

CLIENT CODE : C000138394
CLIENT'S NAME AND ADDRESS :
 ACROFEMI HEALTHCARE LTD (MEDIWHEEL)
 F-703, F-703, LADO SARAI, MEHRAULI
 SOUTH WEST DELHI
 NEW DELHI 110030
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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 : GANESH LOHAKARE PATIENT ID : **GANEM121089181**

ACCESSION NO : **0181WC001637** AGE : 33 Years SEX : Male

DRAWN : RECEIVED : 25/03/2023 09:20 REPORTED : 29/03/2023 15:33

REFERRING DOCTOR : SELF CLIENT PATIENT ID :

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

BLOOD COUNTS, EDTA WHOLE BLOOD

HEMOGLOBIN (HB)	15.4	13.0 - 17.0	g/dL
METHOD : SLS- HEMOGLOBIN DETECTION METHOD			
RED BLOOD CELL (RBC) COUNT	5.50	4.5 - 5.5	mil/ μ L
METHOD : HYDRODYNAMIC FOCUSING BY DC DETECTION			
WHITE BLOOD CELL (WBC) COUNT	4.76	4.0 - 10.0	thou/ μ L
METHOD : FLUORESCENCE FLOW CYTOMETRY			
PLATELET COUNT	197	150 - 410	thou/ μ L
METHOD : HYDRODYNAMIC FOCUSING BY DC DETECTION			

RBC AND PLATELET INDICES

HEMATOCRIT (PCV)	46.3	40.0 - 50.0	%
METHOD : CUMULATIVE PULSE HEIGHT DETECTION METHOD			
MEAN CORPUSCULAR VOLUME (MCV)	84.2	83.0 - 101.0	fL
METHOD : CALCULATED FROM RBC & HCT			
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	28.0	27.0 - 32.0	pg
METHOD : CALCULATED FROM THE RBC & HGB			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)	33.3	31.5 - 34.5	g/dL
METHOD : CALCULATED FROM THE HGB & HCT			
RED CELL DISTRIBUTION WIDTH (RDW)	11.9	11.6 - 14.0	%
METHOD : CALCULATED FROM RBC SIZE DISTRIBUTION CURVE			
MENTZER INDEX	15.3		
MEAN PLATELET VOLUME (MPV)	10.4	6.8 - 10.9	fL
METHOD : CALCULATED FROM PLATELET COUNT & PLATELET HEMATOCRIT			

WBC DIFFERENTIAL COUNT

NEUTROPHILS	55	40 - 80	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
LYMPHOCYTES	36	20 - 40	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
MONOCYTES	4	2 - 10	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
EOSINOPHILS	5	1 - 6	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
ABSOLUTE NEUTROPHIL COUNT	2.62	2.0 - 7.0	thou/ μ L
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			



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ABSOLUTE LYMPHOCYTE COUNT		1.72	1.0 - 3.0	thou/ μ L
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
ABSOLUTE MONOCYTE COUNT		0.19	Low 0.2 - 1.0	thou/ μ L
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
ABSOLUTE EOSINOPHIL COUNT		0.23	0.02 - 0.50	thou/ μ L
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		1.5		
MORPHOLOGY				
RBC		NORMOCYTIC NORMOCHROMIC		
WBC		NORMAL MORPHOLOGY		
METHOD : MICROSCOPIC EXAMINATION				
PLATELETS		ADEQUATE		
ERYTHROCYTE SEDIMENTATION RATE (ESR), WHOLE BLOOD				
E.S.R		4	< 15	mm at 1 hr
METHOD : MODIFIED WESTERGREN				
GLUCOSE FASTING, FLUORIDE PLASMA				
FBS (FASTING BLOOD SUGAR)		83	Normal 75 - 99 Pre-diabetics: 100 - 125 Diabetic: > or = 126	mg/dL
METHOD : ENZYMATIC REFERENCE METHOD WITH HEXOKINASE				
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD				
HBA1C		5.1	Non-diabetic Adult < 5.7 Pre-diabetes 5.7 - 6.4 Diabetes diagnosis: > or = 6.5 Therapeutic goals: < 7.0 Action suggested : > 8.0 (ADA Guideline 2021)	%
METHOD : HPLC				
ESTIMATED AVERAGE GLUCOSE(EAG)		99.7	< 116.0	mg/dL
METHOD : CALCULATED PARAMETER				
GLUCOSE, POST-PRANDIAL, PLASMA				
PPBS(POST PRANDIAL BLOOD SUGAR)		70	70 - 139	mg/dL
METHOD : ENZYMATIC REFERENCE METHOD WITH HEXOKINASE				
LIPID PROFILE, SERUM				



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CHOLESTEROL, TOTAL		141	Desirable cholesterol level < 200 Borderline high cholesterol 200 - 239 High cholesterol > / = 240	mg/dL
METHOD : ENZYMATIC COLORIMETRIC ASSAY				
TRIGLYCERIDES		79	Normal: < 150 Borderline high: 150 - 199 High: 200 - 499 Very High: >/= 500	mg/dL
METHOD : ENZYMATIC COLORIMETRIC ASSAY				
HDL CHOLESTEROL		36	Low Low HDL Cholesterol <40 High HDL Cholesterol >/= 60	mg/dL
METHOD : ENZYMATIC, COLORIMETRIC				
CHOLESTEROL LDL		89	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		105	Desirable : < 130 Above Desirable : 130 -159 Borderline High : 160 - 189 High : 190 - 219 Very high : > / = 220	mg/dL
VERY LOW DENSITY LIPOPROTEIN		15.8	< OR = 30.0	mg/dL
CHOL/HDL RATIO		3.9	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		2.5	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
LIVER FUNCTION PROFILE, SERUM				
BILIRUBIN, TOTAL		1.34	High Upto 1.2	mg/dL
METHOD : COLORIMETRIC DIAZO				
BILIRUBIN, DIRECT		0.53	High < 0.30	mg/dL
BILIRUBIN, INDIRECT		0.81	0.1 - 1.0	mg/dL
TOTAL PROTEIN		6.8	6.0 - 8.0	g/dL
METHOD : COLORIMETRIC				



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ALBUMIN		4.6	3.97 - 4.94	g/dL
METHOD : COLORIMETRIC				
GLOBULIN		2.2	2.0 - 3.5	g/dL
ALBUMIN/GLOBULIN RATIO		2.1	1.0 - 2.1	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT)		23	< OR = 50	U/L
METHOD : UV ABSORBANCE				
ALANINE AMINOTRANSFERASE (ALT/SGPT)		11	< OR = 50	U/L
METHOD : UV ABSORBANCE				
ALKALINE PHOSPHATASE		78	40 - 129	U/L
METHOD : COLORIMETRIC				
GAMMA GLUTAMYL TRANSFERASE (GGT)		12	0 - 60	U/L
METHOD : ENZYMATIC, COLORIMETRIC				
LACTATE DEHYDROGENASE		186	125 - 220	U/L
METHOD : UV ABSORBANCE				
BLOOD UREA NITROGEN (BUN), SERUM				
BLOOD UREA NITROGEN		12	6 - 20	mg/dL
METHOD : ENZYMATIC ASSAY				
CREATININE, SERUM				
CREATININE		0.81	0.7 - 1.2	mg/dL
METHOD : COLORIMETRIC				
BUN/CREAT RATIO				
BUN/CREAT RATIO		14.81	8.0 - 15.0	
URIC ACID, SERUM				
URIC ACID		4.6	3.4 - 7.0	mg/dL
METHOD : ENZYMATIC COLORIMETRIC ASSAY				
TOTAL PROTEIN, SERUM				
TOTAL PROTEIN		6.8	6.0 - 8.0	g/dL
METHOD : COLORIMETRIC				
ALBUMIN, SERUM				
ALBUMIN		4.6	3.97 - 4.94	g/dL
METHOD : COLORIMETRIC				
GLOBULIN				
GLOBULIN		2.2	2.0 - 3.5	g/dL
ELECTROLYTES (NA/K/CL), SERUM				
SODIUM, SERUM		140	136 - 145	mmol/L
POTASSIUM, SERUM		4.51	3.5 - 5.1	mmol/L



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CHLORIDE, SERUM 100 98 - 107 mmol/L

PHYSICAL EXAMINATION, URINE

COLOR PALE YELLOW
 APPEARANCE CLEAR

CHEMICAL EXAMINATION, URINE

PH 6.0 5.00 - 7.50
 SPECIFIC GRAVITY 1.010 1.010 - 1.030

METHOD : URINE ROUTINE & MICROSCOPY EXAMINATION BY INTEGRATED AUTOMATED SYSTEM

PROTEIN NOT DETECTED NOT DETECTED
 GLUCOSE NOT DETECTED NOT DETECTED
 KETONES NOT DETECTED NOT DETECTED
 BLOOD 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) 1-2 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

METHOD : URINE ROUTINE & MICROSCOPY EXAMINATION BY INTEGRATED AUTOMATED SYSTEM

THYROID PANEL, SERUM

T3 121.0 80 - 200 ng/dL
 METHOD : ELECTROCHEMILUMINESCENCE
 T4 8.18 5.1 - 14.1 µg/dL
 METHOD : ELECTROCHEMILUMINESCENCE
 TSH (ULTRASENSITIVE) 2.000 0.27 - 4.2 µIU/mL
 METHOD : ELECTROCHEMILUMINESCENCE

MICROSCOPIC EXAMINATION, STOOL

REMARK SAMPLE NOT RECEIVED

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP TYPE A



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METHOD : GEL COLUMN AGGLUTINATION METHOD.

RH TYPE NEGATIVE

METHOD : GEL COLUMN AGGLUTINATION METHOD.

XRAY-CHEST

IMPRESSION NO ABNORMALITY DETECTED

TMT OR ECHO

TMT OR ECHO NEGATIVE

ECG

ECG WITHIN NORMAL LIMITS

MEDICAL HISTORY

RELEVANT PRESENT HISTORY NOT SIGNIFICANT

RELEVANT PAST HISTORY NOT SIGNIFICANT

RELEVANT PERSONAL HISTORY MARRIED / MIXED DIET / NO ALLERGIES / NO SMOKING / NO ALCOHOL.

RELEVANT FAMILY HISTORY DIABETES : FATHER.

HISTORY OF MEDICATIONS NOT SIGNIFICANT

ANTHROPOMETRIC DATA & BMI

HEIGHT IN METERS 1.71 mts

WEIGHT IN KGS. 52 Kgs

BMI 18
 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 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



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ACCESSION NO : 0181WC001637 AGE : 33 Years SEX : Male

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CAROTID PULSATION		NORMAL		
TEMPERATURE		NORMAL		
PULSE		70/MIN.REGULAR, ALL PERIPHERAL PULSES WELL FELT, NO CAROTID BRUIT		
RESPIRATORY RATE		NORMAL		
CARDIOVASCULAR SYSTEM				
BP		110/70 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		
CEREBELLAR FUNCTIONS		NORMAL		
SENSORY SYSTEM		NORMAL		
MOTOR SYSTEM		NORMAL		
REFLEXES		NORMAL		
MUSCULOSKELETAL SYSTEM				
SPINE		NORMAL		
JOINTS		NORMAL		
BASIC EYE EXAMINATION				



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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	WITHIN NORMAL LIMIT
NEAR VISION LEFT EYE WITHOUT GLASSES	WITHIN NORMAL LIMIT
COLOUR VISION	NORMAL

SUMMARY

RELEVANT HISTORY	NOT SIGNIFICANT
RELEVANT GP EXAMINATION FINDINGS	NOT SIGNIFICANT
REMARKS / RECOMMENDATIONS	ANNUAL HEALTH CHECKED ADVISED.

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.)

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, (Sickle Cells, spherocytes), Microcytosis, Low fibrinogen, Very high WBC counts, Drugs (Quinine,

salicylates)



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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, 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, sulfonylureas, 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:

- 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

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-

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 perniciou 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.

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 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



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PATIENT NAME : GANESH LOHAKARE **PATIENT ID : GANEM121089181**

ACCESSION NO : **0181WC001637** AGE : 33 Years SEX : Male

DRAWN : RECEIVED : 25/03/2023 09:20 REPORTED : 29/03/2023 15:33

REFERRING DOCTOR : SELF CLIENT PATIENT ID :

Test Report Status	Results	Biological Reference Interval	Units
Final			

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, Muscuophy
 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- 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, Waldenstroms 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.
 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 INVIOLEABLE 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
 NO ABNORMALITIES DETECTED

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

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.

SRL Limited
 Fortis Hospital, Sector 62, Phase VIII,
 Mohali 160062



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