

**DIAGNOSTIC REPORT**Patient Ref. No. **666000003707621****CLIENT CODE :** CA00010147 - MEDIWHEEL  
**CLIENT'S NAME AND ADDRESS:**MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED  
F701A, LADO SARAI, NEW DELHI,  
SOUTH DELHI, DELHI,  
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8800465156DDRC SRL DIAGNOSTICS  
Phoenix Tower, Near Central Park Hotel,  
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KOLLAM, 691008  
KERALA, INDIA  
Tel : 93334 93334  
Email : customercare.ddrc@srl.in**PATIENT NAME : ATHIRA SURENDRAN****PATIENT ID : ATHIF1103884071**ACCESSION NO : **4071WC002807** AGE : 34 Years SEX : Female

ABHA NO :

DRAWN :

RECEIVED : 11/03/2023 13:42

REPORTED : 11/03/2023 17:33

**REFERRING DOCTOR :** SELF

CLIENT PATIENT ID :

Test Report Status	Preliminary	Results	Biological Reference Interval	Units
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**MEDIWHEEL HEALTH CHECKUP BELOW 40(F)TMT****TREADMILL TEST**

TREADMILL TEST

REPORTED

**OPHTHAL**

OPHTHAL

CANCELLED

**PHYSICAL EXAMINATION**

PHYSICAL EXAMINATION

REPORTED



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**PATIENT NAME :** ATHIRA SURENDRAN

**PATIENT ID :** ATHIF1103884071

**ACCESSION NO :** 4071WC002807 **AGE :** 34 Years **SEX :** Female

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**MEDIWHEEL HEALTH CHECKUP BELOW 40(F)TMT**

**BLOOD UREA NITROGEN (BUN), SERUM**

BLOOD UREA NITROGEN 9 Adult(<60 yrs) : 6 to 20 mg/dL

**BUN/CREAT RATIO**

BUN/CREAT RATIO 12.5

**CREATININE, SERUM**

CREATININE 0.72 18 - 60 yrs : 0.6 - 1.1 mg/dL

**GLUCOSE, POST-PRANDIAL, PLASMA**

GLUCOSE, POST-PRANDIAL, PLASMA **158** **High** Diabetes Mellitus : > or = 200. mg/dL  
Impaired Glucose tolerance/  
Prediabetes : 140 - 199.  
Hypoglycemia : < 55.

**GLUCOSE FASTING,FLUORIDE PLASMA**

GLUCOSE, FASTING, PLASMA 93 Diabetes Mellitus : > or = 126. mg/dL  
Impaired fasting Glucose/  
Prediabetes : 101 - 125.  
Hypoglycemia : < 55.

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

GLYCOSYLATED HEMOGLOBIN (HBA1C) 5.4 Normal : 4.0 - 5.6%. %  
Non-diabetic level : < 5.7%.  
Diabetic : >6.5%

Glycemic control goal  
More stringent goal : < 6.5 %.  
General goal : < 7%.  
Less stringent goal : < 8%.

Glycemic targets in CKD :-  
If eGFR > 60 : < 7%.  
If eGFR < 60 : 7 - 8.5%.

MEAN PLASMA GLUCOSE 108.3 < 116.0 mg/dL

**LIPID PROFILE, SERUM**

CHOLESTEROL **256** **High** Desirable : < 200 mg/dL  
Borderline : 200-239

TRIGLYCERIDES 86 Normal : < 150 mg/dL  
High : 150-199  
Hypertriglyceridemia : 200-499  
Very High : > 499



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HDL CHOLESTEROL	<b>104</b>	<b>High</b> General range : 40-60	mg/dL
DIRECT LDL CHOLESTEROL	<b>177</b>	<b>High</b> Optimum : < 100 Above Optimum : 100-139 Borderline High : 130-159 High : 160-189 Very High : >or= 190	mg/dL
NON HDL CHOLESTEROL	<b>152</b>	<b>High</b> Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
VERY LOW DENSITY LIPOPROTEIN	17.2	Desirable value :	mg/dL
CHOL/HDL RATIO	<b>2.5</b>	<b>Low</b> 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	1.7	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	



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**Interpretation(s)**

- 1) Cholesterol levels help assess the patient risk status and to follow the progress of patient under treatment to lower serum cholesterol concentrations.
- 2) Serum Triglyceride (TG) are a type of fat and a major source of energy for the body. Both quantity and composition of the diet impact on plasma triglyceride concentrations. Elevations in TG levels are the result of overproduction and impaired clearance. High TG are associated with increased risk for CAD (Coronary artery disease) in patients with other risk factors, such as low HDL-C, some patient groups with elevated apolipoprotein B concentrations, and patients with forms of LDL that may be particularly atherogenic.
- 3) HDL-C plays a crucial role in the initial step of reverse cholesterol transport, this considered to be the primary atheroprotective function of HDL
- 4) LDL -C plays a key role in causing and influencing the progression of atherosclerosis and, in particular, coronary sclerosis. The majority of cholesterol stored in atherosclerotic plaques originates from LDL, thus LDL-C value is the most powerful clinical predictor.
- 5) Non HDL cholesterol: Non-HDL-C measures the cholesterol content of all atherogenic lipoproteins, including LDL hence it is a better marker of risk in both primary and secondary prevention studies. Non-HDL-C also covers, to some extent, the excess ASCVD risk imparted by the sdLDL, which is significantly more atherogenic than the normal large buoyant particles, an elevated non-HDL-C indirectly suggests greater proportion of the small, dense variety of LDL particles

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)





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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 TEST WITH GGT**

BILIRUBIN, TOTAL	0.22	General Range : < 1.1	mg/dL
BILIRUBIN, DIRECT	0.10	General Range : < 0.3	mg/dL
BILIRUBIN, INDIRECT	0.12	0.00 - 0.60	mg/dL
TOTAL PROTEIN	7.4	Ambulatory : 6.4 - 8.3 Recumbant : 6 - 7.8	g/dL
ALBUMIN	4.6	20-60yrs : 3.5 - 5.2	g/dL
GLOBULIN	2.8	General Range : 2 - 3.5 Premature Neonates : 0.29 - 1.04	g/dL
ALBUMIN/GLOBULIN RATIO	1.6	1.0 - 2.0	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	16	Adults : < 33	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)	10	Adults : < 34	U/L
ALKALINE PHOSPHATASE	76	Adult (<60yrs) : 35 - 105	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)	12	Adult (female) : < 40	U/L

**Comments**

\*\*Kindly correlate clinically.  
Kindly inform lab within 24hours if clinically not correlating

**TOTAL PROTEIN, SERUM**

TOTAL PROTEIN	7.4	Ambulatory : 6.4 - 8.3 Recumbant : 6 - 7.8	g/dL
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**URIC ACID, SERUM**

URIC ACID	3.4	Adults : 2.4-5.7	mg/dL
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**ABO GROUP & RH TYPE, EDTA WHOLE BLOOD**



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ABO GROUP		TYPE O	
RH TYPE		POSITIVE	
<b>BLOOD COUNTS,EDTA WHOLE BLOOD</b>			
HEMOGLOBIN		14.3	12.0 - 15.0 g/dL
RED BLOOD CELL COUNT		<b>5.28</b>	<b>High</b> 3.8 - 4.8 mil/ $\mu$ L
WHITE BLOOD CELL COUNT		5.27	4.0 - 10.0 thou/ $\mu$ L
PLATELET COUNT		286	150 - 410 thou/ $\mu$ L
<b>RBC AND PLATELET INDICES</b>			
HEMATOCRIT		44.2	36 - 46 %
MEAN CORPUSCULAR VOL		83.7	83 - 101 fL
MEAN CORPUSCULAR HGB.		27.1	27.0 - 32.0 pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION		32.4	31.5 - 34.5 g/dL
MENTZER INDEX		15.9	
MEAN PLATELET VOLUME		9.1	6.8 - 10.9 fL
<b>WBC DIFFERENTIAL COUNT</b>			
SEGMENTED NEUTROPHILS		53	40 - 80 %
LYMPHOCYTES		<b>41</b>	<b>High</b> 20 - 40 %
MONOCYTES		<b>01</b>	<b>Low</b> 2 - 10 %
EOSINOPHILS		05	1 - 6 %
BASOPHILS		0	< 1 - 2 %
ABSOLUTE NEUTROPHIL COUNT		2.79	2.0 - 7.0 thou/ $\mu$ L
ABSOLUTE LYMPHOCYTE COUNT		2.16	1.0 - 3.0 thou/ $\mu$ L
ABSOLUTE MONOCYTE COUNT		<b>0.05</b>	<b>Low</b> 0.2 - 1.0 thou/ $\mu$ L
ABSOLUTE EOSINOPHIL COUNT		0.26	0.02 - 0.50 thou/ $\mu$ L
ABSOLUTE BASOPHIL COUNT		00	thou/ $\mu$ L
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		1.3	
<b>ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD</b>			
SEDIMENTATION RATE (ESR)		<b>36</b>	<b>High</b> 0 - 20 mm at 1 hr
<b>SUGAR URINE - POST PRANDIAL</b>			
SUGAR URINE - POST PRANDIAL		NOT DETECTED	NOT DETECTED
<b>THYROID PANEL, SERUM</b>			



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T3		119.10	Non-Pregnant : 80-200 Pregnant Trimester-wise 1st : 81-190 2nd : 100-260 3rd : 100-260 ng/dL
T4		7.74	Adults : 4.5-12.1 µg/dl
TSH 3RD GENERATION		1.940	Non-Pregnant : 0.4-4.2 Pregnant Trimester-wise : 1st : 0.1 - 2.5 2nd : 0.2 - 3 3rd : 0.3 - 3 µIU/mL



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**Interpretation(s)**

**Triiodothyronine T3 , Thyroxine T4, and Thyroid Stimulating Hormone TSH** are thyroid hormones which affect almost every physiological process in the body, including growth, development, metabolism, body temperature, and heart rate. Production of T3 and its prohormone thyroxine (T4) is activated by thyroid-stimulating hormone (TSH), which is released from the pituitary gland. Elevated concentrations of T3, and T4 in the blood inhibit the production of TSH. Excessive secretion of thyroxine in the body is hyperthyroidism, and deficient secretion is called hypothyroidism. In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hyperthyroidism, TSH levels are low. Below mentioned are the guidelines for Pregnancy related reference ranges for Total T4, TSH & Total T3. Measurement of the serum TT3 level is a more sensitive test for the diagnosis of hyperthyroidism, and measurement of TT4 is more useful in the diagnosis of hypothyroidism. Most of the thyroid hormone in blood is bound to transport proteins. Only a very small fraction of the circulating hormone is free and biologically active. It is advisable to detect Free T3, FreeT4 along with TSH, instead of testing for albumin bound Total T3, Total T4.

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

**PHYSICAL EXAMINATION, URINE**

**COLOR** PALE YELLOW  
**APPEARANCE** CLEAR

**CHEMICAL EXAMINATION, URINE**

**PH** 6.5 4.7 - 7.5



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SPECIFIC GRAVITY		1.005	1.003 - 1.035
PROTEIN		NOT DETECTED	NOT DETECTED
GLUCOSE		NOT DETECTED	NOT DETECTED
KETONES		NOT DETECTED	NOT DETECTED
BLOOD		NOT DETECTED	NOT DETECTED
BILIRUBIN		NOT DETECTED	NOT DETECTED
UROBILINOGEN		NORMAL	NORMAL
NITRITE		NOT DETECTED	NOT DETECTED
<b>MICROSCOPIC EXAMINATION, URINE</b>			
RED BLOOD CELLS		NOT DETECTED	NOT DETECTED /HPF
WBC		1-2	0-5 /HPF
EPITHELIAL CELLS		2-3	0-5 /HPF
CASTS		NIL	
CRYSTALS		NIL	
BACTERIA		NOT DETECTED	NOT DETECTED
YEAST		NOT DETECTED	NOT DETECTED





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**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
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 infection when present in significant numbers & with pus cells.
Trichomonas vaginalis	Vaginitis, cervicitis or salpingitis

**SUGAR URINE - FASTING**

SUGAR URINE - FASTING	NOT DETECTED	NOT DETECTED
<b>PHYSICAL EXAMINATION, STOOL</b>	RESULT PENDING	
<b>CHEMICAL EXAMINATION, STOOL</b>	RESULT PENDING	
<b>MICROSCOPIC EXAMINATION, STOOL</b>	RESULT PENDING	





Patient Ref. No. 666000003707621

CLIENT CODE : CA00010147 - MEDIWHEEL  
 CLIENT'S NAME AND ADDRESS:

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 KERALA, INDIA  
 Tel : 93334 93334  
 Email : customercare.ddrc@srl.in

PATIENT NAME : ATHIRA SURENDRAN

PATIENT ID : ATHIF1103884071

ACCESSION NO : 4071WC002807 AGE : 34 Years SEX : Female

ABHA NO :

DRAWN :

RECEIVED : 11/03/2023 13:42

REPORTED : 11/03/2023 17:33

REFERRING DOCTOR : SELF

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**Interpretation(s)**

Stool routine analysis is only a screening test for disorders of gastrointestinal tract like infection, malabsorption, etc. The following table describes the probable conditions, in which the analytes are present in stool.

PRESENCE OF	CONDITION
Pus cells	Pus in the stool is an indication of infection
Red Blood cells	Parasitic or bacterial infection or an inflammatory bowel condition such as ulcerative colitis
Parasites	Infection of the digestive system. Stool examination for ova and parasite detects presence of parasitic infestation of gastrointestinal tract. Various forms of parasite that can be detected include cyst, trophozoite and larvae. One negative result does not rule out the possibility of parasitic infestation. Intermittent shedding of parasites warrants examinations of multiple specimens tested on consecutive days. Stool specimens for parasitic examination should be collected before initiation of anti-diarrheal therapy or antiparasitic therapy. This test does not detect presence of opportunistic parasites like Cyclospora, Cryptosporidia and Isospora species. Examination of Ova and Parasite has been carried out by direct and concentration techniques.
Mucus	Mucus is a protective layer that lubricates, protects & reduces damage due to bacteria or viruses.
Charcot-Leyden crystal	Parasitic diseases.
Ova & cyst	Ova & cyst indicate parasitic infestation of intestine.
Frank blood	Bleeding in the rectum or colon.
Occult blood	Occult blood indicates upper GI bleeding.
Macrophages	Macrophages in stool are an indication of infection as they are protective cells.
Epithelial cells	Epithelial cells that normally line the body surface and internal organs show up in stool when there is inflammation or infection.
Fat	Increased fat in stool maybe seen in conditions like diarrhoea or malabsorption.
pH	Normal stool pH is slightly acidic to neutral. Breast-fed babies generally have an acidic stool.

**ADDITIONAL STOOL TESTS :**

- Stool Culture**:- This test is done to find cause of GI infection, make decision about best treatment for GI infection & to find out if treatment for GI infection worked.
- Fecal Calprotectin**: It is a marker of intestinal inflammation. This test is done to differentiate Inflammatory Bowel Disease (IBD) from Irritable Bowel Syndrome (IBS).
- Fecal Occult Blood Test (FOBT)**: This test is done to screen for colon cancer & to evaluate possible cause of unexplained anaemia.
- Clostridium Difficile Toxin Assay**: This test is strongly recommended in healthcare associated bloody or watery diarrhoea, due to overuse of broad spectrum antibiotics which alter the normal GI flora.
- Biofire (Film Array) GI PANEL**: In patients of Diarrhoea, Dysentery, Rice watery Stool, FDA approved, Biofire Film Array Test, (Real Time Multiplex PCR) is strongly recommended as it identifies organisms, bacteria, fungi, virus, parasite and other opportunistic pathogens, Vibrio cholera infections only in 3 hours. Sensitivity 96% & Specificity 99%.
- Rota Virus Immunoassay**: This test is recommended in severe gastroenteritis in infants & children associated with watery



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diarrhoea, vomiting& abdominal cramps. Adults are also affected. It is highly contagious in nature.

**Interpretation(s)**

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
- Muscular dystrophy

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

**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.

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 patient's metabolic control has remained continuously within the target range.

1. eAG (Estimated average glucose) converts percentage HbA1c to mg/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 :**

I. 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.

II. Vitamin C & E are reported to falsely lower test results. (possibly by inhibiting glycation of hemoglobin).

III. 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.

IV. 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

TOTAL PROTEIN, SERUM- Serum 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



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Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma, Waldenstrom's disease  
 Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage), Burns, Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome, Protein-losing enteropathy etc.

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

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD-

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

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

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

BLOOD COUNTS, 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.

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, Vasculitis, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Tissue injury, Pregnancy, Estrogen medication, Aging.

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

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

**Decreased** in: Polycythemia vera, Sickle cell anemia

#### LIMITATIONS

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

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

#### REFERENCE :

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

SUGAR URINE - POST PRANDIAL-METHOD: DIPSTICK/BENEDICT'S TEST

SUGAR URINE - FASTING-METHOD: DIPSTICK/BENEDICT'S TEST



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**DIAGNOSTIC REPORT**

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Email : customercare.ddrc@srl.in**PATIENT NAME :** ATHIRA SURENDRAN**PATIENT ID :** ATHIF1103884071**ACCESSION NO :** 4071WC002807 **AGE :** 34 Years **SEX :** Female**ABHA NO :****DRAWN :****RECEIVED :** 11/03/2023 13:42**REPORTED :** 11/03/2023 17:33**REFERRING DOCTOR :** SELF**CLIENT PATIENT ID :**

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