

PATIENT NAME : RUPALI CHAUDHARI		REF. DOCTOR : SELF	
CODE/NAME & ADDRESS :C000138394 ACROFEMI HEALTHCARE LTD ( MEDIWHEEL ) F-703, F-703, LADO SARAI, MEHRAULISOUTH- WEST DELHI NEW DELHI 110030 8800465156	ACCESSION NO : 0181WE000440 PATIENT ID : RUPAF130590181 CLIENT PATIENT ID: ABHA NO :	AGE/SEX :33 Years Female DRAWN : RECEIVED :13/05/2023 09:18:42 REPORTED :16/05/2023 13:36:23	

Test Report Status	<b>Final</b>	Results	Biological Reference Interval	Units
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**MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FFEMALE**

XRAY-CHEST

**IMPRESSION** NO ABNORMALITY DETECTED

TMT OR ECHO

**TMT OR ECHO** NEGATIVE

ECG

**ECG** WITHIN NORMAL LIMITS

MEDICAL HISTORY

**RELEVANT PRESENT HISTORY** h/o migraine.

**RELEVANT PAST HISTORY** NOT SIGNIFICANT

**RELEVANT PERSONAL HISTORY** MARRIED / 1 CHILD / MIXED DIET / NO ALLERGIES / NO SMOKING / NO ALCOHOL.

**MENSTRUAL HISTORY (FOR FEMALES)** 28 days.

**LMP (FOR FEMALES)** 20/03/2023.

**OBSTETRIC HISTORY (FOR FEMALES)** C-SECTION

**RELEVANT FAMILY HISTORY** HIGH BLOOD PRESSURE : FATHER.

DIABETES : MOTHER.

THYROID : MOTHER.

NOT SIGNIFICANT

**HISTORY OF MEDICATIONS**

**ANTHROPOMETRIC DATA & BMI**

**HEIGHT IN METERS** 1.61 mts

**WEIGHT IN KGS.** 60 Kgs

**BMI** 23 BMI & Weight Status as follows/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** HEALTHY

**BUILT / SKELETAL FRAMEWORK** AVERAGE

**FACIAL APPEARANCE** NORMAL



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MAHARASHTRA, INDIA  
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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	74/MIN.REGULAR, ALL PERIPHERAL PULSES WELL FELT, NO CAROTID BRUIT		
RESPIRATORY RATE	NORMAL		
CARDIOVASCULAR SYSTEM			
BP	112/70 MM HG (SUPINE)		mm/Hg
PERICARDIUM	NORMAL		
APEX BEAT	NORMAL		
HEART SOUNDS	NORMAL		
MURMURS	ABSENT		
RESPIRATORY SYSTEM			
SIZE AND SHAPE OF CHEST	NORMAL		
MOVEMENTS OF CHEST	SYMMETRICAL		
BREATH SOUNDS INTENSITY	NORMAL		
BREATH SOUNDS QUALITY	VESICULAR (NORMAL)		
ADDED SOUNDS	ABSENT		
PER ABDOMEN			
APPEARANCE	NORMAL		
VENOUS PROMINENCE	ABSENT		
LIVER	NOT PALPABLE		
SPLEEN	NOT PALPABLE		
HERNIA	ABSENT		
CENTRAL NERVOUS SYSTEM			
HIGHER FUNCTIONS	NORMAL		
CRANIAL NERVES	NORMAL		



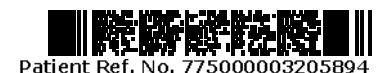
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CEREBELLAR FUNCTIONS	NORMAL
SENSORY SYSTEM	NORMAL
MOTOR SYSTEM	NORMAL
REFLEXES	NORMAL
MUSCULOSKELETAL SYSTEM	
SPINE	NORMAL
JOINTS	NORMAL
BASIC EYE EXAMINATION	
CONJUNCTIVA	NORMAL
EYELIDS	NORMAL
EYE MOVEMENTS	NORMAL
CORNEA	NORMAL
DISTANT VISION RIGHT EYE WITHOUT GLASSES	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
NEAR VISION RIGHT EYE WITH GLASSES	GLASSES NOT BROUGHT
NEAR VISION LEFT EYE WITH GLASSES	GLASSES NOT BROUGHT
COLOUR VISION	NORMAL
SUMMARY	
RELEVANT HISTORY	NOT SIGNIFICANT
RELEVANT GP EXAMINATION FINDINGS	NOT SIGNIFICANT
REMARKS / RECOMMENDATIONS	DRINK 2-3 LITRE WATER DAILY. REPEAT URINE ROUTINE AFTER 15 DAYS ANNUAL USG PELVIS TO MONITOR UTERINE FIBROID.



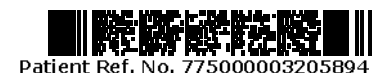
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ULTRASOUND ABDOMEN

ULTRASOUND ABDOMEN

SMALL SUBSEROVAL UTERINE FIBROID.

NO OTHER SIGNIFICANT ABNORMALITY IS SEEN.

**Interpretation(s)**

MEDICAL

HISTORY-

THIS REPORT CARRIES THE SIGNATURE OF OUR LABORATORY DIRECTOR. THIS IS AN INVOLABLE FEATURE OF OUR LAB MANAGEMENT SOFTWARE. HOWEVER, ALL EXAMINATIONS AND INVESTIGATIONS HAVE BEEN CONDUCTED BY OUR PANEL OF DOCTORS.

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**\*\*End Of Report\*\***

Please visit [www.srlworld.com](http://www.srlworld.com) for related Test Information for this accession



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HAEMATOLOGY - CBC

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

BLOOD COUNTS,EDTA WHOLE BLOOD

<b>HEMOGLOBIN (HB)</b> METHOD : SLS- HEMOGLOBIN DETECTION METHOD	13.3	12.0 - 15.0	g/dL
<b>RED BLOOD CELL (RBC) COUNT</b> METHOD : HYDRODYNAMIC FOCUSING BY DC DETECTION	4.81 High	3.8 - 4.8	mil/ $\mu$ L
<b>WHITE BLOOD CELL (WBC) COUNT</b> METHOD : FLUORESCENCE FLOW CYTOMETRY	11.01 High	4.0 - 10.0	thou/ $\mu$ L
<b>PLATELET COUNT</b> METHOD : HYDRODYNAMIC FOCUSING BY DC DETECTION	406	150 - 410	thou/ $\mu$ L
<b>RBC AND PLATELET INDICES</b>			
<b>HEMATOCRIT (PCV)</b> METHOD : CUMULATIVE PULSE HEIGHT DETECTION METHOD	41.4	36.0 - 46.0	%
<b>MEAN CORPUSCULAR VOLUME (MCV)</b> METHOD : CALCULATED FROM RBC & HCT	86.1	83.0 - 101.0	fL
<b>MEAN CORPUSCULAR HEMOGLOBIN (MCH)</b> METHOD : CALCULATED FROM THE RBC & HGB	27.7	27.0 - 32.0	pg
<b>MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)</b> METHOD : CALCULATED FROM THE HGB & HCT	32.1	31.5 - 34.5	g/dL
<b>RED CELL DISTRIBUTION WIDTH (RDW)</b> METHOD : CALCULATED FROM RBC SIZE DISTRIBUTION CURVE	13.0	11.6 - 14.0	%
<b>MENTZER INDEX</b>	17.9		
<b>MEAN PLATELET VOLUME (MPV)</b> METHOD : CALCULATED FROM PLATELET COUNT & PLATELET HEMATOCRIT	9.8	6.8 - 10.9	fL
<b>WBC DIFFERENTIAL COUNT</b>			
<b>NEUTROPHILS</b> METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING	70	40 - 80	%
<b>LYMPHOCYTES</b> METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING	23	20 - 40	%
<b>MONOCYTES</b> METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING	5	2 - 10	%
<b>EOSINOPHILS</b> METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING	2	1 - 6	%
<b>ABSOLUTE NEUTROPHIL COUNT</b> METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING	7.71 High	2.0 - 7.0	thou/ $\mu$ L
<b>ABSOLUTE LYMPHOCYTE COUNT</b>	2.50	1.0 - 3.0	thou/ $\mu$ L

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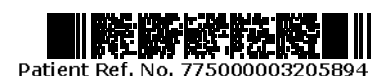


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METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING

**ABSOLUTE MONOCYTE COUNT** 0.55 0.2 - 1.0 thou/ $\mu$ L

METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING

**ABSOLUTE EOSINOPHIL COUNT** 0.16 0.02 - 0.50 thou/ $\mu$ L

METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING

**NEUTROPHIL LYMPHOCYTE RATIO (NLR)** 3.1

MORPHOLOGY

**RBC** NORMOCYTIC NORMOCHROMIC

**WBC** NORMAL MORPHOLOGY

METHOD : MICROSCOPIC EXAMINATION

**PLATELETS** ADEQUATE

**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 BELOW 40 FEMALE

ERYTHROCYTE SEDIMENTATION RATE (ESR), WHOLE BLOOD

**E.S.R** **14** **< 20** mm at 1 hr

METHOD : MODIFIED WESTERGREN

#### Interpretation(s)

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 automatic 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 : Increase in fibrinogen, Drugs (Vitamin A, Dextran etc), Hypercholesterolemia

**False Decreased** : Poikilocytosis, (Sickle Cells, spherocytes), Microcytosis, Low fibrinogen, Very high WBC counts, Drugs (Quinine, salicylates)

#### REFERENCE :

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

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IMMUNOHAEMATOLOGY

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

**ABO GROUP**

**TYPE B**

METHOD : GEL COLUMN AGGLUTINATION METHOD.

**RH TYPE**

**POSITIVE**

METHOD : GEL COLUMN AGGLUTINATION 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.

*Chinchkhede*

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BIOCHEMISTRY

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40 FEMALE

GLUCOSE FASTING, FLUORIDE PLASMA

FBS (FASTING BLOOD SUGAR)	93	Normal 75 - 99 Pre-diabetics: 100 - 125 Diabetic: > or = 126	mg/dL
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METHOD : ENZYMATIC REFERENCE METHOD WITH HEXOKINASE  
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE  
BLOOD

HBA1C	5.1	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)

ESTIMATED AVERAGE GLUCOSE(EAG)	99.7	< 116.0	mg/dL
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METHOD : CALCULATED PARAMETER  
GLUCOSE, POST-PRANDIAL, PLASMA

PPBS(POST PRANDIAL BLOOD SUGAR)	105	70 - 139	mg/dL
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METHOD : ENZYMATIC REFERENCE METHOD WITH HEXOKINASE  
LIPID PROFILE, SERUM

CHOLESTEROL, TOTAL	153	Desirable : < 200 Borderline : 200 - 239 High : > / = 240	mg/dL
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METHOD : ENZYMATIC COLORIMETRIC ASSAY  
TRIGLYCERIDES

TRIGLYCERIDES	63	Normal: < 150 Borderline high: 150 - 199 High: 200 - 499 Very High: > / = 500	mg/dL
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METHOD : ENZYMATIC COLORIMETRIC ASSAY  
HDL CHOLESTEROL

HDL CHOLESTEROL	44	At Risk: < 40 Desirable: > or = 60	mg/dL
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METHOD : ENZYMATIC, COLORIMETRIC

Dr. Ushma Wartikar  
Consultant Pathologist

Dr. Priyal Chinchkhede  
Consultant Pathologist

Dr. (Mrs) Neelu K Bhojani  
Lab Head

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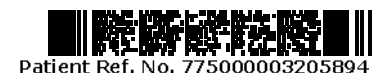
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**CHOLESTEROL LDL** 96 **Adult levels:** mg/dL  
 Optimal < 100  
 Near optimal/above optimal:  
 100-129  
 Borderline high : 130-159  
 High : 160-189  
 Very high : = 190

METHOD : ENZYMATIC COLORIMETRIC ASSAY

**NON HDL CHOLESTEROL** 109 **Desirable :** < 130 mg/dL  
 Above Desirable : 130 -159  
 Borderline High : 160 - 189  
 High : 190 - 219  
 Very high : > / = 220

**VERY LOW DENSITY LIPOPROTEIN** 12.6 **< OR = 30.0** mg/dL

**CHOL/HDL RATIO** 3.5 **Low Risk :** 3.3 - 4.4  
**Average Risk :** 4.5 - 7.0  
**Moderate Risk :** 7.1 - 11.0  
**High Risk :** > 11.0

**LDL/HDL RATIO** 2.2 **0.5 - 3.0 Desirable/Low Risk**  
**3.1 - 6.0 Borderline/Moderate Risk**  
**>6.0 High Risk**

Interpretation(s)

LIVER FUNCTION PROFILE, SERUM

**BILIRUBIN, TOTAL** 0.36 **Upto 1.2** mg/dL

METHOD : COLORIMETRIC DIAZO

**BILIRUBIN, DIRECT** 0.25 **< 0.30** mg/dL

**BILIRUBIN, INDIRECT** 0.11 **0.1 - 1.0** mg/dL

**TOTAL PROTEIN** 7.5 **6.0 - 8.0** g/dL

METHOD : COLORIMETRIC

**ALBUMIN** 4.5 **3.97 - 4.94** g/dL

METHOD : COLORIMETRIC

**GLOBULIN** 3.0 **2.0 - 3.5** g/dL

**ALBUMIN/GLOBULIN RATIO** 1.5 **1.0 - 2.1** RATIO

**ASPARTATE AMINOTRANSFERASE(AST/SGOT)** 15 **< OR = 35** U/L

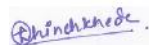
METHOD : UV ABSORBANCE

**ALANINE AMINOTRANSFERASE (ALT/SGPT)** 13 **< OR = 35** U/L

METHOD : UV ABSORBANCE



Dr. Ushma Wartikar  
 Consultant Pathologist



Dr. Priyal Chinchkhede  
 Consultant Pathologist



Dr. (Mrs) Neelu K Bhojani  
 Lab Head



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 CIN - U74899PB1995PLC045956



Patient Ref. No. 775000003205894

PATIENT NAME : RUPALI CHAUDHARI

REF. DOCTOR : SELF

CODE/NAME & ADDRESS : C000138394  
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 NEW DELHI 110030  
 8800465156

ACCESSION NO : 0181WE000440  
 PATIENT ID : RUPAF130590181  
 CLIENT PATIENT ID:  
 ABHA NO :

AGE/SEX : 33 Years Female  
 DRAWN :  
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Test Report Status	Final	Results	Biological Reference Interval	Units
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ALKALINE PHOSPHATASE METHOD : COLORIMETRIC	94	35 - 104	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT) METHOD : ENZYMATIC, COLORIMETRIC	16	0 - 40	U/L
LACTATE DEHYDROGENASE METHOD : UV ABSORBANCE	146	125 - 220	U/L
BLOOD UREA NITROGEN (BUN), SERUM			
BLOOD UREA NITROGEN METHOD : ENZYMATIC ASSAY	6	6 - 20	mg/dL
CREATININE, SERUM			
CREATININE METHOD : COLORIMETRIC	0.57	0.5 - 0.9	mg/dL
BUN/CREAT RATIO			
BUN/CREAT RATIO	10.53	8.0 - 15.0	
URIC ACID, SERUM			
URIC ACID METHOD : ENZYMATIC COLORIMETRIC ASSAY	3.8	2.4 - 5.7	mg/dL
TOTAL PROTEIN, SERUM			
TOTAL PROTEIN METHOD : COLORIMETRIC	7.5	6.0 - 8.0	g/dL
ALBUMIN, SERUM			
ALBUMIN METHOD : COLORIMETRIC	4.5	3.97 - 4.94	g/dL
GLOBULIN			
GLOBULIN	3.0	2.0 - 3.5	g/dL
ELECTROLYTES (NA/K/CL), SERUM			
SODIUM, SERUM	140	136 - 145	mmol/L
POTASSIUM, SERUM	4.40	3.5 - 5.1	mmol/L
CHLORIDE, SERUM	103	98 - 107	mmol/L

Interpretation(s)

Sodium	Potassium	Chloride
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<p><b>Decreased in:</b>CCF,cirrhosis, vomiting, diarrhea, excessive sweating, salt-losing nephropathy,adrenal insufficiency, nephrotic syndrome, water intoxication, SIADH. Drugs: thiazides, diuretics, ACE inhibitors, chlorpropamide, carbamazepine, anti depressants (SSRI), anti psychotics.</p>	<p><b>Decreased in:</b> 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.</p>	<p><b>Decreased in:</b> 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, adrenalinsufficiency, hyperaldosteronism,metabolic alkalosis. Drugs: chronic laxative,corticosteroids, diuretics.</p>
<p><b>Increased in:</b> Dehydration (excessivesweating, severe vomiting or diarrhea),diabetes mellitus, diabetesinsipidus, hyperaldosteronism, inadequate water intake. Drugs: steroids, licorice,oral contraceptives.</p>	<p><b>Increased in:</b> 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.</p>	<p><b>Increased in:</b> Renal failure, nephrotic syndrome, RTA,dehydration, overtreatment with saline,hyperparathyroidism, diabetes insipidus, metabolic acidosis from diarrhea (Loss of HCO<sub>3</sub>-), respiratory alkalosis,hyperadrenocorticism. Drugs: acetazolamide,androgens, hydrochlorothiazide,salicylates.</p>
<p><b>Interferences:</b> Severe lipemia or hyperproteinemi, 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.</p>	<p><b>Interferences:</b> 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.</p>	<p><b>Interferences:</b> 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)</p>

**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 glycaemic 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.

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

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

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

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

1. eAG (Estimated average glucose) converts percentage HbA1c to mg/dl, to compare blood glucose levels.
2. eAG gives an evaluation of blood glucose levels for the last couple of months.
3. eAG is calculated as eAG (mg/dl) = 28.7 \* HbA1c - 46.7

**HbA1c Estimation can get affected due to :**

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).

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3. Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia, uremia, hyperbilirubinemia, chronic alcoholism, chronic ingestion of salicylates & opiates addition are reported to interfere with some assay methods, falsely increasing results.  
 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 correct for HbS & HbC trait).  
 c) HbF > 25% on alternate platform (Boronate affinity chromatography) is recommended for testing of HbA1c. Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy  
 GLUCOSE, 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, Increase insulin response & sensitivity etc. Additional test HbA1c  
 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, Muscuopathy 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.

Dr. Ushma Wartikar  
 Consultant Pathologist

Dr. Priyali Chinchkhede  
 Consultant Pathologist

Dr. (Mrs) Neelu K Bhojani  
 Lab Head



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CLINICAL PATH - URINALYSIS

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40 FEMALE

PHYSICAL EXAMINATION, URINE

COLOR YELLOWISH  
APPEARANCE SLIGHTLY HAZY

CHEMICAL EXAMINATION, URINE

PH 6.0 5.00 - 7.50  
SPECIFIC GRAVITY 1.015 1.010 - 1.030

METHOD : URINE ROUTINE & MICROSCOPY EXAMINATION BY INTEGRATED AUTOMATED SYSTEM

PROTEIN NOT DETECTED NOT DETECTED  
GLUCOSE NOT DETECTED NOT DETECTED  
KETONES NOT DETECTED NOT DETECTED  
BLOOD NOT DETECTED NOT DETECTED  
UROBILINOGEN NORMAL NORMAL  
NITRITE NOT DETECTED NOT DETECTED  
LEUKOCYTE ESTERASE DETECTED (++) NOT DETECTED

MICROSCOPIC EXAMINATION, URINE

RED BLOOD CELLS NOT DETECTED NOT DETECTED /HPF  
PUS CELL (WBC'S) 15-20 0-5 /HPF  
EPITHELIAL CELLS 10-15 0-5 /HPF  
CASTS NOT DETECTED  
CRYSTALS NOT DETECTED  
BACTERIA NOT DETECTED NOT DETECTED  
YEAST NOT DETECTED NOT DETECTED

METHOD : URINE ROUTINE & MICROSCOPY EXAMINATION BY INTEGRATED AUTOMATED SYSTEM

Interpretation(s)

Dr. Priyal Chinchkhede  
Consultant Pathologist

Dr. Ushma Wartikar  
Consultant Pathologist

Dr. (Mrs) Neelu K Bhojani  
Lab Head

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CYTOLOGY

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

PAPANICOLAOU SMEAR

TEST METHOD

SNR

METHOD : MICROSCOPIC EXAMINATION

*Chinchkhede*

Dr.Priyal Chinchkhede  
Consultant Pathologist

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CLINICAL PATH - STOOL ANALYSIS

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

MICROSCOPIC EXAMINATION,STOOL

REMARK

SAMPLE NOT RECEIVED

Interpretation(s)

*Sawant*

Dr. Sheetal Sawant  
Consultant Microbiologist

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SPECIALISED CHEMISTRY - HORMONE

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40 FEMALE

THYROID PANEL, SERUM

**T3** **136.0** Non-Pregnant Women **ng/dL**  
 80.0 - 200.0  
 Pregnant Women  
 1st Trimester: 105.0 - 230.0  
 2nd Trimester: 129.0 - 262.0  
 3rd Trimester: 135.0 - 262.0

METHOD : ELECTROCHEMILUMINESCENCE

**T4** **8.38** Non-Pregnant Women **µg/dL**  
 5.10 - 14.10  
 Pregnant Women  
 1st Trimester: 7.33 - 14.80  
 2nd Trimester: 7.93 - 16.10  
 3rd Trimester: 6.95 - 15.70

METHOD : ELECTROCHEMILUMINESCENCE

**TSH (ULTRASENSITIVE)** **2.370** Non Pregnant Women **µIU/mL**  
 0.27 - 4.20  
 Pregnant Women  
 1st Trimester: 0.33 - 4.59  
 2nd Trimester: 0.35 - 4.10  
 3rd Trimester: 0.21 - 3.15

METHOD : ELECTROCHEMILUMINESCENCE

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 active. It is advisable to detect Free T3, Free T4 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

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Test Report Status	Final	Results	Biological Reference Interval	Units
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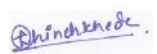
2	High	Normal	Normal	Normal	(1)Subclinical Hypothyroidism (2) Patient with insufficient thyroid hormone replacement therapy (3) In cases of Autoimmune/Hashimoto thyroiditis (4). Isolated increase in TSH levels can be due to Subclinical inflammation, drugs like amphetamines, Iodine containing drug and 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. Guidelines 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.



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View Report

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