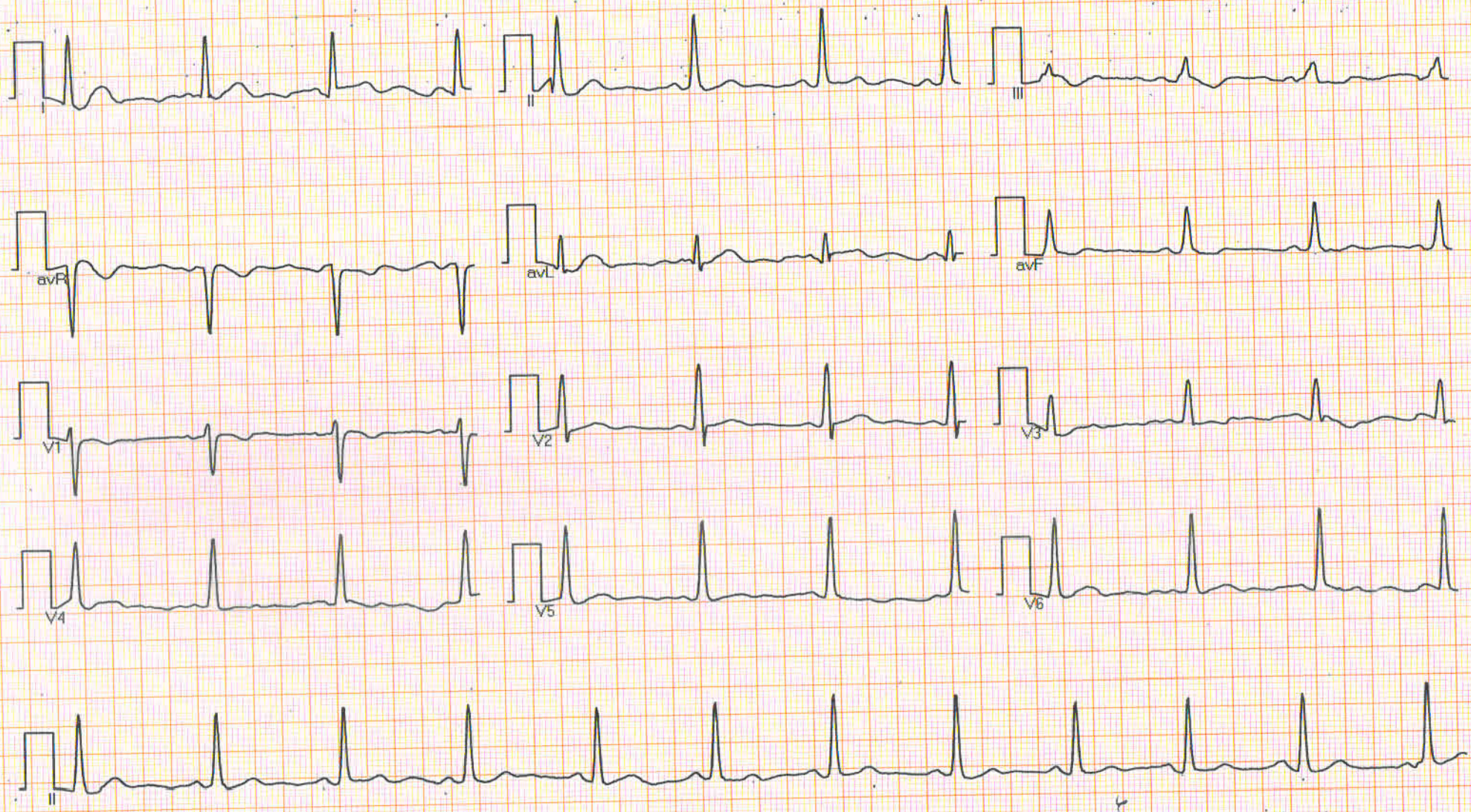
AAKRITI LABS PVT.LTD JAIPUR

ECG

19252 / MRS. PRIYANKA MEENA / 31 Yrs / F/ Non Smoker

Heart Rate : 69 bpm / Tested On : 03-Jun-22 11:05:53 / HF 0.05 Hz - LF 100 Hz / Notch 50 Hz / Sn 1.00 Cm/mV / Sw 25 mm/s

/ Refd By.: MEDIWHEEL



Vent Rate : 69 bpm
PR Interval : 156 ms
QRS Duration: 90 ms
QT/QTc Int : 386/400 ms
P-QRS-T axis: 23.00• 45.00• 5.00•

Allengers ECG (Pisces)(PIS215190517)

Normal Sinus Rhythm. Significant S-T changes.

Dr. NITIZ GOYAL
M.B.B.S., M.D.
RMC - 023319

Reported By:DR. NITIZ GOYAL

wellness partner

Aakriti Labs

3 Mahatma Gandhi Marg, Gandhi Nagar Mod
Tonk Road, Jaipur (Raj.) Ph.: 0141-2710661
www.aakritilabs.com
CIN NO.: U85195RJ2004PTC019563

NAME	MRS PRIYANKA MEENA	AGE	31Y	SEX	FEMALE
REF BY	MEDIWHEEL	DATE	03/06/2022	REG NO	

ECHOCARDIOGRAM REPORT

WINDOW- POOR/ADEQUATE/GOODVALVE

MITRAL	NORMAL	TRICUSPID	NORMAL
AORTIC	NORMAL	PULMONARY	NORMAL

2D/M-MOD

IVSD mm	9.5	IVSS mm	13.9	AORTA mm	21.6
LVID mm	46.0	LVIS mm	29.1	LA mm	29.4
LVPWD mm	9.8	LVPWS mm	11.8	EF%	60%

CHAMBERS

LA	NORMAL	RA	NORMAL
LV	NORMAL	RV	NORMAL
PERICARDIUM	NORMAL		

DOPPLER STUDY MITRAL

PEAK VELOCITY m/s E/A	1.29/0.92	PEAK GRADIANT MmHg	
MEAN VELOCITY m/s		MEAN GRADIANT MmHg	
MVA cm2 (PLANITMETERY)		MVA cm2 (PHT)	
MR			

AORTIC

PEAK VELOCITY m/s	1.67	PEAK GRADIANT MmHg	
MEAN VELOCITY m/s		MEAN GRADIANT MmHg	
AR			

TRICUSPID

PEAK VELOCITY m/s	0.85	PEAK GRADIANT MmHg	
MEAN VELOCITY m/s		MEAN GRADIANT MmHg	
TR		PASP mmHg	

PULMONARY

PEAK VELOCITY m/s	1.48	PEAK GRADIANT MmHg	
MEAN VELOCITY m/s		MEAN GRADIANT MmHg	
PR		RVEDP mmHg	

IMPRESSION

- **NORMAL LV SYSTOLIC & DIASTOLIC FUNCTION**
- **NO RWMA LVEF 60%**
- **NORMAL RV FUNCTION**
- **NORMAL CHAMBER DIMENSIONS**
- **NORMAL VALVULAR ECHO**
- **INTACT IAS / IVS**
- **NO THROMBUS, NO VEGETATION, NORMAL PERICARDIUM.**
- **IVC NORMAL**

CONCLUSION : FAIR LV FUNCTION.

Cardiologist

wellness partner

Aakriti Labs

3 Mahatma Gandhi Marg, Gandhi Nagar Mod
Tonk Road, Jaipur (Raj.) Ph.: 0141-2710661
www.aakritilabs.com
CIN NO.: U85195RJ2004PTC019563

Name	: **Ms. PRIYANKA MEENA**	Registration No:	33241
Age/Gender:	31 Y/Female	Registered	: 03/Jun/2022 09:33AM
Patient ID	: 012206030021	Analysed	: 03/Jun/2022 12:18PM
BarcodeNo	: 10049024	Reported	: 03/Jun/2022 12:18PM
Referred By	: Self	Panel	: Medi Wheel (ArcoFemi Healthcare Ltd)

DIGITAL X-RAY CHEST PA VIEW

Soft tissue shadow and bony cages are normal.

Trachea is central.

Bilateral lung field and both CP angle are clear.

Domes of diaphragm are normally placed.

Transverse diameter of heart appears with normal limits.

IMPRESSION:- NO OBVIOUS ABNORMALITY DETECTED.

*** End Of Report ***

Dr. Neera Mehta
M.B.B.S.,D.M.R.D.
RMCNO.005807/14853

wellness partner

Aakriti Labs

3 Mahatma Gandhi Marg, Gandhi Nagar Mod
Tonk Road, Jaipur (Raj.) Ph.: 0141-2710661
www.aakritilabs.com
CIN NO.: U85195RJ2004PTC019563

Name	: **Ms. PRIYANKA MEENA**	Registration No:	33241
Age/Gender:	31 Y/Female	Registered	: 03/Jun/2022 09:33AM
Patient ID	: 012206030021	Analysed	: 03/Jun/2022 12:44PM
BarcodeNo	: 10049024	Reported	: 03/Jun/2022 12:45PM
Referred By	: Self	Panel	: Medi Wheel (ArcoFemi Healthcare Ltd)

USG: WHOLE ABDOMEN (Female)

LIVER : Is normal in size, shape and echogenecity.
The IHBR and hepatic radicals are not dilated.
No evidence of focal echopoor/echorich lesion seen.
Portal vein diameter and Common bile duct normal in size

GALL BLADDER : Is normal in size,shape and echotexture.Walls are smooth and regular with normal thickness. There is no evidence of cholelithiasis.

PANCREAS: Is normal in size,shape and echotexture. Pancreatic duct is not dilated.

SPLEEN : Is normal in size,shape and echogenecity.Spleenic hilum is not dilated.

KIDNEYS : Right Kidney:-Size:110x40 mm, Left Kidney:-Size: 108x39 mm.
Bilateral Kidneys are normal in size, shape and echotexture,
corticomedullary differentiation is fair and ratio appears normal.
Pelvi calyceal system is normal.No evidence of hydronephrosis/ nephrolithiasis.

URINARY BLADDER : **Bladder is partially filled as patient is not willing to hold the urine.**
Pre void Volume: 85 ml

UTERUS : Uterus & ovaries could not be seen due to partially filled urinary ladder.

SPECIFIC : No evidence of retroperitoneal mass or free fluid seen in peritoneal cavity.
: NO evidence of lymphadenopathy or mass lesion in retroperitoneum.
: Visualized bowel loop appear normal.Great vessels appear normal.

IMPRESSION: Ultra Sonography findings are suggestive of: **NORMAL STUDY.**

*** End Of Report ***

Dr. Neera Mehta
M.B.B.S.,D.M.R.D.
RMCNO.005807/14853

wellness partner

Aakriti Labs

3 Mahatma Gandhi Marg, Gandhi Nagar Mod
Tonk Road, Jaipur (Raj.) Ph.: 0141-2710661
www.aakritilabs.com
CIN NO.: U85195RJ2004PTC019563

Name	: **Ms. PRIYANKA MEENA**	Registration No:	33241
Age/Gender:	31 Y/Female	Registered	: 03/Jun/2022 09:33AM
Patient ID	: 012206030021	Analysed	: 15/Jun/2022 04:28PM
BarcodeNo	: 10049024	Reported	: 15/Jun/2022 04:29PM
Referred By :	Self	Panel	: Medi Wheel (ArcoFemi Healthcare Ltd)

COMPLETE BLOOD COUNT, EDTA WHOLE BLOOD

RED BLOOD CELL COUNT METHOD : ELECTRONIC IMPEDANCE	4.09	3.80-4.80	mil/µL
HEMOGLOBIN,EDTA METHOD : CYANIDE FREE DETERMINATION	**11.0 L**	12.0-15.0	g/dL
HEMATOCRIT,EDTA METHOD : CALCULATED PARAMETER	**33.9 L**	36-46	%
MEAN CORPUSCULAR VOL METHOD : CALCULATED PARAMETER	83	83-101	fL
MEAN CORPUSCULAR HGB. METHOD : CALCULATED PARAMETER	**26.9 L**	27-32	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION METHOD : CALCULATED PARAMETER	32.4	31.5-34.5	g/dL
RED CELL DISTRIBUTION WIDTH METHOD : CALCULATED PARAMETER	**14.4 H**	11.6 - 14.0	%
PLATELET COUNT,EDTA METHOD : ELECTRONIC IMPEDANCE	164	150-410	thou/µL
MEAN PLATELET VOLUME METHOD : CALCULATED PARAMETER	10.5	6.8-10.9	fL
WHITE BLOOD CELL COUNT METHOD : ELECTRONIC IMPEDANCE	6.6	4-10	thou/µL
DIFFERENTIAL LEUCOCYTE COUNT			
SEGMENTED NEUTROPHILS METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY	62	40 - 80	%
ABSOLUTE NEUTROPHIL COUNT METHOD : CALCULATED PARAMETER	4.09	2-7	thou/µL
EOSINOPHIL METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY	3	1-6	%
ABSOLUTE EOSINOPHIL COUNT METHOD : CALCULATED PARAMETER	0.20	0.05-0.50	thou/µL
LYMPHOCYTES METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY	34	20-40	%
ABSOLUTE LYMPHOCYTE COUNT METHOD : CALCULATED PARAMETER	2.24	1-3	thou/µL
MONOCYTES	**1 L**	2-10	%

Dr. Akansha Jain
Consultant Pathologist

Name	: **Ms. PRIYANKA MEENA**	Registration No:	33241
Age/Gender:	31 Y/Female	Registered	: 03/Jun/2022 09:33AM
Patient ID	: 012206030021	Analysed	: 15/Jun/2022 04:28PM
BarcodeNo	: 10049024	Reported	: 15/Jun/2022 04:29PM
Referred By	: Self	Panel	: Medi Wheel (ArcoFemi Healthcare Ltd)

METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY

ABSOLUTE MONOCYTE COUNT	**0.07 L**	0.20-1.00	thou/µL
METHOD : CALCULATED PARAMETER			
BASOPHIL	**0 L**	1 - 2	%
METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY			
BAND (STAB) CELLS	0.00	0-5	%
METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY			

Interpretation(s)
BLOOD COUNTS
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
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.

ERYTHRO SEDIMENTATION RATE(ESR), BLOOD

SEDIMENTATION RATE (ESR)	19.0	0-20	mm at 1 hr
METHOD : AUTOMATED (PHOTOMETRICAL CAPILLARY STOPPED FLOW KINETIC ANALYSIS)			

Interpretation

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"

Dr. Akansha Jain
Consultant Pathologist

Aakriti Labs

wellness partner

3 Mahatma Gandhi Marg, Gandhi Nagar Mod
Tonk Road, Jaipur (Raj.) Ph.: 0141-2710661
www.aakritilabs.com
CIN NO.: U85195RJ2004PTC019563

Name	: **Ms. PRIYANKA MEENA**	Registration No:	33241
Age/Gender:	31 Y/Female	Registered	: 03/Jun/2022 09:33AM
Patient ID	: 012206030021	Analysed	: 15/Jun/2022 04:28PM
BarcodeNo	: 10049024	Reported	: 15/Jun/2022 04:29PM
Referred By :	Self	Panel	: Medi Wheel (ArcoFemi Healthcare Ltd)

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP METHOD : TUBE AGGLUTINATION	TYPE O		
RH TYPE METHOD : TUBE AGGLUTINATION	POSITIVE		

Interpretation

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.

LIVER FUNCTION TEST(LFT),SERUM

TOTAL BILIRUBIN METHOD : DIAZO WITH SULPHANILIC ACID	0.61	0.00-1.00	mg/dL
BILIRUBIN, DIRECT METHOD : DIAZO WITH SULPHANILIC ACID	**0.29 H**	0.0-0.25	mg/dL
BILIRUBIN, INDIRECT METHOD : CALCULATED PARAMETER	0.32	0.0 - 1.00	mg/dL
ASPARTATE AMINOTRANSFERASE (AST/SGOT) METHOD : TRIS BUFFER NO P5P IFCC / SFBC 37° C	**36 H**	0-31	U/L
ALANINE AMINOTRANSFERASE (SGPT) METHOD : TRIS BUFFER NO P5P IFCC / SFBC 37° C	**41 H**	0-31	U/L
ALKALINE PHOSPHATASE METHOD : AMP Optimised to IFCC 37° C	93	39-117	U/L
TOTAL PROTEIN METHOD : BIURET REACTION END POINT	8.0	6.4 - 8.3	g/dL
ALBUMIN,SERUM METHOD : Bromocresol Green	4.7	3.5-5.0	gm/dL
GLOBULIN,SERUM METHOD : CALCULATED PARAMETER	3.30	2.0 - 4.1	g/dL
ALBUMIN/GLOBULIN RATIO METHOD : CALCULATED PARAMETER	1.42	1.0-2.1	Ratio
GAMMA GLUTAMYL TRANSFERASE (GGT) METHOD : GAMMA GLUTAMYL-3 CARBOXY-4 NITROANILIDE (IFCC) 37° C	12	7 - 32	U/L
LACTATE DEHYDROGENASE METHOD : P-> L GERMAN METHODS 37° C	360	230-460	U/L

Interpretation(s)

Dr. Akansha Jain
Consultant Pathologist

wellness partner

Aakriti Labs

3 Mahatma Gandhi Marg, Gandhi Nagar Mod
Tonk Road, Jaipur (Raj.) Ph.: 0141-2710661
www.aakritilabs.com
CIN NO.: U85195RJ2004PTC019563

Name	: Ms. PRIYANKA MEENA	Registration No:	33241
Age/Gender:	31 Y/Female	Registered	: 03/Jun/2022 09:33AM
Patient ID	: 012206030021	Analysed	: 15/Jun/2022 04:28PM
BarcodeNo	: 10049024	Reported	: 15/Jun/2022 04:29PM
Referred By :	Self	Panel	: Medi Wheel (ArcoFemi Healthcare Ltd)

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, 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

ELECTROLYTES (NA/K/CL), SERUM

SODIUM SERUM METHOD : ION SELECTIVE ELECTRODE TECHNOLOGY	142.4	137-145	mmol/L
POTASSIUM, SERUM METHOD : ION SELECTIVE ELECTRODE TECHNOLOGY	3.95	3.5-5.1	mmol/L
CHLORIDE, SERUM METHOD : ION SELECTIVE ELECTRODE TECHNOLOGY	106.7	98-107	mmol/L

Interpretation(s)

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.

CORONARY RISK PROFILE (LIPID PROFILE), SERUM

CHOLESTEROL METHOD : CHOLESTEROL OXIDASE	118	< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
TRIGLYCERIDE METHOD : LIPASE/GPO-PAP NO CORRECTION	67	< 150 Normal 150 - 199 Borderline High 200 - 499 High >/=500 Very High	mg/dL
HDL-CHOLESTEROL	31 L	< 40 Low	mg/dL

Dr. Akansha Jain
Consultant Pathologist

wellness partner

Aakriti Labs

3 Mahatma Gandhi Marg, Gandhi Nagar Mod
Tonk Road, Jaipur (Raj.) Ph.: 0141-2710661
www.aakritilabs.com
CIN NO.: U85195RJ2004PTC019563

Name	: **Ms. PRIYANKA MEENA**	Registration No:	33241
Age/Gender:	31 Y/Female	Registered	: 03/Jun/2022 09:33AM
Patient ID	: 012206030021	Analysed	: 15/Jun/2022 04:28PM
BarcodeNo	: 10049024	Reported	: 15/Jun/2022 04:29PM
Referred By	: Self	Panel	: Medi Wheel (ArcoFemi Healthcare Ltd)

METHOD : DIRECT CLEARANCE METHOD		>/=60 High	
DIRECT LDL CHOLESTEROL METHOD : DIRECT CLEARANCE METHOD	58	< 100 Optimal 100 - 129 Near or above optimal 130 - 159 Borderline High 160 - 189 High >/= 190 Very High	mg/dL
CHOL / HDL RATIO METHOD : CALCULATED PARAMETER	3.8	3.3 - 4.4 Low Risk 4.5 - 7.0 Average Risk 7.1 - 11.0 Moderate Risk > 11.0 High Risk	
LDL/HDL RATIO METHOD : CALCULATED PARAMETER	2	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
VERY LOW DENSITY LIPOPROTEIN METHOD : CALCULATED PARAMETER	13.4	< 30.0	mg/dL

Interpretation

CORONARY RISK PROFILE (LIPID PROFILE), SERUM.-

Serum cholesterol is a blood test that can provide valuable information for the risk of coronary artery disease This test can help determine your risk of the build up of plaques in your arteries that can lead to narrowed or blocked arteries throughout your body (atherosclerosis). High cholesterol levels usually don't cause any signs or symptoms, so a cholesterol test is an important tool. High cholesterol levels often are a significant risk factor for heart disease and important for diagnosis of hyperlipoproteinemia,atherosclerosis, hepatic and thyroid diseases.

Serum Triglyceride are a type of fat in the blood. When you eat, your body converts any calories it doesn't need into triglycerides, which are stored in fat cells. High triglyceride levels are associated with several factors, including being overweight, eating too many sweets or drinking too much alcohol, smoking, being sedentary, or having diabetes with elevated blood sugar levels. Analysis has proven useful in the diagnosis and treatment of patients with diabetes mellitus, nephrosis, liver obstruction, other diseases involving lipid metabolism, and various endocrine disorders. In conjunction with high density lipoprotein and total serum cholesterol, a triglyceride determination provides valuable information for the assessment of coronary heart disease risk.It is done in fasting state.

High-density lipoprotein (HDL) cholesterol. This is sometimes called the ""good"" cholesterol because it helps carry away LDL cholesterol, thus keeping arteries open and blood flowing more freely.HDL cholesterol is inversely related to the risk for cardiovascular disease. It increases following regular exercise, moderate alcohol consumption and with oral estrogen therapy. Decreased levels are associated with obesity, stress, cigarette smoking and diabetes mellitus.

SERUM LDL The small dense LDL test can be used to determine cardiovascular risk in individuals with metabolic syndrome or established/progressing coronary artery disease,individuals with triglyceride levels between 70 and 140 mg/dL, as well as individuals with a diet high in trans-fat or carbohydrates. Elevated sdLDL levels are associated with metabolic syndrome and an 'atherogenic lipoprotein profile', and are a strong, independent predictor of cardiovascular disease.Elevated levels of LDL arise from multiple sources. A major factor is sedentary lifestyle with a diet high in saturated fat. Insulin-resistance and pre-diabetes have also been implicated, as has genetic predisposition. Measurement of sdLDL allows the clinician to get a more comprehensive picture of lipid risk factors and tailor treatment accordingly. Reducing LDL levels will reduce the risk of CVD and MI.

Non HDL Cholesterol - Adult treatment panel ATP III suggested the addition of Non-HDL Cholesterol as an indicator of all atherogenic lipoproteins (mainly LDL and VLDL).NICE guidelines recommend Non-HDL Cholesterol measurement before initiating lipid lowering therapy. It has also been shown to be a better marker of risk in both primary and secondary prevention studies.

Recommendations:Results of Lipids should always be interpreted in conjunction with the patient's medical history, clinical presentation and other findings.

NON FASTING LIPID PROFILE includes Total Cholesterol, HDL Cholesterol and calculated non-HDL Cholesterol. It does not include triglycerides and may be best used in patients for whom fasting is difficult.

GLUCOSE FASTING, PLASMA

GLUCOSE, FASTING, PLASMA METHOD : GLUCOSE OXIDASE	94	70-99	mg/dL

Interpretation

GLUCOSE, FASTING, PLASMA
ADA 2012 guidelines for adults as follows:Pre-diabetics: 100 - 125 mg/dL
Diabetic: > or = 126 mg/dL
(Ref: Tietz 4th Edition & ADA 2012 Guidelines)

Dr. Akansha Jain
Consultant Pathologist

wellness partner

Aakriti Labs

3 Mahatma Gandhi Marg, Gandhi Nagar Mod
Tonk Road, Jaipur (Raj.) Ph.: 0141-2710661
www.aakritilabs.com
CIN NO.: U85195RJ2004PTC019563

Name	: **Ms. PRIYANKA MEENA**	Registration No:	33241
Age/Gender:	31 Y/Female	Registered	: 03/Jun/2022 09:33AM
Patient ID	: 012206030021	Analysed	: 15/Jun/2022 04:28PM
BarcodeNo	: 10049024	Reported	: 15/Jun/2022 04:29PM
Referred By	: Self	Panel	: Medi Wheel (ArcoFemi Healthcare Ltd)

GLUCOSE POST-PRANDIAL, PLASMA

GLUCOSE, POST-PRANDIAL, PLASMA	115	70-140	mg/dL

METHOD : GLUCOSE OXIDASE

Interpretation

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.

GLYCOSYLATED HEMOGLOBIN (HBA1C)

GLYCOSYLATED HEMOGLOBIN (HBA1C)	**5.8 H**	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 ADA Target: 7.0 Action suggested: > 8.0	%
METHOD : HIGH PERFORMANCE LIQUID CHROMATOGRAPHY (HPLC)			
MEAN PLASMA GLUCOSE	**119.8 H**	<116.0	mg/dL
METHOD : CALCULATED PARAMETER			

Interpretation(s)

GLYCOSYLATED HEMOGLOBIN, BLOOD
Glycation is nonenzymatic addition of sugar residue to amino groups of proteins. HbA1C is formed by the condensation of glucose with n-terminal valine residue of each beta chain of hb a to form an unstable schif base. It is the major fraction, constituting approximately 80% of HbA1.
Formation of glycated hemoglobin (GHb) is essentially irreversible and the concentration in the blood depends on both the lifespan of the red blood cells (RBC) (120 days) and the blood glucose concentration. The GHB concentration represents the integrated values for glucose aver the period of 6 to 8 weeks. GHb values are free of day to day glucose fluctuations and are unaffected by recent exercise or food ingestion. Concentration of plasma glucose concentration in GHb depends on the time interval, with more recent values providing a larger contribution than earlier values.
The interpretation of GHb depends on RBC having a normal life span. Patients with hemolytic disease or other conditions with shortened RBC survival exhibit a substantial reduction of GHb. High GHb have been reported in iron deficiency anemia . 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 inpatients with diabetes mellitus. The absolute risk of retinopathy and nephropathy are directly proportional to the mean of HbA1C.
"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."

Dr. Akansha Jain
Consultant Pathologist

Name	: Ms. PRIYANKA MEENA	Registration No:	33241
Age/Gender:	31 Y/Female	Registered	: 03/Jun/2022 09:33AM
Patient ID	: 012206030021	Analysed	: 15/Jun/2022 04:28PM
BarcodeNo	: 10049024	Reported	: 15/Jun/2022 04:29PM
Referred By	: Self	Panel	: Medi Wheel (ArcoFemi Healthcare Ltd)

BLOOD UREA NITROGEN SERUM

BLOOD UREA NITROGEN	13	5-18	mg/dL

METHOD : UREASE KINETIC

Interpretation

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

CREATININE,SERUM	0.97	0.60-1.20	mg/dl

METHOD : ALKALINE PICRATE NO DEPROTEINIZATION

Interpretation
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

Dr. Akansha Jain
Consultant Pathologist

wellness partner

Aakriti Labs

3 Mahatma Gandhi Marg, Gandhi Nagar Mod
Tonk Road, Jaipur (Raj.) Ph.: 0141-2710661
www.aakritilabs.com
CIN NO.: U85195RJ2004PTC019563

Name	: **Ms. PRIYANKA MEENA**	Registration No:	33241
Age/Gender:	31 Y/Female	Registered	: 03/Jun/2022 09:33AM
Patient ID	: 012206030021	Analysed	: 15/Jun/2022 04:28PM
BarcodeNo	: 10049024	Reported	: 15/Jun/2022 04:29PM
Referred By :	Self	Panel	: Medi Wheel (ArcoFemi Healthcare Ltd)

URIC ACID SERUM

URIC ACID SERUM	**7.1 H**	2.4 - 5.7	mg/dL

METHOD : URICASE PEROXIDASE WITH ASCORBATE OXIDASE @546 nm

Interpretation

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
- Antioxidant rich foods

Dr. Akansha Jain
Consultant Pathologist

wellness partner

Aakriti Labs

3 Mahatma Gandhi Marg, Gandhi Nagar Mod
Tonk Road, Jaipur (Raj.) Ph.: 0141-2710661
www.aakritilabs.com
CIN NO.: U85195RJ2004PTC019563

Name	: **Ms. PRIYANKA MEENA**	Registration No:	33241
Age/Gender:	31 Y/Female	Registered	: 03/Jun/2022 09:33AM
Patient ID	: 012206030021	Analysed	: 15/Jun/2022 04:28PM
BarcodeNo	: 10049024	Reported	: 15/Jun/2022 04:29PM
Referred By	: Self	Panel	: Medi Wheel (ArcoFemi Healthcare Ltd)

T3T4TSH (THYROID PANEL)

TRIIODOTHYRONINE T3	100.3	60-181	ng/dL
METHOD : CHEMILUMINESCENCE, COMPETETIVE IMMUNOASSAY			
THYROXINE T4	9.00	4.50-10.90	µg/dl
METHOD : CHEMILUMINESCENCE, COMPETETIVE IMMUNOASSAY			
TSH 3RD GENERATION	1.312	0.55-4.78	µlU/mL
METHOD : CHEMILUMINESCENCE, COMPETETIVE IMMUNOASSAY			

Interpretation(s)

THYROID PANEL BY CHEMILUMINESCENCE, 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.
2. Gowenlock A.H. Varley's Practical Clinical Biochemistry, 6th Edition.
3. Behrman R.E. Kliegman R.M., Jenson H. B. Nelson Text Book of Pediatrics, 17th Edition

URINE ROUTINE

COLOR	PALE YELLOW	
METHOD : GROSS EXAMINATION		
APPEARANCE	CLEAR	
METHOD : GROSS EXAMINATION		
PH	5.5	4.7 - 7.5
METHOD : DOUBLE INDICATOR PRINCIPLE		
SPECIFIC GRAVITY	>=1.030	1.003 - 1.035
METHOD : IONIC CONCENTRATION METHOD		

Dr. Akansha Jain
Consultant Pathologist

Aakriti Labs

wellness partner

3 Mahatma Gandhi Marg, Gandhi Nagar Mod
Tonk Road, Jaipur (Raj.) Ph.: 0141-2710661
www.aakritilabs.com
CIN NO.: U85195RJ2004PTC019563

Name	: **Ms. PRIYANKA MEENA**	Registration No:	33241
Age/Gender:	31 Y/Female	Registered	: 03/Jun/2022 09:33AM
Patient ID	: 012206030021	Analysed	: 15/Jun/2022 04:28PM
BarcodeNo	: 10049024	Reported	: 15/Jun/2022 04:29PM
Referred By	: Self	Panel	: Medi Wheel (ArcoFemi Healthcare Ltd)

GLUCOSE	NOT DETECTED	NOT DETECTED	
METHOD : GLUCOSE OXIDASE PEROXIDASE / BENEDICTS			
PROTEIN	NOT DETECTED	NOT DETECTED	
METHOD : PROTEIN ERROR OF INDICATORS WITH REFLECTANCE			
KETONES	NOT DETECTED	NOT DETECTED	
METHOD : SODIUM NITROPRUSSIDE REACTION			
BLOOD	NOT DETECTED	NOT DETECTED	
METHOD : PEROCIDASE ANTI PEROXIDASE			
BILIRUBIN	NOT DETECTED	NOT DETECTED	
METHOD : DIPSTICK			
UROBILINOGEN	NORMAL	NORMAL	
METHOD : EHRLICH REACTION REFLECTANCE			
NITRITE	NOT DETECTED	NOT DETECTED	
METHOD : NITRATE TO NITRITE CONVERSION METHOD			
WBC	3-5	0-5	/HPF
METHOD : DIPSTICK, MICROSCOPY			
EPITHELIAL CELLS	2-3	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION			
RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
METHOD : MICROSCOPIC EXAMINATION			
CASTS	NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION			
CRYSTALS	NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION			
BACTERIA	NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION			

Interpretation(s)
URINALYSIS-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

11

Dr. Akansha Jain
Consultant Pathologist

wellness partner

Aakriti Labs

3 Mahatma Gandhi Marg, Gandhi Nagar Mod
Tonk Road, Jaipur (Raj.) Ph.: 0141-2710661
www.aakritilabs.com
CIN NO.: U85195RJ2004PTC019563

Name	: **Ms. PRIYANKA MEENA**	Registration No:	33241
Age/Gender:	31 Y/Female	Registered	: 03/Jun/2022 09:33AM
Patient ID	: 012206030021	Analysed	: 15/Jun/2022 04:28PM
BarcodeNo	: 10049024	Reported	: 15/Jun/2022 04:29PM
Referred By	: Self	Panel	: Medi Wheel (ArcoFemi Healthcare Ltd)

Glucose: Uncontrolled diabetes mellitus can lead to presence of glucose in urine. Other causes include pregnancy, hormonal disturbances, liver disease and certainmedications.
Ketones: Uncontrolled diabetes mellitus can lead to presence of ketones in urine. Ketones can also be seen in starvation, frequent vomiting, pregnancy and strenuousexercise.
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 inbladder 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.

*** End Of Report ***

11

Dr. Akansha Jain
Consultant Pathologist