



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, Fax :  
CIN - U74899PB1995PLC045956

**PATIENT NAME : PAROMITA SARKAR**PATIENT ID : **PAROF2611860**ACCESSION NO : **0065VJ000814** AGE : 35 Years SEX : Female

ABHA NO :

DRAWN :

RECEIVED : 08/10/2022 10:53

REPORTED : 11/10/2022 15:16

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 BELOW 40FEMALE****BLOOD COUNTS, EDTA WHOLE BLOOD**

HEMOGLOBIN	12.9	12.0 - 15.0	g/dL
METHOD : PHOTOMETRIC MEASUREMENT			
RED BLOOD CELL COUNT	4.33	3.8 - 4.8	mil/ $\mu$ L
METHOD : COULTER PRINCIPLE			
WHITE BLOOD CELL COUNT	6.80	4.0 - 10.0	thou/ $\mu$ L
METHOD : COULTER PRINCIPLE			
PLATELET COUNT	195	150 - 410	thou/ $\mu$ L
METHOD : ELECTRONIC IMPEDENCE & MICROSCOPY			

**RBC AND PLATELET INDICES**

HEMATOCRIT	38.6	36.0 - 46.0	%
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR VOL	89.1	83.0 - 101.0	fL
METHOD : DERIVED PARAMETER FROM RBC HISTOGRAM			
MEAN CORPUSCULAR HGB.	29.7	27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION	33.3	31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER			
MENTZER INDEX	20.6		
RED CELL DISTRIBUTION WIDTH	13.7	11.6 - 14.0	%
METHOD : DERIVED PARAMETER FROM RBC HISTOGRAM			
MEAN PLATELET VOLUME	10.7	6.8 - 10.9	fL
METHOD : DERIVED PARAMETER FROM PLATELET HISTOGRAM			

**WBC DIFFERENTIAL COUNT**

SEGMENTED NEUTROPHILS	61	40 - 80	%
METHOD : VCSN TECHNOLOGY/ MICROSCOPY			
ABSOLUTE NEUTROPHIL COUNT	4.15	2.0 - 7.0	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER			
LYMPHOCYTES	25	20 - 40	%
METHOD : VCSN TECHNOLOGY/ MICROSCOPY			
ABSOLUTE LYMPHOCYTE COUNT	1.70	1.0 - 3.0	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER			
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	2.4		
METHOD : CALCULATED			
EOSINOPHILS	3	1.0 - 6.0	%





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METHOD : VCSN TECHNOLOGY/ MICROSCOPY				
ABSOLUTE EOSINOPHIL COUNT		0.20	0.02 - 0.50	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
MONOCYTES		10	2.0 - 10.0	%
METHOD : VCSN TECHNOLOGY/ MICROSCOPY				
ABSOLUTE MONOCYTE COUNT		0.68	0.2 - 1.0	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
BASOPHILS		1	0 - 1	%
METHOD : VCSN TECHNOLOGY/ MICROSCOPY				
ABSOLUTE BASOPHIL COUNT		0.07	0.02 - 0.10	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
<b>MORPHOLOGY</b>				
RBC		PREDOMINANTLY NORMOCYTIC NORMOCHROMIC		
METHOD : MICROSCOPIC EXAMINATION				
WBC		NORMAL MORPHOLOGY		
METHOD : MICROSCOPIC EXAMINATION				
PLATELETS		ADEQUATE		
METHOD : ELECTRONIC IMPEDENCE & MICROSCOPY				
<b>ERYTHROCYTE SEDIMENTATION RATE (ESR), WHOLE BLOOD</b>				
SEDIMENTATION RATE (ESR)		11	0 - 20	mm at 1 hr
METHOD : AUTOMATED (PHOTOMETRICAL CAPILLARY STOPPED FLOW KINETIC ANALYSIS)				
<b>GLUCOSE FASTING, FLUORIDE PLASMA</b>				
GLUCOSE, FASTING, PLASMA		96	74 - 99	mg/dL
METHOD : SPECTROPHOTOMETRY HEXOKINASE				
<b>GLYCOSYLATED HEMOGLOBIN (HBA1C), EDTA WHOLE BLOOD</b>				
GLYCOSYLATED HEMOGLOBIN (HBA1C)		5.0	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 ADA Target: 7.0 Action suggested: > 8.0	%
METHOD : ION- EXCHANGE HPLC				
MEAN PLASMA GLUCOSE		96.8	< 116.0	mg/dL
METHOD : CALCULATED PARAMETER				
<b>GLUCOSE, POST-PRANDIAL, PLASMA</b>				
GLUCOSE, POST-PRANDIAL, PLASMA		98	70 - 139	mg/dL
METHOD : SPECTROPHOTOMETRY HEXOKINASE				
<b>LIPID PROFILE, SERUM</b>				





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CHOLESTEROL		141	Desirable cholesterol level < 200 Borderline high cholesterol 200 - 239 High cholesterol > / = 240	mg/dL
METHOD : SPECTROPHOTOMETRY, ENZYMATIC COLORIMETRIC - CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE				
TRIGLYCERIDES		75	Normal: < 150 Borderline high: 150 - 199 High: 200 - 499 Very High: > / = 500	mg/dL
METHOD : SPECTROPHOTOMETRY, ENZYMATIC ENDPOINT WITH GLYCEROL BLANK				
HDL CHOLESTEROL		45	Low HDL cholesterol < 40 High HDL cholesterol > / = 60	mg/dL
METHOD : SPECTROPHOTOMETRY, HOMOGENEOUS DIRECT ENZYMATIC COLORIMETRIC				
CHOLESTEROL LDL		81	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		96	Desirable : < 130 Above Desirable : 130 -159 Borderline High : 160 - 189 High : 190 - 219 Very high : > / = 220	mg/dL
METHOD : CALCULATED PARAMETER				
CHOL/HDL RATIO		<b>3.1</b>	<b>Low</b> 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		1.7	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		15.0	< or = 30.0	mg/dL
METHOD : CALCULATED PARAMETER				
<b>LIVER FUNCTION PROFILE, SERUM</b>				
BILIRUBIN, TOTAL		0.50	Upto 1.2	mg/dL
METHOD : SPECTROPHOTOMETRY, COLORIMETRIC -DIAZO METHOD				





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BILIRUBIN, DIRECT		0.23	High 0.0 - 0.2	mg/dL
METHOD : SPECTROPHOTOMETRY, JENDRASSIK & GROFF - DIAZOTIZATION				
BILIRUBIN, INDIRECT		0.27	0.1 - 1.0	mg/dL
METHOD : CALCULATED PARAMETER				
TOTAL PROTEIN		6.7	6.0 - 8.0	g/dL
METHOD : SPECTROPHOTOMETRY, COLORIMETRIC -BIURET, REAGENT BLANK, SERUM BLANK				
ALBUMIN		4.4	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		1.9	1.0 - 2.1	RATIO
METHOD : CALCULATED PARAMETER				
ASPARTATE AMINOTRANSFERASE (AST/SGOT)		64	High Upto 32	U/L
METHOD : SPECTROPHOTOMETRY, WITHOUT PYRIDOXAL PHOSPHATE ACTIVATION( P5P) - IFCC				
ALANINE AMINOTRANSFERASE (ALT/SGPT)		74	High Upto 33	U/L
METHOD : SPECTROPHOTOMETRY, WITHOUT PYRIDOXAL PHOSPHATE ACTIVATION( P5P) - IFCC				
ALKALINE PHOSPHATASE		90	35 - 104	U/L
METHOD : SPECTROPHOTOMETRY, PNPP, AMP BUFFER - IFCC				
GAMMA GLUTAMYL TRANSFERASE (GGT)		23	< 40	U/L
METHOD : SPECTROPHOTOMETRY, ENZYMATIC COLORIMETRIC - G-GLUTAMYL-CARBOXY-NITROANILIDE - IFCC				
LACTATE DEHYDROGENASE		219	< 223	U/L
METHOD : SPECTROPHOTOMETRY, LACTATE TO PYRUVATE - UV-IFCC				
<b>BLOOD UREA NITROGEN (BUN), SERUM</b>				
BLOOD UREA NITROGEN		5	Low 6 - 20	mg/dL
METHOD : SPECTROPHOTOMETRY, UREASE -COLORIMETRIC				
<b>CREATININE, SERUM</b>				
CREATININE		0.43	Low 0.60 - 1.10	mg/dL
METHOD : SPECTROPHOTOMETRY, JAFFE'S ALKALINE PICRATE KINETIC - RATE BLANKED - IFCC-IDMS STANDARDIZED				
<b>BUN/CREAT RATIO</b>				
BUN/CREAT RATIO		10.90	8 - 15	
METHOD : CALCULATED PARAMETER				
<b>URIC ACID, SERUM</b>				
URIC ACID		3.4	2.4 - 5.7	mg/dL
METHOD : SPECTROPHOTOMETRY, ENZYMATIC COLORIMETRIC- URICASE				
<b>TOTAL PROTEIN, SERUM</b>				
TOTAL PROTEIN		6.7	6.0 - 8.0	g/dL
METHOD : SPECTROPHOTOMETRY, COLORIMETRIC -BIURET, REAGENT BLANK, SERUM BLANK				
<b>ALBUMIN, SERUM</b>				





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ALBUMIN		4.4	3.97 - 4.94	g/dL
METHOD : SPECTROPHOTOMETRY, BROMOCRESOL GREEN(BCG) - DYE BINDING				
<b>GLOBULIN</b>				
GLOBULIN		2.3	2.0 - 3.5	g/dL
METHOD : CALCULATED PARAMETER				
<b>ELECTROLYTES (NA/K/CL), SERUM</b>				
SODIUM		140	136 - 145	mmol/L
METHOD : ISE INDIRECT				
POTASSIUM		4.30	3.5 - 5.1	mmol/L
METHOD : ISE INDIRECT				
CHLORIDE		105	98 - 106	mmol/L
METHOD : ISE INDIRECT				
<b>PHYSICAL EXAMINATION, URINE</b>				
COLOR		YELLOW		
APPEARANCE		<b>SLIGHTLY HAZY</b>		
SPECIFIC GRAVITY		1.015	1.010 - 1.030	
<b>CHEMICAL EXAMINATION, URINE</b>				
PH		6.0	5.00 - 7.50	
PROTEIN		NOT DETECTED	NOT DETECTED	
GLUCOSE		NOT DETECTED	NOT DETECTED	
KETONES		NOT DETECTED	NOT DETECTED	
BLOOD		NOT DETECTED	NOT DETECTED	
BILIRUBIN		NOT DETECTED	NOT DETECTED	
UROBILINOGEN		NOT DETECTED	NOT DETECTED	
NITRITE		NOT DETECTED	NOT DETECTED	
LEUKOCYTE ESTERASE		NOT DETECTED	NOT DETECTED	
<b>MICROSCOPIC EXAMINATION, URINE</b>				
PUS CELL (WBC'S)		1-2	0-5	/HPF
EPITHELIAL CELLS		<b>5-7</b>	0-5	/HPF
ERYTHROCYTES (RBC'S)		NOT DETECTED	NOT DETECTED	/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				





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## Comments

NOTE: KINDLY EXERT CAUTION DURING INTERPRETATION OF FINDINGS REPORTED IN URINALYSIS WHERE IN THE SAMPLE IS MORE THAN TWO HOURS OLD.

## THYROID PANEL, SERUM

T3	105.0	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 : COMPETITIVE ELECTROCHEMILUMINESCENCE IMMUNOASSAY

T4	5.67	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
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METHOD : COMPETITIVE ELECTROCHEMILUMINESCENCE IMMUNOASSAY

TSH 3RD GENERATION	1.290	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
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METHOD : SANDWICH ELECTROCHEMILUMINESCENCE IMMUNOASSAY

## STOOL: OVA &amp; PARASITE

REMARK TEST CANCELLED AS SPECIMEN NOT RECEIVED

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

ABO GROUP O

METHOD : HAEMAGGLUTINATION (AUTOMATED)

RH TYPE POSITIVE

METHOD : HAEMAGGLUTINATION (AUTOMATED)

## XRAY-CHEST

IMPRESSION NO ABNORMALITY DETECTED

## TMT OR ECHO

TMT OR ECHO PENDING

## ECG

ECG T ABNORMALITY IN ANTERIOR LEADS

## MEDICAL HISTORY

RELEVANT PRESENT HISTORY CVS 2 ND DOSE DONE





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RELEVANT PAST HISTORY

TYPHOIS 2014.  
DENGUE 2011.

RELEVANT PERSONAL HISTORY

NOT SIGNIFICANT

MENSTRUAL HISTORY (FOR FEMALES)

REGULAR

LMP (FOR FEMALES)

20.09.2022

OBSTETRIC HISTORY (FOR FEMALES)

NOT SIGNIFICANT

RELEVANT FAMILY HISTORY

HYPERTENSION  
HEART DISEASE

HISTORY OF MEDICATIONS

NOT SIGNIFICANT

## ANTHROPOMETRIC DATA &amp; BMI

HEIGHT IN METERS

1.64

mts

WEIGHT IN KGS.

60

Kgs

BMI

22

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

HEALTHY

BUILT / SKELETAL FRAMEWORK

AVERAGE

FACIAL APPEARANCE

NORMAL

SKIN

NORMAL

UPPER LIMB

NORMAL

LOWER LIMB

NORMAL

NECK

NORMAL

NECK LYMPHATICS / SALIVARY GLANDS

NOT ENLARGED OR TENDER

THYROID GLAND

NOT ENLARGED

CAROTID PULSATION

NORMAL

TEMPERATURE

NORMAL

PULSE

70/MIN, REGULAR, ALL PERIPHERAL PULSES WELL FELT, NO CAROTID BRUIT

RESPIRATORY RATE

NORMAL

## CARDIOVASCULAR SYSTEM

BP

105/72 MM HG  
(SUPINE)

mm/Hg

PERICARDIUM

NORMAL



Scan to View Details



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APEX BEAT	NORMAL
HEART SOUNDS	S1, S2 HEARD NORMALLY
MURMURS	ABSENT
<b>RESPIRATORY SYSTEM</b>	
SIZE AND SHAPE OF CHEST	NORMAL
MOVEMENTS OF CHEST	SYMMETRICAL
BREATH SOUNDS INTENSITY	NORMAL
BREATH SOUNDS QUALITY	VESICULAR (NORMAL)
ADDED SOUNDS	ABSENT
<b>PER ABDOMEN</b>	
APPEARANCE	NORMAL
VENOUS PROMINENCE	ABSENT
LIVER	NOT PALPABLE
SPLEEN	NOT PALPABLE
HERNIA	ABSENT
<b>CENTRAL NERVOUS SYSTEM</b>	
HIGHER FUNCTIONS	NORMAL
CRANIAL NERVES	NORMAL
CEREBELLAR FUNCTIONS	NORMAL
SENSORY SYSTEM	NORMAL
MOTOR SYSTEM	NORMAL
REFLEXES	NORMAL
<b>MUSCULOSKELETAL SYSTEM</b>	
SPINE	NORMAL
JOINTS	NORMAL
<b>BASIC EYE EXAMINATION</b>	
CONJUNCTIVA	NORMAL
EYELIDS	NORMAL
EYE MOVEMENTS	NORMAL
CORNEA	NORMAL
DISTANT VISION RIGHT EYE WITHOUT GLASSES	REDUCE VISUAL ACUITY(6/9)
DISTANT VISION LEFT EYE WITHOUT GLASSES	WITHIN NORMAL LIMIT(6/6)
NEAR VISION RIGHT EYE WITHOUT GLASSES	WITHIN NORMAL LIMIT(N/6)
NEAR VISION LEFT EYE WITHOUT GLASSES	WITHIN NORMAL LIMIT(N/6)







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COLOUR VISION

NORMAL(17/17)

## BASIC ENT EXAMINATION

EXTERNAL EAR CANAL

NO ABNORMALITY DETECTED

TYMPANIC MEMBRANE

NO HISTORY OF TYMPANIC MEMBRANE PERFORATION

NOSE

NO HISTORY OF NASAL DISEASE

SINUSES

NO HISTORY OF SINUSITIS

THROAT

NO HISTORY OF THROAT INFECTION

TONSILS

NO HISTORY OF TONSILS

## SUMMARY

RELEVANT HISTORY

NOT SIGNIFICANT

RELEVANT GP EXAMINATION FINDINGS

NOT SIGNIFICANT

RELEVANT LAB INVESTIGATIONS

URINE EPITHELIAL CELLS(5-7).

RAISED SGPT(74).

RAISED SGOT(64).

RAISED DIRECT BILIRUBIN(0.23).

LOW BLOOD UREA NITROGEN(5).

LOW CREATININE(0.43)

RELEVANT NON PATHOLOGY DIAGNOSTICS

ECG : T ABNORMALITY IN ANTERIOR LEADS

REMARKS / RECOMMENDATIONS

REGULAR PHYSICAL EXERCISES / LOW CALORIC DIET  
REDUCE FATTY AND PROCESSED FOOD IN DIET.

## 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,



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CLIENT CODE : C000138379

## CLIENT'S NAME AND ADDRESS :

ACROFEMI HEALTHCARE LTD ( MEDIWHEEL )  
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MUMBAI, 400093  
MAHARASHTRA, INDIA  
Tel : 09152729959/9111591115, Fax :  
CIN - U74899PB1995PLC045956

PATIENT NAME : PAROMITA SARKAR

PATIENT ID : PAROF2611860

ACCESSION NO : 0065VJ000814 AGE : 35 Years SEX : Female ABHA NO :

DRAWN : RECEIVED : 08/10/2022 10:53 REPORTED : 11/10/2022 15:16

REFERRING DOCTOR : SELF

CLIENT PATIENT ID :

Test Report Status	Final	Results	Biological Reference Interval	Units
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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,(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.

## GLUCOSE FASTING, FLUORIDE PLASMA-TEST DESCRIPTION

Normally, the glucose concentration in extracellular fluid is closely regulated so that a source of energy is readily available to tissues and so that no glucose is excreted in the urine.

**Increased in**

Diabetes mellitus, Cushing's syndrome (10 - 15%), chronic pancreatitis (30%). Drugs:corticosteroids, phenytoin, estrogen, thiazides.

**Decreased in**

Pancreatic islet cell disease with increased insulin, insulinoma, adrenocortical insufficiency, hypopituitarism, diffuse liver disease, malignancy (adrenocortical, stomach, fibrosarcoma), infant of a diabetic mother, enzyme deficiency diseases(e.g., galactosemia), Drugs- insulin, ethanol, propranolol, sulfonylureas, tolbutamide, and other oral hypoglycemic agents.

## NOTE:

Hypoglycemia is defined as a glucose of &lt; 50 mg/dL in men and &lt; 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.

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.)

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, 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





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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

**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.

**ABO GROUP & RH TYPE, EDTA WHOLE BLOOD-**

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

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

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

**MEDICAL**

**HISTORY-**

THIS REPORT CARRIES THE SIGNATURE OF OUR LABORATORY DIRECTOR. THIS IS AN INVOLABLE FEATURE OF OUR LAB MANAGEMENT SOFTWARE. HOWEVER, ALL EXAMINATIONS AND INVESTIGATIONS HAVE BEEN CONDUCTED BY OUR PANEL OF DOCTORS.

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**MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE****ULTRASOUND ABDOMEN****ULTRASOUND ABDOMEN**

NO ABNORMALITIES DETECTED

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

Dr. Rajesh Nayak  
Consultant Radiologist

**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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