DIAGNOSTIC REPORT

Patient Ref. No. 775000001714508

SRL Diagnostics

CLIENT CODE : C000138354

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

SRL Ltd
Shop CG 017, PALM SPRINGS PLAZA
GURUGRAM, 122001
HARYANA, INDIA
Tel : 9111591115

PATIENT NAME : VIKAS SHARMA PATIENT ID : **VIKAM051179282**

ACCESSION NO : **0282VJ000644** AGE : 42 Years SEX : Male ABHA NO :

DRAWN : RECEIVED : 08/10/2022 13:14:52 REPORTED : 10/10/2022 09:07:09

REFERRING DOCTOR : SELF CLIENT PATIENT ID :

Test Report Status **Final**	Results		Biological Reference Interval	Units
MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE				
BLOOD COUNTS,EDTA WHOLE BLOOD				
HEMOGLOBIN METHOD : SPECTROPHOTOMETRY	13.1		13.0 - 17.0	g/dL
RED BLOOD CELL COUNT METHOD : IMPEDANCE	**4.49**	**Low**	4.5 - 5.5	mil/µL
WHITE BLOOD CELL COUNT METHOD : IMPEDANCE	5.96		4.0 - 10.0	thou/µL
PLATELET COUNT METHOD : IMPEDANCE	199		150 - 410	thou/µL
RBC AND PLATELET INDICES				
HEMATOCRIT METHOD : CALCULATED	40.0		40 - 50	%
MEAN CORPUSCULAR VOL METHOD : DERIVED FROM IMPEDANCE MEASURE	89.2		83 - 101	fL
MEAN CORPUSCULAR HGB. METHOD : CALCULATED PARAMETER	29.2		27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION METHOD : CALCULATED PARAMETER	32.8		31.5 - 34.5	g/dL
MENTZER INDEX	19.9			
RED CELL DISTRIBUTION WIDTH METHOD : DERIVED FROM IMPEDANCE MEASURE	**15.6**	**High**	11.6 - 14.0	%
MEAN PLATELET VOLUME METHOD : DERIVED FROM IMPEDANCE MEASURE	10.9		6.8 - 10.9	fL
WBC DIFFERENTIAL COUNT - NLR				
SEGMENTED NEUTROPHILS METHOD : DHSS FLOWCYTOMETRY	64		40 - 80	%
ABSOLUTE NEUTROPHIL COUNT METHOD : DHSS FLOWCYTOMETRY, CALCULATED	3.80		2.0 - 7.0	thou/µL
LYMPHOCYTES METHOD : DHSS FLOWCYTOMETRY	25		20 - 40	%
ABSOLUTE LYMPHOCYTE COUNT METHOD : DHSS FLOWCYTOMETRY, CALCULATED	1.50		1 - 3	thou/µL
NEUTROPHIL LYMPHOCYTE RATIO (NLR) METHOD : CALCULATED	2.5			

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EOSINOPHILS	4		1 - 6	%
METHOD : DHSS FLOWCYTOMETRY				
ABSOLUTE EOSINOPHIL COUNT	0.22		0.02 - 0.50	thou/µL
METHOD : DHSS FLOWCYTOMETRY, CALCULATED				
MONOCYTES	7		2 - 10	%
METHOD : DHSS FLOWCYTOMETRY				
ABSOLUTE MONOCYTE COUNT	0.40		0.20 - 1.00	thou/µL
METHOD : DHSS FLOWCYTOMETRY, CALCULATED				
BASOPHILS	0		0 - 2	%
METHOD : IMPEDANCE				
ABSOLUTE BASOPHIL COUNT	**0**	**Low**	0.02 - 0.10	thou/µL
METHOD : DHSS FLOWCYTOMETRY, CALCULATED				
ERYTHRO SEDIMENTATION RATE, BLOOD				
SEDIMENTATION RATE (ESR)	3		0 - 14	mm at 1 hr
METHOD : AUTOMATED (PHOTOMETRICAL CAPILLARY STOPPED FLOW KINETIC ANALYSIS)				
GLYCOSYLATED HEMOGLOBIN, EDTA WHOLE BLOOD				
GLYCOSYLATED HEMOGLOBIN (HBA1C)	5.5		Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 ADA Target: 7.0 Action suggested: > 8.0	%
METHOD : CAPILLARY ELECTROPHORESIS				
MEAN PLASMA GLUCOSE	111.2		< 116	mg/dL
METHOD : CALCULATED PARAMETER				

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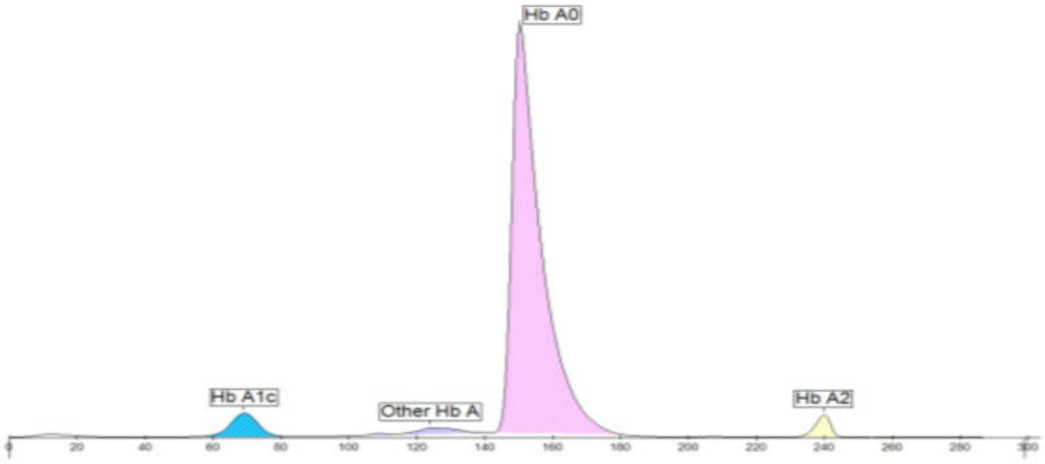
PLOT NO.31,ELECTRONIC CITY,SECTOR 18, GURUGRAM

ID : 28211946142
Name : Rack: 5 Pos.: 6

Sample Date: 10/8/2022
Sample num.: 254



A1c Haemoglobin Electrophoresis

Fractions	%	mmol/mol	Cal. %
Hb A1c	-	**37**	5.5
Other Hb A	2.0		
Hb A0	90.5		
Hb A2	2.6		

HbA1c % cal :**5.5 %**

Comments :

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GLUCOSE, FASTING, PLASMA				
GLUCOSE, FASTING, PLASMA	89		Normal 75 - 99 Pre-diabetics: 100 – 125 Diabetic: > or = 126	mg/dL
METHOD : SPECTROPHOTOMETRY HEXOKINASE				
GLUCOSE, POST-PRANDIAL, PLASMA				
GLUCOSE, POST-PRANDIAL, PLASMA	92		70 - 139	mg/dL
METHOD : SPECTROPHOTOMETRY, HEXOKINASE				
CORONARY RISK PROFILE, SERUM				
CHOLESTEROL	200		Desirable cholesterol level < 200 Borderline high cholesterol 200 - 239 High cholesterol > / = 240	mg/dL
METHOD : ENZYMATIC COLORIMETRIC ASSAY				
TRIGLYCERIDES	141		Normal: < 150 Borderline high: 150 - 199 High: 200 - 499 Very High: >/= 500	mg/dL
METHOD : ENZYMATIC COLORIMETRIC ASSAY				
HDL CHOLESTEROL	42		Low HDL Cholesterol <40 High HDL Cholesterol >/= 60	mg/dL
METHOD : HOMOGENEOUS ENZYMATIC COLORIMETRIC ASSAY				
CHOLESTEROL LDL	**141**	**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	**158**	**High**	Desirable : < 130 Above Desirable : 130 -159 Borderline High : 160 - 189 High : 190 - 219 Very high : > / = 220	mg/dL
METHOD : CALCULATED PARAMETER				
CHOL/HDL RATIO	**5.0**	**High**	Low Risk : 3.3 - 4.4 Average Risk : 4.5 - 7.0 Moderate Risk : 7.1 - 11.0 High Risk : > 11.0	

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METHOD : CALCULATED PARAMETER				
LDL/HDL RATIO	**3.4**	**High**	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
METHOD : CALCULATED PARAMETER				
VERY LOW DENSITY LIPOPROTEIN	28.2		< OR = 30.0	mg/dL
METHOD : CALCULATED PARAMETER				
LIVER FUNCTION PROFILE, SERUM				
BILIRUBIN, TOTAL	1.0		Upto 1.2	mg/dL
METHOD : COLORIMETRIC DIAZO METHOD				
BILIRUBIN, DIRECT	**0.4**	**High**	< 0.30	mg/dL
METHOD : COLORIMETRIC DIAZO METHOD				
BILIRUBIN, INDIRECT	0.60		0.1 - 1.0	mg/dL
METHOD : CALCULATED PARAMETER				
TOTAL PROTEIN	6.9		6.0 - 8.0	g/dL
METHOD : SPECTROPHOTOMETRY, BIURET				
ALBUMIN	4.6		3.97 - 4.94	g/dL
METHOD : SPECTROPHOTOMETRY, BROMOCRESOL GREEN(BCG) - DYE BINDING				
GLOBULIN	2.3		2.0 - 3.5	g/dL
METHOD : CALCULATED PARAMETER				
ALBUMIN/GLOBULIN RATIO	2.0		1.0 - 2.1	RATIO
METHOD : CALCULATED PARAMETER				
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	24		< OR = 50	U/L
METHOD : SPECTROPHOTOMETRY, WITH PYRIDOXAL PHOSPHATE ACTIVATION-IFCC				
ALANINE AMINOTRANSFERASE (ALT/SGPT)	21		< OR = 50	U/L
METHOD : SPECTROPHOTOMETRY, WITH PYRIDOXAL PHOSPHATE ACTIVATION-IFCC				
ALKALINE PHOSPHATASE	52		40 - 129	U/L
METHOD : SPECTROPHOTOMETRY, PNPP, AMP BUFFER - IFCC				
GAMMA GLUTAMYL TRANSFERASE (GGT)	18		0 - 60	U/L
METHOD : ENZYMATIC COLORIMETRIC ASSAY STANDARDIZED AGAINST IFCC / SZASZ				
LACTATE DEHYDROGENASE	177		125 - 220	U/L
METHOD : SPECTROPHOTOMETRY, LACTATE TO PYRUVATE - UV-IFCC				
SERUM BLOOD UREA NITROGEN				
BLOOD UREA NITROGEN	10.1		6 - 20	mg/dL
METHOD : SPECTROPHOTOMETRY, KINETIC TEST WITH UREASE AND GLUTAMATE DEHYDROGENASE				
CREATININE, SERUM				
CREATININE	0.75		0.7 - 1.2	mg/dL

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METHOD : SPECTROPHOTOMETRIC, JAFFE'S KINETICS			
BUN/CREAT RATIO			
BUN/CREAT RATIO	13.50	8.0 - 15.0	
METHOD : CALCULATED PARAMETER			
URIC ACID, SERUM			
URIC ACID	6.3	3.4 - 7.0	mg/dL
METHOD : SPECTROPHOTOMETRY, URICASE			
TOTAL PROTEIN, SERUM			
TOTAL PROTEIN	6.9	6.0 - 8.0	g/dL
METHOD : SPECTROPHOTOMETRY, BIURET			
ALBUMIN, SERUM			
ALBUMIN	4.6	3.97 - 4.94	g/dL
METHOD : SPECTROPHOTOMETRY, BROMOCRESOL GREEN(BCG) - DYE BINDING			
GLOBULIN			
GLOBULIN	2.3	2.0 - 3.5	g/dL
METHOD : CALCULATED PARAMETER			
ELECTROLYTES (NA/K/CL), SERUM			
SODIUM	140	136 - 145	mmol/L
METHOD : ISE INDIRECT			
POTASSIUM	4.3	3.5 - 5.1	mmol/L
METHOD : ISE INDIRECT			
CHLORIDE	104	98 - 107	mmol/L
METHOD : ISE INDIRECT			
PHYSICAL EXAMINATION, URINE			
COLOR	PALE YELLOW		
APPEARANCE	CLEAR		
SPECIFIC GRAVITY	<=1.005	1.003 - 1.035	

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	
PROTEIN	NOT DETECTED	NOT DETECTED	

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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			
PUS CELL (WBC'S)	0-1	0-5	/HPF
EPITHELIAL CELLS	0-1	0-5	/HPF
ERYTHROCYTES (RBC'S)	NOT DETECTED	NOT DETECTED	/HPF
CASTS	NOT DETECTED		
CRYSTALS	NOT DETECTED		
BACTERIA	NOT DETECTED	NOT DETECTED	
METHOD : DIP STICK/MICRO SCOPY/REFLECTANCE SPECTROPHOTOMETRY			
THYROID PANEL, SERUM			
T3	116.0	80 - 200	ng/dL
METHOD : ELECTROCHEMILUMINESCENCE IMMUNO ASSAY			
T4	7.00	5.1 - 14.1	µg/dL
METHOD : ELECTROCHEMILUMINESCENCE IMMUNO ASSAY			
TSH 3RD GENERATION	1.940	0.27 - 4.2	µIU/mL
METHOD : ELECTROCHEMILUMINESCENCE IMMUNO ASSAY			
STOOL: OVA & PARASITE			
REMARK	SAMPLE NOT RECEIVED		
METHOD : MICROSCOPIC EXAMINATION			
ABO GROUP & RH TYPE, EDTA WHOLE BLOOD			
ABO GROUP	B		
METHOD : HEMAGGLUTINATION REACTION ON SOLID PHASE			
RH TYPE	RH+		
METHOD : HEMAGGLUTINATION REACTION ON SOLID PHASE			
XRAY-CHEST			
»»	BOTH THE LUNG FIELDS ARE CLEAR		
»»	BOTH THE COSTOPHRENIC AND CARDIOPHRENIC ANGLES ARE CLEAR		
»»	BOTH THE HILA ARE NORMAL		

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»»	CARDIAC AND AORTIC SHADOWS APPEAR NORMAL		
»»	BOTH THE DOMES OF THE DIAPHRAGM ARE NORMAL		
»»	VISUALIZED BONY THORAX IS NORMAL		
IMPRESSION	NO ABNORMALITY DETECTED		
TMT OR ECHO			
TMT OR ECHO	ECHO REPORT		
	· Normal sized cardiac chambers and normal valves · Trivial TR · No RWMA · Normal LV systolic function LVEF ~ 60 % · Normal LV diastolic function, E>A · No Clot/Vegetation/Pericardial Effusion · IVS/IAS intact,no flow seen across.		
ECG			
ECG	WITHIN NORMAL LIMITS		
MEDICAL HISTORY			
RELEVANT PRESENT HISTORY	NOT SIGNIFICANT		
RELEVANT PAST HISTORY	NOT SIGNIFICANT		
RELEVANT PERSONAL HISTORY	NON SMOKER, OCCASIONAL ALCOHOL		
RELEVANT FAMILY HISTORY	HIGH BLOOD PRESSURE AND DIABETES- PARENTS.		
OCCUPATIONAL HISTORY	SERVICE		
HISTORY OF MEDICATIONS	NOT SIGNIFICANT		
ANTHROPOMETRIC DATA & BMI			
HEIGHT IN METERS	1.72		mts
WEIGHT IN KGS.	91		Kgs
BMI	31	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		
GENERAL APPEARANCE / NUTRITIONAL STATUS	OBESE		
BUILT / SKELETAL FRAMEWORK	AVERAGE		
FACIAL APPEARANCE	NORMAL		

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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	82/ MINUTE, REGULAR, ALL PERIPHERAL PULSES FELT.		
RESPIRATORY RATE	NORMAL		
CARDIOVASCULAR SYSTEM			
BP	120/72 MMHG (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		
CENTRAL NERVOUS SYSTEM			
HIGHER FUNCTIONS	NORMAL		
CRANIAL NERVES	NORMAL		
CEREBELLAR FUNCTIONS	NORMAL		
SENSORY SYSTEM	NORMAL		

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MOTOR SYSTEM	NORMAL		
REFLEXES	NORMAL		
MUSCULOSKELETAL SYSTEM			
SPINE	NORMAL		
JOINTS	NORMAL		
BASIC EYE EXAMINATION			
DISTANT VISION RIGHT EYE WITHOUT GLASSES	6/6		
DISTANT VISION LEFT EYE WITHOUT GLASSES	6/6		
NEAR VISION RIGHT EYE WITHOUT GLASSES	N/6		
NEAR VISION LEFT EYE WITHOUT GLASSES	N/6		
COLOUR VISION	17/17		
SUMMARY			
REMARKS / RECOMMENDATIONS	ADVISED LIFESTYLE CHANGES FOLLOW UP WITH PHYSICIAN & EYE SPECIALIST.		

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MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 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.
WBC DIFFERENTIAL COUNT - NLR-
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.
ERYTHRO SEDIMENTATION RATE, BLOOD-
Erythrocyte sedimentation rate (ESR) is a non - specific phenomena and is clinically useful in the diagnosis and monitoring of disorders associated with an increased production of acute phase reactants. The ESR is increased in pregnancy from about the 3rd month and returns to normal by the 4th week post partum. ESR is influenced by age, sex, menstrual cycle and drugs (eg. corticosteroids, contraceptives). It is especially low (0 -1mm) in polycythaemia, hypofibrinogenemia or congestive cardiac failure and when there are abnormalities of the red cells such as poikilocytosis, spherocytosis or sickle cells.

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, EDTA WHOLE BLOOD-
Glycosylated hemoglobin (GHb) has been firmly established as an index of long-term blood glucose concentrations and as a measure of the risk for the development of complications in patients with diabetes mellitus. Formation of GHb is essentially irreversible, and the concentration in the blood depends on both the life span of the red blood cell (average 120 days) and the blood glucose concentration. Because the rate of formation of GHb is directly proportional to the concentration of glucose in the blood, the GHb concentration represents the integrated values for glucose over the preceding 6-8 weeks.
Any condition that alters the life span of the red blood cells has the potential to alter the GHb level. Samples from patients with hemolytic anemias will exhibit decreased glycated hemoglobin values due to the shortened life span of the red cells. This effect will depend upon the severity of the anemia. Samples from patients with polycythemia or post-splenectomy may exhibit increased glycated hemoglobin values due to a somewhat longer life span of the red cells.
Glycosylated hemoglobins results from patients with HbSS, HbCC, and HbSC and HbD must be interpreted with caution, given the pathological processes, including anemia, increased red cell turnover, transfusion requirements, that adversely impact HbA1c as a marker of long-term glycemic control. In these conditions, alternative forms of testing such as glycated serum protein (fructosamine) should be considered.
"Targets should be individualized; More or less stringent glycemic goals may be appropriate for individual patients. Goals should be individualized based on duration of diabetes, age/life expectancy, comorbid conditions, known CVD or advanced microvascular complications, hypoglycemia unawareness, and individual patient considerations.''

References
1. Tietz Textbook of Clinical Chemistry and Molecular Diagnostics, edited by Carl A Burtis, Edward R.Ashwood, David E Bruns, 4th Edition, Elsevier publication, 2006, 879-884.
2. Forsham PH. Diabetes Mellitus:A rational plan for management. Postgrad Med 1982, 71,139-154.
3. Mayer TK, Freedman ZR: Protein glycosylation in Diabetes Mellitus: A review of laboratory measurements and their clinical utility. Clin Chim Acta 1983, 127, 147-184.
GLUCOSE, FASTING, PLASMA-
ADA 2021 guidelines for adults, after 8 hrs fasting is as follows:
Pre-diabetics: 100 - 125 mg/dL
Diabetic: > or = 126 mg/dL
GLUCOSE, POST-PRANDIAL, PLASMA-ADA Guidelines for 2hr post prandial glucose levels is only after ingestion of 75grams of glucose in 300 ml water,over a period of 5 minutes.
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

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PATIENT NAME : VIKAS SHARMA PATIENT ID : **VIKAM051179282**

ACCESSION NO : **0282VJ000644** AGE : 42 Years SEX : Male ABHA NO :

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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
SERUM BLOOD UREA NITROGEN-
Causes of Increased levels
Pre renal
• High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal
• Renal Failure
Post Renal
• Malignancy, Nephrolithiasis, Prostatism

Causes of decreased levels
• 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's
• Multiple Sclerosis

Nutritional tips to manage increased Uric acid levels
• Drink plenty of fluids
• Limit animal proteins
• High Fibre foods
• Vit C Intake

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• Antioxidant rich foods
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.
ELECTROLYTES (NA/K/CL), SERUM-
Sodium levels are Increased in dehydration, cushing's syndrome, aldosteronism & decreased in Addison's disease, hypopituitarism,liver disease. Hypokalemia (low K) is common in vomiting, diarrhea, alcoholism, folic acid deficiency and primary aldosteronism. Hyperkalemia may be seen in end-stage renal failure, hemolysis, trauma, Addison's disease, metabolic acidosis, acute starvation, dehydration, and with rapid K infusion.Chloride is increased in dehydration, renal tubular acidosis (hyperchloremia metabolic acidosis), acute renal failure, metabolic acidosis associated with prolonged diarrhea and loss of sodium bicarbonate, diabetes insipidus, adrenocortical hyperfuction, salicylate intoxication and with excessive infusion of isotonic saline or extremely high dietary intake of salt.Chloride is decreased in overhydration, chronic respiratory acidosis, salt-losing nephritis, metabolic alkalosis, congestive heart failure, Addisonian crisis, certain types of metabolic acidosis, persistent gastric secretion and prolonged vomiting,
MICROSCOPIC EXAMINATION, URINE-
Routine urine analysis assists in screening and diagnosis of various metabolic, urological, kidney and liver disorders
Protein: Elevated proteins can be an early sign of kidney disease. Urinary protein excretion can also be temporarily elevated by strenuous exercise, orthostatic proteinuria, dehydration, urinary tract infections and acute illness with fever
Glucose: Uncontrolled diabetes mellitus can lead to presence of glucose in urine. Other causes include pregnancy, hormonal disturbances, liver disease and certain medications.
Ketones: Uncontrolled diabetes mellitus can lead to presence of ketones in urine. Ketones can also be seen in starvation, frequent vomiting, pregnancy and strenuous exercise.
Blood: Occult blood can occur in urine as intact erythrocytes or haemoglobin, which can occur in various urological, nephrological and bleeding disorders.
Leukocytes: An increase in leukocytes is an indication of inflammation in urinary tract or kidneys. Most common cause is bacterial urinary tract infection.
Nitrite: Many bacteria give positive results when their number is high. Nitrite concentration during infection increases with length of time the urine specimen is retained in bladder prior to collection.
pH: The kidneys play an important role in maintaining acid base balance of the body. Conditions of the body producing acidosis/ alkalosis or ingestion of certain type of food can affect the pH of urine.
Specific gravity: Specific gravity gives an indication of how concentrated the urine is. Increased specific gravity is seen in conditions like dehydration, glycosuria and proteinuria while decreased specific gravity is seen in excessive fluid intake, renal failure and diabetes insipidus.
Bilirubin: In certain liver diseases such as biliary obstruction or hepatitis, bilirubin gets excreted in urine.
Urobilinogen: Positive results are seen in liver diseases like hepatitis and cirrhosis and in cases of hemolytic anemia
THYROID PANEL, SERUM-
Triiodothyronine T3 , is a thyroid hormone. It affects 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.
Thyroxine T4, Thyroxine's principal function is to stimulate the metabolism of all cells and tissues in the body. Excessive secretion of thyroxine in the body is hyperthyroidism, and deficient secretion is called 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.
In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hypothyroidism, TSH levels are low.
Below mentioned are the guidelines for Pregnancy related reference ranges for Total T4, TSH & Total T3

Levels in Pregnancy	TOTAL T4 (µg/dL)	TSH3G (µIU/mL)	TOTAL T3 (ng/dL)
First Trimester	6.6 - 12.4	0.1 - 2.5	81 - 190
2nd Trimester	6.6 - 15.5	0.2 - 3.0	100 - 260
3rd Trimester	6.6 - 15.5	0.3 - 3.0	100 - 260

Below mentioned are the guidelines for age related reference ranges for T3 and T4.

T3 (ng/dL)	T4 (µg/dL)
New Born: 75 - 260	1-3 day: 8.2 - 19.9
.	1 Week: 6.0 - 15.9

NOTE: TSH concentrations in apparently normal euthyroid subjects are known to be highly skewed, with a strong tailed distribution towards higher TSH values. This is well documented in the pediatric population including the infant age group.
Kindly note: Method specific reference ranges are appearing on the report under biological reference range.

Reference:
1. Burtis C.A., Ashwood E. R. Bruns D.E. Teitz textbook of Clinical Chemistry and Molecular Diagnostics, 4th Edition.

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2. Gowenlock A.H. Varley's Practical Clinical Biochemistry, 6th Edition.
3. Behrman R.E. Kilegman R.M., Jenson H. B. Nelson Text Book of Pediatrics, 17th Edition
STOOL: OVA & PARASITE-
Acute infective diarrhoea and gastroenteritis (diarrhoea with vomiting) are major causes of ill health and premature death in developing countries. Loss of water and electrolytes from the body can lead to severe dehydration which if untreated, can be rapidly fatal in young children, especially that are malnourished, hypoglycaemic, and generally in poor health.

Laboratory diagnosis of parasitic infection is mainly based on microscopic examination and the gross examination of the stool specimen. Depending on the nature of the parasite, the microscopic observations include the identification of cysts, ova, trophozoites, larvae or portions of adult structure. The two classes of parasites that cause human infection are the Protozoa and Helminths. The protozoan infections include amoebiasis mainly caused by Entamoeba histolytica and giardiasis caused by Giardia lamblia. The common helminthic parasites are Trichuris trichiura, Ascaris lumbricoides, Strongyloides stercoralis, Taenia sp. 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-**********
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