



MC-5333

PATIENT NAME : SUGNA DEVI

REF. DOCTOR : SELF

CODE/NAME & ADDRESS : C000049066

SRL JAIPUR WELLNESS CORPORATE WALK IN
AAKRITI LABS PVT LTD. A-430, AGRASEN MARG
JAIPUR 302017
9314660100

ACCESSION NO : 0251WA001950

PATIENT ID : SUGNF280175251

CLIENT PATIENT ID: 012301280021

ABHA NO :

AGE/SEX : 48 Years Female

DRAWN : 28/01/2023 09:48:00

RECEIVED : 28/01/2023 10:16:10

REPORTED : 28/01/2023 16:06:34

Test Report Status	Final	Results	Biological Reference Interval	Units
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HAEMATOLOGY - CBC

MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40FEMALE

BLOOD COUNTS, EDTA WHOLE BLOOD

HEMOGLOBIN (HB)	14.0	12.0 - 15.0	g/dL
METHOD : CYANIDE FREE DETERMINATION			
RED BLOOD CELL (RBC) COUNT	4.30	3.8 - 4.8	mil/ μ L
METHOD : ELECTRICAL IMPEDANCE			
WHITE BLOOD CELL (WBC) COUNT	7.60	4.0 - 10.0	thou/ μ L
METHOD : ELECTRICAL IMPEDANCE			
PLATELET COUNT	150	150 - 410	thou/ μ L
METHOD : ELECTRONIC IMPEDANCE			

RBC AND PLATELET INDICES

HEMATOCRIT (PCV)	43.1	36 - 46	%
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR VOLUME (MCV)	100.0	83 - 101	fL
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	32.6 High	27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)	32.6	31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER			
RED CELL DISTRIBUTION WIDTH (RDW)	12.3	11.6 - 14.0	%
METHOD : CALCULATED PARAMETER			
MENTZER INDEX	23.3		
MEAN PLATELET VOLUME (MPV)	10.8	6.8 - 10.9	fL
METHOD : CALCULATED PARAMETER			

WBC DIFFERENTIAL COUNT

NEUTROPHILS	55	40 - 80	%
METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY			
LYMPHOCYTES	40	20 - 40	%
METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY			
MONOCYTES	03	2 - 10	%
METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY			
EOSINOPHILS	02	1 - 6	%
METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY			

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BASOPHILS		00	0 - 2	%
METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY				
ABSOLUTE NEUTROPHIL COUNT		4.18	2.0 - 7.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE LYMPHOCYTE COUNT		3.04 High	1.0 - 3.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE MONOCYTE COUNT		0.23	0.2 - 1.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE EOSINOPHIL COUNT		0.15	0.02 - 0.50	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE BASOPHIL COUNT		0 Low	0.02 - 0.10	thou/ μ L
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		1.4		

Interpretation(s)

BLOOD COUNTS,EDTA WHOLE BLOOD-The cell morphology is well preserved for 24hrs. However after 24-48 hrs a progressive increase in MCV and HCT is observed leading to a decrease in MCHC. A direct smear is recommended for an accurate differential count and for examination of RBC morphology.

RBC AND PLATELET INDICES-Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia(>13) from Beta thalassaemia trait

(<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.

WBC DIFFERENTIAL COUNT-The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR < 3.3, COVID-19 patients tend to show mild disease.

(Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients ; A.-P. Yang, et al.; International Immunopharmacology 84 (2020) 106504

This ratio element is a calculated parameter and out of NABL scope.


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HAEMATOLOGY

MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40FEMALE

ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD

E.S.R 07 0 - 20 mm at 1 hr

METHOD : AUTOMATED (PHOTOMETRICAL CAPILLARY STOPPED FLOW KINETIC ANALYSIS)"

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 CHECKUP ABOVE 40FEMALE

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP

TYPE A

METHOD : TUBE AGGLUTINATION

RH TYPE

POSITIVE

METHOD : TUBE AGGLUTINATION

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.


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BIOCHEMISTRY

MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40FEMALE

GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

HBA1C	5.2	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)	%
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METHOD : HIGH PERFORMANCE LIQUID CHROMATOGRAPHY (HPLC)

ESTIMATED AVERAGE GLUCOSE(EAG)	102.5	< 116.0	mg/dL
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METHOD : CALCULATED PARAMETER

GLUCOSE FASTING,FLUORIDE PLASMA

FBS (FASTING BLOOD SUGAR)	87	74 - 99	mg/dL
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METHOD : GLUCOSE OXIDASE

GLUCOSE, POST-PRANDIAL, PLASMA

PPBS(POST PRANDIAL BLOOD SUGAR)	118	70 - 140	mg/dL
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METHOD : GLUCOSE OXIDASE

LIPID PROFILE, SERUM

CHOLESTEROL, TOTAL	229 High	< 200 Desirable 200 - 239 Borderline High >= 240 High	mg/dL
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METHOD : CHOLESTEROL OXIDASE

TRIGLYCERIDES	171 High	< 150 Normal 150 - 199 Borderline High 200 - 499 High >= 500 Very High	mg/dL
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METHOD : LIPASE/GPO-PAP NO CORRECTION

HDL CHOLESTEROL	59	< 40 Low >=60 High	mg/dL
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METHOD : DIRECT CLEARANCE METHOD

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CHOLESTEROL LDL **136 High** < 100 Optimal mg/dL
100 - 129
Near optimal/ above optimal
130 - 159
Borderline High
160 - 189 High
>/= 190 Very High

NON HDL CHOLESTEROL **170 High** Desirable: Less than 130 mg/dL
Above Desirable: 130 - 159
Borderline High: 160 - 189
High: 190 - 219
Very high: > or = 220

METHOD : CALCULATED PARAMETER

VERY LOW DENSITY LIPOPROTEIN CHOL/HDL RATIO **34.2 High** </= 30.0 mg/dL
3.9
3.3 - 4.4
Low Risk
4.5 - 7.0
Average Risk
7.1 - 11.0
Moderate Risk
> 11.0
High Risk

LDL/HDL RATIO 2.3 0.5 - 3.0 Desirable/Low Risk
3.1 - 6.0 Borderline/Moderate Risk
>6.0 High Risk

Interpretation(s)

LIVER FUNCTION PROFILE, SERUM

BILIRUBIN, TOTAL 0.43 0 - 1 mg/dL
METHOD : DIAZO WITH SULPHANILIC ACID

BILIRUBIN, DIRECT 0.13 0.00 - 0.25 mg/dL
METHOD : DIAZO WITH SULPHANILIC ACID

BILIRUBIN, INDIRECT 0.30 0.1 - 1.0 mg/dL
METHOD : CALCULATED PARAMETER

TOTAL PROTEIN 7.8 6.4 - 8.2 g/dL
METHOD : BIURET REACTION, END POINT

ALBUMIN **4.5 High** 3.8 - 4.4 g/dL

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METHOD : BROMOCRESOL GREEN				
GLOBULIN		3.3	2.0 - 4.1	g/dL
METHOD : CALCULATED PARAMETER				
ALBUMIN/GLOBULIN RATIO		1.4	1.0 - 2.1	RATIO
METHOD : CALCULATED PARAMETER				
ASPARTATE AMINOTRANSFERASE (AST/SGOT)		24	0 - 31	U/L
METHOD : TRIS BUFFER NO P5P IFCC / SFBC 37° C				
ALANINE AMINOTRANSFERASE (ALT/SGPT)		22	0 - 31	U/L
METHOD : TRIS BUFFER NO P5P IFCC / SFBC 37° C				
ALKALINE PHOSPHATASE		52	39 - 117	U/L
METHOD : AMP OPTIMISED TO IFCC 37° C				
GAMMA GLUTAMYL TRANSFERASE (GGT)		20	7 - 32	U/L
METHOD : GAMMA GLUTAMYL-3 CARBOXY-4 NITROANILIDE (IFCC) 37° C				
LACTATE DEHYDROGENASE		316	230 - 460	U/L
BLOOD UREA NITROGEN (BUN), SERUM				
BLOOD UREA NITROGEN		14	5.0 - 18.0	mg/dL
METHOD : UREASE KINETIC				
CREATININE, SERUM				
CREATININE		0.94	0.6 - 1.2	mg/dL
METHOD : ALKALINE PICRATE NO DEPROTEINIZATION				
BUN/CREAT RATIO				
BUN/CREAT RATIO		14.89		
METHOD : CALCULATED PARAMETER				
URIC ACID, SERUM				
URIC ACID		4.3	2.4 - 5.7	mg/dL
METHOD : URICASE PEROXIDASE WITH ASCORBATE OXIDASE				
TOTAL PROTEIN, SERUM				
TOTAL PROTEIN		7.8	6.4 - 8.3	g/dL
METHOD : BIURET REACTION, END POINT				
ALBUMIN, SERUM				
ALBUMIN		4.5 High	3.8 - 4.4	g/dL
METHOD : BROMOCRESOL GREEN				
GLOBULIN				
GLOBULIN		3.3	2.0 - 4.1	g/dL

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ELECTROLYTES (NA/K/CL), SERUM

SODIUM, SERUM

137.5

137 - 145

mmol/L

METHOD : ION-SELECTIVE ELECTRODE

POTASSIUM, SERUM

4.46

3.6 - 5.0

mmol/L

METHOD : ION-SELECTIVE ELECTRODE

CHLORIDE, SERUM

100.1

98 - 107

mmol/L

METHOD : ION-SELECTIVE ELECTRODE

Interpretation(s)**Interpretation(s)**

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

- Evaluating the long-term control of blood glucose concentrations in diabetic patients.
 - Diagnosing diabetes.
 - 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.
- eAG (Estimated average glucose) converts percentage HbA1c to mg/dl, to compare blood glucose levels.
 - eAG gives an evaluation of blood glucose levels for the last couple of months.
 - eAG is calculated as $eAG (mg/dl) = 28.7 * HbA1c - 46.7$

HbA1c Estimation can get affected due to :

- 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.
- Vitamin C & E are reported to falsely lower test results. (possibly by inhibiting glycation of hemoglobin).
- Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia, uremia, hyperbilirubinemia, chronic alcoholism, chronic ingestion of salicylates & opiates addiction are reported to interfere with some assay methods, falsely increasing results.
- Interference of hemoglobinopathies in HbA1c estimation is seen in
 - Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.
 - Heterozygous state detected (D10 is corrected for HbS & HbC trait.)
 - 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 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; sulfonureas, 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.

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


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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

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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Consultant Pathologist



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Rajasthan, INDIA



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MC-5333

PATIENT NAME : SUGNA DEVI		REF. DOCTOR : SELF	
CODE/NAME & ADDRESS : C000049066		ACCESSION NO : 0251WA001950	AGE/SEX : 48 Years Female
SRL JAIPUR WELLNESS CORPORATE WALK IN AAKRITI LABS PVT LTD. A-430, AGRASEN MARG JAIPUR 302017 9314660100		PATIENT ID : SUGNF280175251	DRAWN : 28/01/2023 09:48:00
		CLIENT PATIENT ID: 012301280021	RECEIVED : 28/01/2023 10:16:10
		ABHA NO :	REPORTED : 28/01/2023 16:06:34

Test Report Status	Final	Results	Biological Reference Interval	Units
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CLINICAL PATH - URINALYSIS

MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40FEMALE

PHYSICAL EXAMINATION, URINE

COLOR PALE YELLOW
METHOD : GROSS EXAMINATION

APPEARANCE CLEAR
METHOD : GROSS EXAMINATION

CHEMICAL EXAMINATION, URINE

PH 6.0 4.7 - 7.5
METHOD : DOUBLE INDICATOR PRINCIPLE

SPECIFIC GRAVITY ≤ 1.005 1.003 - 1.035
METHOD : IONIC CONCENTRATION METHOD

PROTEIN NOT DETECTED NOT DETECTED
METHOD : PROTEIN ERROR OF INDICATORS WITH REFLECTANCE

GLUCOSE NOT DETECTED NOT DETECTED
METHOD : GLUCOSE OXIDASE PEROXIDASE / BENEDICTS

KETONES NOT DETECTED NOT DETECTED
METHOD : SODIUM NITROPRUSSIDE REACTION

BLOOD NOT DETECTED NOT DETECTED
METHOD : PEROXIDASE ANTI PEROXIDASE

BILIRUBIN NOT DETECTED NOT DETECTED
METHOD : DIPSTICK

UROBILINOGEN NORMAL NORMAL
METHOD : EHRLICH REACTION REFLECTANCE

NITRITE NOT DETECTED NOT DETECTED
METHOD : NITRATE TO NITRITE CONVERSION METHOD

LEUKOCYTE ESTERASE NOT DETECTED NOT DETECTED

MICROSCOPIC EXAMINATION, URINE

RED BLOOD CELLS NOT DETECTED NOT DETECTED /HPF
METHOD : MICROSCOPIC EXAMINATION

PUS CELL (WBC'S) 1-2 0-5 /HPF
METHOD : DIPSTICK, MICROSCOPY

EPITHELIAL CELLS 2-3 0-5 /HPF
METHOD : MICROSCOPIC EXAMINATION

CASTS NOT DETECTED

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Consultant Pathologist



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PATIENT NAME : SUGNA DEVI

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CODE/NAME & ADDRESS : C000049066

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9314660100

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METHOD : MICROSCOPIC EXAMINATION

CRYSTALS

NOT DETECTED

METHOD : MICROSCOPIC EXAMINATION

BACTERIA

NOT DETECTED

NOT DETECTED

METHOD : MICROSCOPIC EXAMINATION

YEAST

NOT DETECTED

NOT DETECTED

Interpretation(s)

Dr. Akansha Jain
Consultant Pathologist

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CYTOLOGY

MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40FEMALE

PAPANICOLAOU SMEAR

TEST METHOD

SAMPLE NOT RECEIVED

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 Consultant Pathologist



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

CLINICAL PATH - STOOL ANALYSIS

MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40FEMALE

PHYSICAL EXAMINATION,STOOL

COLOUR

SAMPLE NOT RECEIVED

METHOD : GROSS EXAMINATION

Dr. Abhishek Sharma
Consultant Microbiologist



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SPECIALISED CHEMISTRY - HORMONE

MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40FEMALE

THYROID PANEL, SERUM

T3 METHOD : CHEMILUMINESCENCE	97.21	60.0 - 181.0	ng/dL
T4 METHOD : CHEMILUMINESCENCE	11.60 High	4.5 - 10.9	µg/dL
TSH (ULTRASENSITIVE) METHOD : CHEMILUMINESCENCE	2.016	0.550 - 4.780	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. Below mentioned are the guidelines for Pregnancy related reference ranges for Total T4, TSH & Total T3. Measurement of the serum TT3 level is a more sensitive test for the diagnosis of hyperthyroidism, and measurement of TT4 is more useful in the diagnosis of hypothyroidism. Most of the thyroid hormone in blood is bound to transport proteins. Only a very small fraction of the circulating hormone is free and biologically active. It is advisable to detect Free T3, 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

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8	Normal/Low	Normal	Normal	High	(1) T3 thyrotoxicosis (2) Non-Thyroidal illness
9	Low	High	High	Normal	(1) T4 Ingestion (2) Thyroiditis (3) Interfering Anti TPO antibodies

REF: 1. TIETZ Fundamentals of Clinical chemistry 2. Guidelines of the American Thyroid association during pregnancy and Postpartum, 2011.

NOTE: It is advisable to detect Free T3, Free T4 along with TSH, instead of testing for albumin bound Total T3, Total T4. TSH is not affected by variation in thyroid - binding protein. TSH has a diurnal rhythm, with peaks at 2:00 - 4:00 a.m. And troughs at 5:00 - 6:00 p.m. With ultradian variations.

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