

PATIENT NAME : TANIMA LAMA

REF. DOCTOR : DR. ARCOFEMI HEALTHCARE LTD
(MEDIWHEEL)

CODE/NAME & ADDRESS : C000138363

ARCOFEMI HEALTHCARE LTD (MEDIWHEEL)
F-703, LADO SARAI, MEHRAULISOUTH WEST
DELHI
NEW DELHI 110030
8800465156

ACCESSION NO : 0031XC020455

PATIENT ID : TANIF22098231

CLIENT PATIENT ID:

ABITA NO

AGE/SEX : 41 Years Female

DRAWN : 22/03/2024 10:22:00

RECEIVED : 22/03/2024 10:25:04

REPORTED : 30/03/2024 20:12:10

Test Report Status **Final**

Results

Biological Reference Interval Units

MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40FEMALE**XRAY-CHEST**

IMPRESSION

NO ABNORMALITY DETECTED

ECG

ECG

NORMAL

MAMMOGRAPHY (BOTH BREASTS)

MAMMOGRAPHY BOTH BREASTS

TEST PENDING

MEDICAL HISTORY

RELEVANT PRESENT HISTORY

MYOLIPOMA OF ADRENAL GLAND

RELEVANT PAST HISTORY

COVID

RELEVANT PERSONAL HISTORY

NOT SIGNIFICANT

RELEVANT FAMILY HISTORY

PARENTS : HTN, DIABETIC

OCCUPATIONAL HISTORY

NOT SIGNIFICANT

HISTORY OF MEDICATIONS

NOT SIGNIFICANT

ANTHROPOMETRIC DATA & BMI

HEIGHT IN METERS

1.52

mts

WEIGHT IN KGS.

77

Kgs

BMI

33

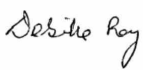
BMI & Weight Status as follows

Below 18.5: Underweight

18.5 - 24.9: Normal

25.0 - 29.9: Overweight

30.0 and Above: Obese


Dr. Debika Roy
MBBS Consultant Physician

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CIN - U74899PB1995PLC045956
Email : customercare.saltlake@agilus.in

Patient Ref. No. 3100004961101

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GENERAL EXAMINATION

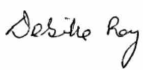
MENTAL / EMOTIONAL STATE	NORMAL	
PHYSICAL ATTITUDE	NORMAL	
GENERAL APPEARANCE / NUTRITIONAL STATUS	OBESE	
BUILT / SKELETAL FRAMEWORK	AVERAGE	
FACIAL APPEARANCE	NORMAL	
SKIN	NORMAL	
UPPER LIMB	NORMAL	
LOWER LIMB	NORMAL	
NECK	NORMAL	
NECK LYMPHATICS / SALIVARY GLANDS	NOT ENLARGED OR TENDER	
THYROID GLAND	NOT ENLARGED	
CAROTID PULSATION	NORMAL	
TEMPERATURE	NORMAL	
PULSE	76/MINS-REGULAR, ALL PERIPHERAL PULSES WELL FELT	
RESPIRATORY RATE	NORMAL	

CARDIOVASCULAR SYSTEM

BP	130/86	mm/Hg
PERICARDIUM	NORMAL	
APEX BEAT	NORMAL	
HEART SOUNDS	S1, S2 HEARD NORMALLY	
MURMURS	ABSENT	

RESPIRATORY SYSTEM

SIZE AND SHAPE OF CHEST	NORMAL
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MOVEMENTS OF CHEST	SYMMETRICAL
BREATH SOUNDS INTENSITY	NORMAL
BREATH SOUNDS QUALITY	VESICULAR (NORMAL)
ADDED SOUNDS	ABSENT

PER ABDOMEN

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

CENTRAL NERVOUS SYSTEM

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

MUSCULOSKELETAL SYSTEM

SPINE	NORMAL
JOINTS	NORMAL

BASIC EYE EXAMINATION

CONJUNCTIVA	NORMAL
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EYELIDS	NORMAL
EYE MOVEMENTS	NORMAL
DISTANT VISION RIGHT EYE WITH GLASSES	6/6
DISTANT VISION LEFT EYE WITH GLASSES	6/6
NEAR VISION RIGHT EYE WITH GLASSES	N6
NEAR VISION LEFT EYE WITH GLASSES	N6
COLOUR VISION	NORMAL

BASIC ENT EXAMINATION

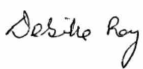
EXTERNAL EAR CANAL	NORMAL
TYMPANIC MEMBRANE	NORMAL
NOSE	NO ABNORMALITY DETECTED
SINUSES	CLEAR
THROAT	NO ABNORMALITY DETECTED
TONSILS	NOT ENLARGED

BASIC DENTAL EXAMINATION

TEETH	NORMAL
GUMS	HEALTHY

SUMMARY

RELEVANT HISTORY	MYOLIPOMA OF ADRENAL GLAND
RELEVANT GP EXAMINATION FINDINGS	OBESE (77 KGS)
RELEVANT LAB INVESTIGATIONS	RAISED LDL (114), NON HDL (144)
RELEVANT NON PATHOLOGY DIAGNOSTICS	NO ABNORMALITIES DETECTED


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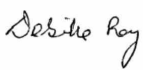
On examination and investigations the candidate is found to be obese and has raised LDL (114), NON HDL (144)

Should follow the given advice:

1. Avoid fat and oily diet
2. Reduce body weight
3. Estimated body weight should be : 55 kg
4. Regular physical exercise and walking
5. Drink plenty of water
6. Physician and Dietician consultation

Comments

MEDICAL EXAMINATION DONE BY:

DR. DEBIKA ROY, MBBS
REG NO: 51651 (WBMC)
CONSULTANT PHYSICIAN
WELLNESS CLINIC
SALT LAKE REF LAB, KOLKATA

Dr. Debika Roy
MBBS Consultant Physician

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MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40FEMALE

ULTRASOUND ABDOMEN

ULTRASOUND ABDOMEN

TEST PENDING

TMT OR ECHO

CLINICAL PROFILE

TMT DONE- NEGATIVE

Interpretation(s)

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.

Dr. Debika Roy
MBBS Consultant Physician



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HAEMATOLOGY - CBC

MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40FEMALE

BLOOD COUNTS, EDTA WHOLE BLOOD

HEMOGLOBIN (HB) METHOD : SPECTROPHOTOMETRY	12.0	12.0 - 15.0	g/dL
RED BLOOD CELL (RBC) COUNT METHOD : ELECTRICAL IMPEDANCE	4.58	3.8 - 4.8	mil/ μ L
WHITE BLOOD CELL (WBC) COUNT METHOD : ELECTRICAL IMPEDANCE	7.58	4.0 - 10.0	thou/ μ L
PLATELET COUNT METHOD : ELECTRONIC IMPEDANCE & MICROSCOPY	253	150 - 410	thou/ μ L

RBC AND PLATELET INDICES

HEMATOCRIT (PCV) METHOD : CALCULATED	36.8	36 - 46	%
MEAN CORPUSCULAR VOLUME (MCV) METHOD : ELECTRICAL IMPEDANCE	80.3 Low	83 - 101	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH) METHOD : CALCULATED	26.3 Low	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC) METHOD : CALCULATED	32.7	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW) METHOD : ELECTRICAL IMPEDANCE	15.2 High	11.6 - 14.0	%
MENTZER INDEX	17.5		
MEAN PLATELET VOLUME (MPV) METHOD : CALCULATED	9.4	6.8 - 10.9	fL

WBC DIFFERENTIAL COUNT

NEUTROPHILS METHOD : FLOWCYTOMETRY, ELECTRONIC IMPEDANCE & MICROSCOPY.	60	40 - 80	%
LYMPHOCYTES METHOD : FLOWCYTOMETRY, ELECTRONIC IMPEDANCE & MICROSCOPY.	30	20 - 40	%


Dr. Chaitali Ray, PHD
Chief Biochemist cum MRQA

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MONOCYTES		7	2 - 10	%
METHOD : FLOWCYTOMETRY, ELECTRONIC IMPEDANCE & MICROSCOPY.				
EOSINOPHILS		3	1 - 6	%
BASOPHILS		0	0 - 2	%
METHOD : FLOWCYTOMETRY, ELECTRONIC IMPEDANCE & MICROSCOPY.				
ABSOLUTE NEUTROPHIL COUNT		4.55	2.0 - 7.0	thou/ μ L
METHOD : FLOWCYTOMETRY & CALCULATED				
ABSOLUTE LYMPHOCYTE COUNT		2.27	1 - 3	thou/ μ L
METHOD : FLOWCYTOMETRY & CALCULATED				
ABSOLUTE MONOCYTE COUNT		0.53	0.20 - 1.00	thou/ μ L
METHOD : FLOWCYTOMETRY & CALCULATED				
ABSOLUTE EOSINOPHIL COUNT		0.23	0.02 - 0.50	thou/ μ L
METHOD : FLOWCYTOMETRY & CALCULATED				
ABSOLUTE BASOPHIL COUNT		0.00 Low	0.02 - 0.10	thou/ μ L
METHOD : FLOWCYTOMETRY & CALCULATED				

MORPHOLOGY

RBC	PREDOMINANTLY NORMOCYTIC NORMOCHROMIC
METHOD : MICROSCOPIC EXAMINATION	
WBC	NO IMMATURE CELLS SEEN.
METHOD : MICROSCOPIC EXAMINATION	
PLATELETS	ADEQUATE
METHOD : MICROSCOPIC EXAMINATION	

Interpretation(s)

BLOOD COUNTS, EDTA WHOLE BLOOD-The cell morphology is well preserved for 24hrs. However after 24-48 hrs a progressive increase in MCV and HCT is observed leading to a decrease in MCHC. A direct smear is recommended for an accurate differential count and for examination of RBC morphology.
 RBC AND PLATELET INDICES-Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia (>13) from Beta thalassaemia trait (<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.
 WBC DIFFERENTIAL COUNT-The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR < 3.3, COVID-19 patients tend to show mild disease.
 (Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients A.-P. Yang, et al. International Immunopharmacology 84 (2020) 106504
 This ratio element is a calculated parameter and out of NABL scope.

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HAEMATOLOGY

MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40FEMALE

ERYTHROCYTE SEDIMENTATION RATE (ESR), EDTA BLOOD

E.S.R	12	0 - 20	mm at 1 hr
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METHOD : AUTOMATED (PHOTOMETRICAL CAPILLARY STOPPED FLOW KINETIC ANALYSIS)"

GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

HBA1C	5.5	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)
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METHOD : HPLC

ESTIMATED AVERAGE GLUCOSE(EAG)	111.2	< 116.0	mg/dL
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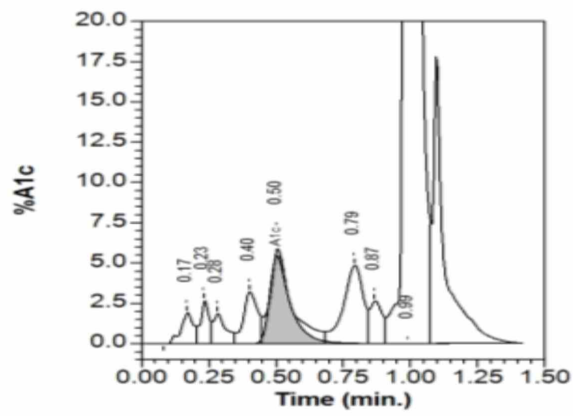
AGILUS DIAGNOSTICS LIMITED - KOLKATA **PATIENT REP**
Bio-Rad Variant II Turbo CDM 5.4 S/N : 13466 **V2TURBO_A1c**

Patient Data		Analysis Data	
Sample ID:	3107502498	Analysis Performed:	22/03/2024 13:46:30
Patient ID:		Injection Number:	3160
Name:		Run Number:	201
Physician:		Rack ID:	
Sex:		Tube Number:	10
DOB:		Report Generated:	22/03/2024 14:06:26
Comments:		Operator ID:	

Peak Name	NGSP %	Area %	Retention Time (min)	Peak Area
A1a	---	1.0	0.167	19469
A1b	---	0.9	0.231	17730
F	---	1.0	0.280	18387
LA1c	---	1.9	0.401	37124
A1c	5.5	---	0.503	88974
P3	---	4.0	0.790	75599
P4	---	1.3	0.866	25182
Ao	---	85.2	0.990	1625804

Total Area: 1,908,268

HbA1c (NGSP) = 5.5 %



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Interpretation(s)

ERYTHROCYTE SEDIMENTATION RATE (ESR),EDTA 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 (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.

GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD-Used For:

1. Evaluating the long-term control of blood glucose concentrations in diabetic patients.

2. Diagnosing diabetes.

3. Identifying patients at increased risk for diabetes (prediabetes).

The ADA recommends measurement of HbA1c (typically 3-4 times per year for type 1 and poorly controlled type 2 diabetic patients, and 2 times per year for well-controlled type 2 diabetic patients) to determine whether a patients metabolic control has remained continuously within the target range.

1. eAG (Estimated average glucose) converts percentage HbA1c to md/dl, to compare blood glucose levels.

2. eAG gives an evaluation of blood glucose levels for the last couple of months.

3. eAG is calculated as eAG (mg/dl) = 28.7 * HbA1c - 46.7

HbA1c Estimation can get affected due to :

1. Shortened Erythrocyte survival : Any condition that shortens erythrocyte survival or decreases mean erythrocyte age (e.g. recovery from acute blood loss,hemolytic anemia) will falsely lower HbA1c test results.Fructosamine is recommended in these patients which indicates diabetes control over 15 days.

2.Vitamin C & E are reported to falsely lower test results.(possibly by inhibiting glycation of hemoglobin.

3. Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia,uremia, hyperbilirubinemia, chronic alcoholism,chronic ingestion of salicylates & opiates addiction are reported to interfere with some assay methods,falsely increasing results.

4. Interference of hemoglobinopathies in HbA1c estimation is seen in

a) Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.

b) Heterozygous state detected (D10 is corrected for HbS & HbC trait.)

c) HbF > 25% on alternate platform (Boronate affinity chromatography) is recommended for testing of HbA1c.Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy

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Patient Ref. No. 3100004961101



PATIENT NAME : TANIMA LAMA

REF. DOCTOR : DR. ARCOFEMI HEALTHCARE LTD (MEDIWHEEL)

CODE/NAME & ADDRESS : C000138363 ARCOFEMI HEALTHCARE LTD (MEDIWHEEL F-703, LADO SARAI, MEHRAULISOUTH WEST DELHI NEW DELHI 110030 8800465156

ACCESSION NO : 0031XC020455 PATIENT ID : TANIF22098231 CLIENT PATIENT ID: ABITA NO

AGE/SEX : 41 Years Female DRAWN : 22/03/2024 10:22:00 RECEIVED : 22/03/2024 10:25:04 REPORTED : 30/03/2024 20:12:10

Table with 4 columns: Test Report Status (Final), Results, Biological Reference Interval, Units

IMMUNOHAEMATOLOGY

MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40FEMALE

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP TYPE O METHOD : GEL CARD METHOD RH TYPE POSITIVE METHOD : GEL CARD METHOD

Interpretation(s) ABO GROUP & RH TYPE, EDTA WHOLE BLOOD-Blood group is identified by antigens and antibodies present in the blood. Antigens are protein molecules found on the surface of red blood cells. Antibodies are found in plasma. To determine blood group, red cells are mixed with different antibody solutions to give A,B,O or AB.

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

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

Handwritten signature of Dr. Chaitali Ray

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BIOCHEMISTRY

MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40FEMALE

GLUCOSE FASTING,FLUORIDE PLASMA

FBS (FASTING BLOOD SUGAR)	90	74 - 100	mg/dL
METHOD : ENZYMATIC (HEXOKINASE/G-6-PDH)			

GLUCOSE, POST-PRANDIAL, PLASMA

PPBS(POST PRANDIAL BLOOD SUGAR)	TEST NOT PERFORMED	140 Normal 140 - 199 Pre-diabetic > or = 200 Diabetic	mg/dL
METHOD : ENZYMATIC (HEXOKINASE/G-6-PDH)			

LIPID PROFILE WITH CALCULATED LDL, SERUM

CHOLESTEROL, TOTAL	195	< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
METHOD : ENZYMATIC ASSAY			

TRIGLYCERIDES	150	< 150 Normal 150 - 199 Borderline High 200 - 499 High >/=500 Very High	mg/dL
METHOD : GLYCEROL PHOSPHATE OXIDASE			

HDL CHOLESTEROL	51	Low : < 40 High : > / = 60	mg/dL
METHOD : ACCELERATOR SELECTIVE DETERGENT METHODOLOGY			

CHOLESTEROL LDL	114 High	Optimal : < 100 Near optimal/above optimal : 100-129 Borderline high : 130-159 High : 160-189 Very high : > or = 190	mg/dL
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NON HDL CHOLESTEROL **144 High** Desirable: Less than 130 mg/dL
Above Desirable: 130-159
Borderline High: 160-189
High: 190 -219
Very High: >or = 220

METHOD : CALCULATED

VERY LOW DENSITY LIPOPROTEIN 30.0 mg/dL
CHOL/HDL RATIO 3.8
LDL/HDL RATIO 2.2

Interpretation(s)

Serum lipid profile is measured for cardiovascular risk prediction. Lipid Association of India recommends LDL-C as primary target and Non HDL-C as co-primary treatment target.

Risk Stratification for ASCVD (Atherosclerotic cardiovascular disease) by Lipid Association of India

Risk Category	
Extreme risk group	A.CAD with > 1 feature of high risk group B. CAD with > 1 feature of Very high risk group or recurrent ACS (within 1 year) despite LDL-C < or = 50 mg/dl or polyvascular disease
Very High Risk	1. Established ASCVD 2. Diabetes with 2 major risk factors or evidence of end organ damage 3. Familial Homozygous Hypercholesterolemia
High Risk	1. Three major ASCVD risk factors. 2. Diabetes with 1 major risk factor or no evidence of end organ damage. 3. CKD stage 3B or 4. 4. LDL >190 mg/dl 5. Extreme of a single risk factor. 6. Coronary Artery Calcium - CAC >300 AU. 7. Lipoprotein a >/= 50mg/dl 8. Non stenotic carotid plaque
Moderate Risk	2 major ASCVD risk factors
Low Risk	0-1 major ASCVD risk factors
Major ASCVD (Atherosclerotic cardiovascular disease) Risk Factors	
1. Age > or = 45 years in males and > or = 55 years in females	3. Current Cigarette smoking or tobacco use
2. Family history of premature ASCVD	4. High blood pressure
5. Low HDL	

Newer treatment goals and statin initiation thresholds based on the risk categories proposed by LAI in 2020.

Risk Group	Treatment Goals		Consider Drug Therapy	
	LDL-C (mg/dl)	Non-HDL (mg/dl)	LDL-C (mg/dl)	Non-HDL (mg/dl)
Extreme Risk Group Category A	<50 (Optional goal < OR = 30)	< 80 (Optional goal <OR = 60)	>OR = 50	>OR = 80
Extreme Risk Group Category B	<OR = 30	<OR = 60	> 30	>60
Very High Risk	<50	<80	>OR= 50	>OR= 80
High Risk	<70	<100	>OR= 70	>OR= 100

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Moderate Risk	<100	<130	>OR= 100	>OR= 130
Low Risk	<100	<130	>OR= 130*	>OR= 160

*After an adequate non-pharmacological intervention for at least 3 months.

References: Management of Dyslipidaemia for the Prevention of Stroke: Clinical Practice Recommendations from the Lipid Association of India. Current Vascular Pharmacology, 2022, 20, 134-155.

LIVER FUNCTION PROFILE, SERUM

BILIRUBIN, TOTAL METHOD : DIAZONIUM SALT	0.50	0.2 - 1.2	mg/dL
BILIRUBIN, DIRECT METHOD : DIAZO REACTION	0.16	0.0 - 0.5	mg/dL
BILIRUBIN, INDIRECT METHOD : CALCULATED	0.34	0.1 - 1.0	mg/dL
TOTAL PROTEIN METHOD : BIURET	8.1	6.0 - 8.30	g/dL
ALBUMIN METHOD : COLORIMETRIC (BROMCRESOL GREEN)	4.8	3.5 - 5.2	g/dL
GLOBULIN	3.3	2.0 - 3.5	g/dL
ALBUMIN/GLOBULIN RATIO METHOD : CALCULATED PARAMETER	1.5	1 - 2.1	RATIO
ASPARTATE AMINOTRANSFERASE(AST/SGOT) METHOD : ENZYMATIC (NADH (WITHOUT P-5'-P)	16	5 - 34	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT) METHOD : ENZYMATIC (NADH (WITHOUT P-5'-P)	12	0 - 55	U/L
ALKALINE PHOSPHATASE METHOD : PARA-NITROPHENYL PHOSPHATE	78	40 - 150	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT) METHOD : L-GAMMA-GLUTAMYL-4-NITROANALIDE /GLYCYLGLYCINE KINETIC METHOD	21	8 -33	U/L
LACTATE DEHYDROGENASE METHOD : IFCC LACTATE TO PYRUVATE	146	125 - 220	U/L

BLOOD UREA NITROGEN (BUN), SERUM

BLOOD UREA NITROGEN METHOD : UREASE METHOD	9	7.0 - 18.7	mg/dL
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CREATININE, SERUM

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CREATININE 0.72 0.50 - 1.10 mg/dL
METHOD : KINETIC ALKALINE PICRATE

BUN/CREAT RATIO
BUN/CREAT RATIO 12.50 5.0 - 15.0

URIC ACID, SERUM
URIC ACID 4.9 2.6 - 6.0 mg/dL
METHOD : URICASE

TOTAL PROTEIN, SERUM
TOTAL PROTEIN 8.1 6.0 - 8.3 g/dL
METHOD : BIURET

ALBUMIN, SERUM
ALBUMIN 4.8 3.5 - 5.2 g/dL
METHOD : COLORIMETRIC (BROMCRESOL GREEN)

GLOBULIN
GLOBULIN 3.3 2.0 - 3.5 g/dL
METHOD : CALCULATED PARAMETER

ELECTROLYTES (NA/K/CL), SERUM
SODIUM, SERUM 138 136 - 145 mmol/L
METHOD : ION SELECTIVE ELECTRODE TECHNOLOGY INDIRECT
POTASSIUM, SERUM 4.40 3.5 - 5.1 mmol/L

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METHOD : ION SELECTIVE ELECTRODE TECHNOLOGY INDIRECT
CHLORIDE, SERUM 105 98 - 107 mmol/L
METHOD : ION SELECTIVE ELECTRODE TECHNOLOGY INDIRECT

Interpretation(s)

Sodium	Potassium	Chloride
Decreased in: CCF, cirrhosis, vomiting, diarrhea, excessive sweating, salt-losing nephropathy, adrenal insufficiency, nephrotic syndrome, water intoxication, SIADH. Drugs: thiazides, diuretics, ACE inhibitors, chlorpropamide, carbamazepine, antidepressants (SSRI), antipsychotics.	Decreased in: Low potassium intake, prolonged vomiting or diarrhea, RTA types I and II, hyperaldosteronism, Cushing's syndrome, osmotic diuresis (e.g., hyperglycemia), alkalosis, familial periodic paralysis, trauma (transient). Drugs: Adrenergic agents, diuretics.	Decreased in: Vomiting, diarrhea, renal failure combined with salt deprivation, over-treatment with diuretics, chronic respiratory acidosis, diabetic ketoacidosis, excessive sweating, SIADH, salt-losing nephropathy, porphyria, expansion of extracellular fluid volume, adrenal insufficiency, hyperaldosteronism, metabolic alkalosis. Drugs: chronic laxative, corticosteroids, diuretics.
Increased in: Dehydration (excessive sweating, severe vomiting or diarrhea), diabetes mellitus, diabetes insipidus, hyperaldosteronism, inadequate water intake. Drugs: steroids, licorice, oral contraceptives.	Increased in: Massive hemolysis, severe tissue damage, rhabdomyolysis, acidosis, dehydration, renal failure, Addison's disease, RTA type IV, hyperkalemic familial periodic paralysis. Drugs: potassium salts, potassium-sparing diuretics, NSAIDs, beta-blockers, ACE inhibitors, high-dose trimethoprim-sulfamethoxazole.	Increased in: Renal failure, nephrotic syndrome, RTA, dehydration, overtreatment with saline, hyperparathyroidism, diabetes insipidus, metabolic acidosis from diarrhea (Loss of HCO ₃ -), respiratory alkalosis, hyperadrenocorticism. Drugs: acetazolamide, androgens, hydrochlorothiazide, salicylates.
Interferences: Severe lipemia or hyperproteinemia, if sodium analysis involves a dilution step can cause spurious results. The serum sodium falls about 1.6 mEq/L for each 100 mg/dL increase in blood glucose.	Interferences: Hemolysis of sample, delayed separation of serum, prolonged fist clenching during blood drawing, and prolonged tourniquet placement. Very high WBC/PLT counts may cause spurious. Plasma potassium levels are normal.	Interferences: Test is helpful in assessing normal and increased anion gap metabolic acidosis and in distinguishing hypercalcemia due to hyperparathyroidism (high serum chloride) from that due to malignancy (Normal serum chloride)

Interpretation(s)

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: 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.

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

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LIVER FUNCTION PROFILE, SERUM-

Bilirubin is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. Bilirubin is excreted in bile and urine, and elevated levels may give yellow discoloration in jaundice. **Elevated levels** results from increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Conjugated (direct) bilirubin is elevated more than unconjugated (indirect) bilirubin in Viral hepatitis, Drug reactions, Alcoholic liver disease. Conjugated (direct) bilirubin is also elevated more than unconjugated (indirect) bilirubin when there is some kind of blockage of the bile ducts like in Gallstones getting into the bile ducts, tumors & Scarring of the bile ducts. Increased unconjugated (indirect) bilirubin may be a result of Hemolytic or pernicious anemia, Transfusion reaction & a common metabolic condition termed Gilbert syndrome, due to low levels of the enzyme that attaches sugar molecules to bilirubin.

AST is an enzyme found in various parts of the body. AST is found in the liver, heart, skeletal muscle, kidneys, brain, and red blood cells, and it is commonly measured clinically as a marker for liver health. AST levels increase during chronic viral hepatitis, blockage of the bile duct, cirrhosis of the liver, liver cancer, kidney failure, hemolytic anemia, pancreatitis, hemochromatosis. AST levels may also increase after a heart attack or strenuous activity. ALT test measures the amount of this enzyme in the blood. ALT is found mainly in the liver, but also in smaller amounts in the kidneys, heart, muscles, and pancreas. It is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health. AST levels increase during acute hepatitis, sometimes due to a viral infection, ischemia to the liver, chronic hepatitis, obstruction of bile ducts, cirrhosis.

ALP is a protein found in almost all body tissues. Tissues with higher amounts of ALP include the liver, bile ducts and bone. Elevated ALP levels are seen in Biliary obstruction, Osteoblastic bone tumors, osteomalacia, hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, Pagets disease, Rickets, Sarcoidosis etc. Lower-than-normal ALP levels seen in Hypophosphatasia, Malnutrition, Protein deficiency, Wilsons disease.

GGT is an enzyme found in cell membranes of many tissues mainly in the liver, kidney and pancreas. It is also found in other tissues including intestine, spleen, heart, brain and seminal vesicles. The highest concentration is in the kidney, but the liver is considered the source of normal enzyme activity. Serum GGT has been widely used as an index of liver dysfunction. Elevated serum GGT activity can be found in diseases of the liver, biliary system and pancreas. Conditions that increase serum GGT are obstructive liver disease, high alcohol consumption and use of enzyme-inducing drugs etc.

Total Protein also known as total protein, is a biochemical test for measuring the total amount of protein in serum. Protein in the plasma is made up of albumin and globulin. Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma, Waldenstroms disease. Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage), Burns, Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome, Protein-losing enteropathy etc.

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

BLOOD UREA NITROGEN (BUN), SERUM- Causes of Increased levels include Pre renal (High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal), Renal Failure, Post Renal (Malignancy, Nephrolithiasis, Prostatism)

Causes of decreased level include Liver disease, SIADH.

CREATININE, SERUM- Higher than normal level may be due to:

- Blockage in the urinary tract, Kidney problems, such as kidney damage or failure, infection, or reduced blood flow, Loss of body fluid (dehydration), Muscle problems, such as breakdown of muscle fibers, Problems during pregnancy, such as seizures (eclampsia)), or high blood pressure caused by pregnancy (preeclampsia)

Lower than normal level may be due to: Myasthenia Gravis, Muscuophy

URIC ACID, SERUM- Causes of Increased levels: Dietary (High Protein Intake, Prolonged Fasting, Rapid weight loss), Gout, Lesch nyhan syndrome, Type 2 DM, Metabolic syndrome

Causes of decreased levels: Low Zinc intake, OCP, Multiple Sclerosis

TOTAL PROTEIN, SERUM- is a biochemical test for measuring the total amount of protein in serum. Protein in the plasma is made up of albumin and globulin.

Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma, Waldenstroms disease.

Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage), Burns, Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome, Protein-losing enteropathy etc.

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

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PATIENT NAME : TANIMA LAMA

REF. DOCTOR : DR. ARCOFEMI HEALTHCARE LTD (MEDIWHEEL)

CODE/NAME & ADDRESS : C000138363 ARCOFEMI HEALTHCARE LTD (MEDIWHEEL) F-703, LADO SARAI, MEHRAULISOUTH WEST DELHI NEW DELHI 110030 8800465156	ACCESSION NO : 0031XC020455	AGE/SEX : 41 Years Female
	PATIENT ID : TANIF22098231	DRAWN : 22/03/2024 10:22:00
	CLIENT PATIENT ID: ABITA NO	RECEIVED : 22/03/2024 10:25:04
		REPORTED : 30/03/2024 20:12:10

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SPECIALISED CHEMISTRY - HORMONE

MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40FEMALE

THYROID PANEL, SERUM

T3 77.7 Non-Pregnant Women 35 - 193/dL
 Pregnant Women
 1st Trimester:105.0 - 230.0
 2nd Trimester:129.0 - 262.0
 3rd Trimester:135.0 - 262.0

METHOD : TWO-STEP CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY

T4 6.66 Non-Pregnant Women µg/dL
 4.87 - 11.71
 Pregnant Women
 1st Trimester: 7.33 - 14.80
 2nd Trimester: 7.93 - 16.10
 3rd Trimester: 6.95 - 15.70

METHOD : TWO-STEP CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY

TSH (ULTRASENSITIVE) 3.074 Non-Pregnant Women 0.35 - µIU/mL
 4.94
 Pregnant Women (As per American Thyroid Association)
 1st Trimester 0.100 - 2.500
 2nd Trimester 0.200 - 3.000
 3rd Trimester 0.300 - 3.000

METHOD : TWO-STEP CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY

Interpretation(s)

Triiodothyronine T3 , Thyroxine T4, and Thyroid Stimulating Hormone TSH are thyroid hormones which affect almost every physiological process in the body, including growth, development, metabolism, body temperature, and heart rate. Production of T3 and its prohormone thyroxine (T4) is activated by thyroid-stimulating hormone (TSH), which is released from the pituitary gland. Elevated concentrations of T3, and T4 in the blood inhibit the production of TSH. Excessive secretion of thyroxine in the body is hyperthyroidism, and deficient secretion is called hypothyroidism. In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hyperthyroidism, TSH levels are low. Below mentioned are the guidelines for Pregnancy related reference ranges for Total T4, TSH & Total T3. Measurement of the serum TT3 level is a more sensitive test for the diagnosis of hyperthyroidism, and measurement of TT4 is more useful in the diagnosis of hypothyroidism. Most of the thyroid hormone in blood is bound to transport proteins. Only a very small fraction of the circulating hormone is free and biologically

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Patient Ref. No. 3100004961101



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active. It is advisable to detect Free T3, FreeT4 along with TSH, instead of testing for albumin bound Total T3, Total T4.

Sr. No.	TSH	Total T4	FT4	Total T3	Possible Conditions
1	High	Low	Low	Low	(1) Primary Hypothyroidism (2) Chronic autoimmune Thyroiditis (3) Post Thyroidectomy (4) Post Radio-Iodine treatment
2	High	Normal	Normal	Normal	(1)Subclinical Hypothyroidism (2) Patient with insufficient thyroid hormone replacement therapy (3) In cases of Autoimmune/Hashimoto thyroiditis (4). Isolated increase in TSH levels can be due to Subclinical inflammation, drugs like amphetamines, Iodine containing drug and dopamine antagonist e.g. domperidone and other physiological reasons.
3	Normal/Low	Low	Low	Low	(1) Secondary and Tertiary Hypothyroidism
4	Low	High	High	High	(1) Primary Hyperthyroidism (Graves Disease) (2) Multinodular Goitre (3)Toxic Nodular Goitre (4) Thyroiditis (5) Over treatment of thyroid hormone (6) Drug effect e.g. Glucocorticoids, dopamine, T4 replacement therapy (7) First trimester of Pregnancy
5	Low	Normal	Normal	Normal	(1) Subclinical Hyperthyroidism
6	High	High	High	High	(1) TSH secreting pituitary adenoma (2) TRH secreting tumor
7	Low	Low	Low	Low	(1) Central Hypothyroidism (2) Euthyroid sick syndrome (3) Recent treatment for Hyperthyroidism
8	Normal/Low	Normal	Normal	High	(1) T3 thyrotoxicosis (2) Non-Thyroidal illness
9	Low	High	High	Normal	(1) T4 Ingestion (2) Thyroiditis (3) Interfering Anti TPO antibodies

REF: 1. TIETZ Fundamentals of Clinical chemistry 2.Guidlines of the American Thyroid association during pregnancy and Postpartum, 2011.

NOTE: It is advisable to detect Free T3,FreeT4 along with TSH, instead of testing for albumin bound Total T3, Total T4.TSH is not affected by variation in thyroid - binding protein. TSH has a diurnal rhythm, with peaks at 2:00 - 4:00 a.m. And troughs at 5:00 - 6:00 p.m. With ultradian variations.

****End Of Report****

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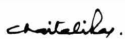
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CONDITIONS OF LABORATORY TESTING & REPORTING

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 AGILUS 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.
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 - i. Specimen received is insufficient or inappropriate
 - ii. Specimen quality is unsatisfactory
 - iii. Incorrect specimen type
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