PATIENT NAME : POORNIMA PUNDLIK SAWANT		**REF. DOCTOR :** SELF	
CODE/NAME & ADDRESS : C000138394 ACROFEMI HEALTHCARE LTD (MEDIWHEEL) F-703, F-703, LADO SARAI, MEHRAULISOUTH WEST DELHI NEW DELHI 110030 8800465156	ACCESSION NO : **0181WD000389** PATIENT ID : POORF010572181 CLIENT PATIENT ID: ABHA NO :	AGE/SEX : 50 Years Female DRAWN : RECEIVED : 07/04/2023 09:39:53 REPORTED : 12/04/2023 10:01:17	

Test Report Status **Final**	Results	Biological Reference Interval	Units

MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40FEMALE

XRAY-CHEST

IMPRESSION	MILD UNFOLDING OF AORTA (AGE RELATED)		

TMT OR ECHO

TMT OR ECHO	2D ECHO : NORMAL		

ECG

ECG	WITHIN NORMAL LIMITS		

MEDICAL HISTORY

RELEVANT PRESENT HISTORY	DIABETES SINCE 6 YEARS.		
RELEVANT PAST HISTORY	NOT SIGNIFICANT		
RELEVANT PERSONAL HISTORY	MARRIED / MIXED DIET / NO ALLERGIES / NO SMOKING / NO ALCOHOL.		
MENSTRUAL HISTORY (FOR FEMALES)	MENOPAUSAL.		
OBSTETRIC HISTORY (FOR FEMALES)	2FTNDA0L3. 1LSCS		
RELEVANT FAMILY HISTORY	NOT SIGNIFICANT		
OCCUPATIONAL HISTORY	NOT SIGNIFICANT		
HISTORY OF MEDICATIONS	NOT SIGNIFICANT		

ANTHROPOMETRIC DATA & BMI

HEIGHT IN METERS	1.48		mts
WEIGHT IN KGS.	52		Kgs
BMI	24	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		

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Email : customercare.thane@srl.in

Patient Ref. No. 775000002833063

LOWER LIMB	NORMAL	
NECK	NORMAL	
NECK LYMPHATICS / SALIVARY GLANDS	NOT ENLARGED OR TENDER	
THYROID GLAND	NOT ENLARGED	
CAROTID PULSATION	NORMAL	
TEMPERATURE	NORMAL	
PULSE	84/MIN.REGULAR, ALL PERIPHERAL PULSES WELL FELT, NO CAROTID BRUIT	
RESPIRATORY RATE	NORMAL	
CARDIOVASCULAR SYSTEM		
BP	150/90 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		
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			
CONJUNCTIVA	NORMAL		
EYELIDS	NORMAL		
EYE MOVEMENTS	NORMAL		
CORNEA	NORMAL		
DISTANT VISION RIGHT EYE WITHOUT GLASSES	REDUCED VISUAL ACUITY 6/9		
DISTANT VISION LEFT EYE WITHOUT GLASSES	REDUCED VISUAL ACUITY 6/9		
DISTANT VISION RIGHT EYE WITH GLASSES	WITH GLASSES NORMAL		
DISTANT VISION LEFT EYE WITH GLASSES	WITH GLASSES NORMAL		
NEAR VISION RIGHT EYE WITHOUT GLASSES	REDUCED VISUAL ACUITY N/10		
NEAR VISION LEFT EYE WITHOUT GLASSES	REDUCED VISUAL ACUITY N/12		
NEAR VISION RIGHT EYE WITH GLASSES	WITHIN NORMAL LIMIT		
NEAR VISION LEFT EYE WITH GLASSES	WITHIN NORMAL LIMIT		
COLOUR VISION	NORMAL		
SUMMARY			
RELEVANT HISTORY	NOT SIGNIFICANT		
RELEVANT GP EXAMINATION FINDINGS	NOT SIGNIFICANT		

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REMARKS / RECOMMENDATIONS

BP MONITORING FOR 5 DAYS. IF PERSISTENTLY HIGH, WILL REQUIRE EVALUATION BY PHYSICIAN.

LOW FAT,LOW CALORIE, LOW CARBOHYDRATE, HIGH FIBRE DIET.

REGULAR EXERCISE.REGULAR WALK FOR 30-40 MIN DAILY.

REPEAT LIPID PROFILE, BLOOD SUGAR,URINE ROUTIN AFTER 3 MONTHS OF DIET AND EXERCISE.

ADD YOGA, PRANAYAM MEDITATION TO DAILY ROUTINE.

IRON RICH DIET ADVISED.

ADD GREEN LEAFY VEGETABLES, DATES BEETROOT TO THE DAILY DIET.

TO DO S.IRON STUDIES.

FOLLOW UP WITH PHYSICIAN FOR BLOOD SUGAR CONTROL AND DYSLIPDEMIA.

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

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HAEMATOLOGY - CBC

MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40FEMALE

BLOOD COUNTS,EDTA WHOLE BLOOD			
HEMOGLOBIN (HB)	**10.4 Low**	12.0 - 15.0	g/dL
METHOD : SLS- HEMOGLOBIN DETECTION METHOD			
RED BLOOD CELL (RBC) COUNT	4.06	3.8 - 4.8	mil/µL
METHOD : HYDRODYNAMIC FOCUSING BY DC DETECTION			
WHITE BLOOD CELL (WBC) COUNT	8.42	4.0 - 10.0	thou/µL
METHOD : FLUORESCENCE FLOW CYTOMETRY			
PLATELET COUNT	**454 High**	150 - 410	thou/µL
METHOD : HYDRODYNAMIC FOCUSING BY DC DETECTION			
RBC AND PLATELET INDICES			
HEMATOCRIT (PCV)	**34.2 Low**	36.0 - 46.0	%
METHOD : CUMULATIVE PULSE HEIGHT DETECTION METHOD			
MEAN CORPUSCULAR VOLUME (MCV)	84.2	83.0 - 101.0	fL
METHOD : CALCULATED FROM RBC & HCT			
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	**25.6 Low**	27.0 - 32.0	pg
METHOD : CALCULATED FROM THE RBC & HGB			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)	**30.4 Low**	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	20.7		
MEAN PLATELET VOLUME (MPV)	10.9	6.8 - 10.9	fL
METHOD : CALCULATED FROM PLATELET COUNT & PLATELET HEMATOCRIT			
WBC DIFFERENTIAL COUNT			
NEUTROPHILS	68	40 - 80	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
LYMPHOCYTES	23	20 - 40	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
MONOCYTES	5	2 - 10	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
EOSINOPHILS	4	1 - 6	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
ABSOLUTE NEUTROPHIL COUNT	5.73	2.0 - 7.0	thou/µL
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
ABSOLUTE LYMPHOCYTE COUNT	1.90	1.0 - 3.0	thou/µL

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Lab Head

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METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING ABSOLUTE MONOCYTE COUNT	0.40	0.2 - 1.0	thou/µL
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING ABSOLUTE EOSINOPHIL COUNT	0.36	0.02 - 0.50	thou/µL
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING NEUTROPHIL LYMPHOCYTE RATIO (NLR)	3.0		
MORPHOLOGY			
RBC	NORMOCYTIC NORMOCHROMIC		
WBC	NORMAL MORPHOLOGY		
METHOD : MICROSCOPIC EXAMINATION PLATELETS	ADEQUATE		

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.

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HAEMATOLOGY

MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40FEMALE

ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD			
E.S.R	**26 High**	< 20	mm at 1 hr

METHOD : MODIFIED WESTERGREN

Interpretation(s)
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.

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IMMUNOHAEMATOLOGY

MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40FEMALE

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP	TYPE A		
METHOD : GEL COLUMN AGGLUTINATION METHOD.			
RH TYPE	POSITIVE		
METHOD : GEL COLUMN AGGLUTINATION METHOD.			

Interpretation(s)
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.

Dr.Priyal Chinchkhede
Consultant Pathologist

Dr. Ushma Wartikar
Consultant Pathologist

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BIOCHEMISTRY

MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40FEMALE

GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD			
HBA1C	**6.5 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 : HPLC			
ESTIMATED AVERAGE GLUCOSE(EAG)	**139.9 High**	< 116.0	mg/dL
METHOD : CALCULATED PARAMETER			
GLUCOSE FASTING,FLUORIDE PLASMA			
FBS (FASTING BLOOD SUGAR)	**112 High**	Normal 75 - 99 Pre-diabetics: 100 – 125 Diabetic: > or = 126	mg/dL
METHOD : ENZYMATIC REFERENCE METHOD WITH HEXOKINASE			
GLUCOSE, POST-PRANDIAL, PLASMA			
PPBS(POST PRANDIAL BLOOD SUGAR)	**201 High**	70 - 139	mg/dL
METHOD : ENZYMATIC REFERENCE METHOD WITH HEXOKINASE			
LIPID PROFILE, SERUM			
CHOLESTEROL, TOTAL	**240 High**	Desirable : < 200 Borderline : 200 - 239 High : > / = 240	mg/dL
METHOD : ENZYMATIC COLORIMETRIC ASSAY			
TRIGLYCERIDES	**189 High**	Normal: < 150 Borderline high: 150 - 199 High: 200 - 499 Very High: >/= 500	mg/dL
METHOD : ENZYMATIC COLORIMETRIC ASSAY			
HDL CHOLESTEROL	**39 Low**	At Risk: < 40 Desirable: > or = 60	mg/dL
METHOD : ENZYMATIC, COLORIMETRIC			

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CHOLESTEROL LDL	**163 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	**201 High**	Desirable : < 130 Above Desirable : 130 -159 Borderline High : 160 - 189 High : 190 - 219 Very high : > / = 220	mg/dL
VERY LOW DENSITY LIPOPROTEIN	**37.8 High**	< OR = 30.0	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	**4.2 High**	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
Interpretation(s)			
LIVER FUNCTION PROFILE, SERUM			
BILIRUBIN, TOTAL	0.34	Upto 1.2	mg/dL
METHOD : COLORIMETRIC DIAZO			
BILIRUBIN, DIRECT	0.16	< 0.30	mg/dL
BILIRUBIN, INDIRECT	0.18	0.1 - 1.0	mg/dL
TOTAL PROTEIN	6.5	6.0 - 8.0	g/dL
METHOD : COLORIMETRIC			
ALBUMIN	4.1	3.97 - 4.94	g/dL
METHOD : COLORIMETRIC			
GLOBULIN	2.4	2.0 - 3.5	g/dL
ALBUMIN/GLOBULIN RATIO	1.7	1.0 - 2.1	RATIO
ASPARTATE AMINOTRANSFERASE(AST/SGOT)	16	< OR = 35	U/L
METHOD : UV ABSORBANCE			
ALANINE AMINOTRANSFERASE (ALT/SGPT)	16	< OR = 35	U/L
METHOD : UV ABSORBANCE			

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ALKALINE PHOSPHATASE	84	35 - 104	U/L
METHOD : COLORIMETRIC			
GAMMA GLUTAMYL TRANSFERASE (GGT)	18	0 - 40	U/L
METHOD : ENZYMATIC, COLORIMETRIC			
LACTATE DEHYDROGENASE	158	125 - 220	U/L
METHOD : UV ABSORBANCE			
BLOOD UREA NITROGEN (BUN), SERUM			
BLOOD UREA NITROGEN	13	6 - 20	mg/dL
METHOD : ENZYMATIC ASSAY			
CREATININE, SERUM			
CREATININE	0.66	0.5 - 0.9	mg/dL
METHOD : COLORIMETRIC			
BUN/CREAT RATIO			
BUN/CREAT RATIO	**19.70 High**	8.0 - 15.0	
URIC ACID, SERUM			
URIC ACID	4.4	2.4 - 5.7	mg/dL
METHOD : ENZYMATIC COLORIMETRIC ASSAY			
TOTAL PROTEIN, SERUM			
TOTAL PROTEIN	6.5	6.0 - 8.0	g/dL
METHOD : COLORIMETRIC			
ALBUMIN, SERUM			
ALBUMIN	4.1	3.97 - 4.94	g/dL
METHOD : COLORIMETRIC			
GLOBULIN			
GLOBULIN	2.4	2.0 - 3.5	g/dL
ELECTROLYTES (NA/K/CL), SERUM			
SODIUM, SERUM	141	136 - 145	mmol/L
POTASSIUM, SERUM	4.55	3.5 - 5.1	mmol/L
CHLORIDE, SERUM	106	98 - 107	mmol/L

Interpretation(s)

Sodium	Potassium	Chloride

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Patient Ref. No. 775000002833063

PATIENT NAME : POORNIMA PUNDLIK SAWANT		REF. DOCTOR : SELF
CODE/NAME & ADDRESS : C000138394 ACROFEMI HEALTHCARE LTD (MEDIWHEEL) F-703, F-703, LADO SARAI, MEHRAULISOUTH WEST DELHI NEW DELHI 110030 8800465156	ACCESSION NO : **0181WD000389** PATIENT ID : POORF010572181 CLIENT PATIENT ID: ABHA NO :	AGE/SEX : 50 Years Female DRAWN : RECEIVED : 07/04/2023 09:39:53 REPORTED : 12/04/2023 10:01:17

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Decreased In: CCF, cirrhosis, vomiting, diarrhea, excessive sweating, salt-losing nephropathy, adrenal insufficiency, nephrotic syndrome, water intoxication, SIADH. Drugs: thiazides, diuretics, ACE inhibitors, chlorpropamide, carbamazepine, anti depressants (SSRI), antipsychotics.	**Decreased In:** Low potassium intake, prolonged vomiting or diarrhea, RTA types I and II, hyperaldosteronism, Cushing's syndrome, osmotic diuresis (e.g., hyperglycemia), alkalosis, familial periodic paralysis, trauma (transient). Drugs: Adrenergic agents, diuretics.	**Decreased In:** Vomiting, diarrhea, renal failure combined with salt deprivation, over-treatment with diuretics, chronic respiratory acidosis, diabetic ketoacidosis, excessive sweating, SIADH, salt-losing nephropathy, porphyria, expansion of extracellular fluid volume, adrenalinsufficiency, hyperaldosteronism, metabolic alkalosis. Drugs: chronic laxative, corticosteroids, diuretics.
Increased in: Dehydration (excessivesweating, severe vomiting or diarrhea), diabetes mellitus, diabetesinsipidus, hyperaldosteronism, inadequate water intake. Drugs: steroids, licorice, oral contraceptives.	**Increased in:** Massive hemolysis, severe tissue damage, rhabdomyolysis, acidosis, dehydration, renal failure, Addison' s disease, RTA type IV, hyperkalemic familial periodic paralysis. Drugs: potassium salts, potassium- sparing diuretics, NSAIDs, beta-blockers, ACE inhibitors, high-dose trimethoprim-sulfamethoxazole.	**Increased in:** Renal failure, nephrotic syndrome, RTA, dehydration, overtreatment with saline, hyperparathyroidism, diabetes insipidus, metabolic acidosis from diarrhea (Loss of HCO3-), respiratory alkalosis, hyperadrenocorticism. Drugs: acetazolamide, androgens, hydrochlorothiazide, salicylates.
Interferences: Severe lipemia or hyperproteinemi, if sodium analysis involves a dilution step can cause spurious results. The serum sodium falls about 1.6 mEq/L for each 100 mg/dL increase in blood glucose.	**Interferences:** Hemolysis of sample, delayed separation of serum, prolonged fist clenching during blood drawing, and prolonged tourniquet placement. Very high WBC/PLT counts may cause spurious. Plasma potassium levels are normal.	**Interferences:** Test is helpful in assessing normal and increased anion gap metabolic acidosis and in distinguishing hypercalcemia due to hyperparathyroidism (high serum chloride) from that due to malignancy (Normal serum chloride)

Interpretation(s)
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 :
1. 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.
2. Vitamin C & E are reported to falsely lower test results.(possibly by inhibiting glycation of hemoglobin.
3. 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.
4. 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.

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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-
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, Pagets disease,Rickets,Sarcoidosis etc. Lower-than-normal ALP levels seen in Hypophosphatasia,Malnutrition,Protein deficiency,Wilsons 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.
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,Waldenstroms 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 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, Muscuophy
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-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,Waldenstroms 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.

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CLINICAL PATH - URINALYSIS

MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40FEMALE

PHYSICAL EXAMINATION, URINE			
COLOR	PALE YELLOW		
APPEARANCE	CLEAR		
CHEMICAL EXAMINATION, URINE			
PH	5.0	5.00 - 7.50	
SPECIFIC GRAVITY	1.025	1.010 - 1.030	
METHOD : URINE ROUTINE & MICROSCOPY EXAMINATION BY INTEGRATED AUTOMATED SYSTEM			
PROTEIN	**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	
MICROSCOPIC EXAMINATION, URINE			
RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
PUS CELL (WBC'S)	3-5	0-5	/HPF
EPITHELIAL CELLS	3-5	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			
REMARKS	PRESENCE OF URINARY PROTEINS RECHECKED BY MANUAL METHOD.		

Interpretation(s)

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CYTOLOGY

MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40FEMALE

PAPANICOLAOU SMEAR

TEST METHOD	CONVENTIONAL GYNEC CYTOLOGY	
METHOD : MICROSCOPIC EXAMINATION		
SPECIMEN TYPE	P-507/23	
	TWO UNSTAINED CERVICAL SMEARS RECEIVED	
METHOD : MICROSCOPIC EXAMINATION		
REPORTING SYSTEM	2014 BETHESDA SYSTEM FOR REPORTING CERVICAL CYTOLOGY	
SPECIMEN ADEQUACY	SATISFACTORY	
METHOD : PAP STAIN & MICROSCOPIC EXAMINATION		
MICROSCOPY	THE SMEARS SHOW MAINLY SUPERFICIAL SQUAMOUS CELLS, FEW INTERMEDIATE SQUAMOUS CELLS, FEW SQUAMOUS METAPLASTIC CELLS, MANY PARABASAL CELLS AND MANY CLUSTERS OF ENDOCERVICAL CELLS IN THE BACKGROUND OF FEW POLYMORPHS & RBC"S.	
METHOD : PAP STAIN		
INTERPRETATION / RESULT	NEGATIVE FOR INTRAEPITHELIAL LESION OR MALIGNANCY	
METHOD : PAP STAIN & MICROSCOPIC EXAMINATION		
ENDOMETRIAL CELLS (IN A WOMAN >/= 45 YRS)	ABSENT	
METHOD : PAP STAIN & 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.

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CLINICAL PATH - STOOL ANALYSIS

MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40FEMALE

MICROSCOPIC EXAMINATION,STOOL

REMARK	SAMPLE NOT RECEIVED

Interpretation(s)

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SPECIALISED CHEMISTRY - HORMONE

MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40FEMALE

THYROID PANEL, SERUM

T3	86.0	Non-Pregnant Women 80.0 - 200.0 Pregnant Women 1st Trimester:105.0 - 230.0 2nd Trimester:129.0 - 262.0 3rd Trimester:135.0 - 262.0	ng/dL
METHOD : ELECTROCHEMILUMINESCENCE			
T4	7.12	Non-Pregnant Women 5.10 - 14.10 Pregnant Women 1st Trimester: 7.33 - 14.80 2nd Trimester: 7.93 - 16.10 3rd Trimester: 6.95 - 15.70	µg/dL
METHOD : ELECTROCHEMILUMINESCENCE			
TSH (ULTRASENSITIVE)	3.980	Non Pregnant Women 0.27 - 4.20 Pregnant Women 1st Trimester: 0.33 - 4.59 2nd Trimester: 0.35 - 4.10 3rd Trimester: 0.21 - 3.15	µIU/mL
METHOD : ELECTROCHEMILUMINESCENCE			

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.
owidctlparowidctlparBelow 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, FreeT4 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

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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.Guidlines of the American Thyroid association duriing pregnancy and Postpartum, 2011.
NOTE: It is advisable to detect Free T3,FreeT4 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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