DIAGNOSTIC REPORT

Patient Ref. No. 777000002337721

SRL Diagnostics

CLIENT CODE : C000138364

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

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GRAND MALL, OPPOSITE SBI ZONAL OFFICE,SM ROAD, AMBAWADI,
AHMEDABAD, 380015
GUJRAT, INDIA
Tel : 079-48912999,079-48913999,079-48914999
Email : customercare.ahmedabad@srl.in

PATIENT NAME : TARKESHWARI B. RAJAN PATIENT ID : **TARKM040682321**

ACCESSION NO : **0321VI000772** AGE : 40 Years SEX : Female ABHA NO :

DRAWN : RECEIVED : 10/09/2022 09:20 REPORTED : 13/09/2022 17:44

REFERRING DOCTOR : SELF CLIENT PATIENT ID :

Test Report Status **Final**	Results		Biological Reference Interval	Units
MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE				
BLOOD COUNTS,EDTA WHOLE BLOOD				
HEMOGLOBIN	13.5		12.0 - 15.0	g/dL
RED BLOOD CELL COUNT	**4.82**	**High**	3.8 - 4.8	mil/µL
WHITE BLOOD CELL COUNT	8.34		4.0 - 10.0	thou/µL
PLATELET COUNT	314		150 - 410	thou/µL
RBC AND PLATELET INDICES				
HEMATOCRIT	43.1		36.0 - 46.0	%
MEAN CORPUSCULAR VOL	89.4		83.0 - 101.0	fL
MEAN CORPUSCULAR HGB.	28.0		27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION	**31.3**	**Low**	31.5 - 34.5	g/dL
MENTZER INDEX	18.6			
RED CELL DISTRIBUTION WIDTH	**14.7**	**High**	11.6 - 14.0	%
MEAN PLATELET VOLUME	7.6		6.8 - 10.9	fL
WBC DIFFERENTIAL COUNT - NLR				
SEGMENTED NEUTROPHILS	58		40 - 80	%
ABSOLUTE NEUTROPHIL COUNT	4.84		2.0 - 7.0	thou/µL
LYMPHOCYTES	34		20 - 40	%
ABSOLUTE LYMPHOCYTE COUNT	2.84		1.0 - 3.0	thou/µL
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	1.7			
EOSINOPHILS	2		1.0 - 6.0	%
ABSOLUTE EOSINOPHIL COUNT	0.17		0.02 - 0.50	thou/µL
MONOCYTES	6		2.0 - 10.0	%
ABSOLUTE MONOCYTE COUNT	0.50		0.2 - 1.0	thou/µL
BASOPHILS	0		0 - 1	%
ABSOLUTE BASOPHIL COUNT	**0.00**	**Low**	0.02 - 0.10	thou/µL
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)	09		0 - 20	mm at 1 hr
GLUCOSE, FASTING, PLASMA				
GLUCOSE, FASTING, PLASMA	94		74 - 99	mg/dL
GLYCOSYLATED HEMOGLOBIN, EDTA WHOLE BLOOD				
GLYCOSYLATED HEMOGLOBIN (HBA1C)	5.5		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	111.2		< 116.0	mg/dL
GLUCOSE, POST-PRANDIAL, PLASMA				
GLUCOSE, POST-PRANDIAL, PLASMA	89		70 - 140	mg/dL
CORONARY RISK PROFILE, SERUM				
CHOLESTEROL	**204**	**High**	Desirable: < 200 BorderlineHigh: 200 - 239 High: > or = 240	mg/dL
TRIGLYCERIDES	106		Desirable: < 150 BorderlineHigh: 150 - 199 High: 200 - 499 Very High: > or = 500	mg/dL
HDL CHOLESTEROL	42		< 40 Low > or = 60 High	mg/dL
CHOLESTEROL LDL	**141**	**High**	Adult levels: Optimal < 100 Near optimal/above optimal: 100-129 Borderline high : 130-159 High : 160-189 Very high : = 190	mg/dL
NON HDL CHOLESTEROL	**162**	**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	4.9			
LDL/HDL RATIO	**3.4**	**High**	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
VERY LOW DENSITY LIPOPROTEIN	21.2			mg/dL
LIVER FUNCTION PROFILE, SERUM				
BILIRUBIN, TOTAL	0.39		Upto 1.2	mg/dL
BILIRUBIN, DIRECT	0.16		Upto 0.2	mg/dL
BILIRUBIN, INDIRECT	0.23		0.00 - 1.00	mg/dL

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TOTAL PROTEIN	7.1		6.4 - 8.3	g/dL
ALBUMIN	4.7		3.5 - 5.2	g/dL
GLOBULIN	2.4		2.0 - 4.1	g/dL
ALBUMIN/GLOBULIN RATIO	2.0		1.0 - 2.0	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	27		0 - 32	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)	31		0 - 33	U/L
ALKALINE PHOSPHATASE	**117**	**High**	35 - 104	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)	23		5 - 36	U/L
LACTATE DEHYDROGENASE	151		135 - 214	U/L
SERUM BLOOD UREA NITROGEN				
BLOOD UREA NITROGEN	13		6 - 20	mg/dL
CREATININE, SERUM				
CREATININE	0.62		0.60 - 1.10	mg/dL
BUN/CREAT RATIO				
BUN/CREAT RATIO	**20.97**	**High**	5.0 - 15.0	
URIC ACID, SERUM				
URIC ACID	4.0		2.4 - 5.7	mg/dL
ELECTROLYTES (NA/K/CL), SERUM				
SODIUM	141.9		136- 145	mmol/L
POTASSIUM	4.17		3.50- 5.10	mmol/L
CHLORIDE	102.4		98 - 107	mmol/L
PHYSICAL EXAMINATION, URINE				
COLOR	Yellow			
APPEARANCE	Clear			
SPECIFIC GRAVITY	1.025		1.003 - 1.035	
CHEMICAL EXAMINATION, URINE				
PH	5.0		4.7 - 7.5	
PROTEIN	NOT DETECTED		NOT DETECTED	
GLUCOSE	NOT DETECTED		NOT DETECTED	
KETONES	NOT DETECTED		NOT DETECTED	
BLOOD	**DETECTED (+++)**		NOT DETECTED	
BILIRUBIN	NOT DETECTED		NOT DETECTED	
UROBILINOGEN	NORMAL		NORMAL	
NITRITE	NOT DETECTED		NOT DETECTED	

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LEUKOCYTE ESTERASE	NOT DETECTED		NOT DETECTED	
MICROSCOPIC EXAMINATION, URINE				
PUS CELL (WBC'S)	NOT DETECTED		0-5	/HPF
EPITHELIAL CELLS	**5-7**		0-5	/HPF
ERYTHROCYTES (RBC'S)	**20 - 30**		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	82.6		80.00 - 200.00	ng/dL
T4	7.48		5.10 - 14.10	µg/dL
TSH 3RD GENERATION	**4.740**	**High**	0.270 - 4.200	µIU/mL
PAPANICOLAOU SMEAR				
TEST METHOD	CONVENTIONAL GYNEC CYTOLOGY			
SPECIMEN TYPE	TWO UNSTAINED CERVICAL SMEARS RECEIVED			
REPORTING SYSTEM	2014 BETHESDA SYSTEM FOR REPORTING CERVICAL CYTOLOGY			
SPECIMEN ADEQUACY	SATISFACTORY			
MICROSCOPY	SMEARS SHOW SUPERFICIAL AND INTERMEDIATE SQUAMOUS CELLS AGAINST BACKGROUND OF NORMAL VAGINAL FLORA. ENDOCERVICAL CELLS NOT SEEN ON SMEAR. NO EVIDENCE OF DYSPLASIA OR MALIGNANCY SEEN ON SMEAR.			
INTERPRETATION / RESULT	NEGATIVE FOR INTRAEPITHELIAL LESION OR MALIGNANCY			

Comments

PAP SMEAR IS ASCREENING PROCEDURE FOR CERVICAL CANCER WITH INHERENT FALSE NEGATIVE RESULTS HENCE RESULTS SHOULD BE INTERPRETED WITH CAUTION.

STOOL: OVA & PARASITE			
COLOUR	YELLOW		
CONSISTENCY	WELL FORMED		
ODOUR	FAECAL		
MUCUS	ABSENT	NOT DETECTED	
VISIBLE BLOOD	ABSENT	ABSENT	
POLYMORPHONUCLEAR LEUKOCYTES	NOT DETECTED	0 - 5	/HPF
RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF

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MACROPHAGES	NOT DETECTED	NOT DETECTED	
CHARCOT-LEYDEN CRYSTALS	NOT DETECTED	NOT DETECTED	
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 O		
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	K/C/O HYPOTHYROIDISM SINCE 10 YEARS C/O LOW VITAMIN D3 LAST 10 DAYS		
RELEVANT PAST HISTORY	P/H/O LAPROSCOPY IN 2015 1 CESARIAN SECTION IN 2016		
RELEVANT PERSONAL HISTORY	NOT SIGNIFICANT		
MENSTRUAL HISTORY (FOR FEMALES)	REGULAR		
LMP (FOR FEMALES)	17/08/2022		
OBSTETRIC HISTORY (FOR FEMALES)	G1,P1,A0,L1		
LCB (FOR FEMALES)	01/02/2016		
RELEVANT FAMILY HISTORY	DIABETES		
OCCUPATIONAL HISTORY	NOT SIGNIFICANT		
HISTORY OF MEDICATIONS	TAB. THYRONORM (25)		
ANTHROPOMETRIC DATA & BMI			
HEIGHT IN METERS	1.53		mts
WEIGHT IN KGS.	71.9		Kgs

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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	76/MIN		
RESPIRATORY RATE	NORMAL		
CARDIOVASCULAR SYSTEM			
BP	130/80 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)		
ADDED SOUNDS	ABSENT		
PER ABDOMEN			
APPEARANCE	NORMAL		
LIVER	NOT PALPABLE		

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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	6/18		
DISTANT VISION LEFT EYE WITHOUT GLASSES	6/9		
NEAR VISION RIGHT EYE WITHOUT GLASSES	N/6		
NEAR VISION LEFT EYE WITHOUT GLASSES	N/6		
COLOUR VISION	NORMAL		
SUMMARY			
RELEVANT HISTORY	NOT SIGNIFICANT		
RELEVANT GP EXAMINATION FINDINGS	NOT SIGNIFICANT		
RELEVANT LAB INVESTIGATIONS	S.CHOLESTEROL:- HIGH, LDL:- HIGH ALKALINE PHOSPHATASE:- HIGH URINE:- BLOOD DETECTED (+ + +), RBC - HIGH, EPITHELIAL CELLS - HIGH TSH:- HIGH		
RELEVANT NON PATHOLOGY DIAGNOSTICS	USG ABDOMEN:- FATTY LIVER		

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REMARKS / RECOMMENDATIONS

1) S.CHOLESTEROL:- HIGH, LDL:- HIGH, ALKALINE PHOSPHATASE:- HIGH

ADV:- LOW FAT DIET, REGULAR PHYSICAL EXERCISE

2) URINE:- BLOOD DETECTED (+ + +), RBC - HIGH, EPITHELIAL CELLS - HIGH

ADV:- DRINK PLENTY OF WATER, REPEAT URINE ANALYSIS AFTER 10 DAYS AND PHYSICIAN OPINION SOS

3) TSH:- HIGH

ADV:- ENDO-CRINOLOGIST OPINION

Comments

OUR PANEL DOCTORS FOR NON-PATHOLOGY TESTS:-

CHECK UP DONE BY:- DR. NAMRATA AGRAWAL (M.B.B.S)

REPORT REVIEWED BY:- 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-

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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 glycated 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 glycated 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 glycated 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.
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
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

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)

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PATIENT NAME : TARKESHWARI B. RAJAN PATIENT ID : **TARKM040682321**

ACCESSION NO : **0321VI000772** AGE : 40 Years SEX : Female ABHA NO :

DRAWN : RECEIVED : 10/09/2022 09:20 REPORTED : 13/09/2022 17:44

REFERRING DOCTOR : SELF CLIENT PATIENT ID :

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

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 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	T4

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(ng/dL) (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
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.

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DIAGNOSTIC REPORT

Patient Ref. No. 777000002337721

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MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

ULTRASOUND ABDOMEN

ULTRASOUND ABDOMEN

FATTY LIVER

****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.
3. Result delays could occur due to unforeseen circumstances such as non-availability of kits / equipment breakdown / natural calamities / technical downtime or any other unforeseen event.
4. A requested test might not be performed if:
   i. Specimen received is insufficient or inappropriate
   ii. Specimen quality is unsatisfactory
   iii. Incorrect specimen type
   iv. Discrepancy between identification on specimen container label and test requisition form
5. SRL confirms that all tests have been performed or assayed with highest quality standards, clinical safety & technical integrity.
6. Laboratory results should not be interpreted in isolation; it must be correlated with clinical information and be interpreted by registered medical practitioners only to determine final diagnosis.
7. Test results may vary based on time of collection, physiological condition of the patient, current medication or nutritional and dietary changes. Please consult your doctor or call us for any clarification.
8. Test results cannot be used for Medico legal purposes.
9. In case of queries please call customer care (91115 91115) within 48 hours of the report.

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