

PATIENT NAME : ABDULMAJID QURESHI

REF. DOCTOR : SELF

CODE/NAME & ADDRESS : C000138364

ACROFEMI HEALTHCARE LTD (MEDIWHEEL)
F-703, LADO SARAI, MEHRAULISOUTH WEST
DELHINEW DELHI 110030
8800465156

ACCESSION NO : 0321WA002494

PATIENT ID : ABDUM110188321

CLIENT PATIENT ID:

ABHA NO :

AGE/SEX : 35 Years Male

DRAWN : 28/01/2023 00:00:00

RECEIVED : 28/01/2023 08:20:03

REPORTED : 01/02/2023 14:28:29

Test Report Status **Final**

Results

Biological Reference Interval Units

MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE**XRAY-CHEST**

IMPRESSION

NO ABNORMALITY DETECTED

TMT OR ECHO

TMT OR ECHO

TMT:- NORMAL

ECG

ECG

NORMAL SINUS RHYTHM

MEDICAL HISTORY

RELEVANT PRESENT HISTORY

NOT SIGNIFICANT

RELEVANT PAST HISTORY

NOT SIGNIFICANT

RELEVANT PERSONAL HISTORY

NOT SIGNIFICANT

RELEVANT FAMILY HISTORY

NOT SIGNIFICANT

OCCUPATIONAL HISTORY

NOT SIGNIFICANT

HISTORY OF MEDICATIONS

NOT SIGNIFICANT

ANTHROPOMETRIC DATA & BMI

HEIGHT IN METERS

1.70

mts

WEIGHT IN KGS.

63.3

Kgs

BMI

22

BMI & Weight Status as follows

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

SKIN

NORMAL

UPPER LIMB

NORMAL

LOWER LIMB

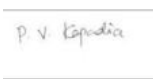
NORMAL

NECK

NORMAL

NECK LYMPHATICS / SALIVARY GLANDS

NOT ENLARGED OR TENDER


Dr.Sahil .N.Shah
Consultant Radiologist

Dr.Priyank Kapadia
Physician

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Patient Ref. No. 775000002220758

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THYROID GLAND

NOT ENLARGED

TEMPERATURE

NORMAL

PULSE

80/MIN

RESPIRATORY RATE

NORMAL

CARDIOVASCULAR SYSTEM

BP

110/70 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

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 WITH GLASSES WITH GLASSES NORMAL


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DISTANT VISION LEFT EYE WITH GLASSES
NEAR VISION RIGHT EYE WITHOUT GLASSES
NEAR VISION LEFT EYE WITHOUT GLASSES
COLOUR VISIONWITH GLASSES NORMAL
WITHIN NORMAL LIMIT
WITHIN NORMAL LIMIT
NORMAL**SUMMARY**

RELEVANT HISTORY

NOT SIGNIFICANT

RELEVANT GP EXAMINATION FINDINGS

NOT SIGNIFICANT

RELEVANT LAB INVESTIGATIONS

S.CHOLESTEROL:- HIGH, TRIGLYCERIDES:- HIGH, LDL:- HIGH

RELEVANT NON PATHOLOGY DIAGNOSTICS

NO ABNORMALITIES DETECTED

REMARKS / RECOMMENDATIONS

1) S.CHOLESTEROL:- HIGH, TRIGLYCERIDES:- HIGH, LDL:- HIGH

ADV:- LOW FAT DIET, REGULAR PHYSICAL EXERCISE

2) TOTAL BILIRUBIN:- HIGH, DIRECT BILIRUBIN:- HIGH, INDIRECT
BILIRUBIN:- HIGHADV:- REDUCE INTAKE OF FRIED AND OILY FOODS, PHYSICIAN OPINION
SOS**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)


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MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

ULTRASOUND ABDOMEN

ULTRASOUND ABDOMEN

NO ABNORMALITIES DETECTED

Interpretation(s)

MEDICAL

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



Dr.Sahil .N.Shah
Consultant Radiologist



Dr.Priyank Kapadia
Physician



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HAEMATOLOGY - CBC

MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

BLOOD COUNTS, EDTA WHOLE BLOOD

HEMOGLOBIN (HB)	15.5	13.0 - 17.0	g/dL
RED BLOOD CELL (RBC) COUNT	5.34	4.5 - 5.5	mil/ μ L
WHITE BLOOD CELL (WBC) COUNT	6.71	4.0 - 10.0	thou/ μ L
PLATELET COUNT	305	150 - 410	thou/ μ L

RBC AND PLATELET INDICES

HEMATOCRIT (PCV)	47.8	40.0 - 50.0	%
MEAN CORPUSCULAR VOLUME (MCV)	89.5	83.0 - 101.0	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	29.1	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)	32.5	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW)	14.7 High	11.6 - 14.0	%
MENTZER INDEX	16.8		
MEAN PLATELET VOLUME (MPV)	7.9	6.8 - 10.9	fL

WBC DIFFERENTIAL COUNT

NEUTROPHILS	35 Low	40 - 80	%
LYMPHOCYTES	52 High	20 - 40	%
MONOCYTES	9	2.0 - 10.0	%
EOSINOPHILS	4	1.0 - 6.0	%
BASOPHILS	0	0 - 1	%
ABSOLUTE NEUTROPHIL COUNT	2.35	2.0 - 7.0	thou/ μ L
ABSOLUTE LYMPHOCYTE COUNT	3.49 High	1.0 - 3.0	thou/ μ L
ABSOLUTE MONOCYTE COUNT	0.60	0.2 - 1.0	thou/ μ L
ABSOLUTE EOSINOPHIL COUNT	0.27	0.02 - 0.50	thou/ μ L
ABSOLUTE BASOPHIL COUNT	0.00 Low	0.02 - 0.10	thou/ μ L
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	0.7		

MORPHOLOGY

RBC	NORMOCYTIC NORMOCHROMIC
WBC	RELATIVE LYMPHOCYTOSIS
PLATELETS	ADEQUATE


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Consultant Pathologist

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REMARKS

NO PREMATURE CELLS ARE SEEN. MALARIAL PARASITE NOT DETECTED.

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 CHECK UP BELOW 40 MALE**ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD**

E.S.R 05 0 - 14 mm at 1 hr

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 automated instruments are available to measure ESR.

ESR is not diagnostic; it is a non-specific test that may be elevated in a number of different conditions. It provides general information about the presence of an inflammatory condition. CRP is superior to ESR because it is more sensitive and reflects a more rapid change.

TEST INTERPRETATION

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

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

REFERENCE :

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



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IMMUNOHAEMATOLOGY

MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE**ABO GROUP & RH TYPE, EDTA WHOLE BLOOD**

ABO GROUP

TYPE B

RH TYPE

POSITIVE


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.


Dr.Miral Gajera
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BIOCHEMISTRY

MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

GLUCOSE FASTING,FLUORIDE PLASMA

FBS (FASTING BLOOD SUGAR) 93 74 - 99 mg/dL

GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

HBA1C 4.9 Non-diabetic: < 5.7 %
Pre-diabetics: 5.7 - 6.4
Diabetics: > or = 6.5
Therapeutic goals: < 7.0
Action suggested : > 8.0
(ADA Guideline 2021)

ESTIMATED AVERAGE GLUCOSE(EAG) 93.9 < 116.0 mg/dL

GLUCOSE, POST-PRANDIAL, PLASMA

PPBS(POST PRANDIAL BLOOD SUGAR) 88 70 - 140 mg/dL

LIPID PROFILE, SERUM

CHOLESTEROL, TOTAL **231 High** Desirable: < 200 mg/dL
BorderlineHigh: 200 - 239
High: > or = 240

TRIGLYCERIDES **184 High** Desirable: < 150 mg/dL
BorderlineHigh: 150 - 199
High: 200 - 499
Very High: > or = 500

HDL CHOLESTEROL 49 < 40 Low mg/dL
> or = 60 High

CHOLESTEROL LDL **145 High** Adult levels: mg/dL
Optimal < 100
Near optimal/above optimal:
100-129
Borderline high : 130-159
High : 160-189
Very high : = 190

NON HDL CHOLESTEROL **182 High** Desirable: Less than 130 mg/dL
Above Desirable: 130 - 159
Borderline High: 160 - 189
High: 190 - 219
Very high: > or = 220

VERY LOW DENSITY LIPOPROTEIN 36.8 mg/dL

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CHOL/HDL RATIO		4.7		
LDL/HDL RATIO		3.0	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	1.54 High	Upto 1.2	mg/dL
BILIRUBIN, DIRECT	0.45 High	Upto 0.2	mg/dL
BILIRUBIN, INDIRECT	1.09 High	0.00 - 1.00	mg/dL
TOTAL PROTEIN	6.9	6.4 - 8.3	g/dL
ALBUMIN	5.0	3.5 - 5.2	g/dL
GLOBULIN	1.9 Low	2.0 - 4.1	g/dL
ALBUMIN/GLOBULIN RATIO	2.6 High	1.0 - 2.0	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	21	0 - 40	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)	27	0 - 41	U/L
ALKALINE PHOSPHATASE	95	40 - 129	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)	23	8 - 61	U/L
LACTATE DEHYDROGENASE	145	135 - 225	U/L

BLOOD UREA NITROGEN (BUN), SERUM

BLOOD UREA NITROGEN	10	6 - 20	mg/dL
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CREATININE, SERUM

CREATININE	0.82	0.70 - 1.30	mg/dL
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BUN/CREAT RATIO

BUN/CREAT RATIO	12.20	5.0 - 15.0	
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URIC ACID, SERUM

URIC ACID	5.7	3.4 - 7.0	mg/dL
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TOTAL PROTEIN, SERUM

TOTAL PROTEIN	6.9	6.4 - 8.3	g/dL
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ALBUMIN, SERUM

ALBUMIN	5.0	3.5 - 5.2	g/dL
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8800465156

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PATIENT ID : ABDUM110188321

CLIENT PATIENT ID:

ABHA NO :

AGE/SEX : 35 Years Male

DRAWN : 28/01/2023 00:00:00

RECEIVED : 28/01/2023 08:20:03

REPORTED : 01/02/2023 14:28:29

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GLOBULIN

GLOBULIN	1.9 Low	2.0 - 4.1	g/dL
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ELECTROLYTES (NA/K/CL), SERUM

SODIUM, SERUM	140.3	136- 145	mmol/L
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POTASSIUM, SERUM	4.39	3.50- 5.10	mmol/L
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CHLORIDE, SERUM	104.5	98 - 107	mmol/L
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Interpretation(s)**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; sulfonyleureas, 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 glycemic control.

High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal 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 :

I. Shortened Erythrocyte survival : Any condition that shortens erythrocyte survival or decreases mean erythrocyte age (e.g. recovery from acute blood loss, hemolytic anemia) will falsely lower HbA1c test results. Fructosamine is recommended in these patients which indicates diabetes control over 15 days.

II. Vitamin C & E are reported to falsely lower test results. (possibly by inhibiting glycation of hemoglobin).

III. Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia, uremia, hyperbilirubinemia, chronic alcoholism, chronic ingestion of salicylates & opiates addition are reported to interfere with some assay methods, falsely increasing results.

IV. Interference of hemoglobinopathies in HbA1c estimation is seen in

a. Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.

b. Heterozygous state detected (D10 is corrected for HbS & HbC trait.)

c. HbF > 25% on alternate 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, Increased insulin response & sensitivity etc. Additional test HbA1c

LIVER FUNCTION PROFILE, SERUM - LIVER FUNCTION PROFILE

Bilirubin is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. Bilirubin is excreted in bile and urine, and elevated levels may give



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yellow discoloration in jaundice. Elevated levels results from increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Conjugated (direct) bilirubin is elevated more than unconjugated (indirect) bilirubin in Viral hepatitis, Drug reactions, Alcoholic liver disease. Conjugated (direct) bilirubin is also elevated more than unconjugated (indirect) bilirubin when there is some kind of blockage of the bile ducts like in Gallstones getting into the bile ducts, tumors & Scarring of the bile ducts. Increased unconjugated (indirect) bilirubin may be a result of Hemolytic or pernicious anemia, Transfusion reaction & a common metabolic condition termed Gilbert syndrome, due to low levels of the enzyme that attaches sugar molecules to bilirubin.

AST is an enzyme found in various parts of the body. AST is found in the liver, heart, skeletal muscle, kidneys, brain, and red blood cells, and it is commonly measured clinically as a marker for liver health. AST levels increase during chronic viral hepatitis, blockage of the bile duct, cirrhosis of the liver, liver cancer, kidney failure, hemolytic anemia, pancreatitis, hemochromatosis. AST levels may also increase after a heart attack or strenuous activity. ALT test measures the amount of this enzyme in the blood. ALT is found mainly in the liver, but also in smaller amounts in the kidneys, heart, muscles, and pancreas. It is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health. AST levels increase during acute hepatitis, sometimes due to a viral infection, ischemia to the liver, chronic hepatitis, obstruction of bile ducts, cirrhosis.

ALP is a protein found in almost all body tissues. Tissues with higher amounts of ALP include the liver, bile ducts and bone. Elevated ALP levels are seen in Biliary obstruction, Osteoblastic bone tumors, osteomalacia, hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, Paget's disease, Rickets, Sarcoidosis etc. Lower-than-normal ALP levels seen in Hypophosphatasia, Malnutrition, Protein deficiency, Wilson's disease. GGT is an enzyme found in cell membranes of many tissues mainly in the liver, kidney and pancreas. It is also found in other tissues including intestine, spleen, heart, brain and seminal vesicles. The highest concentration is in the kidney, but the liver is considered the source of normal enzyme activity. Serum GGT has been widely used as an index of liver dysfunction. Elevated serum GGT activity can be found in diseases of the liver, biliary system and pancreas. Conditions that increase serum GGT are obstructive liver disease, high alcohol consumption and use of enzyme-inducing drugs etc. Serum total protein, also known as total protein, is a biochemical test for measuring the total amount of protein in serum. Protein in the plasma is made up of albumin and globulin. Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma, Waldenstrom's disease. Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage), Burns, Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome, Protein-losing enteropathy etc. Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. Low blood albumin levels (hypoalbuminemia) can be caused by: Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance, malnutrition and wasting etc

BLOOD UREA NITROGEN (BUN), SERUM- Causes of Increased levels include Pre renal (High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal), Renal Failure, Post Renal (Malignancy, Nephrolithiasis, Prostatism)

Causes of decreased level include Liver disease, SIADH.

CREATININE, SERUM- Higher than normal level may be due to:

- Blockage in the urinary tract
- Kidney problems, such as kidney damage or failure, infection, or reduced blood flow
- Loss of body fluid (dehydration)
- Muscle problems, such as breakdown of muscle fibers
- Problems during pregnancy, such as seizures (eclampsia), or high blood pressure caused by pregnancy (preeclampsia)

Lower than normal level may be due to:

- Myasthenia Gravis
- Muscular dystrophy

URIC ACID, SERUM- Causes of Increased levels: -Dietary (High Protein Intake, Prolonged Fasting, Rapid weight loss), Gout, Lesch nyhan syndrome, Type 2 DM, Metabolic syndrome

Causes of decreased levels - Low Zinc intake, OCP, Multiple Sclerosis

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.

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CLINICAL PATH - URINALYSIS

MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

PHYSICAL EXAMINATION, URINE

COLOR Yellow
APPEARANCE Clear

CHEMICAL EXAMINATION, URINE

PH	5.0	4.7 - 7.5
SPECIFIC GRAVITY	1.025	1.003 - 1.035
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

RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
PUS CELL (WBC'S)	2-3	0-5	/HPF
EPITHELIAL CELLS	1-2	0-5	/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.

Interpretation(s)



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SPECIALISED CHEMISTRY - HORMONE

MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

THYROID PANEL, SERUM

T3	145.20	80.00 - 200.00	ng/dL
T4	9.02	5.10 - 14.10	µg/dL
TSH (ULTRASENSITIVE)	2.450	0.270 - 4.200	µIU/mL

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.

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, FreeT4 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
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.Guidlines of the American Thyroid association during pregnancy and Postpartum, 2011.

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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.

****End Of Report****

Please visit www.srlworld.com for related Test Information for this accession

CONDITIONS OF LABORATORY TESTING & REPORTING

- | | |
|---|---|
| <ol style="list-style-type: none"> 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: <ol style="list-style-type: none"> 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 | <ol style="list-style-type: none"> 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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