



Patient Ref. No. 775000001774041

CLIENT CODE : C000138394

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

SRL Ltd  
S.K. Tower, Hari Niwas, LBS Marg  
THANE, 400602  
MAHARASHTRA, INDIA  
Tel : 9111591115, Fax : CIN - U74899PB1995PLC045956  
Email : customercare.thane@srl.in

PATIENT NAME : ANIL NAMDEV SALUNKHE

PATIENT ID : ANILM221076181

ACCESSION NO : 0181VJ001042 AGE : 46 Years SEX : Male

ABHA NO :

DRAWN : RECEIVED : 22/10/2022 08:59:43

REPORTED : 27/10/2022 14:26:23

REFERRING DOCTOR : SELF

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Test Report Status	Final	Results	Biological Reference Interval	Units
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**MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE**

**BLOOD COUNTS, EDTA WHOLE BLOOD**

HEMOGLOBIN	15.8	13.0 - 17.0	g/dL
METHOD : SLS-HEMOGLOBIN DETECTION METHOD			
RED BLOOD CELL COUNT	5.16	4.5 - 5.5	mil/ $\mu$ L
METHOD : HYDRODYNAMIC FOCUSING BY DC DETECTION			
WHITE BLOOD CELL COUNT	7.62	4.0 - 10.0	thou/ $\mu$ L
METHOD : FLUORESCENCE FLOW CYTOMETRY			
PLATELET COUNT	180	150 - 410	thou/ $\mu$ L
METHOD : HYDRODYNAMIC FOCUSING BY DC DETECTION			

**RBC AND PLATELET INDICES**

HEMATOCRIT	46.7	40.0 - 50.0	%
METHOD : CUMULATIVE PULSE HEIGHT DETECTION METHOD			
MEAN CORPUSCULAR VOL	90.5	83.0 - 101.0	fL
METHOD : CALCULATED FROM RBC & HCT			
MEAN CORPUSCULAR HGB.	30.6	27.0 - 32.0	pg
METHOD : CALCULATED FROM THE RBC & HGB			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION	33.8	31.5 - 34.5	g/dL
METHOD : CALCULATED FROM THE HGB & HCT			
MENTZER INDEX	17.5		
RED CELL DISTRIBUTION WIDTH	13.3	11.6 - 14.0	%
METHOD : CALCULATED FROM RBC SIZE DISTRIBUTION CURVE			
MEAN PLATELET VOLUME	10.1	6.8 - 10.9	fL
METHOD : CALCULATED FROM PLATELET COUNT & PLATELET HEMATOCRIT			

**WBC DIFFERENTIAL COUNT - NLR**

NEUTROPHILS	65	40 - 80	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
ABSOLUTE NEUTROPHIL COUNT	4.92	2.0 - 7.0	thou/ $\mu$ L
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
LYMPHOCYTES	29	20 - 40	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
ABSOLUTE LYMPHOCYTE COUNT	2.19	1.0 - 3.0	thou/ $\mu$ L
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	2.3		
EOSINOPHILS	1	1 - 6	%





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METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING

ABSOLUTE EOSINOPHIL COUNT 0.08 0.02 - 0.50 thou/ $\mu$ L

METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING

MONOCYTES 5 2 - 10 %

METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING

ABSOLUTE MONOCYTE COUNT 0.40 0.2 - 1.0 thou/ $\mu$ L

METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING

DIFFERENTIAL COUNT PERFORMED ON: EDTA SMEAR

MORPHOLOGY

RBC NORMOCYTIC NORMOCHROMIC

WBC NORMAL MORPHOLOGY

METHOD : MICROSCOPIC EXAMINATION

PLATELETS ADEQUATE

ERYTHROCYTE SEDIMENTATION RATE (ESR), WHOLE BLOOD

E.S.R 21 High < 15 mm at 1 hr

GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

HBA1C 5.7 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) 116.9 High < 116.0 mg/dL

METHOD : CALCULATED PARAMETER

GLUCOSE FASTING, FLUORIDE PLASMA

FBS (FASTING BLOOD SUGAR) 118 High Normal 75 - 99 mg/dL  
Pre-diabetics: 100 - 125  
Diabetic: > or = 126

METHOD : ENZYMATIC REFERENCE METHOD WITH HEXOKINASE

GLUCOSE, POST-PRANDIAL, PLASMA

PPBS(POST PRANDIAL BLOOD SUGAR) 99 70 - 139 mg/dL

METHOD : ENZYMATIC REFERENCE METHOD WITH HEXOKINASE

CORONARY RISK PROFILE, SERUM





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CHOLESTEROL, TOTAL		184	Desirable cholesterol level < 200 Borderline high cholesterol 200 - 239 High cholesterol > / = 240	mg/dL
METHOD : ENZYMATIC COLORIMETRIC ASSAY				
TRIGLYCERIDES		169	High Normal: < 150 Borderline high: 150 - 199 High: 200 - 499 Very High: >/= 500	mg/dL
METHOD : ENZYMATIC COLORIMETRIC ASSAY				
HDL CHOLESTEROL		32	Low Low HDL Cholesterol <40 High HDL Cholesterol >/= 60	mg/dL
METHOD : ENZYMATIC, COLORIMETRIC				
CHOLESTEROL LDL		118	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		152	High Desirable : < 130 Above Desirable : 130 - 159 Borderline High : 160 - 189 High : 190 - 219 Very high : > / = 220	mg/dL
CHOL/HDL RATIO		5.8	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		3.7	High 0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
VERY LOW DENSITY LIPOPROTEIN		33.8	High < OR = 30.0	mg/dL
<b>LIVER FUNCTION PROFILE, SERUM</b>				
BILIRUBIN, TOTAL		0.92	Upto 1.2	mg/dL
METHOD : COLORIMETRIC DIAZO				
BILIRUBIN, DIRECT		0.30	< 0.30	mg/dL
BILIRUBIN, INDIRECT		0.62	0.1 - 1.0	mg/dL





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TOTAL PROTEIN		7.7	6.0 - 8.0	g/dL
METHOD : COLORIMETRIC				
ALBUMIN		4.4	3.97 - 4.94	g/dL
METHOD : COLORIMETRIC				
GLOBULIN		3.3	2.0 - 3.5	g/dL
ALBUMIN/GLOBULIN RATIO		1.3	1.0 - 2.1	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT)		29	< OR = 50	U/L
METHOD : UV ABSORBANCE				
ALANINE AMINOTRANSFERASE (ALT/SGPT)		31	< OR = 50	U/L
METHOD : UV ABSORBANCE				
ALKALINE PHOSPHATASE		51	40 - 129	U/L
METHOD : COLORIMETRIC				
GAMMA GLUTAMYL TRANSFERASE (GGT)		30	0 - 60	U/L
METHOD : ENZYMATIC, COLORIMETRIC				
LACTATE DEHYDROGENASE		192	125 - 220	U/L
METHOD : UV ABSORBANCE				
<b>BLOOD UREA NITROGEN (BUN), SERUM</b>				
BLOOD UREA NITROGEN		7	6 - 20	mg/dL
METHOD : ENZYMATIC ASSAY				
<b>CREATININE, SERUM</b>				
CREATININE		0.73	0.7 - 1.2	mg/dL
METHOD : COLORIMETRIC				
<b>BUN/CREAT RATIO</b>				
BUN/CREAT RATIO		9.59	8.0 - 15.0	
<b>URIC ACID, SERUM</b>				
URIC ACID		6.0	3.4 - 7.0	mg/dL
METHOD : ENZYMATIC COLORIMETRIC ASSAY				
<b>TOTAL PROTEIN, SERUM</b>				
TOTAL PROTEIN		7.7	6.0 - 8.0	g/dL
METHOD : COLORIMETRIC				
<b>ALBUMIN, SERUM</b>				
ALBUMIN		4.4	3.97 - 4.94	g/dL
METHOD : COLORIMETRIC				
<b>GLOBULIN</b>				
GLOBULIN		3.3	2.0 - 3.5	g/dL





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**ELECTROLYTES (NA/K/CL), SERUM**

SODIUM	138	136 - 145	mmol/L
POTASSIUM	3.80	3.5 - 5.1	mmol/L
CHLORIDE	101	98 - 107	mmol/L

**PHYSICAL EXAMINATION, URINE**

COLOR PALE YELLOW

METHOD : VISUAL INSPECTION

APPEARANCE CLEAR

METHOD : VISUAL INSPECTION

SPECIFIC GRAVITY 1.005 1.003 - 1.035

METHOD : IONIC CONCENTRATION METHOD

**CHEMICAL EXAMINATION, URINE**

PH 6.0 4.7 - 7.5

METHOD : DOUBLE INDICATOR PRINCIPLE

PROTEIN NOT DETECTED NOT DETECTED

METHOD : TETRA BROMOPHENOL BLUE/SULFOSALICYLIC ACID

GLUCOSE NOT DETECTED NOT DETECTED

METHOD : GLUCOSE OXIDASE PEROXIDASE

KETONES NOT DETECTED NOT DETECTED

METHOD : NITROPRUSSIDE REACTION

BLOOD NOT DETECTED NOT DETECTED

METHOD : PEROXIDASE

UROBILINOGEN NORMAL NORMAL

METHOD : MODIFIED EHRlich REACTION

NITRITE NOT DETECTED NOT DETECTED

METHOD : 1,2,3,4-TETRAHYDROBENZO(H)QUINOLIN-3-OL

LEUKOCYTE ESTERASE NOT DETECTED NOT DETECTED

**MICROSCOPIC EXAMINATION, URINE**

PUS CELL (WBC'S) 1-2 0-5 /HPF

METHOD : MICROSCOPIC EXAMINATION

EPITHELIAL CELLS 0-1 0-5 /HPF

METHOD : MICROSCOPIC EXAMINATION

ERYTHROCYTES (RBC'S) NOT DETECTED NOT DETECTED /HPF

METHOD : MICROSCOPIC EXAMINATION

CASTS NOT DETECTED





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METHOD : MICROSCOPIC EXAMINATION

CRYSTALS NOT DETECTED

METHOD : MICROSCOPIC EXAMINATION

BACTERIA NOT DETECTED NOT DETECTED

METHOD : MICROSCOPIC EXAMINATION

YEAST NOT DETECTED NOT DETECTED

THYROID PANEL, SERUM

T3 100.0 80 - 200 ng/dL

METHOD : ELECTROCHEMILUMINESCENCE

T4 5.15 5.1 - 14.1 µg/dL

METHOD : ELECTROCHEMILUMINESCENCE

TSH 3RD GENERATION 2.480 0.27 - 4.2 µIU/mL

METHOD : ELECTROCHEMILUMINESCENCE

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP TYPE O

METHOD : GEL COLUMN AGGLUTINATION METHOD.

RH TYPE POSITIVE

METHOD : GEL COLUMN AGGLUTINATION METHOD.

XRAY-CHEST

IMPRESSION NO ABNORMALITY DETECTED

TMT OR ECHO

TMT OR ECHO NEGATIVE

ECG

ECG WITHIN NORMAL LIMITS

MEDICAL HISTORY

RELEVANT PRESENT HISTORY CONIUNCTINITIS SINCE TODAY MORNING.

RELEVANT PAST HISTORY NOT SIGNIFICANT

RELEVANT PERSONAL HISTORY MARRIED / 2 CHILD / MIXED DIET / NO ALLERGIES / NO SMOKING / OCC. ALCOHOL.

RELEVANT FAMILY HISTORY NOT SIGNIFICANT

HISTORY OF MEDICATIONS NOT SIGNIFICANT

ANTHROPOMETRIC DATA & BMI

HEIGHT IN METERS 1.71 mts

WEIGHT IN KGS. 103 Kgs





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BMI	35	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
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**GENERAL EXAMINATION**

MENTAL / EMOTIONAL STATE	NORMAL
PHYSICAL ATTITUDE	NORMAL
GENERAL APPEARANCE / NUTRITIONAL STATUS	OBESE
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	78/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





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**PER ABDOMEN**

APPEARANCE	NORMAL
VENOUS PROMINENCE	ABSENT
LIVER	NOT PALPABLE
SPLEEN	NOT PALPABLE
HERNIA	ABSENT

**CENTRAL NERVOUS SYSTEM**

HIGHER FUNCTIONS	NORMAL
CRANIAL NERVES	NORMAL
CEREBELLAR FUNCTIONS	NORMAL
SENSORY SYSTEM	NORMAL
MOTOR SYSTEM	NORMAL
REFLEXES	NORMAL

**MUSCULOSKELETAL SYSTEM**

SPINE	NORMAL
JOINTS	NORMAL

**BASIC EYE EXAMINATION**

CONJUNCTIVA	CONJUNCTIVITIS CONGESTION BOTH EYES
EYELIDS	NORMAL
EYE MOVEMENTS	NORMAL
CORNEA	NORMAL
DISTANT VISION RIGHT EYE WITHOUT GLASSES	REDUCED VISUAL ACUITY 6/12
DISTANT VISION LEFT EYE WITHOUT GLASSES	REDUCED VISUAL ACUITY 6/12
NEAR VISION RIGHT EYE WITHOUT GLASSES	WITHIN NORMAL LIMIT
NEAR VISION LEFT EYE WITHOUT GLASSES	WITHIN NORMAL LIMIT
COLOUR VISION	NORMAL

**SUMMARY**

RELEVANT HISTORY	NOT SIGNIFICANT
RELEVANT GP EXAMINATION FINDINGS	OBESE :- BMI 35







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REMARKS / RECOMMENDATIONS

ADVICE:-

- 1)OPHTHALMOLOGY CONSULT FOR CONJUNCTIVITIS
- 2)HEPATOLOGY CONSULT ON VIEW OF USG FINDINGS.
- 3)BP MONITORING FOR 5 DAYS. IF PERSISTENTLY HIGH, WILL REQUIRE EVALUATION BY PHYSICIAN.BP MONITORING AND FOLLOW UP.
- 4)ADD YOGA, PRANAYAM MEDITATION TO DAILY ROUTINE.
- 5)WEIGHT LOSS -STRICT LOW SALT,LOW FAT, LOW CARBOHYDRATE, HIGH FIBRE DIET.
- 6)REGULAR EXERCISE,REGULAR WALK FOR 30-40 MIN DAILY.
- 7)REPEAT BLOOD SUGAR ,LIPID PROFILE AFTER 3 MONTHS OF DIET AND EXERCISE.





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ULTRASOUND ABDOMEN

ULTRASOUND ABDOMEN

HEPATOMEGALY WITH GRADE II FATTY LIVER.

Interpretation(s)

BLOOD COUNTS, EDTA WHOLE BLOOD-

The cell morphology is well preserved for 24hrs. However after 24-48 hrs a progressive increase in MCV and HCT is observed leading to a decrease in MCHC. A direct smear is recommended for an accurate differential count and for examination of RBC morphology.

WBC DIFFERENTIAL COUNT-

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, 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 (Paraproteinemia, 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, (Sickle Cells, spherocytes), Microcytosis, Low fibrinogen, Very high WBC counts, Drugs (Quinine, salicylates)

REFERENCE :

1. Nathan and Oski's Haematology of Infancy and Childhood, 5th edition; 2. Paediatric reference intervals. AACC Press, 7th edition. Edited by S. Soldin; 3. The reference for the adult reference range is "Practical Haematology by Dacie and Lewis, 10th edition.

GLYCOSYLATED HEMOGLOBIN (HbA1c), EDTA WHOLE BLOOD-Used For:

- 1. Evaluating the long-term control of blood glucose concentrations in diabetic patients.
2. Diagnosing diabetes.
3. Identifying patients at increased risk for diabetes (prediabetes).

The ADA recommends measurement of HbA1c (typically 3-4 times per year for type 1 and poorly controlled type 2 diabetic patients, and 2 times per year for well-controlled type 2 diabetic patients) to determine whether a 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.





CLIENT CODE : C000138394

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

SRL Ltd
S.K. Tower, Hari Niwas, LBS Marg
THANE, 400602
MAHARASHTRA, INDIA
Tel : 9111591115, Fax : CIN - U74899PB1995PLC045956
Email : customercare.thane@srl.in

PATIENT NAME : ANIL NAMDEV SALUNKHE

PATIENT ID : ANILM221076181

ACCESSION NO : 0181VJ001042 AGE : 46 Years SEX : Male

ABHA NO :

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Test Report Status Final Results Biological Reference Interval Units

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 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; sulfonyleureas, tolbutamide, and other oral hypoglycemic agents.

NOTE:

Hypoglycemia is defined as a glucose of < 50 mg/dL in men and < 40 mg/dL in women.

While normal 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 glucose 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.

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 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 Hypophosphatemia, 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. Hum an 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.





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SOUTH WEST DELHI
NEW DELHI 110030
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- 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

TOTAL PROTEIN, SERUM-

Serum total protein, also known as total protein, is a biochemical test for measuring the total amount of protein in serum..Protein in the plasma is made up of albumin and globulin

Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma, Waldenstrom's disease
Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage), Burns, Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome, Protein-losing enteropathy etc.

ALBUMIN, SERUM-

Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. Low blood albumin levels (hypoalbuminemia) can be caused by: Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance, malnutrition and wasting etc.

ELECTROLYTES (NA/K/CL), SERUM-

Sodium levels are Increased in dehydration, cushing's syndrome, aldosteronism & decreased in Addison's disease, hypopituitarism, liver disease. Hypokalemia (low K) is common in vomiting, diarrhea, alcoholism, folic acid deficiency and primary aldosteronism. Hyperkalemia may be seen in end-stage renal failure, hemolysis, trauma, Addison's disease, metabolic acidosis, acute starvation, dehydration, and with rapid K infusion. Chloride is increased in dehydration, renal tubular acidosis (hyperchloremic metabolic acidosis), acute renal failure, metabolic acidosis associated with prolonged diarrhea and loss of sodium bicarbonate, diabetes insipidus, adrenocortical hyperfunction, salicylate intoxication and with excessive infusion of isotonic saline or extremely high dietary intake of salt. Chloride is decreased in overhydration, chronic respiratory acidosis, salt-losing nephritis, metabolic alkalosis, congestive heart failure, Addisonian crisis, certain types of metabolic acidosis, persistent gastric secretion and prolonged vomiting.

MICROSCOPIC EXAMINATION, URINE-

Routine urine analysis assists in screening and diagnosis of various metabolic, urological, kidney and liver disorders

Protein: Elevated proteins can be an early sign of kidney disease. Urinary protein excretion can also be temporarily elevated by strenuous exercise, orthostatic proteinuria, dehydration, urinary tract infections and acute illness with fever

Glucose: Uncontrolled diabetes mellitus can lead to presence of glucose in urine. Other causes include pregnancy, hormonal disturbances, liver disease and certain medications.

Ketones: Uncontrolled diabetes mellitus can lead to presence of ketones in urine. Ketones can also be seen in starvation, frequent vomiting, pregnancy and strenuous exercise.

Blood: Occult blood can occur in urine as intact erythrocytes or haemoglobin, which can occur in various urological, nephrological and bleeding disorders.

Leukocytes: An increase in leukocytes is an indication of inflammation in urinary tract or kidneys. Most common cause is bacterial urinary tract infection.

Nitrite: Many bacteria give positive results when their number is high. Nitrite concentration during infection increases with length of time the urine specimen is retained in bladder prior to collection.

pH: The kidneys play an important role in maintaining acid base balance of the body. Conditions of the body producing acidosis/ alkalosis or ingestion of certain type of food can affect the pH of urine.

Specific gravity: Specific gravity gives an indication of how concentrated the urine is. Increased specific gravity is seen in conditions like dehydration, glycosuria and proteinuria while decreased specific gravity is seen in excessive fluid intake, renal failure and diabetes insipidus.

Bilirubin: In certain liver diseases such as biliary obstruction or hepatitis, bilirubin gets excreted in urine.

Urobilinogen: Positive results are seen in liver diseases like hepatitis and cirrhosis and in cases of hemolytic anemia

THYROID PANEL, SERUM-Triiodothyronine T3, is a thyroid hormone. It affects almost every physiological process in the body, including growth, development, metabolism, body temperature, and heart rate. Production of T3 and its prohormone thyroxine (T4) is activated by thyroid-stimulating hormone (TSH), which is released from the pituitary gland. Elevated concentrations of T3, and T4 in the blood inhibit the production of TSH.

Thyroxine T4, Thyroxine's principal function is to stimulate the metabolism of all cells and tissues in the body. Excessive secretion of thyroxine in the body is hyperthyroidism, and deficient secretion is called hypothyroidism. Most of the thyroid hormone in blood is bound to transport proteins. Only a very small fraction of the circulating hormone is free and biologically active.

In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hypothyroidism, TSH levels are low.

Below mentioned are the guidelines for Pregnancy related reference ranges for Total T4, TSH & Total T3

Levels in TOTAL T4 TSH3G TOTAL T3





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SOUTH WEST DELHI
NEW DELHI 110030
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Table with 4 columns: Test Name, Unit 1, Unit 2, Unit 3. Rows include Pregnancy, First Trimester, 2nd Trimester, 3rd Trimester.

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

Table with 2 columns: Test Name, Reference Range. Rows include T3, T4, New Born, 1-3 day, 1 Week.

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

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 INVIOABLE FEATURE OF OUR LAB MANAGEMENT SOFTWARE. HOWEVER, ALL EXAMINATIONS AND INVESTIGATIONS HAVE BEEN CONDUCTED BY OUR PANEL OF DOCTORS.

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\*\*End Of Report\*\*

Please visit www.srlworld.com for related Test Information for this accession

