DIAGNOSTIC REPORT

agilus diagnostics

PATIENT NAME : SUVASRIKANT NAYAK		**REF. DOCTOR :** SELF
CODE/NAME & ADDRESS : C000138363 ACROFEMI HEALTHCARE LTD (MEDIWHEEL) F-703, LADO SARAI, MEHRAULISOUTH WEST DELHI NEW DELHI 110030 8800465156	ACCESSION NO : **0031WD022780** PATIENT ID : SUVAM15089131 CLIENT PATIENT ID: ABHA NO :	AGE/SEX :31 Years Male DRAWN :29/04/2023 08:50:00 RECEIVED :29/04/2023 09:00:37 REPORTED :02/05/2023 15:05:26

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

MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

XRAY-CHEST

IMPRESSION	NO ABNORMALITY DETECTED

TMT OR ECHO

TMT OR ECHO	Echo Done - Normal

ECG

ECG	WITHIN NORMAL LIMITS

MEDICAL HISTORY

RELEVANT PRESENT HISTORY	NOT SIGNIFICANT
RELEVANT PAST HISTORY	NOT SIGNIFICANT
RELEVANT PERSONAL HISTORY	NOT SIGNIFICANT
RELEVANT FAMILY HISTORY	NOT SIGNIFICANT
OCCUPATIONAL HISTORY	NOT SIGNIFICANT
HISTORY OF MEDICATIONS	NOT SIGNIFICANT

ANTHROPOMETRIC DATA & BMI

HEIGHT IN METERS	1.71		mts
WEIGHT IN KGS.	80		Kgs
BMI	27	BMI & Weight Status as follows: Below 18.5: Underweight 18.5 - 24.9: Normal 25.0 - 29.9: Overweight 30.0 and Above: Obese	kg/sqmts

Debika Roy

Dr. Debika Roy
MBBS Consultant Physician

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West Bengal, India
Tel : 9111591115,
CIN - U74899PB1995PLC045956
Email : customercare.saltlake@srl.in

Patient Ref. No. 31000004686016

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GENERAL EXAMINATION

MENTAL / EMOTIONAL STATE	NORMAL		
PHYSICAL ATTITUDE	NORMAL		
GENERAL APPEARANCE / NUTRITIONAL STATUS	OVERWEIGHT		
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		
CAROTID PULSATION	NORMAL		
TEMPERATURE	NORMAL		
PULSE	78/min-REGULAR, ALL PERIPHERAL PULSES WELL FELT		
RESPIRATORY RATE	NORMAL		

CARDIOVASCULAR SYSTEM

BP	120/84 mm Hg		mm/Hg
PERICARDIUM	NORMAL		
APEX BEAT	NORMAL		
HEART SOUNDS	S1, S2 HEARD NORMALLY		
MURMURS	ABSENT		

RESPIRATORY SYSTEM

SIZE AND SHAPE OF CHEST	NORMAL		
MOVEMENTS OF CHEST	SYMMETRICAL		

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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

CONJUNCTIVA	NORMAL		
EYELIDS	NORMAL		
EYE MOVEMENTS	NORMAL		

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DISTANT VISION RIGHT EYE WITHOUT GLASSES	6/6		
DISTANT VISION LEFT EYE WITHOUT GLASSES	6/6		
NEAR VISION RIGHT EYE WITHOUT GLASSES	N6		
NEAR VISION LEFT EYE WITHOUT GLASSES	N6		
COLOUR VISION	NORMAL		

BASIC ENT EXAMINATION

EXTERNAL EAR CANAL	NORMAL
TYMPANIC MEMBRANE	NORMAL
NOSE	NO ABNORMALITY DETECTED
SINUSES	NORMAL
THROAT	NO ABNORMALITY DETECTED
TONSILS	NOT ENLARGED

BASIC DENTAL EXAMINATION

TEETH	NORMAL
GUMS	HEALTHY

SUMMARY

RELEVANT HISTORY	NOT SIGNIFICANT
RELEVANT GP EXAMINATION FINDINGS	Overweight (80 kg)
RELEVANT LAB INVESTIGATIONS	Raised HbA1C(5.9),BIL(1.57),U/A(7.9)
RELEVANT NON PATHOLOGY DIAGNOSTICS	Grade I fatty liver in USG

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REMARKS / RECOMMENDATIONS

On examination and investigations the candidate is found to be overweight and has raised HbA1C(5.9),BIL(1.57),U/A(7.9) Grade I fatty liver in USG

Should follow the given advice:
1. Diabetic diet
2. Reduce body weight
3. Estimated body weight should be : 73 kg
4. Regular physical exercise and walking
5. Avoid fat, oil and high protein in diet
6. Physician opinion

Comments

MEDICAL EXAMINATION DONE BY:

DR. DEBIKA ROY, MBBS
REG NO: 51651 (WBMC)
CONSULTANT PHYSICIAN
WELLNESS CLINIC
SALT LAKE REF LAB, KOLKATA

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ULTRASOUND ABDOMEN

ULTRASOUND ABDOMEN

Grade I fatty liver

Interpretation(s)
MEDICAL
HISTORY-**********
THIS REPORT CARRIES THE SIGNATURE OF OUR LABORATORY DIRECTOR. THIS IS AN INVIOLABLE FEATURE OF OUR LAB MANAGEMENT SOFTWARE. HOWEVER, ALL EXAMINATIONS AND INVESTIGATIONS HAVE BEEN CONDUCTED BY OUR PANEL OF DOCTORS.

****

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HAEMATOLOGY - CBC

MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

BLOOD COUNTS,EDTA WHOLE BLOOD

HEMOGLOBIN (HB) METHOD : SPECTROPHOTOMETRY	14.2	13.0 - 17.0	g/dL
RED BLOOD CELL (RBC) COUNT METHOD : ELECTRICAL IMPEDANCE	5.26	4.5 - 5.5	mil/µL
WHITE BLOOD CELL (WBC) COUNT METHOD : ELECTRICAL IMPEDANCE	8.19	4.0 - 10.0	thou/µL
PLATELET COUNT METHOD : ELECTRONIC IMPEDENCE & MICROSCOPY	275	150 - 410	thou/µL

RBC AND PLATELET INDICES

HEMATOCRIT (PCV) METHOD : CALCULATED	41.7	40 - 50	%
MEAN CORPUSCULAR VOLUME (MCV) METHOD : ELECTRICAL IMPEDANCE	**79.4 Low**	83 - 101	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH) METHOD : CALCULATED	**26.9 Low**	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC) METHOD : CALCULATED	33.9	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW) METHOD : ELECTRICAL IMPEDANCE	**15.1 High**	11.6 - 14.0	%
MENTZER INDEX	15.1		
MEAN PLATELET VOLUME (MPV) METHOD : CALCULATED	9.2	6.8 - 10.9	fL

WBC DIFFERENTIAL COUNT

NEUTROPHILS METHOD : FLOWCYTOMETRY, ELECTRONIC IMPEDANCE & MICROSCOPY.	46	40 - 80	%
LYMPHOCYTES METHOD : FLOWCYTOMETRY, ELECTRONIC IMPEDANCE & MICROSCOPY.	**41 High**	20 - 40	%
MONOCYTES	9	2 - 10	%

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Pathologist

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METHOD : FLOWCYTOMETRY, ELECTRONIC IMPEDANCE & MICROSCOPY.			
EOSINOPHILS	4	1 - 6	%
BASOPHILS	0	0 - 2	%
METHOD : FLOWCYTOMETRY, ELECTRONIC IMPEDANCE & MICROSCOPY.			
ABSOLUTE NEUTROPHIL COUNT	3.77	2.0 - 7.0	thou/µL
METHOD : FLOWCYTOMETRY & CALCULATED			
ABSOLUTE LYMPHOCYTE COUNT	**3.36 High**	1 - 3	thou/µL
METHOD : FLOWCYTOMETRY & CALCULATED			
ABSOLUTE MONOCYTE COUNT	0.74	0.20 - 1.00	thou/µL
METHOD : FLOWCYTOMETRY & CALCULATED			
ABSOLUTE EOSINOPHIL COUNT	0.33	0.02 - 0.50	thou/µL
METHOD : FLOWCYTOMETRY & CALCULATED			
ABSOLUTE BASOPHIL COUNT	**0.00 Low**	0.02 - 0.10	thou/µL
METHOD : FLOWCYTOMETRY & CALCULATED			

MORPHOLOGY

RBC	PREDOMINANTLY NORMOCYTIC NORMOCHROMIC
METHOD : MICROSCOPIC EXAMINATION	
WBC	NORMAL MORPHOLOGY
METHOD : MICROSCOPIC EXAMINATION	
PLATELETS	ADEQUATE & NORMAL
METHOD : MICROSCOPIC EXAMINATION	

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

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ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD

E.S.R	3	0 - 14	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, 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.

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MC-2396

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IMMUNOHAEMATOLOGY

MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP	TYPE O		
METHOD : GEL CARD METHOD			
RH TYPE	POSITIVE		
METHOD : GEL CARD METHOD			

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

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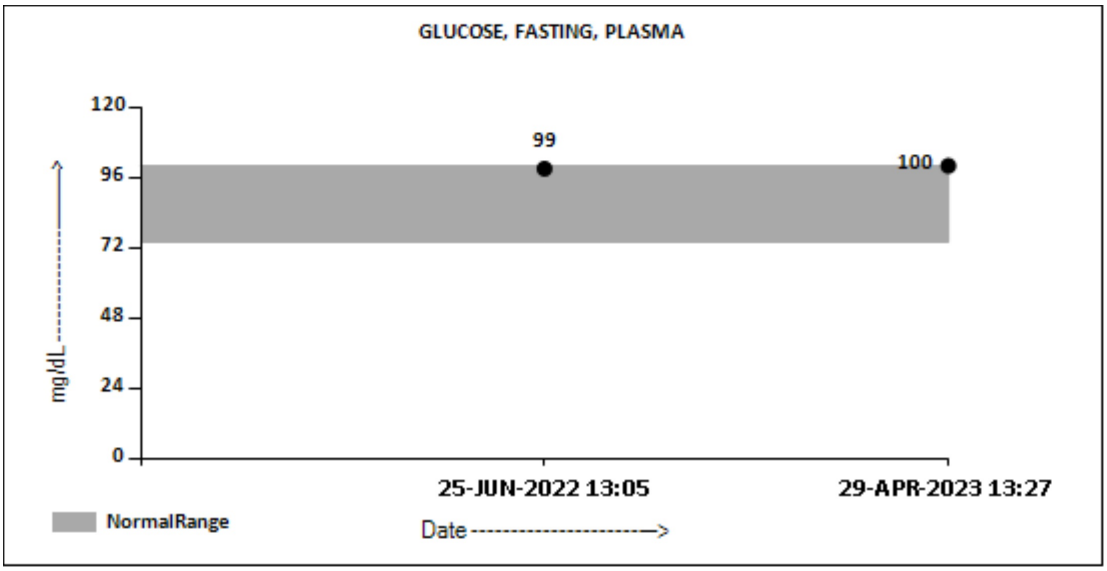
GLUCOSE FASTING,FLUORIDE PLASMA

FBS (FASTING BLOOD SUGAR)	100	74 - 100	mg/dL

METHOD : ENZYMATIC (HEXOKINASE/G-6-PDH)



GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

HBA1C	**5.9 High**	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)	**122.6 High**	< 116.0	mg/dL

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Pathologist

Dr. Chaitali Ray, PhD
Chief Biochemist cum MRQA

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SRL LIMITED - KOLKATA REF. LAB **PATIENT REP**
Bio-Rad Variant II Turbo CDM 5.4 S/N : 13466 **V2TURBO_A1c**

Patient Data

Sample ID:	3106906019
Patient ID:	0031WD022780
Name:	SUVASRIKANTNAYAK
Physician:	
Sex:	
DOB:	

Comments:

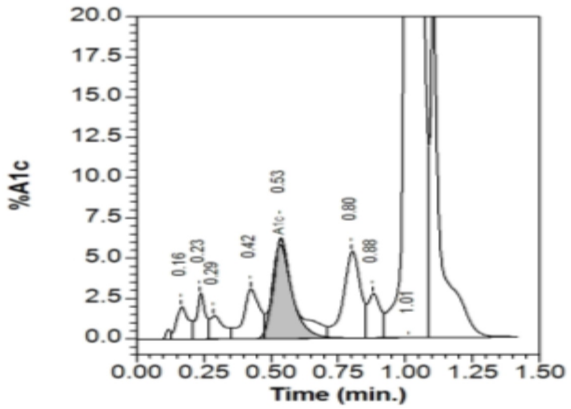
Analysis Data

Analysis Performed:	29/04/2023 12:26:33
Injection Number:	2865
Run Number:	172
Rack ID:	
Tube Number:	1
Report Generated:	29/04/2023 14:21:08
Operator ID:	

Peak Name	NGSP %	Area %	Retention Time (min)	Peak Area
A1a	---	1.0	0.164	11945
A1b	---	1.0	0.234	11885
F	---	0.8	0.287	9649
LA1c	---	1.8	0.425	21315
A1c	5.9	---	0.534	55761
P3	---	3.7	0.799	43633
P4	---	1.4	0.877	16388
Ao	---	85.6	1.014	1012084

Total Area: 1,182,662

HbA1c (NGSP) = 5.9 %



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Pathologist

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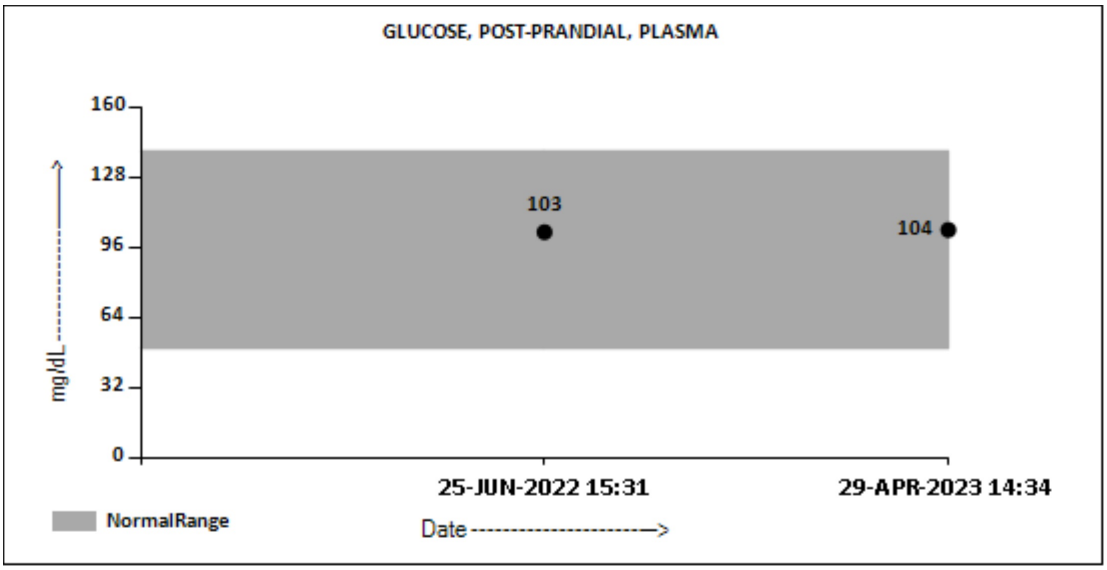
Patient Ref. No. 31000004686016

PATIENT NAME : SUVASRIKANT NAYAK **REF. DOCTOR :** SELF

CODE/NAME & ADDRESS : C000138363 ACROFEMI HEALTHCARE LTD (MEDIWHEEL) F-703, LADO SARAI, MEHRAULISOUTH WEST DELHI NEW DELHI 110030 8800465156	ACCESSION NO : **0031WD022780** PATIENT ID : SUVAM15089131 CLIENT PATIENT ID: ABHA NO :	AGE/SEX :31 Years Male DRAWN :29/04/2023 08:50:00 RECEIVED :29/04/2023 09:00:37 REPORTED :02/05/2023 15:05:26

Test Report Status **Final**	Results	Biological Reference Interval	Units
GLUCOSE, POST-PRANDIAL, PLASMA			
PPBS(POST PRANDIAL BLOOD SUGAR)	104	140 Normal 140 - 199 Pre-diabetic > or = 200 Diabetic	mg/dL
METHOD : ENZYMATIC (HEXOKINASE/G-6-PDH)			



LIPID PROFILE, SERUM			
CHOLESTEROL, TOTAL	186	< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
METHOD : ENZYMATIC ASSAY			
TRIGLYCERIDES	107	< 150 Normal 150 - 199 Borderline High 200 - 499 High >/=500 Very High	mg/dL
METHOD : GLYCEROL PHOSPHATE OXIDASE			
HDL CHOLESTEROL	56	Low : < 40 High : > / = 60	mg/dL
METHOD : ACCELERATOR SELECTIVE DETERGENT METHODOLOGY			

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CHOLESTEROL LDL	109		mg/dL
NON HDL CHOLESTEROL	130	Desirable: Less than 130 Above Desirable: 130-159 Borderline High: 160-189 High: 190 -219 Very High: >or = 220	mg/dL
METHOD : CALCULATED			
VERY LOW DENSITY LIPOPROTEIN	21.4		mg/dL
CHOL/HDL RATIO	3.3		
LDL/HDL RATIO	1.9		

Interpretation(s)

LIVER FUNCTION PROFILE, SERUM

BILIRUBIN, TOTAL	**1.57 High**	0.2 - 1.2	mg/dL
METHOD : DIAZONIUM SALT			
BILIRUBIN, DIRECT	0.45	0.0 - 0.5	mg/dL
METHOD : DIAZO REACTION			
BILIRUBIN, INDIRECT	**1.12 High**	0.1 - 1.0	mg/dL
METHOD : CALCULATED			
TOTAL PROTEIN	7.6	6.0 - 8.30	g/dL
METHOD : BIURET			
ALBUMIN	4.9	3.5 - 5.2	g/dL
METHOD : COLORIMETRIC (BROMCRESOL GREEN)			
GLOBULIN	2.7	2.0 - 3.5	g/dL
ALBUMIN/GLOBULIN RATIO	1.8	1 - 2.1	RATIO
METHOD : CALCULATED PARAMETER			
ASPARTATE AMINOTRANSFERASE(AST/SGOT)	25	5 - 34	U/L
METHOD : ENZYMATIC (NADH (WITHOUT P-5'-P)			
ALANINE AMINOTRANSFERASE (ALT/SGPT)	51	0 - 55	U/L
METHOD : ENZYMATIC (NADH (WITHOUT P-5'-P)			
ALKALINE PHOSPHATASE	50	40 - 150	U/L
METHOD : PARA-NITROPHENYL PHOSPHATE			
GAMMA GLUTAMYL TRANSFERASE (GGT)	31	11 - 59	U/L
METHOD : L-GAMMA-GLUTAMYL-4-NITROANALIDE /GLYCYLGLYCINE KINETIC METHOD			
LACTATE DEHYDROGENASE	144	125 - 220	U/L
METHOD : IFCC LACTATE TO PYRUVATE			

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MC-2396

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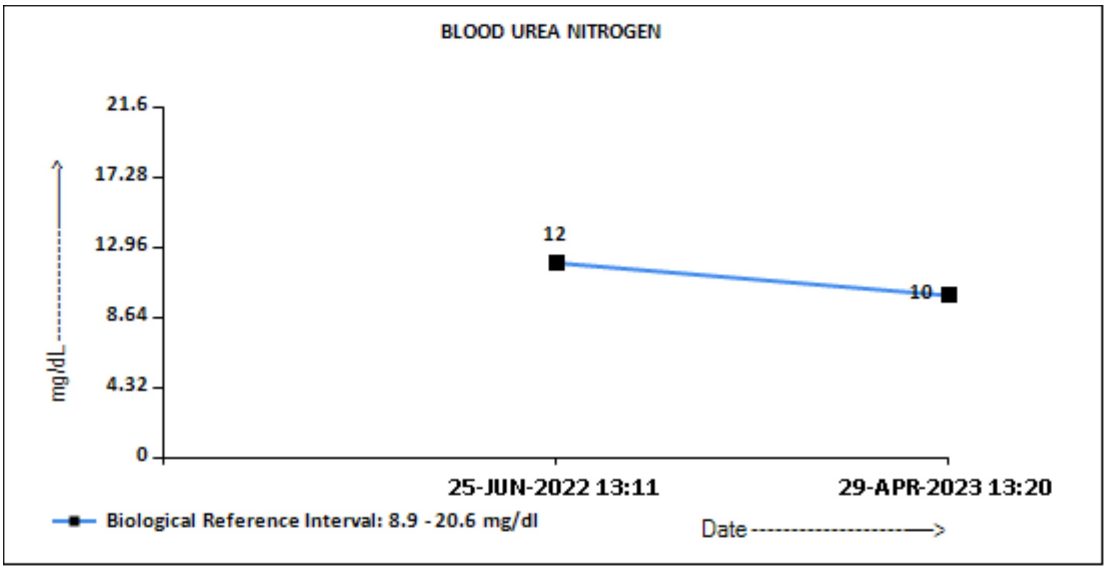
BLOOD UREA NITROGEN (BUN), SERUM

BLOOD UREA NITROGEN	10	8.9 - 20.6	mg/dL

METHOD : UREASE METHOD



CREATININE, SERUM

CREATININE	0.99	0.60 - 1.2	mg/dL

METHOD : KINETIC ALKALINE PICRATE

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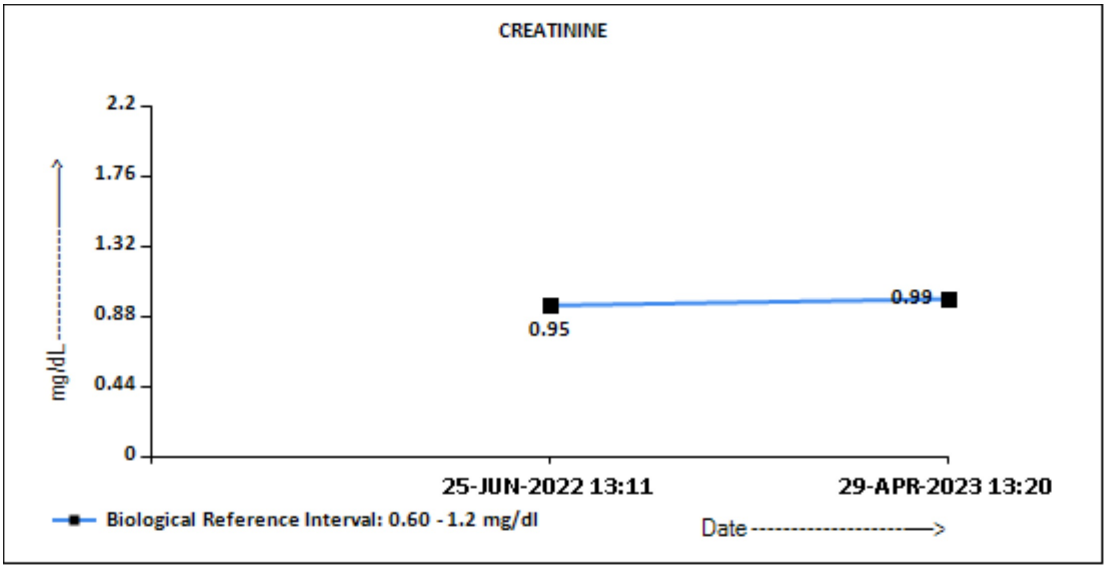

BUN/CREAT RATIO

BUN/CREAT RATIO	10.10	5.0 - 15.0	

URIC ACID, SERUM

URIC ACID	**7.9 High**	3.5 - 7.2	mg/dL
METHOD : URICASE			

TOTAL PROTEIN, SERUM

TOTAL PROTEIN	7.6	6.0 - 8.3	g/dL
METHOD : BIURET			

ALBUMIN, SERUM

ALBUMIN	4.9	3.5 - 5.2	g/dL
METHOD : COLORIMETRIC (BROMCRESOL GREEN)			

GLOBULIN

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GLOBULIN METHOD : CALCULATED PARAMETER	2.7	2.0 - 3.5	g/dL
ELECTROLYTES (NA/K/CL), SERUM			
SODIUM, SERUM METHOD : ION SELECTIVE ELECTRODE TECHNOLOGY INDIRECT	139	136 - 145	mmol/L
POTASSIUM, SERUM METHOD : ION SELECTIVE ELECTRODE TECHNOLOGY INDIRECT	4.70	3.5 - 5.1	mmol/L
CHLORIDE, SERUM METHOD : ION SELECTIVE ELECTRODE TECHNOLOGY INDIRECT	104	98 - 107	mmol/L

Interpretation(s)

Interpretation(s)
GLUCOSE FASTING,FLUORIDE PLASMA-**TEST DESCRIPTION**
Normally, the glucose concentration in extracellular fluid is closely regulated so that a source of energy is readily available to tissues and 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.
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.
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
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

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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 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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CLINICAL PATH - URINALYSIS

MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

PHYSICAL EXAMINATION, URINE			
COLOR	PALE YELLOW		
APPEARANCE	CLEAR		
CHEMICAL EXAMINATION, URINE			
PH	6.0	4.7 - 7.5	
SPECIFIC GRAVITY	1.020	1.003 - 1.035	
METHOD : DIPSTICK			
PROTEIN	NOT DETECTED	NOT DETECTED	
METHOD : DIPSTICK			
GLUCOSE	NOT DETECTED	NOT DETECTED	
METHOD : DIPSTICK			
KETONES	NOT DETECTED	NOT DETECTED	
METHOD : DIPSTICK			
BLOOD	NOT DETECTED	NOT DETECTED	
METHOD : DIPSTICK			
BILIRUBIN	NOT DETECTED	NOT DETECTED	
METHOD : DIPSTICK			
UROBILINOGEN	NORMAL	NORMAL	
METHOD : DIPSTICK			
NITRITE	NOT DETECTED	NOT DETECTED	
METHOD : DIPSTICK			
LEUKOCYTE ESTERASE	NEGATIVE	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		

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BACTERIA	NOT DETECTED	NOT DETECTED	
YEAST	NOT DETECTED	NOT DETECTED	

Comments

URINALYSIS: MICROSCOPIC EXAMINATION IS CARRIED OUT ON CENTRIFUGED URINARY SEDIMENT.

Interpretation(s)

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CLINICAL PATH - STOOL ANALYSIS

MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

PHYSICAL EXAMINATION,STOOL

COLOUR METHOD : VISUAL	BROWN		
CONSISTENCY METHOD : MANUAL	SEMI FORMED		
MUCUS METHOD : MANUAL	**PRESENT**	NOT DETECTED	
VISIBLE BLOOD METHOD : VISUAL	ABSENT	ABSENT	
ADULT PARASITE METHOD : VISUAL	NOT DETECTED		

CHEMICAL EXAMINATION,STOOL

STOOL PH METHOD : PH INDICATOR	6.0		
OCCULT BLOOD METHOD : MANUAL	NOT DETECTED	NOT DETECTED	

MICROSCOPIC EXAMINATION,STOOL

PUS CELLS	1-2		/hpf
RED BLOOD CELLS METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED	NOT DETECTED	/HPF
CYSTS METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED	NOT DETECTED	
OVA METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED		
LARVAE METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED	NOT DETECTED	
TROPHOZOITES METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED	NOT DETECTED	
FAT	ABSENT		
VEGETABLE CELLS	ABSENT		

Dr.Himadri Mondal, MD
Consultant Microbiologist

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West Bengal, India
Tel : 9111591115,
CIN - U74899PB1995PLC045956
Email : customercare.saltlake@srl.in

Patient Ref. No. 31000004686016

MC-2396

PATIENT NAME : SUVASRIKANT NAYAK **REF. DOCTOR :** SELF

CODE/NAME & ADDRESS : C000138363 ACROFEMI HEALTHCARE LTD (MEDIWHEEL) F-703, LADO SARAI, MEHRAULISOUTH WEST DELHI NEW DELHI 110030 8800465156	ACCESSION NO : **0031WD022780** PATIENT ID : SUVAM15089131 CLIENT PATIENT ID: ABHA NO :	AGE/SEX :31 Years Male DRAWN :29/04/2023 08:50:00 RECEIVED :29/04/2023 09:00:37 REPORTED :02/05/2023 15:05:26

Test Report Status **Final**	Results	Biological Reference Interval	Units
CHARCOT LEYDEN CRYSTALS	ABSENT		

Interpretation(s)

Dr.Himadri Mondal, MD
Consultant Microbiologist

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DIAGNOSTIC REPORT

MC-2396

agilus diagnostics

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

SPECIALISED CHEMISTRY - HORMONE

MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

THYROID PANEL, SERUM

T3	97.9	35 - 193	ng/dL
METHOD : TWO-STEP CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY			
T4	8.89	4.87 - 11.71	µg/dL
METHOD : TWO-STEP CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY			
TSH (ULTRASENSITIVE)	2.979	0.350 - 4.940	µIU/mL
METHOD : TWO-STEP CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY			

Interpretation(s)

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

Dr. Chaitali Ray, PhD
Chief Biochemist cum MRQA

Dr.Anwesha Chatterjee,MD
Pathologist

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MC-2396

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

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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Agilus Diagnostics Limited
Fortis Hospital, Sector 62, Phase VIII,
Mohali 160062

Dr. Chaitali Ray, PhD
Chief Biochemist cum MRQA

Dr.Anwesha Chatterjee,MD
Pathologist

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