DIAGNOSTIC REPORT

SRL Diagnostics

PATIENT NAME : DEEPA KUMARI		**REF. DOCTOR :** DR. BANK OF BARODA
CODE/NAME & ADDRESS : C000138377 DEEPA KUMARI	ACCESSION NO : **0063WB000364** PATIENT ID : DEEPF15017363 CLIENT PATIENT ID: ABHA NO :	AGE/SEX :50 Years Female DRAWN :11/02/2023 09:15:56 RECEIVED :11/02/2023 09:17:59 REPORTED :13/02/2023 09:25:23

Test Report Status **Final**	Results	Biological Reference Interval	Units
MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40FEMALE			
BLOOD COUNTS,EDTA WHOLE BLOOD			
HEMOGLOBIN (HB) METHOD : SPECTROPHOTOMETRY	13.4	12.0 - 15.0	g/dL
RED BLOOD CELL (RBC) COUNT METHOD : IMPEDANCE	4.77	3.8 - 4.8	mil/µL
WHITE BLOOD CELL (WBC) COUNT METHOD : IMPEDANCE	7.57	4.0 - 10.0	thou/µL
PLATELET COUNT METHOD : IMPEDANCE	285	150 - 410	thou/µL
RBC AND PLATELET INDICES			
HEMATOCRIT (PCV) METHOD : CALCULATED	40.4	36 - 46	%
MEAN CORPUSCULAR VOLUME (MCV) METHOD : DERIVED FROM IMPEDANCE MEASURE	84.8	83 - 101	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH) METHOD : CALCULATED PARAMETER	28.1	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC) METHOD : CALCULATED PARAMETER	33.2	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW) METHOD : DERIVED FROM IMPEDANCE MEASURE	**17.2 High**	11.6 - 14.0	%
MENTZER INDEX	17.8		
MEAN PLATELET VOLUME (MPV) METHOD : DERIVED FROM IMPEDANCE MEASURE	9.6	6.8 - 10.9	fL
WBC DIFFERENTIAL COUNT			
NEUTROPHILS METHOD : DHSS FLOWCYTOMETRY	58	40 - 80	%
LYMPHOCYTES METHOD : DHSS FLOWCYTOMETRY	31	20 - 40	%
MONOCYTES METHOD : DHSS FLOWCYTOMETRY	6	2 - 10	%
EOSINOPHILS METHOD : DHSS FLOWCYTOMETRY	5	1 - 6	%
BASOPHILS METHOD : IMPEDANCE	0	0 - 2	%

K.I. Prajapati

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Consultant Pathologist

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NEW DELHI, INDIA
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Patient Ref. No. 63000000581268

SRL Diagnostics

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CODE/NAME & ADDRESS : C000138377
DEEPA KUMARI

ACCESSION NO : **0063WB000364**
PATIENT ID : DEEPF15017363
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ABSOLUTE NEUTROPHIL COUNT METHOD : DHSS FLOWCYTOMETRY, CALCULATED	4.38	2.0 - 7.0	thou/µL
ABSOLUTE LYMPHOCYTE COUNT METHOD : DHSS FLOWCYTOMETRY, CALCULATED	2.36	1 - 3	thou/µL
ABSOLUTE MONOCYTE COUNT METHOD : DHSS FLOWCYTOMETRY, CALCULATED	0.43	0.20 - 1.00	thou/µL
ABSOLUTE EOSINOPHIL COUNT METHOD : DHSS FLOWCYTOMETRY, CALCULATED	0.38	0.02 - 0.50	thou/µL
ABSOLUTE BASOPHIL COUNT METHOD : DHSS FLOWCYTOMETRY, CALCULATED	0.02	0.02 - 0.10	thou/µL
NEUTROPHIL LYMPHOCYTE RATIO (NLR) METHOD : CALCULATED	1.9		
ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD			
E.S.R METHOD : AUTOMATED (PHOTOMETRICAL CAPILLARY STOPPED FLOW KINETIC ANALYSIS)	**34 High**	0 - 20	mm at 1 hr
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD			
HBA1C METHOD : CAPILLARY ELECTROPHORESIS	5.7	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 ADA Target: 7.0 Action suggested: > 8.0	%
ESTIMATED AVERAGE GLUCOSE(EAG) METHOD : CALCULATED PARAMETER	**116.9 High**	< 116	mg/dL

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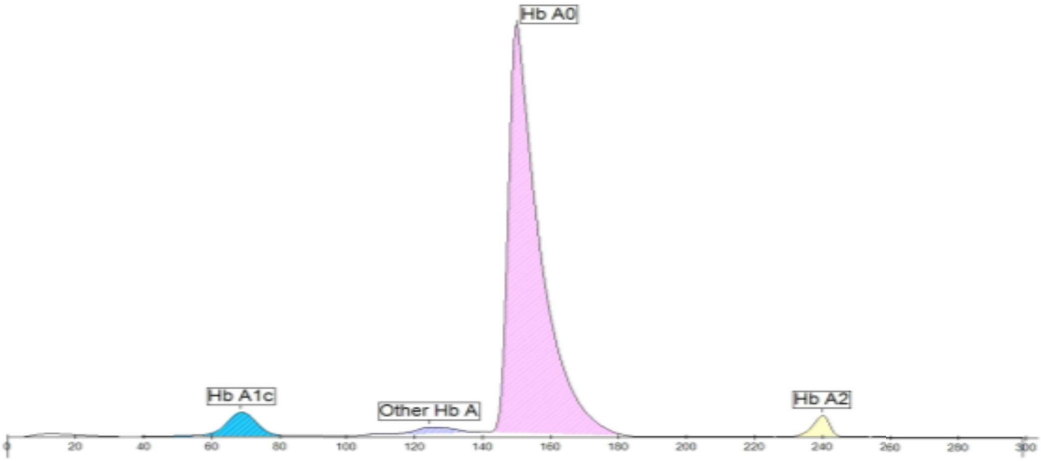
PLOT NO.31,ELECTRONIC CITY,SECTOR 18, GURUGRAM

ID : 914947861
Name :

Sample Date: 2/11/2023
Sample num.: 286



A1c Haemoglobin Electrophoresis

Fractions	%	mmol/mol	Cal. %
Hb A1c	-	**39**	5.7
Other Hb A	2.1		
Hb A0	90.2		
Hb A2	2.5		

HbA1c % cal :**5.7 %**

Comments :

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GLUCOSE FASTING,FLUORIDE PLASMA			
FBS (FASTING BLOOD SUGAR)	99	Normal 75 - 99 Pre-diabetics: 100 – 125 Diabetic: > or = 126	mg/dL
METHOD : SPECTROPHOTOMETRY HEXOKINASE			
GLUCOSE, POST-PRANDIAL, PLASMA			
PPBS(POST PRANDIAL BLOOD SUGAR)	89	70 - 139	mg/dL
METHOD : SPECTROPHOTOMETRY, HEXOKINASE			
LIVER FUNCTION PROFILE, SERUM			
BILIRUBIN, TOTAL	0.4	Upto 1.2	mg/dL
METHOD : COLORIMETRIC DIAZO METHOD			
BILIRUBIN, DIRECT	0.3	< 0.30	mg/dL
METHOD : COLORIMETRIC DIAZO METHOD			
BILIRUBIN, INDIRECT	0.10	0.1 - 1.0	mg/dL
METHOD : CALCULATED PARAMETER			
TOTAL PROTEIN	7.5	6.0 - 8.0	g/dL
METHOD : SPECTROPHOTOMETRY, BIURET			
ALBUMIN	4.7	3.97 - 4.94	g/dL
METHOD : SPECTROPHOTOMETRY, BROMOCRESOL GREEN(BCG) - DYE BINDING			
GLOBULIN	2.8	2.0 - 3.5	g/dL
METHOD : CALCULATED PARAMETER			
ALBUMIN/GLOBULIN RATIO	1.7	1.0 - 2.1	RATIO
METHOD : CALCULATED PARAMETER			
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	**42 High**	< OR = 35	U/L
METHOD : SPECTROPHOTOMETRY, WITH PYRIDOXAL PHOSPHATE ACTIVATION-IFCC			
ALANINE AMINOTRANSFERASE (ALT/SGPT)	**63 High**	< OR = 35	U/L
METHOD : SPECTROPHOTOMETRY, WITH PYRIDOXAL PHOSPHATE ACTIVATION-IFCC			
ALKALINE PHOSPHATASE	**172 High**	35 - 104	U/L
METHOD : SPECTROPHOTOMETRY, PNPP, AMP BUFFER - IFCC			
GAMMA GLUTAMYL TRANSFERASE (GGT)	**262 High**	0 - 40	U/L
METHOD : ENZYMATIC COLORIMETRIC ASSAY STANDARDIZED AGAINST IFCC / SZASZ			
LACTATE DEHYDROGENASE	205	125 - 220	U/L
METHOD : SPECTROPHOTOMETRY, LACTATE TO PYRUVATE - UV-IFCC			
BLOOD UREA NITROGEN (BUN), SERUM			

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BLOOD UREA NITROGEN	9.0	6 - 20	mg/dL
METHOD : SPECTROPHOTOMETRY, KINETIC TEST WITH UREASE AND GLUTAMATE DEHYDROGENASE			
CREATININE, SERUM			
CREATININE	0.50	0.5 - 0.9	mg/dL
METHOD : SPECTROPHOTOMETRIC, JAFFE'S KINETICS			
BUN/CREAT RATIO			
BUN/CREAT RATIO	**18.00 High**	8.0 - 15.0	
METHOD : CALCULATED PARAMETER			
URIC ACID, SERUM			
URIC ACID	5.2	2.4 - 5.7	mg/dL
METHOD : SPECTROPHOTOMETRY, URICASE			
TOTAL PROTEIN, SERUM			
TOTAL PROTEIN	7.5	6.0 - 8.0	g/dL
METHOD : SPECTROPHOTOMETRY, BIURET			
ALBUMIN, SERUM			
ALBUMIN	4.7	3.97 - 4.94	g/dL
METHOD : SPECTROPHOTOMETRY, BROMOCRESOL GREEN(BCG) - DYE BINDING			
GLOBULIN			
GLOBULIN	2.8	2.0 - 3.5	g/dL
METHOD : CALCULATED PARAMETER			
ELECTROLYTES (NA/K/CL), SERUM			
SODIUM, SERUM	136	136 - 145	mmol/L
METHOD : ISE INDIRECT			
POTASSIUM, SERUM	3.9	3.5 - 5.1	mmol/L
METHOD : ISE INDIRECT			
CHLORIDE, SERUM	**97 Low**	98 - 107	mmol/L
METHOD : ISE INDIRECT			

Interpretation(s)

PHYSICAL EXAMINATION, URINE

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Test Report Status **Final**	Results	Biological Reference Interval	Units
COLOR	PALE YELLOW		
APPEARANCE	CLEAR		

Comments

NOTE :MICROSCOPIC EXAMINATION OF URINE IS PERFORMED ON CENTRIFUGED URINARY SEDIMENT.
IN NORMAL URINE SAMPLES CAST AND CRYSTALS ARE NOT DETECTED.

CHEMICAL EXAMINATION, URINE

PH	7.0	4.7 - 7.5	
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	
LEUKOCYTE ESTERASE	NOT DETECTED	NOT DETECTED	

MICROSCOPIC EXAMINATION, URINE

RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
PUS CELL (WBC'S)	1-2	0-5	/HPF
EPITHELIAL CELLS	2-3	0-5	/HPF
CASTS	NOT DETECTED		
CRYSTALS	NOT DETECTED		
BACTERIA	NOT DETECTED	NOT DETECTED	

METHOD : DIP STICK/MICRO SCOPY/REFLECTANCE SPECTROPHOTOMETRY

Interpretation(s)

THYROID PANEL, SERUM

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T3	147.0	Non-Pregnant Women 80.0 - 200.0 Pregnant Women 1st Trimester:105.0 - 230.0 2nd Trimester:129.0 - 262.0 3rd Trimester:135.0 - 262.0	ng/dL
METHOD : ELECTROCHEMILUMINESCENCE IMMUNO ASSAY			
T4	10.10	Non-Pregnant Women 5.10 - 14.10 Pregnant Women 1st Trimester: 7.33 - 14.80 2nd Trimester: 7.93 - 16.10 3rd Trimester: 6.95 - 15.70	µg/dL
METHOD : ELECTROCHEMILUMINESCENCE IMMUNO ASSAY			
TSH (ULTRASENSITIVE)	**5.700 High**	Non Pregnant Women 0.27 - 4.20 Pregnant Women 1st Trimester: 0.33 - 4.59 2nd Trimester: 0.35 - 4.10 3rd Trimester: 0.21 - 3.15	µIU/mL
METHOD : ELECTROCHEMILUMINESCENCE IMMUNO ASSAY			

Interpretation(s)

MICROSCOPIC EXAMINATION,STOOL

PUS CELLS	NOT DETECTED		/hpf
RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
CYSTS	NOT DETECTED	NOT DETECTED	
OVA	NOT DETECTED		
LARVAE	NOT DETECTED	NOT DETECTED	
TROPHOZOITES	NOT DETECTED	NOT DETECTED	
FAT	ABSENT		
VEGETABLE CELLS	ABSENT		
CHARCOT LEYDEN CRYSTALS	ABSENT		
CONCENTRATION METHOD	OVA OR CYSTS NOT SEEN		

Interpretation(s)

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ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP	A		
METHOD : HEMAGGLUTINATION REACTION ON SOLID PHASE			
RH TYPE	RH+		
METHOD : HEMAGGLUTINATION REACTION ON SOLID PHASE			

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MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40FEMALE

LIPID PROFILE, SERUM

CHOLESTEROL, TOTAL	195	Desirable cholesterol level < 200 Borderline high cholesterol 200 - 239 High cholesterol > / = 240	mg/dL
METHOD : ENZYMATIC COLORIMETRIC ASSAY			
TRIGLYCERIDES	**162 High**	Normal: < 150 Borderline high: 150 - 199 High: 200 - 499 Very High: >/= 500	mg/dL
METHOD : ENZYMATIC COLORIMETRIC ASSAY			
HDL CHOLESTEROL	52	Low HDL Cholesterol <40 High HDL Cholesterol >/= 60	mg/dL
METHOD : HOMOGENEOUS ENZYMATIC COLORIMETRIC ASSAY			
CHOLESTEROL LDL	**114 High**	Adult levels: Optimal < 100 Near optimal/above optimal: 100-129 Borderline high : 130-159 High : 160-189 Very high : = 190	mg/dL
METHOD : HOMOGENEOUS ENZYMATIC COLORIMETRIC ASSAY			
NON HDL CHOLESTEROL	**143 High**	Desirable : < 130 Above Desirable : 130 -159 Borderline High : 160 - 189 High : 190 - 219 Very high : > / = 220	mg/dL
METHOD : CALCULATED PARAMETER			
VERY LOW DENSITY LIPOPROTEIN	**32.4 High**	< OR = 30.0	mg/dL
METHOD : CALCULATED PARAMETER			
CHOL/HDL RATIO	3.8	Low Risk : 3.3 - 4.4 Average Risk : 4.5 - 7.0 Moderate Risk : 7.1 - 11.0 High Risk : > 11.0	
METHOD : CALCULATED PARAMETER			

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LDL/HDL RATIO	2.2	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	

METHOD : CALCULATED PARAMETER

Interpretation(s)

PAPANICOLAOU SMEAR

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SPECIMEN TYPE

Serial no : C/834/2023

CLASSIFICATION
Bethesda 2014

SPECIMEN SITE
Cervix

SPECIMEN TYPE
Conventional PAP smear - Cervix
Received two unstained smears in a slides mailer labelled with two identifiers.

Processing and evaluation - Manual

SPECIMEN ADEQUACY
Satisfactory for evaluation
Endocervical component - Absent

GENERAL CATEGORIZATION
Negative for intraepithelial lesion or malignancy

FINDINGS
Superficial and intermediate squamous epithelial cells along with metaplastic epithelial cells seen in background of minimal acute inflammation.

INTERPRETATION/RESULTS
Negative for intraepithelial lesion or malignancy

DISCLAIMER
Gynaecological cytology is a screening procedure subject to both false negative and false positive results. It is most reliable when a satisfactory sample is obtained on a regular and repetitive basis. Results must be interpreted in context of the historic and current clinical information. Corroboration of cytopathologic findings with colposcopic/ local examination and ancillary findings is recommended.

PHYSICAL EXAMINATION,STOOL

COLOUR	BROWN
CONSISTENCY	SEMI FORMED

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MUCUS	ABSENT	NOT DETECTED	
VISIBLE BLOOD	ABSENT	ABSENT	
ADULT PARASITE	NOT DETECTED		
CHEMICAL EXAMINATION,STOOL			
STOOL PH	6.0		
XRAY-CHEST			
IMPRESSION	NO ABNORMALITY DETECTED		
TMT OR ECHO			
TMT OR ECHO	ECHO MILD CONCENTRIC LVH		
ECG			
ECG	WITHIN NORMAL LIMITS		
MAMOGRAPHY (BOTH BREASTS)			
MAMOGRAPHY BOTH BREASTS	DONE		
MEDICAL HISTORY			
RELEVANT PRESENT HISTORY	K/C/O HTN		
RELEVANT PAST HISTORY	NOT SIGNIFICANT		
RELEVANT PERSONAL HISTORY	MARRIED, NO KID, VEG, NO S/D.		
RELEVANT FAMILY HISTORY	HIGH BLOOD PRESSURE, DIABETES.		
OCCUPATIONAL HISTORY	ANNUAL		
HISTORY OF MEDICATIONS	ON ANTIHYPERTENSIVES.		
ANTHROPOMETRIC DATA & BMI			
HEIGHT IN METERS	1.56		mts
WEIGHT IN KGS.	81		Kgs
BMI	33	BMI & Weight Status as follows: Below 18.5: Underweight 18.5 - 24.9: Normal 25.0 - 29.9: Overweight 30.0 and Above: Obese	kg/sqmts
GENERAL EXAMINATION			
MENTAL / EMOTIONAL STATE	NORMAL		
PHYSICAL ATTITUDE	NORMAL		
GENERAL APPEARANCE / NUTRITIONAL STATUS	HEALTHY		
BUILT / SKELETAL FRAMEWORK	AVERAGE		

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Consultant Pathologist

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Patient Ref. No. 63000000581268

SRL Diagnostics

PATIENT NAME : DEEPA KUMARI | **REF. DOCTOR :** DR. BANK OF BARODA

CODE/NAME & ADDRESS : C000138377
DEEPA KUMARI

ACCESSION NO : **0063WB000364**
PATIENT ID : DEEPF15017363
CLIENT PATIENT ID:
ABHA NO :

AGE/SEX : 50 Years Female
DRAWN : 11/02/2023 09:15:56
RECEIVED : 11/02/2023 09:17:59
REPORTED : 13/02/2023 09:25:23

Test Report Status **Final**	Results	Biological Reference Interval	Units
FACIAL APPEARANCE	NORMAL		
SKIN	NORMAL		
UPPER LIMB	NORMAL		
LOWER LIMB	NORMAL		
NECK	NORMAL		
NECK LYMPHATICS / SALIVARY GLANDS	NOT ENLARGED OR TENDER		
THYROID GLAND	NOT ENLARGED		
CAROTID PULSATION	NORMAL		
TEMPERATURE	NORMAL		
PULSE	90/MIN REGULAR, ALL PERIPHERAL PULSES WELL FELT, NO CAROTID BRUIT		
RESPIRATORY RATE	NORMAL		
CARDIOVASCULAR SYSTEM			
BP	149/92 MM HG (SITTING)		mm/Hg
PERICARDIUM	NORMAL		
APEX BEAT	NORMAL		
HEART SOUNDS	NORMAL		
MURMURS	ABSENT		
RESPIRATORY SYSTEM			
SIZE AND SHAPE OF CHEST	NORMAL		
MOVEMENTS OF CHEST	SYMMETRICAL		
BREATH SOUNDS INTENSITY	NORMAL		
BREATH SOUNDS QUALITY	VESICULAR (NORMAL)		
ADDED SOUNDS	ABSENT		
PER ABDOMEN			
APPEARANCE	NORMAL		
VENOUS PROMINENCE	ABSENT		
LIVER	NOT PALPABLE		
SPLEEN	NOT PALPABLE		
CENTRAL NERVOUS SYSTEM			
HIGHER FUNCTIONS	NORMAL		
CRANIAL NERVES	NORMAL		

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CEREBELLAR FUNCTIONS	NORMAL		
SENSORY SYSTEM	NORMAL		
MOTOR SYSTEM	NORMAL		
REFLEXES	NORMAL		
MUSCULOSKELETAL SYSTEM			
SPINE	NORMAL		
JOINTS	NORMAL		
BASIC EYE EXAMINATION			
CONJUNCTIVA	NORMAL		
EYELIDS	NORMAL		
EYE MOVEMENTS	NORMAL		
CORNEA	NORMAL		
DISTANT VISION RIGHT EYE WITH GLASSES	6/36		
DISTANT VISION LEFT EYE WITH GLASSES	6/9		
NEAR VISION RIGHT EYE WITH GLASSES	N36		
NEAR VISION LEFT EYE WITH GLASSES	N36		
COLOUR VISION	NORMAL		
BASIC ENT EXAMINATION			
EXTERNAL EAR CANAL	NORMAL		
TYMPANIC MEMBRANE	NORMAL		
NOSE	NO ABNORMALITY DETECTED		
SINUSES	NORMAL		
THROAT	NO ABNORMALITY DETECTED		
TONSILS	NOT ENLARGED		
SUMMARY			
RELEVANT HISTORY	NOT SIGNIFICANT		
RELEVANT GP EXAMINATION FINDINGS	NOT SIGNIFICANT		
RELEVANT LAB INVESTIGATIONS	RAISED TSH, DERANGED LFT		
RELEVANT NON PATHOLOGY DIAGNOSTICS	NO ABNORMALITIES DETECTED		
REMARKS / RECOMMENDATIONS	PHYSICIAN'S CONSULT		
FITNESS STATUS			
FITNESS STATUS	FIT WITH MEDICAL ADVICE		

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DIAGNOSTIC REPORT

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MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40FEMALE

ULTRASOUND ABDOMEN

ULTRASOUND ABDOMEN

HEPATOMEGALY WITH GRADE II FATTY LIVER.
BULKY UTERUS WITH MULTIPLE FIBROIDS (AS DESCRIBED ABOVE).
THICKENED ENDOMETRIUM.

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.
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.
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

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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 addiction 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 paltform (Boronate affinity chromatography) is recommended for testing of HbA1c.Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy
GLUCOSE FASTING,FLUORIDE PLASMA-**TEST DESCRIPTION**
Normally, the glucose concentration in extracellular fluid is closely regulated so that a source of energy is readily available to tissues and sothat no glucose is excreted in the urine.
Increased in
Diabetes mellitus, Cushing' s syndrome (10 – 15%), chronic pancreatitis (30%). Drugs:corticosteroids,phenytoin, estrogen, thiazides.
Decreased in
Pancreatic islet cell disease with increased insulin,insulinoma,adrenocortical insufficiency, hypopituitarism,diffuse liver disease, malignancy (adrenocortical, stomach,fibrosarcoma), infant of a diabetic mother, enzyme deficiency diseases(e.g., galactosemia),Drugs- insulin, ethanol, propranolol; sulfonylureas,tolbutamide, and other oral hypoglycemic agents.
NOTE: While random serum glucose levels correlate with home glucose monitoring results (weekly mean capillary glucose values), there is wide fluctuation within individuals.Thus, glycosylated hemoglobin(HbA1c) levels are favored to monitor glycemic control.
High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glyosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.
GLUCOSE, POST-PRANDIAL, PLASMA-High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glyosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.Additional test HbA1c
LIVER FUNCTION PROFILE, SERUM-LIVER FUNCTION PROFILE
Bilirubin is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. Bilirubin is excreted in bile and urine, and elevated levels may give yellow discoloration in jaundice.Elevated levels results from increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Conjugated (direct) bilirubin is elevated more than unconjugated (indirect) bilirubin in Viral hepatitis, Drug reactions, Alcoholic liver disease Conjugated (direct) bilirubin is also elevated more than unconjugated (indirect) bilirubin when there is some kind of blockage of the bile ducts like in Gallstones getting into the bile ducts, tumors &Scarring of the bile ducts. Increased unconjugated (indirect) bilirubin may be a result of Hemolytic or pernicious anemia, Transfusion reaction & a common metabolic condition termed Gilbert syndrome, due to low levels of the enzyme that attaches sugar molecules to bilirubin.
AST is an enzyme found in various parts of the body. AST is found in the liver, heart, skeletal muscle, kidneys, brain, and red blood cells, and it is commonly measured clinically as a marker for liver health. AST levels increase during chronic viral hepatitis, blockage of the bile duct, cirrhosis of the liver,liver cancer,kidney failure,hemolytic anemia,pancreatitis,hemochromatosis. AST levels may also increase after a heart attack or strenuous activity.ALT test measures the amount of this enzyme in the blood.ALT is found mainly in the liver, but also in smaller amounts in the kidneys,heart,muscles, and pancreas.It is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health.AST levels increase during acute hepatitis,sometimes due to a viral infection,ischemia to the liver,chronic hepatitis,obstruction of bile ducts,cirrhosis.
ALP is a protein found in almost all body tissues.Tissues with higher amounts of ALP include the liver,bile ducts and bone.Elevated ALP levels are seen in Biliary obstruction, Osteoblastic bone tumors, osteomalacia, hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, Paget''''s disease,Rickets,Sarcoidosis etc. Lower-than-normal ALP levels seen in Hypophosphatasia,Malnutrition,Protein deficiency,Wilson''''s 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.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.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.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
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:

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• Myasthenia Gravis
• Muscular dystrophy
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-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

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

****
FITNESS STATUS-Conclusion on an individual's Fitness, which is commented upon mainly for Pre employment cases, is based on multi factorial findings and does not depend on any one single parameter. The final Fitness assigned to a candidate will depend on the Physician's findings and overall judgement on a case to case basis, details of the candidate's past and personal history; as well as the comprehensiveness of the diagnostic panel which has been requested for .These are then further correlated with details of the job under consideration to eventually fit the right man to the right job.
Basis the above, SRL classifies a candidate's Fitness Status into one of the following categories:
• Fit (As per requested panel of tests) – SRL Limited gives the individual a clean chit to join the organization, on the basis of the General Physical Examination and the specific test panel requested for.
• Fit (with medical advice) (As per requested panel of tests) - This indicates that although the candidate can be declared as FIT to join the job, minimal problems have been detected during the Pre- employment examination. Examples of conditions which could fall in this category could be cases of mild reversible medical abnormalities such as height weight disproportions, borderline raised Blood Pressure readings, mildly raised Blood sugar and Blood Lipid levels, Hematuria, etc. Most of these relate to sedentary lifestyles and come under the broad category of life style disorders. The idea is to caution an individual to bring about certain lifestyle changes as well as seek a Physician''s consultation and counseling in order to bring back to normal the mildly deranged parameters. For all purposes the individual is FIT to join the job.
• Fitness on Hold (Temporary Unfit) (As per requested panel of tests) - Candidate's reports are kept on hold when either the diagnostic tests or the physical findings reveal the presence of a medical condition which warrants further tests, counseling and/or specialist opinion, on the basis of which a candidate can either be placed into Fit, Fit (With Medical Advice), or Unfit category. Conditions which may fall into this category could be high blood pressure, abnormal ECG, heart murmurs, abnormal vision, grossly elevated blood sugars, etc.
• Unfit (As per requested panel of tests) - An unfit report by SRL Limited clearly indicates that the individual is not suitable for the respective job profile e.g. total color blindness in color related jobs.

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