



CLIENT CODE : C000138364

CLIENT'S NAME AND ADDRESS :
ACROFEMI HEALTHCARE LTD (MEDIWHEEL)
F-703, LADO SARAI, MEHRAULI
SOUTH WEST DELHI
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AHMEDABAD, 380015
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Tel : 079-48912999, 079-48913999, 079-48914999
Email : customercare.ahmedabad@srl.in

PATIENT NAME : CHITRA SHARMA

PATIENT ID : CHITF190282321

ACCESSION NO : 0321VF001955 AGE : 40 Years SEX : Female

ABHA NO :

DRAWN : 25-06-2022 00:00

RECEIVED : 25-06-2022 09:37

REPORTED : 01-07-2022 16:27

REFERRING DOCTOR : SELF

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Test Report Status	Preliminary	Results	Biological Reference Interval	Units
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MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE**BLOOD COUNTS, EDTA WHOLE BLOOD**

HEMOGLOBIN	11.4	Low	12.0 - 15.0	g/dL
RED BLOOD CELL COUNT	4.37		3.8 - 4.8	mil/ μ L
WHITE BLOOD CELL COUNT	8.63		4.0 - 10.0	thou/ μ L
PLATELET COUNT	357		150 - 410	thou/ μ L

RBC AND PLATELET INDICES

HEMATOCRIT	35.7	Low	36.0 - 46.0	%
MEAN CORPUSCULAR VOL	81.8	Low	83.0 - 101.0	fL
MEAN CORPUSCULAR HGB.	26.1	Low	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION	31.9		31.5 - 34.5	g/dL
MENTZER INDEX	18.7			
RED CELL DISTRIBUTION WIDTH	15.8	High	11.6 - 14.0	%
MEAN PLATELET VOLUME	7.9		6.8 - 10.9	fL

WBC DIFFERENTIAL COUNT - NLR

SEGMENTED NEUTROPHILS	60		40 - 80	%
ABSOLUTE NEUTROPHIL COUNT	5.18		2.0 - 7.0	thou/ μ L
LYMPHOCYTES	33		20 - 40	%
ABSOLUTE LYMPHOCYTE COUNT	2.85		1.0 - 3.0	thou/ μ L
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	1.8			
EOSINOPHILS	3		1.0 - 6.0	%
ABSOLUTE EOSINOPHIL COUNT	0.26		0.02 - 0.50	thou/ μ L
MONOCYTES	4		2.0 - 10.0	%
ABSOLUTE MONOCYTE COUNT	0.35		0.2 - 1.0	thou/ μ L
BASOPHILS	0		0 - 1	%
ABSOLUTE BASOPHIL COUNT	0.00	Low	0.02 - 0.10	thou/ μ L

DIFFERENTIAL COUNT PERFORMED ON: EDTA SMEAR

MORPHOLOGY

RBC	NORMOCYTIC NORMOCHROMIC
WBC	NORMAL MORPHOLOGY
PLATELETS	ADEQUATE
REMARKS	NO PREMATURE CELLS ARE SEEN. MALARIAL PARASITE NOT DETECTED.

ERYTHRO SEDIMENTATION RATE, BLOOD

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SEDIMENTATION RATE (ESR)		40	High 0 - 20	mm at 1 hr
GLUCOSE, FASTING, PLASMA				
GLUCOSE, FASTING, PLASMA		112	High 74 - 99	mg/dL
GLYCOSYLATED HEMOGLOBIN, EDTA WHOLE BLOOD				
GLYCOSYLATED HEMOGLOBIN (HBA1C)		5.6	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		114.0	< 116.0	mg/dL
GLUCOSE, POST-PRANDIAL, PLASMA				
GLUCOSE, POST-PRANDIAL, PLASMA		120	70 - 140	mg/dL
CORONARY RISK PROFILE (LIPID PROFILE), SERUM.				
CHOLESTEROL		194	Desirable: < 200 BorderlineHigh: 200 - 239 High: > or = 240	mg/dL
TRIGLYCERIDES		86	Desirable: < 150 BorderlineHigh: 150 - 199 High: 200 - 499 Very High: > or = 500	mg/dL
HDL CHOLESTEROL		39	Low < 40 Low > or = 60 High	mg/dL
DIRECT LDL CHOLESTEROL		135	High Optimal: < 100 NearOptimal/AboveOptimal: 100 - 129 BorderlineHigh: 130 - 159 High: 160 - 189 VeryHigh: = 190	mg/dL
NON HDL CHOLESTEROL		155	High Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
CHOL/HDL RATIO		5.0	High 3.30 - 4.40	
LDL/HDL RATIO		3.5	High 0.5 - 3.0	
VERY LOW DENSITY LIPOPROTEIN		17.2	< or = 30.0	mg/dL
LIVER FUNCTION PROFILE, SERUM				
BILIRUBIN, TOTAL		0.27	Upto 1.2	mg/dL
BILIRUBIN, DIRECT		0.12	Upto 0.2	mg/dL
BILIRUBIN, INDIRECT		0.15	0.00 - 1.00	mg/dL
TOTAL PROTEIN		7.8	6.4 - 8.3	g/dL
ALBUMIN		4.6	3.5 - 5.2	g/dL





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GLOBULIN		3.2	2.0 - 4.1	g/dL
ALBUMIN/GLOBULIN RATIO		1.4	1.0 - 2.0	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT)		11	0 - 32	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)		8	0 - 33	U/L
ALKALINE PHOSPHATASE		112	High 35 - 104	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)		15	5 - 36	U/L
LACTATE DEHYDROGENASE		182	135 - 214	U/L
SERUM BLOOD UREA NITROGEN				
BLOOD UREA NITROGEN		5	Low 6 - 20	mg/dL
CREATININE, SERUM				
CREATININE		0.70	0.60 - 1.10	mg/dL
BUN/CREAT RATIO				
BUN/CREAT RATIO		7.14	5.0 - 15.0	
URIC ACID, SERUM				
URIC ACID		4.8	2.4 - 5.7	mg/dL
ELECTROLYTES (NA/K/CL), SERUM				
SODIUM		141.9	136- 145	mmol/L
POTASSIUM		4.57	3.50- 5.10	mmol/L
CHLORIDE		105.3	98 - 107	mmol/L
PHYSICAL EXAMINATION, URINE				
COLOR		Yellow		
APPEARANCE		Clear		
SPECIFIC GRAVITY		1.020	1.003 - 1.035	
CHEMICAL EXAMINATION, URINE				
PH		6.0	4.7 - 7.5	
PROTEIN		NOT DETECTED	NOT DETECTED	
GLUCOSE		NOT DETECTED	NOT DETECTED	
KETONES		NOT DETECTED	NOT DETECTED	
BLOOD		NOT DETECTED	NOT DETECTED	
BILIRUBIN		NOT DETECTED	NOT DETECTED	
UROBILINOGEN		NORMAL	NORMAL	
NITRITE		NOT DETECTED	NOT DETECTED	
LEUKOCYTE ESTERASE		NOT DETECTED	NOT DETECTED	
MICROSCOPIC EXAMINATION, URINE				





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PUS CELL (WBC'S)		2-3	0-5	/HPF
EPITHELIAL CELLS		NOT DETECTED	NOT DETECTED	/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				

MICROSCOPIC EXAMINATION OF URINE IS CARRIED OUT ON
CENTRIFUGED URINARY SEDIMENT.

THYROID PANEL, SERUM

T3	126.6	80.00 - 200.00	ng/dL
T4	7.63	5.10 - 14.10	µg/dL
TSH 3RD GENERATION	2.980	0.270 - 4.200	µIU/mL

PAPANICOLAOU SMEAR

RESULT PENDING

LETTER

RESULT PENDING

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP	TYPE AB
RH TYPE	POSITIVE

XRAY-CHEST

IMPRESSION NO ABNORMALITY DETECTED

TMT OR ECHO

TMT OR ECHO TMT:- NORMAL

ECG

ECG NORMAL SINUS RHYTHM

MEDICAL HISTORY

RELEVANT PRESENT HISTORY	NOT SIGNIFICANT
RELEVANT PAST HISTORY	NOT SIGNIFICANT
RELEVANT PERSONAL HISTORY	NOT SIGNIFICANT
MENSTRUAL HISTORY (FOR FEMALES)	REGULAR
LMP (FOR FEMALES)	12/06/2022
OBSTETRIC HISTORY (FOR FEMALES)	G1,P1,A0,L1
LCB (FOR FEMALES)	10 YEARS SON
RELEVANT FAMILY HISTORY	DIABETES
OCCUPATIONAL HISTORY	NOT SIGNIFICANT



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HISTORY OF MEDICATIONS

NOT SIGNIFICANT

ANTHROPOMETRIC DATA & BMI

HEIGHT IN METERS

1.66

mts

WEIGHT IN KGS.

85.5

Kgs

BMI

31

BMI & Weight Status as follows: kg/sqmts
Below 18.5: Underweight
18.5 - 24.9: Normal
25.0 - 29.9: Overweight
30.0 and Above: Obese

GENERAL EXAMINATION

MENTAL / EMOTIONAL STATE

NORMAL

PHYSICAL ATTITUDE

NORMAL

GENERAL APPEARANCE / NUTRITIONAL STATUS

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

TEMPERATURE

NORMAL

PULSE

78/MIN

RESPIRATORY RATE

NORMAL

CARDIOVASCULAR SYSTEM

BP

130/84 MM HG
(SITTING)

mm/Hg

PERICARDIUM

NORMAL

APEX BEAT

NORMAL

HEART SOUNDS

S1, S2 HEARD NORMALLY

MURMURS

ABSENT

RESPIRATORY SYSTEM

SIZE AND SHAPE OF CHEST

NORMAL

MOVEMENTS OF CHEST

SYMMETRICAL

BREATH SOUNDS INTENSITY

NORMAL

BREATH SOUNDS QUALITY

VESICULAR (NORMAL)



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ADDED SOUNDS ABSENT

PER ABDOMEN

APPEARANCE NORMAL

LIVER NOT PALPABLE

SPLEEN NOT PALPABLE

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

DISTANT VISION RIGHT EYE WITHOUT GLASSES WITHIN NORMAL LIMIT

DISTANT VISION LEFT EYE WITHOUT GLASSES WITHIN NORMAL LIMIT

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 NOT SIGNIFICANT

RELEVANT LAB INVESTIGATIONS ESR:- HIGH

HDL:- LOW, LDL:- HIGH

ALKALINE PHOSPHATASE:- HIGH

RELEVANT NON PATHOLOGY DIAGNOSTICS USG ABDOMEN:- FATTY LIVER WITH HEPATOMEGALY

REMARKS / RECOMMENDATIONS 1) ESR:- HIGH

ADV:- PHYSICIAN OPINION

2) HDL:- LOW, LDL:- HIGH, ALKALINE PHOSPHATASE:- HIGH

ADV:- LOW FAT DIET, REGULAR PHYSICAL EXERCISE





Patient Ref. No. 777000002182393

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Comments

OUR PANEL DOCTORS FOR NON-PATHOLOGY TESTS:-

GENERAL PHYSICIAN:- DR. PRIYANK KAPADIYA (M.B.B.S DNB MEDICINE)

RADIOLOGIST:- DR. KALPANA MODI (M.D.RADIOLOGY) // DR. SAHIL N SHAH (M.D.RADIOLOGY)

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 - 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.

ERYTHRO SEDIMENTATION RATE, BLOOD-

Erythrocyte sedimentation rate (ESR) is a non-specific phenomena and is clinically useful in the diagnosis and monitoring of disorders associated with an increased production of acute phase reactants. The ESR is increased in pregnancy from about the 3rd month and returns to normal by the 4th week post partum. ESR is influenced by age, sex, menstrual cycle and drugs (eg. corticosteroids, contraceptives). It is especially low (0 -1mm) in polycythaemia, hypofibrinogenemia or congestive cardiac failure and when there are abnormalities of the red cells such as poikilocytosis, spherocytosis or sickle cells.

Reference :

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

GLUCOSE, FASTING, PLASMA-

ADA 2021 guidelines for adults, after 8 hrs fasting is as follows:

Pre-diabetics: 100 - 125 mg/dL

Diabetic: > or = 126 mg/dL

GLYCOSYLATED HEMOGLOBIN, EDTA WHOLE BLOOD-

Glycosylated hemoglobin (GHb) has been firmly established as an index of long-term blood glucose concentrations and as a measure of the risk for the development of complications in patients with diabetes mellitus. Formation of GHb is essentially irreversible, and the concentration in the blood depends on both the life span of the red blood cell (average 120 days) and the blood glucose concentration. Because the rate of formation of GHb is directly proportional to the concentration of glucose in the blood, the GHb concentration represents the integrated values for glucose over the preceding 6-8 weeks.

Any condition that alters the life span of the red blood cells has the potential to alter the GHb level. Samples from patients with hemolytic anemias will exhibit decreased glycosylated hemoglobin values due to the shortened life span of the red cells. This effect will depend upon the severity of the anemia. Samples from patients with polycythemia or post-splenectomy may exhibit increased glycosylated hemoglobin values due to a somewhat longer life span of the red cells.

Glycosylated hemoglobins results from patients with HbSS, HbCC, and HbSC and HbD must be interpreted with caution, given the pathological processes, including anemia, increased red cell turnover, transfusion requirements, that adversely impact HbA1c as a marker of long-term glycemic control. In these conditions, alternative forms of testing such as glycosylated serum protein (fructosamine) should be considered.

"Targets should be individualized; More or less stringent glycemic goals may be appropriate for individual patients. Goals should be individualized based on duration of diabetes, age/life expectancy, comorbid conditions, known CVD or advanced microvascular complications, hypoglycemia unawareness, and individual patient considerations."

References

1. Tietz Textbook of Clinical Chemistry and Molecular Diagnostics, edited by Carl A Burtis, Edward R. Ashwood, David E Bruns, 4th Edition, Elsevier publication, 2006, 879-884.
 2. Forsham PH. Diabetes Mellitus: A rational plan for management. Postgrad Med 1982, 71, 139-154.
 3. Mayer TK, Freedman ZR: Protein glycosylation in Diabetes Mellitus: A review of laboratory measurements and their clinical utility. Clin Chim Acta 1983, 127, 147-184.
- GLUCOSE, POST-PRANDIAL, PLASMA-ADA Guidelines for 2hr post prandial glucose levels is only after ingestion of 75grams of glucose in 300 ml water, over a period of 5 minutes.



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CORONARY RISK PROFILE (LIPID PROFILE), SERUM.-

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

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

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

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

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

Recommendations:

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

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

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 and 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.

SERUM BLOOD UREA NITROGEN-

Causes of Increased levels

Pre renal

- High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal
- Renal Failure

Post Renal

- Malignancy, Nephrolithiasis, Prostatism





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PATIENT NAME : CHITRA SHARMA

PATIENT ID : CHITF190282321

ACCESSION NO : 0321VF001955 AGE : 40 Years SEX : Female ABHA NO :

DRAWN : 25-06-2022 00:00 RECEIVED : 25-06-2022 09:37 REPORTED : 01-07-2022 16:27

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Causes of decreased levels

- 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
- 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

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 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



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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 (µg/dL)	TSH3G (µIU/mL)	TOTAL T3 (ng/dL)
Pregnancy			
First Trimester	6.6 - 12.4	0.1 - 2.5	81 - 190
2nd Trimester	6.6 - 15.5	0.2 - 3.0	100 - 260
3rd Trimester	6.6 - 15.5	0.3 - 3.0	100 - 260

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

	T3 (ng/dL)	T4 (µg/dL)
New Born:	75 - 260	1-3 day: 8.2 - 19.9
.		1 Week: 6.0 - 15.9

NOTE: TSH concentrations in apparently normal euthyroid subjects are known to be highly skewed, with a strong tailed distribution towards higher TSH values. This is well documented in the pediatric population including the infant age group.

Kindly note: Method specific reference ranges are appearing on the report under biological reference range.

Reference:

1. Burtis C.A., Ashwood E. R. Bruns D.E. Teitz textbook of Clinical Chemistry and Molecular Diagnostics, 4th Edition.
2. Gowenlock A.H. Varley's Practical Clinical Biochemistry, 6th Edition.
3. Behrman R.E. Kilegman 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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MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE**ULTRASOUND ABDOMEN****ULTRASOUND ABDOMEN**

FATTY LIVER WITH HEPATMOEGALY

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

Dr. Priyank Kapadia
Physician

Dr. Kalpana Modi
Radiologist

Dr. Sahil .N. Shah
Consultant Radiologist

Dr. Miral Gajera
Consultant Pathologist

CONDITIONS OF LABORATORY TESTING & REPORTING

1. It is presumed that the test sample belongs to the patient named or identified in the test requisition form.
2. All Tests are performed and reported as per the turnaround time stated in the SRL Directory of services (DOS).
3. SRL confirms that all tests have been performed or assayed with highest quality standards, clinical safety & technical integrity.
4. A requested test might not be performed if:
 - a. Specimen received is insufficient or inappropriate specimen quality is unsatisfactory
 - b. Incorrect specimen type
 - c. Request for testing is withdrawn by the ordering doctor or patient
 - d. There is a discrepancy between the label on the specimen container and the name on the test requisition form
5. The results of a laboratory test are dependent on the quality of the sample as well as the assay technology.
6. Result delays could be because of uncontrolled circumstances. e.g. assay run failure.
7. Tests parameters marked by asterisks are excluded from the "scope" of NABL accredited tests. (If laboratory is accredited).
8. Laboratory results should be correlated with clinical information to determine Final diagnosis.
9. Test results are not valid for Medico- legal purposes.
10. In case of queries or unexpected test results please call at SRL customer care (Toll free: 1800-222-000). Post proper investigation repeat analysis may be carried out.

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