



Patient Ref. No. 775000001712525

CLIENT CODE : C000138394

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

SRL Ltd
S.K. Tower, Hari Niwas, LBS Marg
THANE, 400602
MAHARASHTRA, INDIA
Tel : 9111591115, Fax : CIN - U74899PB1995PLC045956
Email : customercare.thane@srl.in

PATIENT NAME : SUDHIR ANANT JADHAV

PATIENT ID : SUDHM070178181

ACCESSION NO : 0181VJ000358 AGE : 44 Years SEX : Male

ABHA NO :

DRAWN : RECEIVED : 08/10/2022 08:42:36

REPORTED : 12/10/2022 15:32:12

REFERRING DOCTOR : SELF

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Test Report Status	Final	Results	Biological Reference Interval	Units
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MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE

BLOOD COUNTS, EDTA WHOLE BLOOD

HEMOGLOBIN	15.2	13.0 - 17.0	g/dL
METHOD : SLS- HEMOGLOBIN DETECTION METHOD			
RED BLOOD CELL COUNT	5.39	4.5 - 5.5	mil/ μ L
METHOD : HYDRODYNAMIC FOCUSING BY DC DETECTION			
WHITE BLOOD CELL COUNT	5.32	4.0 - 10.0	thou/ μ L
METHOD : FLUORESCENCE FLOW CYTOMETRY			
PLATELET COUNT	208	150 - 410	thou/ μ L
METHOD : HYDRODYNAMIC FOCUSING BY DC DETECTION			

RBC AND PLATELET INDICES

HEMATOCRIT	45.1	40.0 - 50.0	%
METHOD : CUMULATIVE PULSE HEIGHT DETECTION METHOD			
MEAN CORPUSCULAR VOL	83.7	83.0 - 101.0	fL
METHOD : CALCULATED FROM RBC & HCT			
MEAN CORPUSCULAR HGB.	28.2	27.0 - 32.0	pg
METHOD : CALCULATED FROM THE RBC & HGB			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION	33.7	31.5 - 34.5	g/dL
METHOD : CALCULATED FROM THE HGB & HCT			
MENTZER INDEX	15.5		
RED CELL DISTRIBUTION WIDTH	12.7	11.6 - 14.0	%
METHOD : CALCULATED FROM RBC SIZE DISTRIBUTION CURVE			
MEAN PLATELET VOLUME	10.6	6.8 - 10.9	fL
METHOD : CALCULATED FROM PLATELET COUNT & PLATELET HEMATOCRIT			

WBC DIFFERENTIAL COUNT - NLR

SEGMENTED NEUTROPHILS	62	40 - 80	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
ABSOLUTE NEUTROPHIL COUNT	3.30	2.0 - 7.0	thou/ μ L
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
LYMPHOCYTES	28	20 - 40	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
ABSOLUTE LYMPHOCYTE COUNT	1.50	1.0 - 3.0	thou/ μ L
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	2.2		
EOSINOPHILS	5	1 - 6	%





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METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
ABSOLUTE EOSINOPHIL COUNT		0.27	0.02 - 0.50	thou/ μ L
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
MONOCYTES		5	2 - 10	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
ABSOLUTE MONOCYTE COUNT		0.24	0.2 - 1.0	thou/ μ L
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
DIFFERENTIAL COUNT PERFORMED ON:		EDTA SMEAR		
MORPHOLOGY				
RBC		NORMOCYTIC NORMOCHROMIC		
WBC		NORMAL MORPHOLOGY		
METHOD : MICROSCOPIC EXAMINATION				
PLATELETS		ADEQUATE		
ERYTHRO SEDIMENTATION RATE, BLOOD				
SEDIMENTATION RATE (ESR)		02	0 - 14	mm at 1 hr
METHOD : WESTERGREIN METHOD				
GLYCOSYLATED HEMOGLOBIN, EDTA WHOLE BLOOD				
GLYCOSYLATED HEMOGLOBIN (HBA1C)		5.9	High Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 ADA Target: 7.0 Action suggested: > 8.0	%
METHOD : HPLC				
MEAN PLASMA GLUCOSE		122.6	High < 116.0	mg/dL
METHOD : CALCULATED PARAMETER				
GLUCOSE, FASTING, PLASMA				
GLUCOSE, FASTING, PLASMA		119	High Normal 75 - 99 Pre-diabetics: 100 - 125 Diabetic: > or = 126	mg/dL
METHOD : ENZYMATIC REFERENCE METHOD WITH HEXOKINASE				
GLUCOSE, POST-PRANDIAL, PLASMA				
GLUCOSE, POST-PRANDIAL, PLASMA		172	High 70 - 139	mg/dL
METHOD : ENZYMATIC REFERENCE METHOD WITH HEXOKINASE				
CORONARY RISK PROFILE, SERUM				





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CHOLESTEROL		175	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		29	Low Low HDL Cholesterol <40 High HDL Cholesterol >/= 60	mg/dL
METHOD : ENZYMATIC, COLORIMETRIC				
CHOLESTEROL LDL		121	High Adult levels: Optimal < 100 Near optimal/above optimal: 100-129 Borderline high : 130-159 High : 160-189 Very high : = 190	mg/dL
METHOD : ENZYMATIC COLORIMETRIC ASSAY				
NON HDL CHOLESTEROL		146	High Desirable : < 130 Above Desirable : 130 - 159 Borderline High : 160 - 189 High : 190 - 219 Very high : > / = 220	mg/dL
CHOL/HDL RATIO		6.0	High Low Risk : 3.3 - 4.4 Average Risk : 4.5 - 7.0 Moderate Risk : 7.1 - 11.0 High Risk : > 11.0	
LDL/HDL RATIO		4.2	High 0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
VERY LOW DENSITY LIPOPROTEIN		24.8	< OR = 30.0	mg/dL
LIVER FUNCTION PROFILE, SERUM				
BILIRUBIN, TOTAL		0.59		mg/dL
BILIRUBIN, DIRECT		0.24	< 0.30	mg/dL
BILIRUBIN, INDIRECT		0.35	0.1 - 1.0	mg/dL
TOTAL PROTEIN		7.5	6.0 - 8.0	g/dL





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METHOD : COLORIMETRIC

ALBUMIN 4.8 3.97 - 4.94 g/dL

METHOD : COLORIMETRIC

GLOBULIN 2.7 2.0 - 3.5 g/dL

ALBUMIN/GLOBULIN RATIO 1.8 1.0 - 2.1 RATIO

ASPARTATE AMINOTRANSFERASE (AST/SGOT) 33 < OR = 50 U/L

METHOD : UV ABSORBANCE

ALANINE AMINOTRANSFERASE (ALT/SGPT) 54 High < OR = 50 U/L

METHOD : UV ABSORBANCE

ALKALINE PHOSPHATASE 59 40 - 129 U/L

METHOD : COLORIMETRIC

GAMMA GLUTAMYL TRANSFERASE (GGT) 35 0 - 60 U/L

METHOD : ENZYMATIC, COLORIMETRIC

LACTATE DEHYDROGENASE 214 125 - 220 U/L

METHOD : UV ABSORBANCE

SERUM BLOOD UREA NITROGEN

BLOOD UREA NITROGEN 7 6 - 20 mg/dL

METHOD : ENZYMATIC ASSAY

CREATININE, SERUM

CREATININE 1.01 0.7 - 1.2 mg/dL

METHOD : COLORIMETRIC

BUN/CREAT RATIO

BUN/CREAT RATIO 7.14 Low 8.0 - 15.0

URIC ACID, SERUM

URIC ACID 6.3 3.4 - 7.0 mg/dL

METHOD : ENZYMATIC COLORIMETRIC ASSAY

TOTAL PROTEIN, SERUM

TOTAL PROTEIN 7.5 6.0 - 8.0 g/dL

METHOD : COLORIMETRIC

ALBUMIN, SERUM

ALBUMIN 4.8 3.97 - 4.94 g/dL

METHOD : COLORIMETRIC

GLOBULIN

GLOBULIN 2.7 2.0 - 3.5 g/dL

ELECTROLYTES (NA/K/CL), SERUM





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SODIUM		136	136 - 145	mmol/L
POTASSIUM		4.81	3.5 - 5.1	mmol/L
CHLORIDE		97	Low 98 - 107	mmol/L

PHYSICAL EXAMINATION, URINE

COLOR PALE YELLOW

METHOD : VISUAL INSPECTION

APPEARANCE CLEAR

METHOD : VISUAL INSPECTION

SPECIFIC GRAVITY 1.005 1.003 - 1.035

METHOD : IONIC CONCENTRATION METHOD

CHEMICAL EXAMINATION, URINE

PH 6.0 4.7 - 7.5

METHOD : DOUBLE INDICATOR PRINCIPLE

PROTEIN NOT DETECTED NOT DETECTED

METHOD : TETRA BROMOPHENOL BLUE/SULFOSALICYLIC ACID

GLUCOSE NOT DETECTED NOT DETECTED

METHOD : GLUCOSE OXIDASE PEROXIDASE

KETONES NOT DETECTED NOT DETECTED

METHOD : NITROPRUSSIDE REACTION

BLOOD NOT DETECTED NOT DETECTED

METHOD : PEROXIDASE

UROBILINOGEN NORMAL NORMAL

METHOD : MODIFIED EHRlich REACTION

NITRITE NOT DETECTED NOT DETECTED

METHOD : 1,2,3,4-TETRAHYDROBENZO(H)QUINOLIN-3-OL

LEUKOCYTE ESTERASE NOT DETECTED NOT DETECTED

MICROSCOPIC EXAMINATION, URINE

PUS CELL (WBC'S) 1-2 0-5 /HPF

METHOD : MICROSCOPIC EXAMINATION

EPITHELIAL CELLS 1-2 0-5 /HPF

METHOD : MICROSCOPIC EXAMINATION

ERYTHROCYTES (RBC'S) NOT DETECTED NOT DETECTED /HPF

METHOD : MICROSCOPIC EXAMINATION

CASTS NOT DETECTED

METHOD : MICROSCOPIC EXAMINATION





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CRYSTALS		NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION				
BACTERIA		NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION				
YEAST		NOT DETECTED	NOT DETECTED	
THYROID PANEL, SERUM				
T3		174.0	80 - 200	ng/dL
METHOD : ELECTROCHEMILUMINESCENCE				
T4		8.39	5.1 - 14.1	µg/dL
METHOD : ELECTROCHEMILUMINESCENCE				
TSH 3RD GENERATION		1.780	0.27 - 4.2	µIU/mL
METHOD : ELECTROCHEMILUMINESCENCE				
STOOL: OVA & PARASITE				
COLOUR		BROWN		
METHOD : VISUAL				
CONSISTENCY		WELL FORMED		
METHOD : VISUAL				
ODOUR		FAECAL		
METHOD : PHYSICAL				
MUCUS		ABSENT	NOT DETECTED	
METHOD : VISUAL				
VISIBLE BLOOD		ABSENT	ABSENT	
METHOD : VISUAL				
POLYMPHONUCLEAR LEUKOCYTES		0-1	0 - 5	/HPF
METHOD : MICROSCOPIC EXAMINATION				
RED BLOOD CELLS		NOT DETECTED	NOT DETECTED	/HPF
METHOD : MICROSCOPIC EXAMINATION				
TROPHOZOITES		NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION				
CYSTS		NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION				
OVA		NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION				
LARVAE		NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION				
OCCULT BLOOD		NOT DETECTED	NOT DETECTED	





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METHOD : HEMOSPOT

REMARK

NO OVA CYST SEEN AFTER PERFORMING CONCENTRATION TECHNIQUE FOR STOOL SAMPLE.

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP

TYPE A

METHOD : GEL COLUMN AGGLUTINATION METHOD.

RH TYPE

POSITIVE

METHOD : GEL COLUMN AGGLUTINATION METHOD.

XRAY-CHEST

IMPRESSION

NO ABNORMALITY DETECTED

TMT OR ECHO

TMT OR ECHO

2D ECHO :- MILD MR
CONCENTRIC LVH
GRADE I LV DIASTOLIC DYSFUNCTION

ECG

ECG

LEFT AXIS DEVIATION

MEDICAL HISTORY

RELEVANT PRESENT HISTORY

DIABETES SINCE 6 MONTHS
C/O BREATHLESSNESS ON EXERTION

RELEVANT PAST HISTORY

H/O SKIN GRAFTING RIGHT FOOT 15 YEARS BACK.

RELEVANT PERSONAL HISTORY

MARRIED / 2 CHILD / MIXED DIET / NO ALLERGIES / NO SMOKING / NO ALCOHO / TABACOO

RELEVANT FAMILY HISTORY

NOT SIGNIFICANT

HISTORY OF MEDICATIONS

TAB :- GLIMI / METFORMIN / VILDAGLIPTIN

ANTHROPOMETRIC DATA & BMI

HEIGHT IN METERS

1.74

mts

WEIGHT IN KGS.

102

Kgs

BMI

34

BMI & Weight Status as follows: kg/sqmts
Below 18.5: Underweight
18.5 - 24.9: Normal
25.0 - 29.9: Overweight
30.0 and Above: Obese

GENERAL EXAMINATION

MENTAL / EMOTIONAL STATE

NORMAL

PHYSICAL ATTITUDE

NORMAL

GENERAL APPEARANCE / NUTRITIONAL STATUS

OBESE

BUILT / SKELETAL FRAMEWORK

AVERAGE





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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/MIN.REGULAR, ALL PERIPHERAL PULSES WELL FELT, NO CAROTID BRUIT		
RESPIRATORY RATE		NORMAL		
CARDIOVASCULAR SYSTEM				
BP		164/94 MM HG (SUPINE)		mm/Hg
PERICARDIUM		NORMAL		
APEX BEAT		NORMAL		
HEART SOUNDS		NORMAL		
MURMURS		ABSENT		
RESPIRATORY SYSTEM				
SIZE AND SHAPE OF CHEST		NORMAL		
MOVEMENTS OF CHEST		SYMMETRICAL		
BREATH SOUNDS INTENSITY		NORMAL		
BREATH SOUNDS QUALITY		VESICULAR (NORMAL)		
ADDED SOUNDS		ABSENT		
PER ABDOMEN				
APPEARANCE		NORMAL		
VENOUS PROMINENCE		ABSENT		
LIVER		NOT PALPABLE		
SPLEEN		NOT PALPABLE		
HERNIA		ABSENT		
CENTRAL NERVOUS SYSTEM				
HIGHER FUNCTIONS		NORMAL		
CRANIAL NERVES		NORMAL		





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CEREBELLAR FUNCTIONS		NORMAL		
SENSORY SYSTEM		NORMAL		
MOTOR SYSTEM		NORMAL		
REFLEXES		NORMAL		
MUSCULOSKELETAL SYSTEM				
SPINE		NORMAL		
JOINTS		NORMAL		
BASIC EYE EXAMINATION				
CONJUNCTIVA		NORMAL		
EYELIDS		NORMAL		
EYE MOVEMENTS		NORMAL		
CORNEA		NORMAL		
DISTANT VISION RIGHT EYE WITHOUT GLASSES		WITHIN NORMAL LIMIT		
DISTANT VISION LEFT EYE WITHOUT GLASSES		WITHIN NORMAL LIMIT		
NEAR VISION RIGHT EYE WITHOUT GLASSES		REDUCED VISUAL ACUITY N/18		
NEAR VISION LEFT EYE WITHOUT GLASSES		REDUCED VISUAL ACUITY N/12		
NEAR VISION RIGHT EYE WITH GLASSES		REDUCED VISUAL ACUITY N/8		
NEAR VISION LEFT EYE WITH GLASSES		WITHIN NORMAL LIMIT		
COLOUR VISION		NORMAL		

SUMMARY

RELEVANT HISTORY NOT SIGNIFICANT

RELEVANT GP EXAMINATION FINDINGS OBESE :- BMI 34

REMARKS / RECOMMENDATIONS

ADVICE:
1)WEIGHT LOSS - STRICT LOW FAT,LOW CALORIE, LOW CARBOHYDRATE, HIGH FIBRE DIET.
2)REGULAR EXERCISE.REGULAR WALK FOR 30-40 MIN DAILY.
3)REPEAT LIPID PROFILE, BLOOD SUGAR AFTER 3 MONTHS OF DIET AND EXERCISE.
4)BP MONITORING FOR 5 DAYS. IF PERSISTENTLY HIGH, WILL REQUIRE EVALUATION BY PHYSICIAN.
5)ADD YOGA, PRANAYAM MEDITATION TO DAILY ROUTINE.
6)PHYSICIAN`S CONSULT FOR MANAGEMENT OF DYSLIPIDEMIA AND BLOOD SUGAR CONTROL.
7)SURGICAL CONSULT FOR CHOLELITHIASIS.
8)CARDIOLOGIST CONSULT IN VIEW OF SYMPTOMS & 2 D ECHO FINDINGS & DYSLIPIDEMIA.





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Patient Ref. No. 77500001712525

CLIENT CODE : C000138394

CLIENT'S NAME AND ADDRESS :

ACROFEMI HEALTHCARE LTD (MEDI WHEEL)
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Email : customercare.thane@srl.in

PATIENT NAME : SUDHIR ANANT JADHAV

PATIENT ID : SUDHM070178181

ACCESSION NO : 0181VJ000358 AGE : 44 Years SEX : Male ABHA NO :

DRAWN : RECEIVED : 08/10/2022 08:42:36 REPORTED : 12/10/2022 15:32:12

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MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE

ULTRASOUND ABDOMEN

ULTRASOUND ABDOMEN

GRADE I FATTY LIVER

CHOLELITHIASIS

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.

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"

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 glycosylated 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 glycosylated 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 glycaemic control. In these conditions, alternative forms of testing such as glycosylated 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, 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

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,





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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: Agamaglobulinemia, Bleeding (hemorrhage), Burns, Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome, Protein-losing enteropathy etc. Hum an serum albumin is the most abundant protein in hum an 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, hem odilution, 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 (preedampsia)

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





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- 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, hemodialysis, 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, Addison's disease, metabolic acidosis, acute starvation, dehydration, and with rapid K infusion. Chloride is increased in dehydration, renal tubular acidosis (hyperchloremic metabolic acidosis), acute renal failure, metabolic acidosis associated with prolonged diarrhea and loss of sodium bicarbonate, diabetes insipidus, adrenocortical hyperfunction, 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

Table with 4 columns: Levels in, TOTAL T4 (µg/dL), TSH3G (µIU/mL), TOTAL T3 (ng/dL). Rows for Pregnancy, First Trimester, 2nd Trimester, 3rd Trimester.

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

Table with 2 columns: T3 (ng/dL), T4 (µg/dL). Rows for 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.





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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, Kliegman R.M., Jenson H. B. Nelson Text Book of Pediatrics, 17th Edition

STOOL: OVA & PARASITE-

Acute infective diarrhoea and gastroenteritis (diarrhoea with vomiting) are major causes of ill health and premature death in developing countries. Loss of water and electrolytes from the body can lead to severe dehydration which if untreated, can be rapidly fatal in young children, especially that are malnourished, hypoglycaemic, and generally in poor health.

Laboratory diagnosis of parasitic infection is mainly based on microscopic examination and the gross examination of the stool specimen. Depending on the nature of the parasite, the microscopic observations include the identification of cysts, ova, trophozoites, larvae or portions of adult structure. The two classes of parasites that cause human infection are the Protozoa and Helminths. The protozoan infections include amoebiasis mainly caused by Entamoeba histolytica and giardiasis caused by Giardia lamblia. The common helminthic parasites are Trichuris trichiura, Ascaris lumbricoides, Strongyloides stercoralis, Taenia sp. etc

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD-

Blood group is identified by antigens and antibodies present in the blood. Antigens are protein molecules found on the surface of red blood cells. Antibodies are found in plasma. To determine blood group, red cells are mixed with different antibody solutions to give A,B,O or AB.

Disclaimer: "Please note, as the results of previous ABO and Rh group (Blood Group) for pregnant women are not available, please check with the patient records for availability of the same."

The test is performed by both forward as well as reverse grouping methods.

MEDICAL

HISTORY-*****

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

End Of Report

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

