DIAGNOSTIC REPORT

Patient Ref. No. 777000002280226

SRL Diagnostics

CLIENT CODE : C000138354

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

SRL Ltd
Shop CG 017, PALM SPRINGS PLAZA
GURUGRAM, 122001
HARYANA, INDIA
Tel : 9111591115

PATIENT NAME : SUNIL KUMAR PATIENT ID : **SUNIM140190282**

ACCESSION NO : **0282VH000525** AGE : 32 Years SEX : Male ABHA NO :

DRAWN : RECEIVED : 09/08/2022 12:36 REPORTED : 10/08/2022 07:44

REFERRING DOCTOR : SELF CLIENT PATIENT ID :

Test Report Status **Final**	Results		Biological Reference Interval	Units
MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE				
BLOOD COUNTS,EDTA WHOLE BLOOD				
HEMOGLOBIN METHOD : SPECTROPHOTOMETRY	15.8		13.0 - 17.0	g/dL
RED BLOOD CELL COUNT METHOD : IMPEDANCE	5.29		4.5 - 5.5	mil/µL
WHITE BLOOD CELL COUNT METHOD : IMPEDANCE	5.70		4.0 - 10.0	thou/µL
PLATELET COUNT METHOD : IMPEDANCE	182		150 - 410	thou/µL
RBC AND PLATELET INDICES				
HEMATOCRIT METHOD : CALCULATED	49.2		40 - 50	%
MEAN CORPUSCULAR VOL METHOD : DERIVED FROM IMPEDANCE MEASURE	93.0		83 - 101	fL
MEAN CORPUSCULAR HGB. METHOD : CALCULATED PARAMETER	29.8		27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION METHOD : CALCULATED PARAMETER	32.0		31.5 - 34.5	g/dL
MENTZER INDEX	17.6			
RED CELL DISTRIBUTION WIDTH METHOD : DERIVED FROM IMPEDANCE MEASURE	**14.8**	**High**	11.6 - 14.0	%
MEAN PLATELET VOLUME METHOD : DERIVED FROM IMPEDANCE MEASURE	**12.9**	**High**	6.8 - 10.9	fL
WBC DIFFERENTIAL COUNT - NLR				
SEGMENTED NEUTROPHILS METHOD : DHSS FLOWCYTOMETRY	44		40 - 80	%
ABSOLUTE NEUTROPHIL COUNT METHOD : DHSS FLOWCYTOMETRY, CALCULATED	2.50		2.0 - 7.0	thou/µL
LYMPHOCYTES METHOD : DHSS FLOWCYTOMETRY	**48**	**High**	20 - 40	%
ABSOLUTE LYMPHOCYTE COUNT METHOD : DHSS FLOWCYTOMETRY, CALCULATED	2.75		1 - 3	thou/µL
NEUTROPHIL LYMPHOCYTE RATIO (NLR) METHOD : CALCULATED	0.9			
EOSINOPHILS	02		1 - 6	%

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METHOD : DHSS FLOWCYTOMETRY				
ABSOLUTE EOSINOPHIL COUNT	0.11		0.02 - 0.50	thou/µL
METHOD : DHSS FLOWCYTOMETRY, CALCULATED				
MONOCYTES	06		2 - 10	%
METHOD : DHSS FLOWCYTOMETRY				
ABSOLUTE MONOCYTE COUNT	0.34		0.20 - 1.00	thou/µL
METHOD : DHSS FLOWCYTOMETRY, CALCULATED				
BASOPHILS	00		0 - 2	%
METHOD : IMPEDANCE				
ABSOLUTE BASOPHIL COUNT	**00**	**Low**	0.02 - 0.10	thou/µL
METHOD : DHSS FLOWCYTOMETRY, CALCULATED				
ERYTHRO SEDIMENTATION RATE, BLOOD				
SEDIMENTATION RATE (ESR)	2		0 - 14	mm at 1 hr
METHOD : AUTOMATED (PHOTOMETRICAL CAPILLARY STOPPED FLOW KINETIC ANALYSIS)				
GLUCOSE, FASTING, PLASMA				
GLUCOSE, FASTING, PLASMA	88		Normal 75 - 99 Pre-diabetics: 100 – 125 Diabetic: > or = 126	mg/dL
METHOD : SPECTROPHOTOMETRY HEXOKINASE				
GLYCOSYLATED HEMOGLOBIN, EDTA WHOLE BLOOD				
GLYCOSYLATED HEMOGLOBIN (HBA1C)	5.3		Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 ADA Target: 7.0 Action suggested: > 8.0	%
METHOD : CAPILLARY ELECTROPHORESIS				
MEAN PLASMA GLUCOSE	105.4		< 116	mg/dL
METHOD : CALCULATED PARAMETER				

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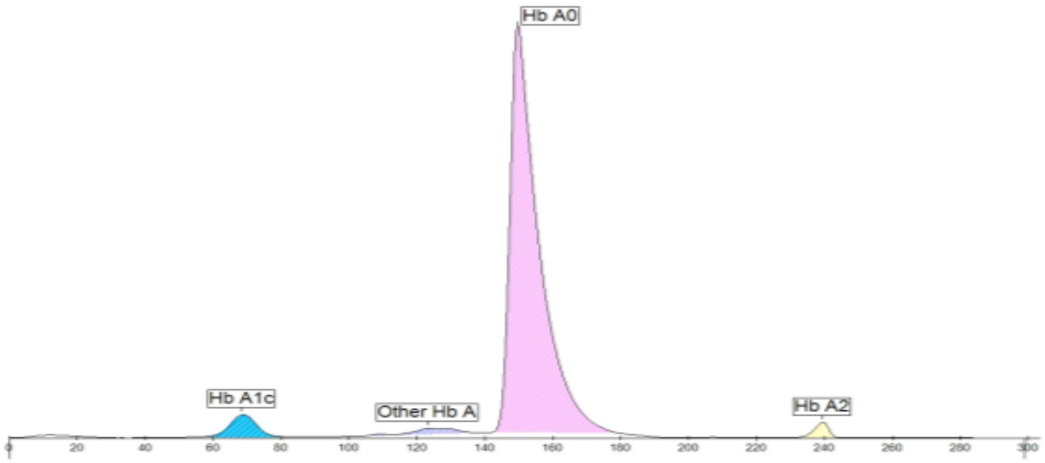
PLOT NO.31,ELECTRONIC CITY,SECTOR 18, GURUGRAM

ID : 28211579001
Name :

Sample Date: 8/10/2022
Sample num.: 58



A1c Haemoglobin Electrophoresis

Fractions	%	mmol/mol	Cal. %
Hb A1c	-	**35**	5.3
Other Hb A	2.0		
Hb A0	91.5		
Hb A2	1.8		

HbA1c % cal :**5.3 %**

Comments :

GLUCOSE, POST-PRANDIAL, PLASMA

GLUCOSE, POST-PRANDIAL, PLASMA	91	70 - 139	mg/dL

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METHOD : SPECTROPHOTOMETRY, HEXOKINASE			
CORONARY RISK PROFILE (LIPID PROFILE), SERUM.			
CHOLESTEROL	172	Desirable cholesterol level < 200 Borderline high cholesterol 200 - 239 High cholesterol > / = 240	mg/dL
METHOD : ENZYMATIC COLORIMETRIC ASSAY			
TRIGLYCERIDES	124	Normal: < 150 Borderline high: 150 - 199 High: 200 - 499 Very High: >/= 500	mg/dL
METHOD : ENZYMATIC COLORIMETRIC ASSAY			
HDL CHOLESTEROL	47	Low HDL Cholesterol <40 High HDL Cholesterol >/= 60	mg/dL
METHOD : HOMOGENEOUS ENZYMATIC COLORIMETRIC ASSAY			
DIRECT LDL CHOLESTEROL	109.00	Optimal : < 100 Near optimal/above optimal : 100 - 129 Borderline high : 130 - 159 High : 160 - 189 Very high : > / = 190	mg/dL
METHOD : HOMOGENEOUS ENZYMATIC COLORIMETRIC ASSAY			
NON HDL CHOLESTEROL	125	Desirable : < 130 Above Desirable : 130 -159 Borderline High : 160 - 189 High : 190 - 219 Very high : > / = 220	mg/dL
METHOD : CALCULATED PARAMETER			
CHOL/HDL RATIO	4.0	Low Risk : 3.3 - 4.4 Average Risk : 4.5 - 7.0 Moderate Risk : 7.1 - 11.0 High Risk : > 11.0	
METHOD : CALCULATED PARAMETER			
LDL/HDL RATIO	2.3	Desirable/Low Risk - 0.5-3 Borderline/Moderate Risk- 3.1-6 High Risk- >6.0	
METHOD : CALCULATED PARAMETER			
VERY LOW DENSITY LIPOPROTEIN	24.8	</= 30.0	mg/dL
METHOD : CALCULATED PARAMETER			

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Interpretation(s)

Serum lipid profile is measured for cardiovascular risk prediction, the test includes five basic parameters: total cholesterol, triglycerides, HDL cholesterol, LDL cholesterol and Non HDL cholesterol.
1) Cholesterol levels help assess the patient risk status and to follow the progress of patient under treatment to lower serum cholesterol concentrations.
2) Serum Triglyceride (TG) are a type of fat and a major source of energy for the body.
- Both quantity and composition of the diet impact on plasma triglyceride concentrations
- Elevations in TG levels are the result of overproduction and impaired clearance.
- High TG are associated with increased risk for CAD (Coronary artery disease) in patients with other risk factors, such as low HDL-C, some patient groups with elevated apolipoprotein B concentrations, and patients with forms of LDL that may be particularly atherogenic.

3)HDL-C plays a crucial role in the initial step of reverse cholesterol transport, this considered to be the primary atheroprotective function of HDL
4) LDL -C plays a key role in causing and influencing the progression of atherosclerosis and, in particular, coronary sclerosis.
The majority of cholesterol stored in atherosclerotic plaques originates from LDL, thus LDL-C value is the most powerful clinical predictor.
5)Non HDL cholesterol: Non-HDL-C measures the cholesterol content of all atherogenic lipoproteins, including LDL hence it is a better marker of risk in both primary and secondary prevention studies.
Non-HDL-C also covers, to some extent, the excess ASCVD risk imparted by the sdLDL, which is significantly more atherogenic than the normal large buoyant particles, an elevated non-HDL-C indirectly suggests greater proportion of the small, dense variety of LDL particles
Lipid Association of India recommends LDL-C as primary target and Non HDL-C as co-primary treatment target.

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

Risk Category	
Extreme risk group	A.CAD with > 1 feature of high risk group
	B. CAD with > 1 feature of Very high risk group or recurrent ACS (within 1 year) despite LDL-C < or = 50 mg/dl or polyvascular disease
Very High Risk	1. Established ASCVD 2. Diabetes with 2 major risk factors or evidence of end organ damage 3. Familial Homozygous Hypercholesterolemia
High Risk	1. Three major ASCVD risk factors. 2. Diabetes with 1 major risk factor or no evidence of end organ damage. 3. CKD stage 3B or 4. 4. LDL >190 mg/dl 5. Extreme of a single risk factor. 6. Coronary Artery Calcium - CAC >300 AU. 7. Lipoprotein a >/= 50mg/dl 8. Non stenotic carotid plaque
Moderate Risk	2 major ASCVD risk factors
Low Risk	0-1 major ASCVD risk factors

Major ASCVD (Atherosclerotic cardiovascular disease) Risk Factors	
1. Age > or = 45 years in males and > or = 55 years in females	3. Current Cigarette smoking or tobacco use
2. Family history of premature ASCVD	4. High blood pressure
5 Low HDL	

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

Risk Group	Treatment Goals		Consider Drug Therapy	
	LDL-C (mg/dl)	Non-HDL (mg/dl)	LDL-C (mg/dl)	Non-HDL (mg/dl)
Extreme Risk Group Category A	<50 (Optional goal < OR = 30)	< 80 (Optional goal <OR = 60)	>OR = 50	>OR = 80
Extreme Risk Group Category B	<OR = 30	<OR = 60	> 30	>60
Very High Risk	<50	<80	>OR= 50	>OR= 80
High Risk	<70	<100	>OR= 70	>OR= 100
Moderate Risk	<100	<130	>OR= 100	>OR= 130
Low Risk	<100	<130	>OR= 130*	>OR= 160

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

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

LIVER FUNCTION PROFILE, SERUM

BILIRUBIN, TOTAL	0.4		Upto 1.2	mg/dL
METHOD : COLORIMETRIC DIAZO METHOD				
BILIRUBIN, DIRECT	0.2		< 0.30	mg/dL
METHOD : COLORIMETRIC DIAZO METHOD				
BILIRUBIN, INDIRECT	0.20		0.1 - 1.0	mg/dL
METHOD : CALCULATED PARAMETER				
TOTAL PROTEIN	7.9		6.0 - 8.0	g/dL
METHOD : SPECTROPHOTOMETRY, BIURET				
ALBUMIN	**5.1**	**High**	3.97 - 4.94	g/dL
METHOD : SPECTROPHOTOMETRY, BROMOCRESOL GREEN(BCG) - DYE BINDING				
GLOBULIN	2.9		2.0 - 3.5	g/dL
METHOD : CALCULATED PARAMETER				
ALBUMIN/GLOBULIN RATIO	1.8		1.0 - 2.1	RATIO
METHOD : CALCULATED PARAMETER				
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	35		< OR = 50	U/L
METHOD : SPECTROPHOTOMETRY, WITH PYRIDOXAL PHOSPHATE ACTIVATION-IFCC				
ALANINE AMINOTRANSFERASE (ALT/SGPT)	**72**	**High**	< OR = 50	U/L
METHOD : SPECTROPHOTOMETRY, WITH PYRIDOXAL PHOSPHATE ACTIVATION-IFCC				
ALKALINE PHOSPHATASE	95		40 - 129	U/L
METHOD : SPECTROPHOTOMETRY, PNPP, AMP BUFFER - IFCC				
GAMMA GLUTAMYL TRANSFERASE (GGT)	29		0 - 60	U/L

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METHOD : ENZYMATIC COLORIMETRIC ASSAY STANDARDIZED AGAINST IFCC / SZASZ				
LACTATE DEHYDROGENASE	204		125 - 220	U/L
METHOD : SPECTROPHOTOMETRY, LACTATE TO PYRUVATE - UV-IFCC				
SERUM BLOOD UREA NITROGEN				
BLOOD UREA NITROGEN	7.0		6 - 20	mg/dL
METHOD : SPECTROPHOTOMETRY, KINETIC TEST WITH UREASE AND GLUTAMATE DEHYDROGENASE				
CREATININE, SERUM				
CREATININE	0.90		0.7 - 1.2	mg/dL
METHOD : SPECTROPHOTOMETRIC, JAFFE'S KINETICS				
BUN/CREAT RATIO				
BUN/CREAT RATIO	**7.78**	**Low**	8.0 - 15.0	
METHOD : CALCULATED PARAMETER				
URIC ACID, SERUM				
URIC ACID	5.0		3.4 - 7.0	mg/dL
METHOD : SPECTROPHOTOMETRY, URICASE				
TOTAL PROTEIN, SERUM				
TOTAL PROTEIN	7.9		6.0 - 8.0	g/dL
METHOD : SPECTROPHOTOMETRY, BIURET				
ALBUMIN, SERUM				
ALBUMIN	**5.1**	**High**	3.97 - 4.94	g/dL
METHOD : SPECTROPHOTOMETRY, BROMOCRESOL GREEN(BCG) - DYE BINDING				
GLOBULIN				
GLOBULIN	2.9		2.0 - 3.5	g/dL
METHOD : CALCULATED PARAMETER				
ELECTROLYTES (NA/K/CL), SERUM				
SODIUM	141		136 - 145	mmol/L
METHOD : ISE INDIRECT				
POTASSIUM	**4.6**	**High**	3.5 - 4.5	mmol/L
METHOD : ISE INDIRECT				
CHLORIDE	105		98 - 107	mmol/L
METHOD : ISE INDIRECT				
PHYSICAL EXAMINATION, URINE				
COLOR	PALE YELLOW			
APPEARANCE	CLEAR			
SPECIFIC GRAVITY	<=1.005		1.003 - 1.035	

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Comments

NOTE :MICROSCOPIC EXAMINATION OF URINE IS PERFORMED ON CENTRIFUGED URINARY SEDIMENT.
IN NORMAL URINE SAMPLES CAST AND CRYSTALS ARE NOT DETECTED.

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			
PUS CELL (WBC'S)	0-1	0-5	/HPF
EPITHELIAL CELLS	0-1	0-5	/HPF
ERYTHROCYTES (RBC'S)	NOT DETECTED	NOT DETECTED	/HPF
CASTS	NOT DETECTED		
CRYSTALS	NOT DETECTED		
BACTERIA	NOT DETECTED	NOT DETECTED	
THYROID PANEL, SERUM			
T3	131.0	80 - 200	ng/dL
METHOD : ELECTROCHEMILUMINESCENCE IMMUNO ASSAY			
T4	8.30	5.1 - 14.1	µg/dL
METHOD : ELECTROCHEMILUMINESCENCE IMMUNO ASSAY			
TSH 3RD GENERATION	2.650	0.27 - 4.2	µIU/mL
METHOD : ELECTROCHEMILUMINESCENCE IMMUNO ASSAY			
STOOL: OVA & PARASITE			
COLOUR	YELLOW		
CONSISTENCY	SEMI FORMED		
ODOUR	FOUL		
MUCUS	ABSENT	NOT DETECTED	
VISIBLE BLOOD	ABSENT	ABSENT	
POLYMORPHONUCLEAR LEUKOCYTES	NOT DETECTED	0 - 5	/HPF

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RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
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		
ABO GROUP & RH TYPE, EDTA WHOLE BLOOD			
ABO GROUP	O		
METHOD : HEMAGGLUTINATION REACTION ON SOLID PHASE			
RH TYPE	RH+		
METHOD : HEMAGGLUTINATION REACTION ON SOLID PHASE			
XRAY-CHEST			
»»	BOTH THE LUNG FIELDS ARE CLEAR		
»»	BOTH THE COSTOPHRENIC AND CARDIOPHRENIC ANGLES ARE CLEAR		
»»	BOTH THE HILA ARE NORMAL		
»»	CARDIAC AND AORTIC SHADOWS APPEAR NORMAL		
»»	BOTH THE DOMES OF THE DIAPHRAGM ARE NORMAL		
»»	VISUALIZED BONY THORAX IS NORMAL		
IMPRESSION	NO ABNORMALITY DETECTED		
TMT OR ECHO			
TMT OR ECHO	ECHO DONE		
	· Normal sized cardiac chambers and normal valves · No RWMA · Mild PR, Trivial MR · Normal LV systolic function LVEF ~ 60 % · Normal LV diastolic function, E>A · No Clot/Vegetation/Pericardial Effusion · IVS/IAS intact,no flow seen across.		
ECG			
ECG	WITHIN NORMAL LIMITS		
MEDICAL HISTORY			
RELEVANT PRESENT HISTORY	H/O ACIDITY - 2 YRS		
RELEVANT PAST HISTORY	NOT SIGNIFICANT		
RELEVANT PERSONAL HISTORY	NON SMOKER NO ALCOHOL		
RELEVANT FAMILY HISTORY	NOT SIGNIFICANT		

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OCCUPATIONAL HISTORY	SERVICE		
HISTORY OF MEDICATIONS	NOT SIGNIFICANT		
ANTHROPOMETRIC DATA & BMI			
HEIGHT IN METERS	1.71		mts
WEIGHT IN KGS.	69.1		Kgs
BMI	24	BMI & Weight Status as follows: Below 18.5: Underweight 18.5 - 24.9: Normal 25.0 - 29.9: Overweight 30.0 and Above: Obese	kg/sqmts
GENERAL EXAMINATION			
MENTAL / EMOTIONAL STATE	NORMAL		
PHYSICAL ATTITUDE	NORMAL		
GENERAL APPEARANCE / NUTRITIONAL STATUS	HEALTHY		
BUILT / SKELETAL FRAMEWORK	AVERAGE		
FACIAL APPEARANCE	NORMAL		
SKIN	NORMAL		
UPPER LIMB	NORMAL		
LOWER LIMB	NORMAL		
NECK	NORMAL		
NECK LYMPHATICS / SALIVARY GLANDS	NOT ENLARGED OR TENDER		
THYROID GLAND	NOT ENLARGED		
CAROTID PULSATION	NORMAL		
TEMPERATURE	NORMAL		
PULSE	82 / REGULAR, ALL PERIPHERAL PULSES WELL FELT		
RESPIRATORY RATE	NORMAL		
CARDIOVASCULAR SYSTEM			
BP	120/84 MMHG (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		

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DELHI INDIA
8800465156

SRL Ltd
Shop CG 017, PALM SPRINGS PLAZA
GURUGRAM, 122001
HARYANA, INDIA
Tel : 9111591115

PATIENT NAME : SUNIL KUMAR PATIENT ID : **SUNIM140190282**

ACCESSION NO : **0282VH000525** AGE : 32 Years SEX : Male ABHA NO :

DRAWN : RECEIVED : 09/08/2022 12:36 REPORTED : 10/08/2022 07:44

REFERRING DOCTOR : SELF CLIENT PATIENT ID :

Test Report Status **Final**	Results	Biological Reference Interval	Units
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		
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	6/6		
DISTANT VISION LEFT EYE WITHOUT GLASSES	6/6		
NEAR VISION RIGHT EYE WITHOUT GLASSES	N/6		
NEAR VISION LEFT EYE WITHOUT GLASSES	N/6		
COLOUR VISION	17/17		
SUMMARY			
REMARKS / RECOMMENDATIONS	ADVISED LIFESTYLE CHANGES REVIEW WITH MD PHYSICIAN WITH ALL REPORTS FOR FURTHER ADVICE AND MANAGEMENT. ADVISED GASTEROENTEROLOGY CONSULTATION IN VIEW OF SYMPTOMS.		

Interpretation(s)

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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 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

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PATIENT NAME : SUNIL KUMAR PATIENT ID : **SUNIM140190282**

ACCESSION NO : **0282VH000525** AGE : 32 Years SEX : Male ABHA NO :

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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)

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

Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma, Waldenstrom's disease
Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage),Burns,Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome,Protein-losing enteropathy etc.
ALBUMIN, SERUM-
Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. Low blood albumin levels (hypoalbuminemia) can be caused by: Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance,malnutrition and wasting etc.
ELECTROLYTES (NA/K/CL), SERUM-
Sodium levels are Increased in dehydration, cushing's syndrome, aldosteronism & decreased in Addison's disease, hypopituitarism,liver disease. Hypokalemia (low K) is common in vomiting, diarrhea, alcoholism, folic acid deficiency and primary aldosteronism. Hyperkalemia may be seen in end-stage renal failure, hemolysis, trauma,

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Addison's disease, metabolic acidosis, acute starvation, dehydration, and with rapid K infusion.Chloride is increased in dehydration, renal tubular acidosis (hyperchloremia metabolic acidosis), acute renal failure, metabolic acidosis associated with prolonged diarrhea and loss of sodium bicarbonate, diabetes insipidus, adrenocortical hyperfuction, salicylate intoxication and with excessive infusion of isotonic saline or extremely high dietary intake of salt.Chloride is decreased in overhydration, chronic respiratory acidosis, salt-losing nephritis, metabolic alkalosis, congestive heart failure, Addisonian crisis, certain types of metabolic acidosis, persistent gastric secretion and prolonged vomiting,

MICROSCOPIC EXAMINATION, URINE-

Routine urine analysis assists in screening and diagnosis of various metabolic, urological, kidney and liver disorders

Protein: Elevated proteins can be an early sign of kidney disease. Urinary protein excretion can also be temporarily elevated by strenuous exercise, orthostatic proteinuria, dehydration, urinary tract infections and acute illness with fever

Glucose: Uncontrolled diabetes mellitus can lead to presence of glucose in urine. Other causes include pregnancy, hormonal disturbances, liver disease and certain medications.

Ketones: Uncontrolled diabetes mellitus can lead to presence of ketones in urine. Ketones can also be seen in starvation, frequent vomiting, pregnancy and strenuous exercise.

Blood: Occult blood can occur in urine as intact erythrocytes or haemoglobin, which can occur in various urological, nephrological and bleeding disorders.

Leukocytes: An increase in leukocytes is an indication of inflammation in urinary tract or kidneys. Most common cause is bacterial urinary tract infection.

Nitrite: Many bacteria give positive results when their number is high. Nitrite concentration during infection increases with length of time the urine specimen is retained in bladder prior to collection.

pH: The kidneys play an important role in maintaining acid base balance of the body. Conditions of the body producing acidosis/ alkalosis or ingestion of certain type of food can affect the pH of urine.

Specific gravity: Specific gravity gives an indication of how concentrated the urine is. Increased specific gravity is seen in conditions like dehydration, glycosuria and proteinuria while decreased specific gravity is seen in excessive fluid intake, renal failure and diabetes insipidus.

Bilirubin: In certain liver diseases such as biliary obstruction or hepatitis, bilirubin gets excreted in urine.

Urobilinogen: Positive results are seen in liver diseases like hepatitis and cirrhosis and in cases of hemolytic anemia

THYROID PANEL, SERUM-

Triiodothyronine T3 , is a thyroid hormone. It affects almost every physiological process in the body, including growth, development, metabolism, body temperature, and heart rate. Production of T3 and its prohormone thyroxine (T4) is activated by thyroid-stimulating hormone (TSH), which is released from the pituitary gland. Elevated concentrations of T3, and T4 in the blood inhibit the production of TSH.

Thyroxine T4, Thyroxine's principal function is to stimulate the metabolism of all cells and tissues in the body. Excessive secretion of thyroxine in the body is hyperthyroidism, and deficient secretion is called hypothyroidism. Most of the thyroid hormone in blood is bound to transport proteins. Only a very small fraction of the circulating hormone is free and biologically active.

In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hypothyroidism, TSH levels are low.

Below mentioned are the guidelines for Pregnancy related reference ranges for Total T4, TSH & Total T3

Levels in Pregnancy	TOTAL T4 (µg/dL)	TSH3G (µIU/mL)	TOTAL T3 (ng/dL)
First Trimester	6.6 - 12.4	0.1 - 2.5	81 - 190
2nd Trimester	6.6 - 15.5	0.2 - 3.0	100 - 260
3rd Trimester	6.6 - 15.5	0.3 - 3.0	100 - 260

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

	T3 (ng/dL)	T4 (µg/dL)
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."

DIAGNOSTIC REPORT

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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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MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

ULTRASOUND ABDOMEN

ULTRASOUND ABDOMEN

GRADE I FATTY LIVER

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

Dr. Arpita Roy, MD
Pathologist

Dr. Mamta Kumari
Consultant Microbiologist

Sr.Microbiologist
Microbiologist

Dr. Deblina Naithani
Consultant Physician

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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