Patient Ref. No. 65000000550189

CLIENT CODE : C000138379

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
PLOT No. 88, ROAD No. 15,MIDC ESTATE,ANDHERI (EAST)
MUMBAI, 400093
MAHARASHTRA, INDIA
Tel : 09152729959/9111591115,
CIN - U74899PB1995PLC045956

PATIENT NAME : ARCHANA TIWARI PATIENT ID : **ARCHF25067065**

ACCESSION NO : **0065VL000915** AGE : 52 Years SEX : Female ABHA NO :

DRAWN : RECEIVED : 10/12/2022 08:08:08 REPORTED : 12/12/2022 14:19:23

REFERRING DOCTOR : SELF CLIENT PATIENT ID :

Test Report Status **Preliminary**	Results		Biological Reference Interval	Units
MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40FEMALE				
BLOOD COUNTS,EDTA WHOLE BLOOD				
HEMOGLOBIN (HB)	13.6		12.0 - 15.0	g/dL
METHOD : PHOTOMETRIC MEASUREMENT				
RED BLOOD CELL (RBC) COUNT	**4.90**	**High**	3.8 - 4.8	mil/µL
METHOD : COULTER PRINCIPLE				
WHITE BLOOD CELL (WBC) COUNT	8.90		4.0 - 10.0	thou/µL
METHOD : COULTER PRINCIPLE				
PLATELET COUNT	235		150 - 410	thou/µL
METHOD : ELECTRONIC IMPEDENCE & MICROSCOPY				
RBC AND PLATELET INDICES				
HEMATOCRIT (PCV)	42.2		36.0 - 46.0	%
METHOD : CALCULATED PARAMETER				
MEAN CORPUSCULAR VOLUME (MCV)	86.2		83.0 - 101.0	fL
METHOD : DERIVED PARAMETER FROM RBC HISTOGRAM				
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	27.8		27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER				
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)	32.3		31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER				
RED CELL DISTRIBUTION WIDTH (RDW)	13.8		11.6 - 14.0	%
METHOD : DERIVED PARAMETER FROM RBC HISTOGRAM				
MENTZER INDEX	17.6			
MEAN PLATELET VOLUME (MPV)	10.2		6.8 - 10.9	fL
METHOD : DERIVED PARAMETER FROM PLATELET HISTOGRAM				
WBC DIFFERENTIAL COUNT				
NEUTROPHILS	49		40 - 80	%
METHOD : VCSN TECHNOLOGY/ MICROSCOPY				
LYMPHOCYTES	**42**	**High**	20 - 40	%
METHOD : VCSN TECHNOLOGY/ MICROSCOPY				
MONOCYTES	7		2.0 - 10.0	%
METHOD : VCSN TECHNOLOGY/ MICROSCOPY				
EOSINOPHILS	2		1.0 - 6.0	%
METHOD : VCSN TECHNOLOGY/ MICROSCOPY				
BASOPHILS	0		0 - 1	%
METHOD : VCSN TECHNOLOGY/ MICROSCOPY				

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ABSOLUTE NEUTROPHIL COUNT	4.36		2.0 - 7.0	thou/µL
METHOD : CALCULATED PARAMETER				
ABSOLUTE LYMPHOCYTE COUNT	**3.74**	**High**	1.0 - 3.0	thou/µL
METHOD : CALCULATED PARAMETER				
ABSOLUTE MONOCYTE COUNT	0.62		0.2 - 1.0	thou/µL
METHOD : CALCULATED PARAMETER				
ABSOLUTE EOSINOPHIL COUNT	0.18		0.02 - 0.50	thou/µL
METHOD : CALCULATED PARAMETER				
ABSOLUTE BASOPHIL COUNT	**0.00**	**Low**	0.02 - 0.10	thou/µL
METHOD : CALCULATED PARAMETER				
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	1.1			
METHOD : CALCULATED				
ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD				
E.S.R	**23**	**High**	0 - 20	mm at 1 hr
METHOD : AUTOMATED (PHOTOMETRICAL CAPILLARY STOPPED FLOW KINETIC ANALYSIS)				
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD				
HBA1C	**9.3**	**High**	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 : ION- EXCHANGE HPLC				
ESTIMATED AVERAGE GLUCOSE(EAG)	**220.2**	**High**	< 116.0	mg/dL
METHOD : CALCULATED PARAMETER				
GLUCOSE FASTING,FLUORIDE PLASMA				
FBS (FASTING BLOOD SUGAR)	**138**	**High**	Normal <100 Impaired fasting glucose:100 to 125 Diabetes mellitus: > = 126 (on more than 1 occassion) (ADA guidelines 2021)	mg/dL
METHOD : SPECTROPHOTOMETRY HEXOKINASE				
GLUCOSE, POST-PRANDIAL, PLASMA				

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PPBS(POST PRANDIAL BLOOD SUGAR)	**218**	**High**	Normal <140 Impaired glucose tolerance:140 to 199 Diabetes mellitus : > = 200 (on more than 1 occassion) ADA guideline 2021	mg/dL
METHOD : SPECTROPHOTOMETRY HEXOKINASE				
LIPID PROFILE, SERUM				
CHOLESTEROL, TOTAL	**216**	**High**	Desirable : < 200 Borderline : 200 - 239 High : > / = 240	mg/dL
METHOD : SPECTROPHOTOMETRY, ENZYMATIC COLORIMETRIC - CHOLETSEROL OXIDASE, ESTERASE, PEROXIDASE				
TRIGLYCERIDES	127		Normal: < 150 Borderline high: 150 - 199 High: 200 - 499 Very High: >/= 500	mg/dL
METHOD : SPECTROPHOTOMETRY, ENZYMATIC ENDPOINT WITH GLYCEROL BLANK				
HDL CHOLESTEROL	58		At Risk: < 40 Desirable: > or = 60	mg/dL
METHOD : SPECTROPHOTOMETRY, HOMOGENEOUS DIRECT ENZYMATIC COLORIMETRIC				
CHOLESTEROL LDL	**133**	**High**	Optimal : < 100 Near optimal/above optimal : 100-129 Borderline high : 130-159 High : 160-189 Very high : = 190	mg/dL
METHOD : CALCULATED PARAMETER				
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	3.7		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				
LDL/HDL RATIO	2.2		Desirable/Low Risk : 0.5 - 3.0 Borderline/Moderate Risk : 3.1 - 6.0 High Risk : > 6.0	
METHOD : CALCULATED PARAMETER				
VERY LOW DENSITY LIPOPROTEIN	25.0		< or = 30.0	mg/dL

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METHOD : CALCULATED PARAMETER				
LIVER FUNCTION PROFILE, SERUM				
BILIRUBIN, TOTAL	0.45		Upto 1.2	mg/dL
METHOD : SPECTROPHOTOMETRY, COLORIMETRIC -DIAZO METHOD				
BILIRUBIN, DIRECT	**0.22**	**High**	0.0 - 0.2	mg/dL
METHOD : SPECTROPHOTOMETRY, JENDRASSIK & GROFF - DIAZOTIZATION				
BILIRUBIN, INDIRECT	0.23		0.1 - 1.0	mg/dL
METHOD : CALCULATED PARAMETER				
TOTAL PROTEIN	7.2		6.0 - 8.0	g/dL
METHOD : SPECTROPHOTOMETRY, COLORIMETRIC -BIURET, REAGENT BLANK, SERUM BLANK				
ALBUMIN	4.5		3.97 - 4.94	g/dL
METHOD : SPECTROPHOTOMETRY, BROMOCRESOL GREEN(BCG) - DYE BINDING				
GLOBULIN	2.7		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)	31		Upto 32	U/L
METHOD : SPECTROPHOTOMETRY, WITHOUT PYRIDOXAL PHOSPHATE ACTIVATION(P5P) - IFCC				
ALANINE AMINOTRANSFERASE (ALT/SGPT)	33		Upto 33	U/L
METHOD : SPECTROPHOTOMETRY, WITHOUT PYRIDOXAL PHOSPHATE ACTIVATION(P5P) - IFCC				
ALKALINE PHOSPHATASE	82		35 - 104	U/L
METHOD : SPECTROPHOTOMETRY, PNPP, AMP BUFFER - IFCC				
GAMMA GLUTAMYL TRANSFERASE (GGT)	36		< 40	U/L
METHOD : SPECTROPHOTOMETRY, ENZYMATIC COLORIMETRIC - G-GLUTAMYL-CARBOXY-NITROANILIDE - IFCC				
LACTATE DEHYDROGENASE	138		< 223	U/L
METHOD : SPECTROPHOTOMETRY, LACTATE TO PYRUVATE - UV-IFCC				
BLOOD UREA NITROGEN (BUN), SERUM				
BLOOD UREA NITROGEN	6		6 - 20	mg/dL
METHOD : SPECTROPHOTOMETRY, UREASE -COLORIMETRIC				
CREATININE, SERUM				
CREATININE	**0.58**	**Low**	0.60 - 1.10	mg/dL
METHOD : SPECTROPHOTOMETRY, JAFFE'S ALKALINE PICRATE KINETIC - RATE BLANKED - IFCC-IDMS STANDARIZED				
BUN/CREAT RATIO				
BUN/CREAT RATIO	10.34		8 - 15	
METHOD : CALCULATED PARAMETER				
URIC ACID, SERUM				

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URIC ACID	3.9		2.4 - 5.7	mg/dL
METHOD : SPECTROPHOTOMETRY, ENZYMATIC COLORIMETRIC- URICASE				
TOTAL PROTEIN, SERUM				
TOTAL PROTEIN	7.2		6.0 - 8.0	g/dL
METHOD : SPECTROPHOTOMETRY, COLORIMETRIC -BIURET, REAGENT BLANK, SERUM BLANK				
ALBUMIN, SERUM				
ALBUMIN	4.5		3.97 - 4.94	g/dL
METHOD : SPECTROPHOTOMETRY, BROMOCRESOL GREEN(BCG) - DYE BINDING				
GLOBULIN				
GLOBULIN	2.7		2.0 - 3.5	g/dL
METHOD : CALCULATED PARAMETER				
ELECTROLYTES (NA/K/CL), SERUM				
SODIUM, SERUM	142		136 - 145	mmol/L
METHOD : ISE INDIRECT				
POTASSIUM, SERUM	4.50		3.5 - 5.1	mmol/L
METHOD : ISE INDIRECT				
CHLORIDE, SERUM	106		98 - 106	mmol/L
METHOD : ISE INDIRECT				
Interpretation(s)				
PHYSICAL EXAMINATION, URINE				
COLOR	PALE YELLOW			
APPEARANCE	CLEAR			
CHEMICAL EXAMINATION, URINE				
PH	6.0		5.00 - 7.50	
SPECIFIC GRAVITY	**1.005**	**Low**	1.010 - 1.030	
PROTEIN	NOT DETECTED		NOT DETECTED	
GLUCOSE	**DETECTED (+++)**		NOT DETECTED	
KETONES	NOT DETECTED		NOT DETECTED	
BLOOD	NOT DETECTED		NOT DETECTED	
BILIRUBIN	NOT DETECTED		NOT DETECTED	
UROBILINOGEN	NOT DETECTED			
NITRITE	NOT DETECTED		NOT DETECTED	
LEUKOCYTE ESTERASE	NOT DETECTED		NOT DETECTED	

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MICROSCOPIC EXAMINATION, URINE			
RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
PUS CELL (WBC'S)	2-3	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	
METHOD : URINE ROUTINE & MICROSCOPY EXAMINATION BY INTEGRATED AUTOMATED SYSTEM			
Interpretation(s)			
THYROID PANEL, SERUM			
T3	84.3	Non-Pregnant Women 80.0 - 200.0 Pregnant Women 1st Trimester105.0 - 230.0 2nd Trimester129.0 - 262.0 3rd Trimester135.0 - 262.0	ng/dL
METHOD : COMPETITIVE ELECTROCHEMILUMINESCENCE IMMUNOASSAY			
T4	9.97	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 : COMPETITIVE ELECTROCHEMILUMINESCENCE IMMUNOASSAY			
TSH (ULTRASENSITIVE)	2.150	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 : SANDWICH ELECTROCHEMILUMINESCENCE IMMUNOASSAY			
Interpretation(s)			
PAPANICOLAOU SMEAR	RESULT PENDING		
LETTER	RESULT PENDING		
MICROSCOPIC EXAMINATION,STOOL			
REMARK	SAMPLE NOT RECEIVED		

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ABO GROUP & RH TYPE, EDTA WHOLE BLOOD			
ABO GROUP	B		
RH TYPE	POSITIVE		
XRAY-CHEST			
IMPRESSION	NO ABNORMALITY DETECTED		
TMT OR ECHO			
TMT OR ECHO	NORMAL		
ECG			
ECG	WITHIN NORMAL LIMITS		
MEDICAL HISTORY			
RELEVANT PRESENT HISTORY	NOT SIGNIFICANT		
RELEVANT PAST HISTORY	LEFT ANKLE FRACTURE 2014 DIABETES 2019 HYPOTHYROIDISM 20 YEARS		
RELEVANT PERSONAL HISTORY	NOT SIGNIFICANT		
RELEVANT FAMILY HISTORY	DIABETES		
HISTORY OF MEDICATIONS	NOT SIGNIFICANT		
ANTHROPOMETRIC DATA & BMI			
HEIGHT IN METERS	1.55		mts
WEIGHT IN KGS.	66		Kgs
BMI	27	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		
FACIAL APPEARANCE	NORMAL		
SKIN	NORMAL		
UPPER LIMB	NORMAL		
LOWER LIMB	NORMAL		
NECK	NORMAL		

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NECK LYMPHATICS / SALIVARY GLANDS	NOT ENLARGED OR TENDER		
THYROID GLAND	NOT ENLARGED		
CAROTID PULSATION	NORMAL		
TEMPERATURE	NORMAL		
PULSE	80/MIN, REGULAR, ALL PERIPHERAL PULSES WELL FELT, NO CAROTID BRUIT		
RESPIRATORY RATE	NORMAL		
CARDIOVASCULAR SYSTEM			
BP	100/70 MM HG (SUPINE)		mm/Hg
PERICARDIUM	NORMAL		
APEX BEAT	NORMAL		
HEART SOUNDS	S1, S2 HEARD NORMALLY		
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			
HIGHER FUNCTIONS	NORMAL		
CRANIAL NERVES	NORMAL		
CEREBELLAR FUNCTIONS	NORMAL		
SENSORY SYSTEM	NORMAL		
MOTOR SYSTEM	NORMAL		
REFLEXES	NORMAL		
MUSCULOSKELETAL SYSTEM			

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SPINE	NORMAL		
JOINTS	NORMAL		
BASIC EYE EXAMINATION			
CONJUNCTIVA	NORMAL		
EYELIDS	NORMAL		
EYE MOVEMENTS	NORMAL		
CORNEA	NORMAL		
BASIC ENT EXAMINATION			
EXTERNAL EAR CANAL	NORMAL		
TYMPANIC MEMBRANE	NORMAL		
NOSE	NO ABNORMALITY DETECTED		
SINUSES	CLEAR		
THROAT	NO ABNORMALITY DETECTED		
TONSILS	ENLARGED		
SUMMARY			
RELEVANT HISTORY	NOT SIGNIFICANT		
RELEVANT GP EXAMINATION FINDINGS	OVER WEIGHT		
RELEVANT LAB INVESTIGATIONS	RAISED ESR (23) RAISED RBC (4.90) RAISED LYMPHOCYSTE (42) RAISED FASTING BLOOD SUGAR (138) RAISED POST PRANDIAL BLOOD SUGAR (218) URINE GLUCOSE DETECTED (+++) RAISED BILIRUBIN DIRECT (0.22) LOW CREATININE (0.58) RAISED TOTAL CHOLESTEROL (216) RAISED NON HDL CHOLESTEROL (158) RAISED LDL CHOLESTEROL (133) RAISED HBA1C (9.3) RAISED EAG (220.2)		
RELEVANT NON PATHOLOGY DIAGNOSTICS	MILD FATTY LIVER		
REMARKS / RECOMMENDATIONS	REGULAR PHYSICAL EXERCISES LOW CALORIC DIET REDUCE FATTY AND PROCESSED FOOD IN DIET REDUCE SUGARS, SWEETS IN DIET		

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MUMBAI, 400093
MAHARASHTRA, INDIA
Tel : 09152729959/9111591115,
CIN - U74899PB1995PLC045956

PATIENT NAME : ARCHANA TIWARI PATIENT ID : **ARCHF25067065**

ACCESSION NO : **0065VL000915** AGE : 52 Years SEX : Female ABHA NO :

DRAWN : RECEIVED : 10/12/2022 08:08:08 REPORTED : 12/12/2022 14:19:23

REFERRING DOCTOR : SELF CLIENT PATIENT ID :

Test Report Status **Preliminary**	Results	Units

MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40FEMALE

ULTRASOUND ABDOMEN

ULTRASOUND ABDOMEN

MILD 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, 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

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.

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CLIENT CODE : C000138379

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
PLOT No. 88, ROAD No. 15,MIDC ESTATE,ANDHERI (EAST)
MUMBAI, 400093
MAHARASHTRA, INDIA
Tel : 09152729959/9111591115,
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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:
- 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

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