



CLIENT CODE : C000138394

**CLIENT'S NAME AND ADDRESS :**  
ACROFEMI HEALTHCARE LTD ( MEDIWHEEL )  
F-703, F-703, LADO SARAI, MEHRAULI  
SOUTH WEST DELHI  
NEW DELHI 110030  
DELHI INDIA  
8800465156

SRL Ltd  
S.K. Tower, Hari Niwas, LBS Marg  
THANE, 400602  
MAHARASHTRA, INDIA  
Tel : 9111591115, Fax : CIN - U74899PB1995PLC045956  
Email : customercare.thane@srl.in

**PATIENT NAME : ANITA BHARAT JAGTAP**PATIENT ID : **ANITF010677181**ACCESSION NO : **0181VK000874** AGE : 45 Years SEX : Female

ABHA NO :

DRAWN :

RECEIVED : 19/11/2022 09:51

REPORTED : 22/11/2022 11:13

REFERRING DOCTOR : SELF

CLIENT PATIENT ID :

Test Report Status	Final	Results	Biological Reference Interval	Units
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**MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40FEMALE****BLOOD COUNTS, EDTA WHOLE BLOOD**

HEMOGLOBIN (HB)	<b>11.7</b>	<b>Low</b> 12.0 - 15.0	g/dL
METHOD : SLS- HEMOGLOBIN DETECTION METHOD			
RED BLOOD CELL (RBC) COUNT	4.51	3.8 - 4.8	mil/ $\mu$ L
METHOD : HYDRODYNAMIC FOCUSING BY DC DETECTION			
WHITE BLOOD CELL (WBC) COUNT	4.71	4.0 - 10.0	thou/ $\mu$ L
METHOD : FLUORESCENCE FLOW CYTOMETRY			
PLATELET COUNT	308	150 - 410	thou/ $\mu$ L
METHOD : HYDRODYNAMIC FOCUSING BY DC DETECTION			

**RBC AND PLATELET INDICES**

HEMATOCRIT (PCV)	37.8	36.0 - 46.0	%
METHOD : CUMULATIVE PULSE HEIGHT DETECTION METHOD			
MEAN CORPUSCULAR VOLUME (MCV)	83.8	83.0 - 101.0	fL
METHOD : CALCULATED FROM RBC & HCT			
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	<b>25.9</b>	<b>Low</b> 27.0 - 32.0	pg
METHOD : CALCULATED FROM THE RBC & HGB			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)	<b>31.0</b>	<b>Low</b> 31.5 - 34.5	g/dL
METHOD : CALCULATED FROM THE HGB & HCT			
RED CELL DISTRIBUTION WIDTH (RDW)	14.0	11.6 - 14.0	%
METHOD : CALCULATED FROM RBC SIZE DISTRIBUTION CURVE			
MENTZER INDEX	18.6		
MEAN PLATELET VOLUME (MPV)	10.1	6.8 - 10.9	fL
METHOD : CALCULATED FROM PLATELET COUNT & PLATELET HEMATOCRIT			

**WBC DIFFERENTIAL COUNT**

NEUTROPHILS	62	40 - 80	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
LYMPHOCYTES	31	20 - 40	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
MONOCYTES	4	2 - 10	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
EOSINOPHILS	3	1 - 6	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
ABSOLUTE NEUTROPHIL COUNT	2.92	2.0 - 7.0	thou/ $\mu$ L
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
ABSOLUTE LYMPHOCYTE COUNT	1.45	1.0 - 3.0	thou/ $\mu$ L



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METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
ABSOLUTE MONOCYTE COUNT		<b>0.19</b>	<b>Low</b> 0.2 - 1.0	thou/ $\mu$ L
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
ABSOLUTE EOSINOPHIL COUNT		0.16	0.02 - 0.50	thou/ $\mu$ L
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		2.0		
<b>MORPHOLOGY</b>				
RBC		NORMOCYTIC NORMOCHROMIC		
WBC		NORMAL MORPHOLOGY		
METHOD : MICROSCOPIC EXAMINATION				
PLATELETS		ADEQUATE		
<b>ERYTHROCYTE SEDIMENTATION RATE (ESR), WHOLE BLOOD</b>				
E.S.R		11	< 20	mm at 1 hr
<b>GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD</b>				
HBA1C		<b>5.8</b>	<b>High</b> 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)		<b>119.8</b>	<b>High</b> < 116.0	mg/dL
METHOD : CALCULATED PARAMETER				
<b>GLUCOSE FASTING, FLUORIDE PLASMA</b>				
FBS (FASTING BLOOD SUGAR)		81	Normal 75 - 99 Pre-diabetics: 100 - 125 Diabetic: > or = 126	mg/dL
METHOD : ENZYMATIC REFERENCE METHOD WITH HEXOKINASE				
<b>GLUCOSE, POST-PRANDIAL, PLASMA</b>				
PPBS(POST PRANDIAL BLOOD SUGAR)		<b>58</b>	<b>Low</b> 70 - 139	mg/dL
METHOD : ENZYMATIC REFERENCE METHOD WITH HEXOKINASE				
<b>LIPID PROFILE, SERUM</b>				
CHOLESTEROL, TOTAL		178	Desirable cholesterol level < 200 Borderline high cholesterol 200 - 239 High cholesterol > / = 240	mg/dL
METHOD : ENZYMATIC COLORIMETRIC ASSAY				



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TRIGLYCERIDES		86	Normal: < 150 Borderline high: 150 - 199 High: 200 - 499 Very High: >/= 500	mg/dL
METHOD : ENZYMATIC COLORIMETRIC ASSAY				
HDL CHOLESTEROL		43	Low HDL Cholesterol <40 High HDL Cholesterol >/= 60	mg/dL
METHOD : ENZYMATIC, COLORIMETRIC				
CHOLESTEROL LDL		<b>120</b>	<b>High</b> 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		<b>137</b>	<b>High</b> Desirable : < 130 Above Desirable : 130 -159 Borderline High : 160 - 189 High : 190 - 219 Very high : > / = 220	mg/dL
CHOL/HDL RATIO		4.2	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		2.8	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
VERY LOW DENSITY LIPOPROTEIN		17.0	< OR = 30.0	mg/dL
<b>LIVER FUNCTION PROFILE, SERUM</b>				
BILIRUBIN, TOTAL		0.33	Upto 1.2	mg/dL
METHOD : COLORIMETRIC DIAZO				
BILIRUBIN, DIRECT		0.14	< 0.30	mg/dL
BILIRUBIN, INDIRECT		0.22	0.1 - 1.0	mg/dL
TOTAL PROTEIN		7.6	6.0 - 8.0	g/dL
METHOD : COLORIMETRIC				
ALBUMIN		4.7	3.97 - 4.94	g/dL
METHOD : COLORIMETRIC				
GLOBULIN		2.8	2.0 - 3.5	g/dL
ALBUMIN/GLOBULIN RATIO		1.7	1.0 - 2.1	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT)		21	< OR = 35	U/L
METHOD : UV ABSORBANCE				





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ALANINE AMINOTRANSFERASE (ALT/SGPT)		25	< OR = 35	U/L
METHOD : UV ABSORBANCE				
ALKALINE PHOSPHATASE		67	35 - 104	U/L
METHOD : COLORIMETRIC				
GAMMA GLUTAMYL TRANSFERASE (GGT)		14	0 - 40	U/L
METHOD : ENZYMATIC, COLORIMETRIC				
LACTATE DEHYDROGENASE		189	125 - 220	U/L
METHOD : UV ABSORBANCE				
<b>BLOOD UREA NITROGEN (BUN), SERUM</b>				
BLOOD UREA NITROGEN		9	6 - 20	mg/dL
METHOD : ENZYMATIC ASSAY				
<b>CREATININE, SERUM</b>				
CREATININE		0.66	0.5 - 0.9	mg/dL
METHOD : COLORIMETRIC				
<b>BUN/CREAT RATIO</b>				
BUN/CREAT RATIO		13.43	8.0 - 15.0	
<b>URIC ACID, SERUM</b>				
URIC ACID		3.2	2.4 - 5.7	mg/dL
METHOD : ENZYMATIC COLORIMETRIC ASSAY				
<b>TOTAL PROTEIN, SERUM</b>				
TOTAL PROTEIN		7.6	6.0 - 8.0	g/dL
METHOD : COLORIMETRIC				
<b>ALBUMIN, SERUM</b>				
ALBUMIN		4.7	3.97 - 4.94	g/dL
METHOD : COLORIMETRIC				
<b>GLOBULIN</b>				
GLOBULIN		2.8	2.0 - 3.5	g/dL
<b>ELECTROLYTES (NA/K/CL), SERUM</b>				
SODIUM, SERUM		140	136 - 145	mmol/L
POTASSIUM, SERUM		4.01	3.5 - 5.1	mmol/L
CHLORIDE, SERUM		103	98 - 107	mmol/L
<b>PHYSICAL EXAMINATION, URINE</b>				
COLOR		PALE YELLOW		
APPEARANCE		CLEAR		
<b>CHEMICAL EXAMINATION, URINE</b>				
PH		5.0	5.00 - 7.50	



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SPECIFIC GRAVITY		1.015	1.010 - 1.030	
PROTEIN		NOT DETECTED	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	
<b>MICROSCOPIC EXAMINATION, URINE</b>				
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	
YEAST		NOT DETECTED	NOT DETECTED	
<b>THYROID PANEL, SERUM</b>				
T3		127.0	80 - 200	ng/dL
METHOD : ELECTROCHEMILUMINESCENCE				
T4		8.79	5.1 - 14.1	µg/dL
METHOD : ELECTROCHEMILUMINESCENCE				
TSH (ULTRASENSITIVE)		3.840	0.27 - 4.2	µIU/mL
METHOD : ELECTROCHEMILUMINESCENCE				





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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, 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.

## PAPANICOLAOU SMEAR

TEST METHOD

CONVENTIONAL GYNEC CYTOLOGY

METHOD : MICROSCOPIC EXAMINATION

SPECIMEN TYPE

P 1359/22

METHOD : MICROSCOPIC EXAMINATION

TWO UNSTAINED CERVICAL SMEARS RECEIVED

REPORTING SYSTEM

2014 BETHESDA SYSTEM FOR REPORTING CERVICAL CYTOLOGY



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SPECIMEN ADEQUACY

SATISFACTORY

METHOD : PAP STAIN &amp; MICROSCOPIC EXAMINATION

MICROSCOPY

THE SMEARS SHOW MAINLY SUPERFICIAL SQUAMOUS CELLS AND INTERMEDIATE SQUAMOUS CELLS IN THE BACKGROUND OF MODERATE POLYMORPHS.

METHOD : PAP STAIN

INTERPRETATION / RESULT

NEGATIVE FOR INTRAEPITHELIAL LESION OR MALIGNANCY

METHOD : PAP STAIN &amp; MICROSCOPIC EXAMINATION

ENDOMETRIAL CELLS (IN A WOMAN &gt;= 45 YRS)

ABSENT

METHOD : PAP STAIN &amp; MICROSCOPIC EXAMINATION

## Comments

PLEASE NOTE PAPANICOLAU SMEAR STUDY IS A SCREENING PROCEDURE FOR CERVICAL CANCER WITH INHERENT FALSE NEGATIVE RESULTS HENCE SHOULD BE INTERPRETED WITH CAUTION. NO CYTOLOGICAL EVIDENCE OF HPV INFECTION IN THE SMEARS STUDIED. SMEARS WILL BE PRESERVED FOR 5 YEARS ONLY.

## STOOL: OVA &amp; PARASITE

COLOUR

SAMPLE NOT RECEIVED

METHOD : VISUAL

## ABO GROUP &amp; RH TYPE, EDTA WHOLE BLOOD

ABO GROUP

TYPE B

METHOD : GEL COLUMN AGGLUTINATION METHOD.

RH TYPE

POSITIVE

METHOD : GEL COLUMN AGGLUTINATION METHOD.

XRAY-CHEST

RESULT PENDING

TMT OR ECHO

RESULT PENDING

ECG

RESULT PENDING

MAMOGRAPHY (BOTH BREASTS)

RESULT PENDING

MEDICAL HISTORY

RESULT PENDING

ANTHROPOMETRIC DATA &amp; BMI

RESULT PENDING

GENERAL EXAMINATION

RESULT PENDING

CARDIOVASCULAR SYSTEM

RESULT PENDING

RESPIRATORY SYSTEM

RESULT PENDING

PER ABDOMEN

RESULT PENDING

CENTRAL NERVOUS SYSTEM

RESULT PENDING

MUSCULOSKELETAL SYSTEM

RESULT PENDING

BASIC EYE EXAMINATION

RESULT PENDING

BASIC ENT EXAMINATION

RESULT PENDING



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BASIC DENTAL EXAMINATION

RESULT PENDING

SUMMARY

RESULT PENDING

FITNESS STATUS

RESULT PENDING

## 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, Vasculitides, 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. AACCC 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 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.)



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CLIENT CODE : C000138394

## CLIENT'S NAME AND ADDRESS :

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F-703, F-703, LADO SARAI, MEHRAULI  
SOUTH WEST DELHI  
NEW DELHI 110030  
DELHI INDIA  
8800465156

SRL Ltd  
S.K. Tower, Hari Niwas, LBS Marg  
THANE, 400602  
MAHARASHTRA, INDIA  
Tel : 9111591115, Fax : CIN - U74899PB1995PLC045956  
Email : customercare.thane@srl.in

PATIENT NAME : ANITA BHARAT JAGTAP

PATIENT ID : ANITF010677181

ACCESSION NO : 0181VK000874 AGE : 45 Years SEX : Female ABHA NO :

DRAWN : RECEIVED : 19/11/2022 09:51 REPORTED : 22/11/2022 11:13

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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

## 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, sulfonyleureas, 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 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.

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

## 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. 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:

- 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





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THANE, 400602

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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 &amp; RH TYPE, EDTA WHOLE BLOOD-

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

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

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



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MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40 FEMALE RESULT PENDING

ULTRASOUND ABDOMEN

RESULT PENDING

**\*\*End Of Report\*\***Please visit [www.srlworld.com](http://www.srlworld.com) for related Test Information for this accession**CONDITIONS OF LABORATORY TESTING & REPORTING**

1. It is presumed that the test sample belongs to the patient named or identified in the test requisition form.
2. All tests are performed and reported as per the turnaround time stated in the SRL Directory of Services.
3. Result delays could occur due to unforeseen circumstances such as non-availability of kits / equipment breakdown / natural calamities / technical downtime or any other unforeseen event.
4. A requested test might not be performed if:
  - i. Specimen received is insufficient or inappropriate
  - ii. Specimen quality is unsatisfactory
  - iii. Incorrect specimen type
  - iv. Discrepancy between identification on specimen container label and test requisition form
5. SRL confirms that all tests have been performed or assayed with highest quality standards, clinical safety & technical integrity.
6. Laboratory results should not be interpreted in isolation; it must be correlated with clinical information and be interpreted by registered medical practitioners only to determine final diagnosis.
7. Test results may vary based on time of collection, physiological condition of the patient, current medication or nutritional and dietary changes. Please consult your doctor or call us for any clarification.
8. Test results cannot be used for Medico legal purposes.
9. In case of queries please call customer care (91115 91115) within 48 hours of the report.

**SRL Limited**

Fortis Hospital, Sector 62, Phase VIII,  
Mohali 160062



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