually rise before clinical signs and symptoms of disease appear.

**Alkaline Phosphatase (ALP)**Clinical Significance :

Alkaline Phosphatase levels can be elevated in both liver related as well as bone related conditions. ALP levels are raised (more than 3 fold) in extrahepatic biliary obstruction (eg, by stone or by cancer of the head of the pancreas) than in intrahepatic obstruction, and is directly proportional to the level of obstruction. Levels may rise up to 10 to 12 times the upper limit of normal range and returns to normal on surgical removal of the obstruction. ALP levels rise together with GGT levels and If both GGT and ALP are elevated, a liver source of the ALP is likely. Among bone diseases, ALP levels rise in Paget disease (up to 25 fold), osteomalacia, rickets, primary and secondary hyperparathyroidism and osteogenic bone cancer. Elevated ALP is seen in children following accelerated bone growth. Also, a 2 to 3fold elevation may be observed in women in the third trimester of pregnancy, although the interval is very wide and levels may not exceed the upper limit of the reference interval in some cases.

**Total Protein**Clinical Significance :

High levels of Serum Total Protein is seen in increased acute phase reactants in inflammation, late-stage liver disease, infections, multiple myeloma and other malignant paraproteinemias. Hypoproteinemia is seen in hypogammaglobulinemia, nephrotic syndrome and protein-losing enteropathy.

**Albumin**

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**Client**

**Jeevan Jyoti HLM**

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Clinical Significance :

"Hypoalbuminemia can be caused by impaired synthesis due to liver disease (primary) or due to diminished protein intake (secondary), increased catabolism due to tissue damage and inflammation; malabsorption of amino acids; and increased renal excretion (eg, nephrotic syndrome).Hyperalbuminemia is seen in dehydration."

**Lipid Profile**

Proposed LDL-C goals in very high risk and extreme risk group patients by the Lipid Association of India.

Very High Risk group(VHRG)	Extreme Risk group	
	Category A	Category B
LDL-C goal of <50 mg/dl	LDL-C goal of <50 mg/dl (recommended) LDL-C goal of ≤30 mg/dl (optional)	LDL-C goal of ≤30 mg/dl
High-risk conditions Any one of following:	CAD with ≥1 of following:	CAD with ≥1 of following:
1. ASCVD (CAD/PAD/TIA or stroke) 2. Homozygous familial 3. hypercholesterolemia 4. Diabetes with ≥2 major ASCVD risk factors*/target organ damage	1. Diabetes without target organ damage/≤1 major 2. ASCVD risk factors 3. Familial hypercholesterolemia 4. ≥3 major ASCVD risk factors 5. CKD stage 3B and 4 6. ≥2 major ASCVD risk factors with ≥1 moderate 7. non-conventional risk factor# 8. Lp(a) ≥50 mg/dl 9. Coronary calcium score ≥300 HU 10. Extreme of a single risk factor 11. PAD 12. H/o TIA or stroke 13. Non-stenotic carotid plaque	1. Diabetes + polyvascular disease/≥2 2. major ASCVD risk factors*/target organ 3. damage 4. Recurrent ACS (within 12 months) 5. despite on LDL-C goal 6. Homozygous familial 7. Hypercholesterolemia

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The LDL-C goal of  $\leq 30$  mg/dl must be pursued after detailed risk-benefit discussion between physician and patient.

Clinical judgment to be used in decision making if the patient has disease/risk factors not covered in the table, eg. peripheral arterial disease or cerebrovascular disease.

\*Major ASCVD risk factors: 1. Age- male  $\geq 45$  years, female  $\geq 55$  years, 2. Family h/o premature CAD- male  $< 55$  years, female  $< 65$  years, 3. Smoking/tobacco use, 4. Systemic hypertension, 5. Low HDL (males  $< 40$  mg/dl and females  $< 50$  mg/dl).

#Moderate non-conventional risk factors: 1. Coronary calcium score 100–299 HU, 2. Increased carotid intima-media thickness, 3. Lp(a)  $\geq 20$ –49

**Uric Acid**Clinical Significance :

Uric acid is the final product of purine metabolism. Serum uric acid levels are raised in case of increased purine synthesis, inherited metabolic disorder, excess dietary purine intake, increased nucleic acid turnover, malignancy and cytotoxic drugs. Decreased levels are seen in chronic renal failure, severe hepatocellular disease with reduced purine synthesis, defective renal tubular reabsorption, overtreatment of hyperuricemia with allopurinol, as well as some cancer therapies.

**Urine Routine & Microscopic Examination**Clinical Significance :

Urine routine examination and microscopy comprises of a set of screening tests that can detect some common diseases like urinary tract infections, kidney disorders, liver problems, diabetes or other metabolic conditions. Physical characteristics (colour and appearance), chemical composition (glucose, protein, ketone, blood, bilirubin and urobilinogen) and microscopic content (pus cells, epithelial cells, RBCs, casts and crystals) are analyzed and reported.

\*\* End of Report\*\*

**Dr. Ankit Singh**

MBBS, MD (Pathologist)

Lab Head

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HEART	Lipid Profile	Lipid Profile with Direct LDL	Lipid Profile with Direct LDL
DIABETES	FBS, HbA1c	FBS, HbA1c, Microalbumin	FBS, HbA1c, Microalbumin
KIDNEY	BUN, Creatinine, Bun/Creatinine Ratio, Electrolytes, Uric Acid, Urine R/E	BUN, Creatinine, BUN/Creatinine Ratio, Electrolytes, Uric Acid, Urine R/E	BUN, Creatinine, BUN/Creatinine Ratio, Electrolytes, Uric Acid, Urine R/E
BONES	Vitamin D, Calcium	Vitamin D, Calcium, Phosphorus	Vitamin D, Calcium, Phosphorus, Rheumatoid Factor
THYROID	T3, T4, TSH	T3, T4, TSH	FT3, FT4, TSH
NERVES	Vitamin B12	Vitamin B12	Vitamin B12
LIVER	Bilirubin (Total, Direct, Indirect), SGOT, SGPT, ALP, Protein, Albumin, Globulin, A:G Ratio, HBsAg	Bilirubin (Total, Direct, Indirect), SGOT, SGPT, ALP, GGT, LDH, Protein, Albumin, Globulin, A:G Ratio, HBsAg	Bilirubin (Total, Direct, Indirect), SGOT, SGPT, ALP, GGT, LDH, Protein, Albumin, Globulin, A:G Ratio, HBsAg
ANAEMIA	Iron, TIBC, UIBC, % Saturation	Iron, TIBC, UIBC, % Saturation, Ferritin	Iron, TIBC, UIBC, % Saturation, Ferritin, Folic Acid
INFECTION	CBC, ESR	CBC, ESR	CBC, ESR

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-	Immunoglobulin IgE Total	
-	Immunoglobulin Profile (IgA, IgG, IgM)	