



Patient Ref. No. 775000001841353

CLIENT CODE : C000138394

CLIENT'S NAME AND ADDRESS :
ACROFEMI HEALTHCARE LTD (MEDI WHEEL)
F-703, F-703, LADO SARAI, MEHRAULI
SOUTH WEST DELHI
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S.K. Tower, Hari Niwas, LBS Marg
THANE, 400602
MAHARASHTRA, INDIA
Tel : 9111591115, Fax : CIN - U74899PB1995PLC045956
Email : customercare.thane@srl.in

PATIENT NAME : SWAPNIL CHAVAN PATIENT ID : SWAPM250984181

ACCESSION NO : 0181VK000356 AGE : 38 Years SEX : Male ABHA NO :

DRAWN : RECEIVED : 08/11/2022 09:44:40 REPORTED : 12/11/2022 08:53:14

REFERRING DOCTOR : SELF CLIENT PATIENT ID :

Test Report Status	Final	Results	Biological Reference Interval	Units
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MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

BLOOD COUNTS, EDTA WHOLE BLOOD

HEMOGLOBIN (HB)	15.5	13.0 - 17.0	g/dL
METHOD : SLS- HEMOGLOBIN DETECTION METHOD			
RED BLOOD CELL (RBC) COUNT	5.77	High 4.5 - 5.5	mil/ μ L
METHOD : HYDRODYNAMIC FOCUSING BY DC DETECTION			
WHITE BLOOD CELL (WBC) COUNT	9.45	4.0 - 10.0	thou/ μ L
METHOD : FLUORESCENCE FLOW CYTOMETRY			
PLATELET COUNT	380	150 - 410	thou/ μ L
METHOD : HYDRODYNAMIC FOCUSING BY DC DETECTION			

RBC AND PLATELET INDICES

HEMATOCRIT (PCV)	49.3	40.0 - 50.0	%
METHOD : CUMULATIVE PULSE HEIGHT DETECTION METHOD			
MEAN CORPUSCULAR VOLUME (MCV)	85.4	83.0 - 101.0	fL
METHOD : CALCULATED FROM RBC & HCT			
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	26.9	Low 27.0 - 32.0	pg
METHOD : CALCULATED FROM THE RBC & HGB			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)	31.4	Low 31.5 - 34.5	g/dL
METHOD : CALCULATED FROM THE HGB & HCT			
RED CELL DISTRIBUTION WIDTH (RDW)	14.6	High 11.6 - 14.0	%
METHOD : CALCULATED FROM RBC SIZE DISTRIBUTION CURVE			
MENTZER INDEX	14.8		
MEAN PLATELET VOLUME (MPV)	10.4	6.8 - 10.9	fL
METHOD : CALCULATED FROM PLATELET COUNT & PLATELET HEMATOCRIT			

WBC DIFFERENTIAL COUNT

NEUTROPHILS	63	40 - 80	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
LYMPHOCYTES	21	20 - 40	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
MONOCYTES	5	2 - 10	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
EOSINOPHILS	11	High 1 - 6	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
ABSOLUTE NEUTROPHIL COUNT	5.98	2.0 - 7.0	thou/ μ L
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			





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ABSOLUTE LYMPHOCYTE COUNT		1.98	1.0 - 3.0	thou/ μ L
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
ABSOLUTE MONOCYTE COUNT		0.47	0.2 - 1.0	thou/ μ L
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
ABSOLUTE EOSINOPHIL COUNT		1.03	High 0.02 - 0.50	thou/ μ L
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		3.0		
MORPHOLOGY				
RBC		NORMOCYTIC NORMOCHROMIC		
WBC		EOSINOPHILIA PRESENT		
METHOD : MICROSCOPIC EXAMINATION				
PLATELETS		ADEQUATE		
ERYTHROCYTE SEDIMENTATION RATE (ESR), WHOLE BLOOD				
E.S.R		13	< 15	mm at 1 hr
GLUCOSE FASTING, FLUORIDE PLASMA				
FBS (FASTING BLOOD SUGAR)		96	Normal 75 - 99 Pre-diabetics: 100 - 125 Diabetic: > or = 126	mg/dL
METHOD : ENZYMATIC REFERENCE METHOD WITH HEXOKINASE				
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD				
HBA1C		5.6	Non-diabetic Adult < 5.7 Pre-diabetes 5.7 - 6.4 Diabetes diagnosis: > or = 6.5 Therapeutic goals: < 7.0 Action suggested : > 8.0 (ADA Guideline 2021)	%
METHOD : HPLC				
ESTIMATED AVERAGE GLUCOSE(EAG)		114.0	< 116.0	mg/dL
METHOD : CALCULATED PARAMETER				
GLUCOSE, POST-PRANDIAL, PLASMA				
PPBS(POST PRANDIAL BLOOD SUGAR)		105	70 - 139	mg/dL
METHOD : ENZYMATIC REFERENCE METHOD WITH HEXOKINASE				
CORONARY RISK PROFILE, SERUM				





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CHOLESTEROL, TOTAL		255	High Desirable cholesterol level < 200 Borderline high cholesterol 200 - 239 High cholesterol > / = 240	mg/dL
METHOD : ENZYMATIC COLORIMETRIC ASSAY				
TRIGLYCERIDES		181	High Normal: < 150 Borderline high: 150 - 199 High: 200 - 499 Very High: > / = 500	mg/dL
METHOD : ENZYMATIC COLORIMETRIC ASSAY				
HDL CHOLESTEROL		41	Low HDL Cholesterol <40 High HDL Cholesterol > / = 60	mg/dL
METHOD : ENZYMATIC, COLORIMETRIC				
CHOLESTEROL LDL		178	High Adult levels: Optimal < 100 Near optimal/above optimal: 100-129 Borderline high : 130-159 High : 160-189 Very high : = 190	mg/dL
METHOD : ENZYMATIC COLORIMETRIC ASSAY				
NON HDL CHOLESTEROL		214	High Desirable : < 130 Above Desirable : 130 -159 Borderline High : 160 - 189 High : 190 - 219 Very high : > / = 220	mg/dL
CHOL/HDL RATIO		6.2	High Low Risk : 3.3 - 4.4 Average Risk : 4.5 - 7.0 Moderate Risk : 7.1 - 11.0 High Risk : > 11.0	
LDL/HDL RATIO		4.3	High 0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
VERY LOW DENSITY LIPOPROTEIN		36.2	High < OR = 30.0	mg/dL
LIVER FUNCTION PROFILE, SERUM				
BILIRUBIN, TOTAL		0.42	Upto 1.2	mg/dL
METHOD : COLORIMETRIC DIAZO				
BILIRUBIN, DIRECT		0.16	< 0.30	mg/dL
BILIRUBIN, INDIRECT		0.26	0.1 - 1.0	mg/dL





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TOTAL PROTEIN		8.2	High 6.0 - 8.0	g/dL
METHOD : COLORIMETRIC				
ALBUMIN		4.9	3.97 - 4.94	g/dL
METHOD : COLORIMETRIC				
GLOBULIN		3.3	2.0 - 3.5	g/dL
ALBUMIN/GLOBULIN RATIO		1.5	1.0 - 2.1	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT)		24	< OR = 50	U/L
METHOD : UV ABSORBANCE				
ALANINE AMINOTRANSFERASE (ALT/SGPT)		35	< OR = 50	U/L
METHOD : UV ABSORBANCE				
ALKALINE PHOSPHATASE		67	40 - 129	U/L
METHOD : COLORIMETRIC				
GAMMA GLUTAMYL TRANSFERASE (GGT)		25	0 - 60	U/L
METHOD : ENZYMATIC, COLORIMETRIC				
LACTATE DEHYDROGENASE		184	125 - 220	U/L
METHOD : UV ABSORBANCE				
BLOOD UREA NITROGEN (BUN), SERUM				
BLOOD UREA NITROGEN		9	6 - 20	mg/dL
METHOD : ENZYMATIC ASSAY				
CREATININE, SERUM				
CREATININE		1.19	0.7 - 1.2	mg/dL
METHOD : COLORIMETRIC				
BUN/CREAT RATIO				
BUN/CREAT RATIO		7.56	Low 8.0 - 15.0	
URIC ACID, SERUM				
URIC ACID		6.8	3.4 - 7.0	mg/dL
METHOD : ENZYMATIC COLORIMETRIC ASSAY				
TOTAL PROTEIN, SERUM				
TOTAL PROTEIN		8.2	High 6.0 - 8.0	g/dL
METHOD : COLORIMETRIC				
ALBUMIN, SERUM				
ALBUMIN		4.9	3.97 - 4.94	g/dL
METHOD : COLORIMETRIC				
GLOBULIN				
GLOBULIN		3.3	2.0 - 3.5	g/dL





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ELECTROLYTES (NA/K/CL), SERUM

SODIUM, SERUM	136	136 - 145	mmol/L
POTASSIUM, SERUM	4.52	3.5 - 5.1	mmol/L
CHLORIDE, SERUM	98	98 - 107	mmol/L

Interpretation(s)

PHYSICAL EXAMINATION, URINE

COLOR	PALE YELLOW
APPEARANCE	CLEAR

CHEMICAL EXAMINATION, URINE

PH	6.0	5.00 - 7.50
SPECIFIC GRAVITY	1.025	1.010 - 1.030
PROTEIN	DETECTED (TRACE)	NOT DETECTED
GLUCOSE	NOT DETECTED	NOT DETECTED
KETONES	NOT DETECTED	NOT DETECTED
BLOOD	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	1-2	0-5	/HPF

CASTS	NOT DETECTED
CRYSTALS	NOT DETECTED
BACTERIA	NOT DETECTED
YEAST	NOT DETECTED

REMARKS PRESENCE OF URINARY PROTEINS RECHECKED BY MANUAL METHOD.

Interpretation(s)

THYROID PANEL, SERUM

T3	101.0	80 - 200	ng/dL
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METHOD : ELECTROCHEMILUMINESCENCE

T4 5.68 5.1 - 14.1 µg/dL

METHOD : ELECTROCHEMILUMINESCENCE

TSH 3RD GENERATION 2.240 0.27 - 4.2 µIU/mL

METHOD : ELECTROCHEMILUMINESCENCE

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, Free T4 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. Guidelines of the American Thyroid association during pregnancy and Postpartum, 2011.

NOTE: It is advisable to detect Free T3, Free T4 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.



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STOOL: OVA & PARASITE

REMARK SAMPLE NOT RECEIVED

Interpretation(s)

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP TYPE B

METHOD : GEL COLUMN AGGLUTINATION METHOD.

RH TYPE POSITIVE

METHOD : GEL COLUMN AGGLUTINATION METHOD.

XRAY-CHEST

IMPRESSION NO ABNORMALITY DETECTED

TMT OR ECHO

TMT OR ECHO NEGATIVE

ECG

ECG WITHIN NORMAL LIMITS

MEDICAL HISTORY

RELEVANT PRESENT HISTORY NOT SIGNIFICANT

RELEVANT PAST HISTORY FRACTURE LEFT CLAVICAL 2 YEARS BACK.
COVID 1.5 YEARS BACK.

RELEVANT PERSONAL HISTORY MARRIED / 1 CHILD / MIXED DIET / NO ALLERGIES / NO SMOKING /
OCC ALCOHOL.

RELEVANT FAMILY HISTORY HIGH BLOOD PRESSURE : MOTHER.
CANCER : GRANDMOTHER HAD LEUKEMIA.

HISTORY OF MEDICATIONS NOT SIGNIFICANT

ANTHROPOMETRIC DATA & BMI

HEIGHT IN METERS 1.80 mts

WEIGHT IN KGS. 98 Kgs

BMI 30 BMI & Weight Status as follows: kg/sqmts
Below 18.5: Underweight
18.5 - 24.9: Normal
25.0 - 29.9: Overweight
30.0 and Above: Obese

GENERAL EXAMINATION

MENTAL / EMOTIONAL STATE NORMAL

PHYSICAL ATTITUDE NORMAL



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GENERAL APPEARANCE / NUTRITIONAL STATUS	OBESE			
BUILT / SKELETAL FRAMEWORK	AVERAGE			
FACIAL APPEARANCE	NORMAL			
SKIN	NORMAL			
UPPER LIMB	NORMAL			
LOWER LIMB	NORMAL			
NECK	NORMAL			
NECK LYMPHATICS / SALIVARY GLANDS	NOT ENLARGED OR TENDER			
THYROID GLAND	NOT ENLARGED			
CAROTID PULSATION	NORMAL			
TEMPERATURE	NORMAL			
PULSE	90/MIN.REGULAR, ALL PERIPHERAL PULSES WELL FELT, NO CAROTID BRUIT			
RESPIRATORY RATE	NORMAL			
CARDIOVASCULAR SYSTEM				
BP	130/80 MM HG (SUPINE)			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			
HERNIA	ABSENT			
CENTRAL NERVOUS SYSTEM				





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HIGHER FUNCTIONS	NORMAL
CRANIAL NERVES	NORMAL
CEREBELLAR FUNCTIONS	NORMAL
SENSORY SYSTEM	NORMAL
MOTOR SYSTEM	NORMAL
REFLEXES	NORMAL
MUSCULOSKELETAL SYSTEM	
SPINE	NORMAL
JOINTS	NORMAL
BASIC EYE EXAMINATION	
CONJUNCTIVA	NORMAL
EYELIDS	NORMAL
EYE MOVEMENTS	NORMAL
CORNEA	NORMAL
DISTANT VISION RIGHT EYE WITHOUT GLASSES	REDUCED VISUAL ACUITY 6/24
DISTANT VISION LEFT EYE WITHOUT GLASSES	REDUCED VISUAL ACUITY 6/24
DISTANT VISION RIGHT EYE WITH GLASSES	WITH GLASSES NORMAL
DISTANT VISION LEFT EYE WITH GLASSES	WITH GLASSES NORMAL
NEAR VISION RIGHT EYE WITHOUT GLASSES	WITHIN NORMAL LIMIT
NEAR VISION LEFT EYE WITHOUT GLASSES	WITHIN NORMAL LIMIT
COLOUR VISION	NORMAL

SUMMARY

RELEVANT HISTORY	NOT SIGNIFICANT
RELEVANT GP EXAMINATION FINDINGS	OBESE : BMI 30
REMARKS / RECOMMENDATIONS	WEIGHT LOSS- LOW FAT,LOW CALORIE, LOW CARBOHYDRATE, HIGH FIBRE DIET. REGULAR EXERCISE.REGULAR WALK FOR 30-40 MIN DAILY. REPEAT LIPID PROFILE AFTER 3 MONTHS OF DIET AND EXERCISE. DRINK 2-3 LITTER WATER DAILY. REPEAT URINE ROUTINE AFTER 15 DAYS. AVOID HIGH QUALITY PROTEIN DIET.





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PATIENT NAME : SWAPNIL CHAVAN

PATIENT ID : SWAPM250984181

ACCESSION NO : 0181VK000356 AGE : 38 Years SEX : Male

ABHA NO :

DRAWN : RECEIVED : 08/11/2022 09:44:40

REPORTED : 12/11/2022 08:53:14

REFERRING DOCTOR : SELF

CLIENT PATIENT ID :

Test Report Status	Final	Results	Biological Reference Interval	Units
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MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

ULTRASOUND ABDOMEN

ULTRASOUND ABDOMEN

GRADE I FATTY LIVER.

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, 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, (Sickle cells, 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. AACCPress, 7th edition. Edited by S. Soldin; 3. The reference for the adult reference range is "Practical Haematology by Dacie and Lewis, 10th edition.

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:

Hypoglycemia is defined as a glucose of < 50 mg/dL in men and < 40 mg/dL in women.

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 glycaemic 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.



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Scan to View Report



Patient Ref. No. 775000001841353

CLIENT CODE : C000138394

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GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD -Used For:

- Evaluating the long-term control of blood glucose concentrations in diabetic patients.
 - Diagnosing diabetes.
 - Identifying patients at increased risk for diabetes (prediabetes).
- 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.
- eAG (Estimated average glucose) converts percentage HbA1c to mg/dl, to compare blood glucose levels.
 - eAG gives an evaluation of blood glucose levels for the last couple of months.
 - eAG is calculated as $eAG (mg/dl) = 28.7 * HbA1c - 46.7$

HbA1c Estimation can get affected due to :

- 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.
 - Vitamin C & E are reported to falsely lower test results. (possibly by inhibiting glycation of hemoglobin).
 - 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.
 - Interference of hemoglobinopathies in HbA1c estimation is seen in
 - Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.
 - Heterozygous state detected (D10 is corrected for HbS & HbC trait.)
 - 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
- 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 Hypoglycaemia, 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 result 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 Hypophosphatemia, 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. Hum an 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:

- Myasthenia Gravis
- Muscular dystrophy





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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, Waldenström'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 INVIOABLE FEATURE OF OUR LAB MANAGEMENT SOFTWARE. HOWEVER, ALL EXAMINATIONS AND INVESTIGATIONS HAVE BEEN CONDUCTED BY OUR PANEL OF DOCTORS.

End Of Report

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

