**DIAGNOSTIC REPORT**

MC-5749

agilus diagnostics

**PATIENT NAME : BHAWNA** **REF. DOCTOR :** SELF

| | | |
|---|---|---|
| **CODE/NAME & ADDRESS :** C000138383<br>ARCOFEMI HEALTHCARE LTD (MEDIWHEEL<br>F-703, LADO SARAI, MEHRAULISOUTH WEST DELHI<br>NEW DELHI 110030<br>8800465156 | ACCESSION NO : **0080WI008081**<br>PATIENT ID : BHAWF20088780<br>CLIENT PATIENT ID:<br>ABHA NO : | AGE/SEX : 36 Years Female<br>DRAWN :<br>RECEIVED : 23/09/2023 09:36:29<br>REPORTED : 23/09/2023 16:09:17 |

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**HAEMATOLOGY - CBC**

**MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE**

| | | | |
|---|---|---|---|
| **BLOOD COUNTS,EDTA WHOLE BLOOD** | | | |
| HEMOGLOBIN (HB) | **11.1 Low** | 12.0 - 15.0 | g/dL |
| METHOD : CYANMETHEMOGLOBIN METHOD | | | |
| RED BLOOD CELL (RBC) COUNT | **3.61 Low** | 3.8 - 4.8 | mil/µL |
| WHITE BLOOD CELL (WBC) COUNT | 5.90 | 4.0 - 10.0 | thou/µL |
| PLATELET COUNT | 259 | 150 - 410 | thou/µL |
| **RBC AND PLATELET INDICES** | | | |
| HEMATOCRIT (PCV) | **33.7 Low** | 36.0 - 46.0 | % |
| MEAN CORPUSCULAR VOLUME (MCV) | 93.3 | 83.0 - 101.0 | fL |
| METHOD : DERIVED PARAMETER FROM RBC HISTOGRAM | | | |
| MEAN CORPUSCULAR HEMOGLOBIN (MCH) | 30.8 | 27.0 - 32.0 | pg |
| METHOD : CALCULATED PARAMETER | | | |
| MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC) | 33.1 | 31.5 - 34.5 | g/dL |
| METHOD : CALCULATED PARAMETER | | | |
| RED CELL DISTRIBUTION WIDTH (RDW) | **17.2 High** | 11.6 - 14.0 | % |
| METHOD : CALCULATED PARAMETER | | | |
| MENTZER INDEX | 25.8 | | |
| MEAN PLATELET VOLUME (MPV) | **11.4 High** | 6.8 - 10.9 | fL |
| METHOD : DERIVED PARAMETER FROM PLATELET HISTOGRAM | | | |
| **WBC DIFFERENTIAL COUNT** | | | |
| NEUTROPHILS | 66 | 40 - 80 | % |
| METHOD : LIGHT ABSORBANCE OF CYTCHEMICAL STAINED CELLS IMPEDENCE | | | |
| LYMPHOCYTES | 23 | 20 - 40 | % |
| METHOD : LIGHT ABSORBANCE OF CYTCHEMICAL STAINED CELLS IMPEDENCE | | | |
| MONOCYTES | 8 | 2.0 - 10.0 | % |
| METHOD : LIGHT ABSORBANCE OF CYTCHEMICAL STAINED CELLS IMPEDENCE | | | |
| EOSINOPHILS | 3 | 1.0 - 6.0 | % |
| BASOPHILS | 0 | 0 - 1 | % |
| METHOD : LIGHT ABSORBANCE OF CYTCHEMICAL STAINED CELLS IMPEDENCE | | | |
| ABSOLUTE NEUTROPHIL COUNT | 3.89 | 2.0 - 7.0 | thou/µL |
| ABSOLUTE LYMPHOCYTE COUNT | 1.36 | 1.0 - 3.0 | thou/µL |

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**LAB HEAD**

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Punjab, India
Tel : 9111591115, Fax :
CIN - U74899PB1995PLC045956

**Patient Ref. No. 775000004805858**

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MC-5749

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| ABSOLUTE MONOCYTE COUNT | 0.47 | 0.2 - 1.0 | thou/µL |
| ABSOLUTE EOSINOPHIL COUNT | 0.18 | 0.02 - 0.50 | thou/µL |
| ABSOLUTE BASOPHIL COUNT | **0.00 Low** | 0.02 - 0.10 | thou/µL |
| METHOD : CALCULATED PARAMETER | | | |
| NEUTROPHIL LYMPHOCYTE RATIO (NLR) | 2.9 | | |
| METHOD : CALCULATED PARAMETER | | | |

**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 BELOW 40FEMALE**

| | | | |
|---|---|---|---|
| **ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD** | | | |
| E.S.R | **22 High** | 0 - 20 | mm at 1 hr |
| METHOD : MODIFIED WESTERGREN | | | |
| **GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD** | | | |
| HBA1C | 5.3 | Non-diabetic Adult < 5.7<br>Pre-diabetes 5.7 - 6.4<br>Diabetes diagnosis: > or = 6.5<br>Therapeutic goals: < 7.0<br>Action suggested : > 8.0<br>(ADA Guideline 2021) | % |
| ESTIMATED AVERAGE GLUCOSE(EAG) | 105.4 | < 116.0 | mg/dL |

**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, Vasculities, 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: Polycythermia 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.
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 patients metabolic control has remained continuously within the target range.

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1. eAG (Estimated average glucose) converts percentage HbA1c to md/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 :**
1. 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.
2.Vitamin C & E are reported to falsely lower test results.(possibly by inhibiting glycation of hemoglobin.
3. 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.
4. 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 paltform (Boronate affinity chromatography) is recommended for testing of HbA1c.Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy



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**IMMUNOHAEMATOLOGY**

**MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE**

**ABO GROUP & RH TYPE, EDTA WHOLE BLOOD**

| | | | |
|---|---|---|---|
| ABO GROUP | TYPE A | | |
| METHOD : SLIDE AGGLUTINATION | | | |
| RH TYPE | POSITIVE | | |
| METHOD : SLIDE 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 BELOW 40FEMALE**

**GLUCOSE FASTING,FLUORIDE PLASMA**

| | | | |
|---|---|---|---|
| FBS (FASTING BLOOD SUGAR)<br>METHOD : HEXOKINASE | 80 | 74 - 106 | mg/dL |

**GLUCOSE, POST-PRANDIAL, PLASMA**

| | | | |
|---|---|---|---|
| PPBS(POST PRANDIAL BLOOD SUGAR)<br>METHOD : HEXOKINASE | SAMPLE NOT RECEIVED | Non-Diabetes<br>70 - 140 | mg/dL |

**LIPID PROFILE, SERUM**

| | | | |
|---|---|---|---|
| CHOLESTEROL, TOTAL<br>METHOD : CHOLESTEROL OXIDASE, ESTERASE,PEROXIDASE | **227 High** | < 200 Desirable<br>200 - 239 Borderline High<br>>/= 240 High | mg/dL |
| TRIGLYCERIDES<br>METHOD : ENZYMATIC ASSAY | 84 | < 150 Normal<br>150 - 199 Borderline High<br>200 - 499 High<br>>/= 500 Very High | mg/dL |
| HDL CHOLESTEROL<br>METHOD : DIRECT MEASURE - PEG | 56 | < 40 Low<br>>/=60 High | mg/dL |
| CHOLESTEROL LDL<br>METHOD : CHOLESTEROL OXIDASE, ESTERASE,PEROXIDASE | **154 High** | < 100 Optimal<br>100 - 129<br>Near or above optimal<br>130 - 159<br>Borderline High<br>160 - 189<br>High<br>>/= 190<br>Very High | mg/dL |
| NON HDL CHOLESTEROL<br>METHOD : CALCULATED PARAMETER | 56 | Desirable: Less than 130<br>Above Desirable: 130 - 159<br>Borderline High: 160 - 189<br>High: 190 - 219<br>Very high: > or = 220 | mg/dL |



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| VERY LOW DENSITY LIPOPROTEIN | 16.8 | Desirable value :<br>10 - 35 | mg/dL |
| METHOD : CALCULATED PARAMETER | | | |
| CHOL/HDL RATIO | 4.1 | 3.3-4.4 Low Risk<br>4.5-7.0 Average Risk<br>7.1-11.0 Moderate Risk<br>> 11.0 High Risk | |
| METHOD : CALCULATED PARAMETER | | | |
| LDL/HDL RATIO | 2.8 | 0.5 - 3.0 Desirable/Low Risk<br>3.1 - 6.0 Borderline/Moderate Risk<br>>6.0 High Risk | |
| METHOD : CALCULATED PARAMETER | | | |

**Interpretation(s)**

Serum lipid profile is measured for cardiovascular risk prediction. Lipid Association of India recommends LDL-C as primary target and Non HDL-C as co-primary treatment target.

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

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

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

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

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



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| Moderate Risk | <100 | <130 | >OR= 100 | >OR= 130 |
| Low Risk | <100 | <130 | >OR= 130* | >OR= 160 |

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

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

**LIVER FUNCTION PROFILE, SERUM**

| | | | |
|---|---|---|---|
| BILIRUBIN, TOTAL<br>METHOD : DIAZONIUM ION, BLANKED (ROCHE) | 0.28 | UPTO 1.2 | mg/dL |
| BILIRUBIN, DIRECT<br>METHOD : DIAZOTIZATION | 0.10 | 0.00 - 0.30 | mg/dL |
| BILIRUBIN, INDIRECT<br>METHOD : CALCULATED PARAMETER | 0.18 | 0.00 - 0.60 | mg/dL |
| TOTAL PROTEIN<br>METHOD : BIURET | 7.4 | 6.6 - 8.7 | g/dL |
| ALBUMIN<br>METHOD : BROMOCRESOL GREEN | 4.7 | 3.97 - 4.94 | g/dL |
| GLOBULIN<br>METHOD : CALCULATED PARAMETER | 2.7 | 2.0 - 4.0<br>Neonates - Pre Mature: 0.29 - 1.04 | g/dL |
| ALBUMIN/GLOBULIN RATIO<br>METHOD : CALCULATED PARAMETER | 1.7 | 1.0 - 2.0 | RATIO |
| ASPARTATE AMINOTRANSFERASE(AST/SGOT) | 18 | 0 - 32 | U/L |
| ALANINE AMINOTRANSFERASE (ALT/SGPT)<br>METHOD : UV WITHOUT PYRIDOXAL-5 PHOSPHATE | 18 | 0 - 31 | U/L |
| ALKALINE PHOSPHATASE<br>METHOD : PNPP - AMP BUFFER | 99 | 35 - 105 | U/L |
| GAMMA GLUTAMYL TRANSFERASE (GGT)<br>METHOD : GAMMA GLUTAMYLCARBOXY 4NITROANILIDE | 15 | 5 - 36 | U/L |
| LACTATE DEHYDROGENASE<br>METHOD : LACTATE -PYRUVATE | 194 | 135 - 214 | U/L |

**BLOOD UREA NITROGEN (BUN), SERUM**

| | | | |
|---|---|---|---|
| BLOOD UREA NITROGEN<br>METHOD : UREASE - UV | 8 | 6 - 20 | mg/dL |

**CREATININE, SERUM**

| | | | |
|---|---|---|---|
| CREATININE | 0.57 | 0.50 - 0.90 | mg/dL |



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| METHOD : ALKALINE PICRATE-KINETIC | | | |
| **BUN/CREAT RATIO** | | | |
| BUN/CREAT RATIO | 14.04 | 5.00 - 15.00 | |
| METHOD : CALCULATED PARAMETER | | | |
| **URIC ACID, SERUM** | | | |
| URIC ACID | 4.6 | 2.4 - 5.7 | mg/dL |
| METHOD : URICASE, COLORIMETRIC | | | |
| **TOTAL PROTEIN, SERUM** | | | |
| TOTAL PROTEIN | 7.4 | 6.6 - 8.7 | g/dL |
| METHOD : BIURET | | | |
| **ALBUMIN, SERUM** | | | |
| ALBUMIN | 4.7 | 3.97 - 4.94 | g/dL |
| METHOD : BROMOCRESOL GREEN | | | |
| **GLOBULIN** | | | |
| GLOBULIN | 2.7 | 2.0 - 4.0<br>Neonates -<br>Pre Mature:<br>0.29 - 1.04 | g/dL |
| METHOD : CALCULATED PARAMETER | | | |
| **ELECTROLYTES (NA/K/CL), SERUM** | | | |
| SODIUM, SERUM | 138 | 136 - 145 | mmol/L |
| METHOD : ISE INDIRECT | | | |
| POTASSIUM, SERUM | 4.68 | 3.5 - 5.1 | mmol/L |
| METHOD : ISE INDIRECT | | | |
| CHLORIDE, SERUM | 104 | 98 - 107 | mmol/L |
| METHOD : ISE INDIRECT | | | |

**Interpretation(s)**

| Sodium | Potassium | Chloride |
|---|---|---|

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Chandigarh, 160011
Punjab, India
Tel : 9111591115, Fax :
CIN - U74899PB1995PLC045956

**Patient Ref. No. 775000004805858**

**PATIENT NAME : BHAWNA** **REF. DOCTOR :** SELF

| | | |
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| **CODE/NAME & ADDRESS :** C000138383<br>ARCOFEMI HEALTHCARE LTD (MEDIWHEEL<br>F-703, LADO SARAI, MEHRAULISOUTH WEST DELHI<br>NEW DELHI 110030<br>8800465156 | ACCESSION NO : **0080WI008081**<br>PATIENT ID : BHAWF20088780<br>CLIENT PATIENT ID:<br>ABHA NO : | AGE/SEX :36 Years Female<br>DRAWN :<br>RECEIVED : 23/09/2023 09:36:29<br>REPORTED :23/09/2023 16:09:17 |

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| | | |
|---|---|---|
| **Decreased in:**CCF,cirrhosis, vomiting, diarrhea, excessive sweating, salt-losing nephropathy,adrenal insufficiency, nephrotic syndrome, water intoxication, SIADH. Drugs: thiazides, diuretics, ACE inhibitors, chlorpropamide,carbamazepine,anti depressants (SSRI), antipsychotics. | **Decreased in:** Low potassium intake,prolonged vomiting or diarrhea, RTA types I and II, hyperaldosteronism, Cushing's syndrome,osmotic diuresis (e.g., hyperglycemia),alkalosis, familial periodic paralysis,trauma (transient).Drugs: Adrenergic agents, diuretics. | **Decreased in:** Vomiting, diarrhea, renal failure combined with salt deprivation, over-treatment with diuretics, chronic respiratory acidosis, diabetic ketoacidosis, excessive sweating, SIADH, salt-losing nephropathy, porphyria, expansion of extracellular fluid volume, adrenalinsufficiency, hyperaldosteronism,metabolic alkalosis. Drugs: chronic laxative,corticosteroids, diuretics. |
| **Increased in:** Dehydration (excessivesweating, severe vomiting or diarrhea),diabetes mellitus, diabetesinsipidus, hyperaldosteronism, inadequate water intake. Drugs: steroids, licorice,oral contraceptives. | **Increased in:** Massive hemolysis, severe tissue damage, rhabdomyolysis, acidosis, dehydration,renal failure, Addison' s disease, RTA type IV, hyperkalemic familial periodic paralysis. Drugs: potassium salts, potassium- sparing diuretics,NSAIDs, beta-blockers, ACE inhibitors, high-dose trimethoprim-sulfamethoxazole. | **Increased in:** Renal failure, nephrotic syndrome, RTA,dehydration, overtreatment with saline,hyperparathyroidism, diabetes insipidus, metabolic acidosis from diarrhea (Loss of HCO3-), respiratory alkalosis,hyperadrenocorticism. Drugs: acetazolamide,androgens, hydrochlorothiazide,salicylates. |
| **Interferences:** Severe lipemia or hyperproteinemi, if sodium analysis involves a dilution step can cause spurious results. The serum sodium falls about 1.6 mEq/L for each 100 mg/dL increase in blood glucose. | **Interferences:** Hemolysis of sample, delayed separation of serum, prolonged fist clenching during blood drawing, and prolonged tourniquet placement. Very high WBC/PLT counts may cause spurious. Plasma potassium levels are normal. | **Interferences:**Test is helpful in assessing normal and increased anion gap metabolic acidosis and in distinguishing hypercalcemia due to hyperparathyroidism (high serum chloride) from that due to malignancy (Normal serum chloride) |

**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 sothat 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 Glyosuria,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 Glyosuria, 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 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

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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, Pagets disease,Rickets,Sarcoidosis etc. Lower-than-normal ALP levels seen in Hypophosphatasia,Malnutrition,Protein deficiency,Wilsons 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,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** 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, 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.



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**Patient Ref. No. 775000004805858**

DIAGNOSTIC REPORT

MC-5749

**PATIENT NAME : BHAWNA** **REF. DOCTOR :** SELF

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**CLINICAL PATH - URINALYSIS**

**MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE**

**PHYSICAL EXAMINATION, URINE**

| | | | |
|---|---|---|---|
| COLOR | SAMPLE NOT RECEIVED | | |

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## CYTOLOGY

**MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE**

**PAPANICOLAOU SMEAR**

| | | | |
|---|---|---|---|
| TEST METHOD | SAMPLE NOT RECEIVED | | |
| OTHER MALIGNANT NEOPLASMS | SAMPLE NOT RECEIVED | | |



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**DIAGNOSTIC REPORT**

MC-5749

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**SPECIALISED CHEMISTRY - HORMONE**

**MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE**

**THYROID PANEL, SERUM**

| | | | |
|---|---|---|---|
| T3 | 111.90 | Non-Pregnant Women<br>80.0 - 200.0<br>Pregnant Women<br>1st Trimester:105.0 - 230.0<br>2nd Trimester:129.0 - 262.0<br>3rd Trimester:135.0 - 262.0 | ng/dL |
| METHOD : ECLIA | | | |
| T4 | 7.77 | Non-Pregnant Women<br>5.10 - 14.10<br>Pregnant Women<br>1st Trimester: 7.33 - 14.80<br>2nd Trimester: 7.93 - 16.10<br>3rd Trimester: 6.95 - 15.70 | µg/dL |
| METHOD : ECLIA | | | |
| TSH (ULTRASENSITIVE) | **5.390 High** | Non Pregnant Women<br>0.27 - 4.20<br>Pregnant Women<br>1st Trimester: 0.33 - 4.59<br>2nd Trimester: 0.35 - 4.10<br>3rd Trimester: 0.21 - 3.15 | µIU/mL |
| METHOD : ECLIA | | | |

**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 |
|---|---|---|---|---|---|

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| | | | | | |
|---|---|---|---|---|---|
| 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 duriing pregnancy and Postpartum, 2011.

**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.agilusdiagnostics.com for related Test Information for this accession**

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**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 AGILUS 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. AGILUS Diagnostics 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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