Patient Ref. No. 775000001712864

CLIENT CODE : C000138376

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

SRL Ltd
PLOT NO.160,POCKET D-11 SECTOR 8, ROHINI

NEW DELHI, 110085
NEW DELHI, INDIA
Tel : 9111591115, Fax :
CIN - U74899PB1995PLC045956
Email : customercare.pitampura@srl.in

PATIENT NAME : ARUN KUMAR PATIENT ID : **ARUNM18098827**

ACCESSION NO : **0062VJ000224** AGE : 34 Years SEX : Male ABHA NO :

DRAWN : RECEIVED : 08/10/2022 09:52:24 REPORTED : 10/10/2022 15:30:49

REFERRING DOCTOR : SELF CLIENT PATIENT ID :

Test Report Status **Final**	Results		Biological Reference Interval	Units
MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE				
BLOOD COUNTS,EDTA WHOLE BLOOD				
HEMOGLOBIN	15.7		13.0 - 17.0	g/dL
RED BLOOD CELL COUNT	5.40		4.5 - 5.5	mil/µL
WHITE BLOOD CELL COUNT	7.00		4.0 - 10.0	thou/µL
PLATELET COUNT	176		150 - 410	thou/µL
RBC AND PLATELET INDICES				
HEMATOCRIT	48.6		40 - 50	%
MEAN CORPUSCULAR VOL	90.2		83 - 101	fL
MEAN CORPUSCULAR HGB.	29.1		27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION	32.3		31.5 - 34.5	g/dL
MENTZER INDEX	16.7			
RED CELL DISTRIBUTION WIDTH	13.4		11.6 - 14.0	%
MEAN PLATELET VOLUME	**13.4**	**High**	6.8 - 10.9	fL
WBC DIFFERENTIAL COUNT - NLR				
SEGMENTED NEUTROPHILS	59		40 - 80	%
ABSOLUTE NEUTROPHIL COUNT	4.13		2.0 - 7.0	thou/µL
LYMPHOCYTES	32		20 - 40	%
ABSOLUTE LYMPHOCYTE COUNT	2.24		1 - 3	thou/µL
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	1.8			
EOSINOPHILS	04		1 - 6	%
ABSOLUTE EOSINOPHIL COUNT	0.28		0.02 - 0.50	thou/µL
MONOCYTES	05		2 - 10	%
ABSOLUTE MONOCYTE COUNT	0.35		0.20 - 1.00	thou/µL
BASOPHILS	00		0 - 2	%
ABSOLUTE BASOPHIL COUNT	**0**	**Low**	0.02 - 0.10	thou/µL
DIFFERENTIAL COUNT PERFORMED ON:	EDTA SMEAR			
ERYTHRO SEDIMENTATION RATE, BLOOD				
SEDIMENTATION RATE (ESR)	10		0 - 14	mm at 1 hr
METHOD : WESTERGREN METHOD				
GLUCOSE, FASTING, PLASMA				

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Test Report Status **Final**	Results		Biological Reference Interval	Units
GLUCOSE, FASTING, PLASMA	**106**	**High**	74 - 99	mg/dL
METHOD : SPECTROPHOTOMETRY, O-CRESOLPHTHALEIN COMPLEXONE				
GLYCOSYLATED HEMOGLOBIN, EDTA WHOLE BLOOD				
GLYCOSYLATED HEMOGLOBIN (HBA1C)	5.7		Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 ADA Target: 7.0 Action suggested: > 8.0	%
MEAN PLASMA GLUCOSE	**116.9**	**High**	< 116.0	mg/dL
GLUCOSE, POST-PRANDIAL, PLASMA				
GLUCOSE, POST-PRANDIAL, PLASMA	132		70 - 139	mg/dL
CORONARY RISK PROFILE, SERUM				
CHOLESTEROL	176		< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
METHOD : CHOD-POD				
TRIGLYCERIDES	97		< 150 Normal 150 - 199 Borderline High 200 - 499 High >/=500 Very High	mg/dL
METHOD : LIPASE / GLUCOSE DEHYDROGENASE				
HDL CHOLESTEROL	**34**	**Low**	< 40 Low >/=60 High	mg/dL
CHOLESTEROL LDL	**123**	**High**	< 100 Optimal 100 - 129 Near optimal/ above optimal 130 - 159 Borderline High 160 - 189 High >/= 190 Very High	mg/dL
NON HDL CHOLESTEROL	**142**	**High**	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL

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CHOL/HDL RATIO	**5.2**	**High**	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	**3.6**	**High**	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
VERY LOW DENSITY LIPOPROTEIN	19.4		</= 30.0	mg/dL
LIVER FUNCTION PROFILE, SERUM				
BILIRUBIN, TOTAL	0.62		0.2 - 1.0	mg/dL
METHOD : SULPH ACID DPL/CAFF-BENZ				
BILIRUBIN, DIRECT	0.11		0.0 - 0.2	mg/dL
METHOD : SULPH ACID DPL/CAFF-BENZ				
BILIRUBIN, INDIRECT	0.51		0.1 - 1.0	mg/dL
METHOD : SPECTROPHOTOMETRY, MODIFIED DIAZO METHOD (JENDRASSIK AND GROF)				
TOTAL PROTEIN	7.8		6.4 - 8.2	g/dL
METHOD : SPECTROPHOTOMETRIC				
ALBUMIN	4.1		3.4 - 5.0	g/dL
METHOD : SPECTROPHOTOMETRIC				
GLOBULIN	3.7		2.0 - 4.1	g/dL
METHOD : CALCULATED PARAMETER				
ALBUMIN/GLOBULIN RATIO	1.1		1.0 - 2.1	RATIO
METHOD : CALCULATED PARAMETER				
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	24		15 - 37	U/L
METHOD : SPECTROPHOTOMETRIC-IFCC WITH UV WITH PYRIDOXAL-5-PHOSPHATE				
ALANINE AMINOTRANSFERASE (ALT/SGPT)	**58**	**High**	< 45.0	U/L
METHOD : SPECTROPHOTOMETRIC-IFCC WITH UV WITH PYRIDOXAL-5-PHOSPHATE				
ALKALINE PHOSPHATASE	**152**	**High**	30 - 120	U/L
METHOD : SPECTROPHOTOMETRIC				
GAMMA GLUTAMYL TRANSFERASE (GGT)	25		15 - 85	U/L
METHOD : SPECTROPHOTOMETRY, O-CRESOLPHTHALEIN COMPLEXONE				
LACTATE DEHYDROGENASE	166		100 - 190	U/L
METHOD : SPECTROPHOTOMETRIC				

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SERUM BLOOD UREA NITROGEN				
BLOOD UREA NITROGEN	15		6 - 20	mg/dL
METHOD : UREASE KINETIC				
CREATININE, SERUM				
CREATININE	**0.77**	**Low**	0.90 - 1.30	mg/dL
METHOD : SPECTROPHOTOMETRY, O-CRESOLPHTHALEIN COMPLEXONE				
BUN/CREAT RATIO				
BUN/CREAT RATIO	**19.48**	**High**	5.00 - 15.00	
URIC ACID, SERUM				
URIC ACID	4.7		3.5 - 7.2	mg/dL
METHOD : URICASE/CATALASE UV				
TOTAL PROTEIN, SERUM				
TOTAL PROTEIN	7.8		6.4 - 8.2	g/dL
METHOD : BIURET				
ALBUMIN, SERUM				
ALBUMIN	4.1		3.4 - 5.0	g/dL
METHOD : SPECTROPHOTOMETRY, O-CRESOLPHTHALEIN COMPLEXONE				
GLOBULIN				
GLOBULIN	3.7		2.0 - 4.1	g/dL
METHOD : SPECTROPHOTOMETRY, O-CRESOLPHTHALEIN COMPLEXONE				
ELECTROLYTES (NA/K/CL), SERUM				
SODIUM	136		136 - 145	mmol/L
METHOD : ISE INDIRECT				
POTASSIUM	4.00		3.50 - 5.10	mmol/L
CHLORIDE	98		98 - 107	mmol/L
METHOD : ISE INDIRECT				
PHYSICAL EXAMINATION, URINE				
COLOR	PALE YELLOW			
APPEARANCE	CLEAR			
SPECIFIC GRAVITY	1.015		1.003 - 1.035	
CHEMICAL EXAMINATION, URINE				
PH	5.5		4.7 - 7.5	
PROTEIN	NOT DETECTED		NOT DETECTED	

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GLUCOSE	NOT DETECTED		NOT DETECTED	
KETONES	NOT DETECTED		NOT DETECTED	
BLOOD	NOT DETECTED		NOT DETECTED	
BILIRUBIN	NOT DETECTED		NOT DETECTED	
UROBILINOGEN	NORMAL		NORMAL	
NITRITE	NOT DETECTED		NOT DETECTED	
LEUKOCYTE ESTERASE	**DETECTED (FEW)**		NOT DETECTED	
MICROSCOPIC EXAMINATION, URINE				
PUS CELL (WBC'S)	1-2		0-5	/HPF
EPITHELIAL CELLS	1-2		0-5	/HPF
ERYTHROCYTES (RBC'S)	NOT DETECTED		NOT DETECTED	/HPF
CASTS	NOT DETECTED			
CRYSTALS	NOT DETECTED			
BACTERIA	NOT DETECTED		NOT DETECTED	
YEAST	NOT DETECTED		NOT DETECTED	
REMARKS	NOTE:- MICROSCOPIC EXAMINATION OF URINE IS PERFORMED BY CENTRIFUGED URINARY SEDIMENT.			
THYROID PANEL, SERUM				
T3	149.70		80.00 - 200.00	ng/dL
T4	9.72		5.10 - 14.10	µg/dL
TSH 3RD GENERATION	**6.480**	**High**	0.270 - 4.200	µIU/mL
STOOL: OVA & PARASITE				
COLOUR	BROWN			
CONSISTENCY	SEMI FORMED			
ODOUR	FAECAL			
MUCUS	ABSENT		NOT DETECTED	
VISIBLE BLOOD	ABSENT		ABSENT	
POLYMORPHONUCLEAR LEUKOCYTES	0 - 1		0 - 5	/HPF
RED BLOOD CELLS	NOT DETECTED		NOT DETECTED	/HPF
MACROPHAGES	NOT DETECTED		NOT DETECTED	
CHARCOT-LEYDEN CRYSTALS	NOT DETECTED		NOT DETECTED	

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TROPHOZOITES	NOT DETECTED	NOT DETECTED	
CYSTS	NOT DETECTED	NOT DETECTED	
OVA	NOT DETECTED		
LARVAE	NOT DETECTED	NOT DETECTED	
ADULT PARASITE	NOT DETECTED		
OCCULT BLOOD	NOT DETECTED	NOT DETECTED	
ABO GROUP & RH TYPE, EDTA WHOLE BLOOD			
ABO GROUP	TYPE B		
METHOD : TUBE AGGLUTINATION			
RH TYPE	POSITIVE		
METHOD : TUBE AGGLUTINATION			
XRAY-CHEST			
»»	BOTH THE LUNG FIELDS ARE CLEAR		
»»	BOTH THE COSTOPHRENIC AND CARIOPHRENIC ANGELS ARE CLEAR		
»»	BOTH THE HILA ARE NORMAL		
»»	CARDIAC AND AORTIC SHADOWS APPEAR NORMAL		
»»	BOTH THE DOMES OF THE DIAPHRAM ARE NORMAL		
»»	VISUALIZED BONY THORAX IS NORMAL		
IMPRESSION	NO ABNORMALITY DETECTED		
TMT OR ECHO			
TMT OR ECHO	NEGATIVE		
ECG			
ECG	WITHIN NORMAL LIMITS		
MEDICAL HISTORY			
RELEVANT PRESENT HISTORY	NOT SIGNIFICANT		
RELEVANT PAST HISTORY	NOT SIGNIFICANT		
RELEVANT PERSONAL HISTORY	MARRIED, 01 CHILD, NON VEG.		
RELEVANT FAMILY HISTORY	MOTHER- HIGH BLOOD PRESSURE, THYROID DISEASE; FATHER - DIABETES		
OCCUPATIONAL HISTORY	FATHER- DIABETES.		
HISTORY OF MEDICATIONS	BANKER.		
ANTHROPOMETRIC DATA & BMI			

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HEIGHT IN METERS	1.64		mts
WEIGHT IN KGS.	79.85		Kgs
BMI	30	BMI & Weight Status as follows: Below 18.5: Underweight 18.5 - 24.9: Normal 25.0 - 29.9: Overweight 30.0 and Above: Obese	kg/sqmts
GENERAL EXAMINATION			
MENTAL / EMOTIONAL STATE	NORMAL		
PHYSICAL ATTITUDE	NORMAL		
GENERAL APPEARANCE / NUTRITIONAL STATUS	HEALTHY		
BUILT / SKELETAL FRAMEWORK	AVERAGE		
FACIAL APPEARANCE	NORMAL		
SKIN	NORMAL		
UPPER LIMB	NORMAL		
LOWER LIMB	NORMAL		
NECK	NORMAL		
NECK LYMPHATICS / SALIVARY GLANDS	NOT ENLARGED OR TENDER		
THYROID GLAND	NOT ENLARGED		
CAROTID PULSATION	NORMAL		
BREAST (FOR FEMALES)	NORMAL		
TEMPERATURE	NORMAL		
PULSE	94/MIN REGULAR, ALL PERIPHERAL PULSES WELL FELT, NO CAROTID BRUIT		
RESPIRATORY RATE	NORMAL		
CARDIOVASCULAR SYSTEM			
BP	115/78 MM HG (SITTING)		mm/Hg
PERICARDIUM	NORMAL		
APEX BEAT	NORMAL		
HEART SOUNDS	S1, S2 HEARD NORMALLY		
MURMURS	ABSENT		
RESPIRATORY SYSTEM			

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SIZE AND SHAPE OF CHEST	NORMAL		
MOVEMENTS OF CHEST	SYMMETRICAL		
BREATH SOUNDS INTENSITY	NORMAL		
BREATH SOUNDS QUALITY	VESICULAR (NORMAL)		
ADDED SOUNDS	ABSENT		
PER ABDOMEN			
APPEARANCE	NORMAL		
VENOUS PROMINENCE	ABSENT		
LIVER	NOT PALPABLE		
SPLEEN	NOT PALPABLE		
HERNIA	ABSENT		
ANY OTHER COMMENTS	NIL		
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		
EYELIDS	NORMAL		
EYE MOVEMENTS	NORMAL		
CORNEA	NORMAL		
DISTANT VISION RIGHT EYE WITHOUT GLASSES	6/12		
DISTANT VISION LEFT EYE WITHOUT GLASSES	6/18		
NEAR VISION RIGHT EYE WITHOUT GLASSES	N/12		
NEAR VISION LEFT EYE WITHOUT GLASSES	N/12		

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COLOUR VISION	NORMAL		
BASIC ENT EXAMINATION			
EXTERNAL EAR CANAL	PRESENCE OF WAX		
TYMPANIC MEMBRANE	NORMAL		
NOSE	NO ABNORMALITY DETECTED		
SINUSES	NORMAL		
THROAT	NORMAL		
TONSILS	NOT ENLARGED		
BASIC DENTAL EXAMINATION			
TEETH	NORMAL		
GUMS	HEALTHY		
ANY OTHER COMMENTS	NIL		
SUMMARY			
RELEVANT HISTORY	NOT SIGNIFICANT		
RELEVANT GP EXAMINATION FINDINGS	NOT SIGNIFICANT		
RELEVANT LAB INVESTIGATIONS	LIPID PROFILE, LIVER ENZYMES, TSH, BUN/CR. RATIO - ABOVE NORMAL LIMITS		
RELEVANT NON PATHOLOGY DIAGNOSTICS	NO ABNORMALITIES DETECTED		
REMARKS / RECOMMENDATIONS	CURTAIL FAT INTAKE; MONITOR DERANED LAB PARAMETERS; EAR PROPHYLAXIS; OPHTHALMOLOGIST CONSULTATION		
FITNESS STATUS			
FITNESS STATUS	FIT (WITH MEDICAL ADVICE) (AS PER REQUESTED PANEL OF TESTS)		

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

MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

ULTRASOUND ABDOMEN

ULTRASOUND ABDOMEN

ULTRASOUND WHOLE ABDOMEN

Liver is normal in size, outline **and shows grade I fatty changes.** No obvious focal parenchymal lesion/biliary dilatation is seen. Hepatic veins and portal venous radicals are normal.
Gall bladder well distended and reveals an echo-free lumen. No wall edema is seen.
No evidence of any calculus, mass lesion or any other abnormality is seen in gall bladder.
Common bile duct is not dilated. Portal vein is normal in course and caliber.
Pancreas
Pancreas is normal in size, outline and echotexture. No evidence of any focal lesion or calcification is seen.
Pancreatic duct is not dilated.
Spleen
Spleen is normal in size, outline and echotexture .No focal lesion/ calcification is seen.
Kidneys
Both kidneys are normal in size, outline and echotexture. Corticomedullary differentiation is well maintained. Parenchymal thickness is normal. No mass lesion, calculus or hydronephrosis is seen.
No significant retroperitoneal lymphadenopathy/ascites is seen.
Urinary Bladder
Urinary bladder is well distended with normal outline.
Prostate
Prostate is normal in size.

Correlate clinically

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.

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Patient Ref. No. 775000001712864

CLIENT CODE : C000138376

CLIENT'S NAME AND ADDRESS :
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Tel : 9111591115, Fax :
CIN - U74899PB1995PLC045956
Email : customercare.pitampura@srl.in

PATIENT NAME : ARUN KUMAR PATIENT ID : **ARUNM18098827**

ACCESSION NO : **0062VJ000224** AGE : 34 Years SEX : Male ABHA NO :

DRAWN : RECEIVED : 08/10/2022 09:52:24 REPORTED : 10/10/2022 15:30:49

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

WBC DIFFERENTIAL COUNT - NLR-
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, Vasculities, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Tissue injury, Pregnancy, Estrogen medication, Aging.
Finding a very accelerated ESR**(>100 mm/hour)** in patients with ill-defined symptoms directs the physician to search for a systemic disease (Paraproteinemias, Disseminated malignancies, connective tissue disease, severe infections such as bacterial endocarditis).
In pregnancy BRI in first trimester is 0-48 mm/hr(62 if anemic) and in second trimester (0-70 mm /hr(95 if anemic). ESR returns to normal 4th week post partum.
Decreased in: Polycythermia vera, Sickle cell anemia

LIMITATIONS
False elevated ESR : Increased fibrinogen, Drugs(Vitamin A, Dextran etc), Hypercholesterolemia
False Decreased : Poikilocytosis,(SickleCells,spherocytes),Microcytosis, Low fibrinogen, Very high WBC counts, Drugs(Quinine, salicylates)

REFERENCE :
1. Nathan and Oski's Haematology of Infancy and Childhood, 5th edition;2. Paediatric reference intervals. AACC Press, 7th edition. Edited by S. Soldin;3. The reference for the adult reference range is "Practical Haematology by Dacie and Lewis,10th edition.
GLUCOSE FASTING,FLUORIDE PLASMA-**TEST DESCRIPTION**
Normally, the glucose concentration in extracellular fluid is closely regulated so that a source of energy is readily available to tissues and sothat no glucose is excreted in the urine.
Increased in
Diabetes mellitus, Cushing' s syndrome (10 – 15%), chronic pancreatitis (30%). Drugs:corticosteroids,phenytoin, estrogen, thiazides.
Decreased in
Pancreatic islet cell disease with increased insulin,insulinoma,adrenocortical insufficiency, hypopituitarism,diffuse liver disease, malignancy (adrenocortical, stomach,fibrosarcoma), infant of a diabetic mother, enzyme deficiency diseases(e.g., galactosemia),Drugs- insulin, ethanol, propranolol; sulfonylureas,tolbutamide, and other oral hypoglycemic agents.
NOTE:
Hypoglycemia is defined as a glucoseof < 50 mg/dL in men and< 40 mg/dL in women.
While random serum glucose levels correlate with home glucose monitoring results (weekly mean capillary glucose values), there is wide fluctuation within individuals.Thus, glycosylated hemoglobin(HbA1c) levels are favored to monitor glycemic control.
High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glyosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD-**Used For**:

1.Evaluating the long-term control of blood glucose concentrations in diabetic patients.
2.Diagnosing diabetes.
3.Identifying patients at increased risk for diabetes (prediabetes).
The ADA recommends measurement of HbA1c (typically 3-4 times per year for type 1 and poorly controlled type 2 diabetic patients, and 2 times per year for well-controlled type 2 diabetic patients) to determine whether a 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 :
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 addiction are reported to interfere with some assay methods,falsely increasing results.

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IV.Interference of hemoglobinopathies in HbA1c estimation is seen in
a.Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.
b.Heterozygous state detected (D10 is corrected for HbS & HbC trait.)
c.HbF > 25% on alternate paltform (Boronate affinity chromatography) is recommended for testing of HbA1c.Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy
GLUCOSE, POST-PRANDIAL, PLASMA-High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glyosuria, 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 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
BLOOD UREA NITROGEN (BUN), SERUM-Causes of Increased levels include Pre renal (High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal), Renal Failure, Post Renal (Malignancy, Nephrolithiasis, Prostatism)
Causes of decreased level include Liver disease, SIADH.
CREATININE, SERUM-Higher than normal level may be due to:
• Blockage in the urinary tract
• Kidney problems, such as kidney damage or failure, infection, or reduced blood flow
• Loss of body fluid (dehydration)
• Muscle problems, such as breakdown of muscle fibers
• Problems during pregnancy, such as seizures (eclampsia)), or high blood pressure caused by pregnancy (preeclampsia)

Lower than normal level may be due to:
• Myasthenia Gravis
• Muscular dystrophy
URIC ACID, SERUM-
Causes of Increased levels
Dietary
• High Protein Intake.
• Prolonged Fasting,
• Rapid weight loss.
Gout
Lesch nyhan syndrome.
Type 2 DM.
Metabolic syndrome.

Causes of decreased levels
• Low Zinc Intake
• OCP's

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PATIENT NAME : ARUN KUMAR PATIENT ID : **ARUNM18098827**

ACCESSION NO : **0062VJ000224** AGE : 34 Years SEX : Male ABHA NO :

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• 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 (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,

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 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)

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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. Kilegman R.M., Jenson H. B. Nelson Text Book of Pediatrics, 17th Edition
STOOL: OVA & PARASITE-
Acute infective diarrhoea and gastroenteritis (diarrhoea with vomiting) are major causes of ill health and premature death in developing countries. Loss of water and electrolytes from the body can lead to severe dehydration which if untreated, can be rapidly fatal in young children, especially that are malnourished, hypoglycaemic, and generally in poor health.

Laboratory diagnosis of parasitic infection is mainly based on microscopic examination and the gross examination of the stool specimen. Depending on the nature of the parasite, the microscopic observations include the identification of cysts, ova, trophozoites, larvae or portions of adult structure. The two classes of parasites that cause human infection are the Protozoa and Helminths. The protozoan infections include amoebiasis mainly caused by Entamoeba histolytica and giardiasis caused by Giardia lamblia. The common helminthic parasites are Trichuris trichiura, Ascaris lumbricoides, Strongyloides stercoralis, Taenia sp. etc
ABO GROUP & RH TYPE, EDTA WHOLE BLOOD-
Blood group is identified by antigens and antibodies present in the blood. Antigens are protein molecules found on the surface of red blood cells. Antibodies are found in plasma. To determine blood group, red cells are mixed with different antibody solutions to give A,B,O or AB.

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

The test is performed by both forward as well as reverse grouping methods.
MEDICAL
HISTORY-**********
THIS REPORT CARRIES THE SIGNATURE OF OUR LABORATORY DIRECTOR. THIS IS AN INVIOLABLE FEATURE OF OUR LAB MANAGEMENT SOFTWARE. HOWEVER, ALL EXAMINATIONS AND INVESTIGATIONS HAVE BEEN CONDUCTED BY OUR PANEL OF DOCTORS.

****
FITNESS STATUS-
Conclusion on an individual's Fitness, which is commented upon mainly for Pre employment cases, is based on multi factorial findings and does not depend on any one single parameter. The final Fitness assigned to a candidate will depend on the Physician's findings and overall judgement on a case to case basis, details of the candidate's past and personal history; as well as the comprehensiveness of the diagnostic panel which has been requested for .These are then further correlated with details of the job under consideration to eventually fit the right man to the right job.
Basis the above, SRL classifies a candidate's Fitness Status into one of the following categories:
• Fit (As per requested panel of tests) – SRL Limited gives the individual a clean chit to join the organization, on the basis of the General Physical Examination and the specific test panel requested for.
• Fit (with medical advice) (As per requested panel of tests) - This indicates that although the candidate can be declared as FIT to join the job, minimal problems have been detected during the Pre- employment examination. Examples of conditions which could fall in this category could be cases of mild reversible medical abnormalities such as height weight disproportions, borderline raised Blood Pressure readings, mildly raised Blood sugar and Blood Lipid levels, Hematuria, etc. Most of these relate to sedentary lifestyles and come under the broad category of life style disorders. The idea is to caution an individual to bring about certain lifestyle changes as well as seek a Physician's consultation and counseling in order to bring back to normal the mildly deranged parameters. For all purposes the individual is FIT to join the job.
• Fitness on Hold (Temporary Unfit) (As per requested panel of tests) - Candidate's reports are kept on hold when either the diagnostic tests or the physical findings reveal the presence of a medical condition which warrants further tests, counseling and/or specialist opinion, on the basis of which a candidate can either be placed into Fit, Fit (With Medical Advice), or Unfit category. Conditions which may fall into this category could be high blood pressure, abnormal ECG, heart murmurs, abnormal vision, grossly elevated blood sugars, etc.
• Unfit (As per requested panel of tests) - An unfit report by SRL Limited clearly indicates that the individual is not suitable for the respective job profile e.g. total color blindness in color related jobs.

****End Of Report****
Please visit www.srlworld.com for related Test Information for this accession

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K.I. Prajapati

Dr. Kamlesh I Prajapati
Consultant Pathologist

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