



CLIENT CODE : C000138384

CLIENT'S NAME AND ADDRESS :

ACROFEMI HEALTHCARE LTD (MEDIWHEEL)
F-703, LADO SARAI, MEHRAULI
SOUTH WEST DELHI
NEW DELHI 110030
DELHI INDIA
8800465156

SRL Ltd
30-B, CHOWRINGEE MANSION, JAWAHARLAL NEHRU ROAD,
KOLKATA, 700016
WEST BENGAL, INDIA
Tel : 033-22267333,46019048, Fax : 033-22271324
CIN - U74899PB1995PLC045956

PATIENT NAME : SUSHMITA MANDAL

PATIENT ID : SUSHF27129182

ACCESSION NO : 0082VK000228 AGE : 30 Years SEX : Female

ABHA NO :

DRAWN : 08/11/2022 08:50

RECEIVED : 08/11/2022 08:58

REPORTED : 09/11/2022 18:22

REFERRING DOCTOR : DR. ACROFEMI HEALTHCARE LTD (MEDIWHEEL)

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Test Report Status	Final	Results	Biological Reference Interval	Units
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MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE**BLOOD COUNTS,EDTA WHOLE BLOOD**

HEMOGLOBIN (HB)	12.4	12.0 - 15.0	g/dL
METHOD : SPECTROPHOTOMETRY			
RED BLOOD CELL (RBC) COUNT	4.15	3.8 - 4.8	mil/ μ L
METHOD : ELECTRICAL IMPEDANCE			
WHITE BLOOD CELL (WBC) COUNT	6.66	4.0 - 10.0	thou/ μ L
METHOD : ELECTRICAL IMPEDANCE			
PLATELET COUNT	215	150 - 410	thou/ μ L
METHOD : ELECTRONIC IMPEDANCE & MICROSCOPY			

RBC AND PLATELET INDICES

HEMATOCRIT (PCV)	37.0	36 - 46	%
METHOD : CALCULATED			
MEAN CORPUSCULAR VOLUME (MCV)	89.1	83 - 101	fL
METHOD : ELECTRICAL IMPEDANCE			
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	29.8	27.0 - 32.0	pg
METHOD : CALCULATED			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)	33.5	31.5 - 34.5	g/dL
METHOD : CALCULATED			
RED CELL DISTRIBUTION WIDTH (RDW)	13.3	11.6 - 14.0	%
METHOD : ELECTRICAL IMPEDANCE			
MENTZER INDEX	21.5		
MEAN PLATELET VOLUME (MPV)	9.3	6.8 - 10.9	fL
METHOD : CALCULATED			

WBC DIFFERENTIAL COUNT

NEUTROPHILS	70	40 - 80	%
METHOD : FLOWCYTOMETRY, ELECTRONIC IMPEDANCE & MICROSCOPY.			
LYMPHOCYTES	22	20 - 40	%
METHOD : FLOWCYTOMETRY, ELECTRONIC IMPEDANCE & MICROSCOPY.			
MONOCYTES	7	2 - 10	%
METHOD : FLOWCYTOMETRY, ELECTRONIC IMPEDANCE & MICROSCOPY.			
EOSINOPHILS	1	1 - 6	%
BASOPHILS	0	0 - 2	%
METHOD : FLOWCYTOMETRY, ELECTRONIC IMPEDANCE & MICROSCOPY.			
ABSOLUTE NEUTROPHIL COUNT	4.66	2.0 - 7.0	thou/ μ L
METHOD : FLOWCYTOMETRY & CALCULATED			





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ABSOLUTE LYMPHOCYTE COUNT		1.47	1 - 3	thou/ μ L
METHOD : FLOWCYTOMETRY & CALCULATED				
ABSOLUTE MONOCYTE COUNT		0.47	0.20 - 1.00	thou/ μ L
METHOD : FLOWCYTOMETRY & CALCULATED				
ABSOLUTE EOSINOPHIL COUNT		0.07	0.02 - 0.50	thou/ μ L
METHOD : FLOWCYTOMETRY & CALCULATED				
ABSOLUTE BASOPHIL COUNT		0.00	Low 0.02 - 0.10	thou/ μ L
METHOD : FLOWCYTOMETRY & CALCULATED				
MORPHOLOGY				
RBC		NORMOCYTIC NORMOCHROMIC		
METHOD : MICROSCOPIC EXAMINATION				
WBC		NORMAL MORPHOLOGY		
METHOD : MICROSCOPIC EXAMINATION				
PLATELETS		ADEQUATE		
METHOD : MICROSCOPIC EXAMINATION				
ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD				
E.S.R		19	0 - 20	mm at 1 hr
METHOD : AUTOMATED (PHOTOMETRICAL CAPILLARY STOPPED FLOW KINETIC ANALYSIS)"				
GLUCOSE FASTING,FLUORIDE PLASMA				
FBS (FASTING BLOOD SUGAR)		88	74 - 100	mg/dL
METHOD : ENZYMATIC (HEXOKINASE/G-6-PDH)				
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD				
HBA1C		5.2	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)		102.5	< 116.0	mg/dL



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

PATIENT REP
V2TURBO_A1c

Patient Data

Sample ID: 8212260472
 Patient ID: 0082VK000228
 Name: SUSHMITAMANDAL
 Physician:
 Sex:
 DOB:

Analysis Data

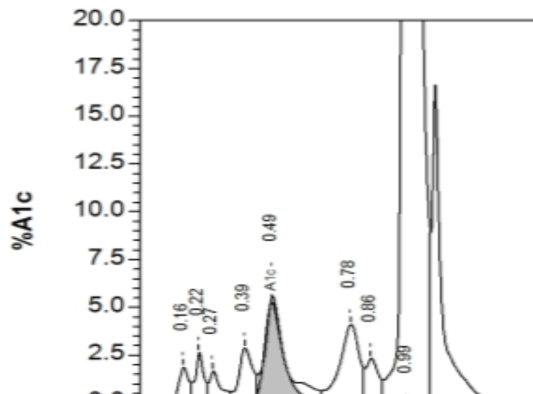
Analysis Performed: 08/11/2022 14:28:57
 Injection Number: 2261
 Run Number: 181
 Rack ID:
 Tube Number: 3
 Report Generated: 08/11/2022 15:19:41
 Operator ID:

Comments:

Peak Name	NGSP %	Area %	Retention Time (min)	Peak Area
A1a	---	0.8	0.160	20766
A1b	---	0.9	0.218	24297
F	---	0.9	0.271	21945
LA1c	---	1.7	0.391	42799
A1c	5.2	---	0.491	108679
P3	---	3.4	0.783	86397
P4	---	1.2	0.859	30933
Ao	---	86.9	0.993	2224202

Total Area: 2,560,018

HbA1c (NGSP) = 5.2 %



GLUCOSE, POST-PRANDIAL, PLASMA



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PPBS(POST PRANDIAL BLOOD SUGAR)		128	140 Normal 140 - 199 Pre-diabetic > or = 200 Diabetic	mg/dL
METHOD : ENZYMATIC (HEXOKINASE/G-6-PDH)				
LIPID PROFILE, SERUM				
CHOLESTEROL, TOTAL		149	< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
METHOD : ENZYMATIC ASSAY				
TRIGLYCERIDES		54	< 150 Normal 150 - 199 Borderline High 200 - 499 High >/=500 Very High	mg/dL
METHOD : GLYCEROL PHOSPHATE OXIDASE				
HDL CHOLESTEROL		46	Low : < 40 High : > / = 60	mg/dL
METHOD : ACCELERATOR SELECTIVE DETERGENT METHODOLOGY				
CHOLESTEROL LDL		92		mg/dL
NON HDL CHOLESTEROL		103	Desirable: Less than 130 Above Desirable: 130-159 Borderline High: 160-189 High: 190 -219 Very High: >or = 220	mg/dL
METHOD : CALCULATED				
CHOL/HDL RATIO		3.2		
LDL/HDL RATIO		2		
VERY LOW DENSITY LIPOPROTEIN		10.8		mg/dL
LIVER FUNCTION PROFILE, SERUM				
BILIRUBIN, TOTAL		1.00	0.2 - 1.2	mg/dL
METHOD : DIAZONIUM SALT				
BILIRUBIN, DIRECT		0.30	0.0 - 0.5	mg/dL
METHOD : DIAZO REACTION				
BILIRUBIN, INDIRECT		0.70	0.1 - 1.0	mg/dL
METHOD : CALCULATED				
TOTAL PROTEIN		7.4	6.0 - 8.30	g/dL
METHOD : BIURET				
ALBUMIN		4.1	3.5 - 5.2	g/dL
METHOD : COLORIMETRIC (BROMCRESOL GREEN)				
GLOBULIN		3.3	2.0 - 3.5	g/dL
ALBUMIN/GLOBULIN RATIO		1.3	1 - 2.1	RATIO
METHOD : CALCULATED PARAMETER				





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ASPARTATE AMINOTRANSFERASE (AST/SGOT)		20	5 - 34	U/L
METHOD : ENZYMATIC (NADH (WITHOUT P-5'-P))				
ALANINE AMINOTRANSFERASE (ALT/SGPT)		21	0 - 55	U/L
METHOD : ENZYMATIC (NADH (WITHOUT P-5'-P))				
ALKALINE PHOSPHATASE		109	40 - 150	U/L
METHOD : PARA-NITROPHENYL PHOSPHATE				
GAMMA GLUTAMYL TRANSFERASE (GGT)		9	8 - 33	U/L
METHOD : L-GAMMA-GLUTAMYL-4-NITROANALIDE /GLYCYLGLYCINE KINETIC METHOD				
LACTATE DEHYDROGENASE		142	125 - 220	U/L
METHOD : IFCC LACTATE TO PYRUVATE				
BLOOD UREA NITROGEN (BUN), SERUM				
BLOOD UREA NITROGEN		9	7.0 - 18.7	mg/dL
METHOD : UREASE METHOD				
CREATININE, SERUM				
CREATININE		0.80	0.50 - 1.00	mg/dL
METHOD : KINETIC ALKALINE PICRATE				
BUN/CREAT RATIO				
BUN/CREAT RATIO		10.84	5.0 - 15.0	
URIC ACID, SERUM				
URIC ACID		6.5	High 2.6 - 6.0	mg/dL
METHOD : URICASE				
TOTAL PROTEIN, SERUM				
TOTAL PROTEIN		7.4	6.0 - 8.3	g/dL
METHOD : BIURET				
ALBUMIN, SERUM				
ALBUMIN		4.1	3.5 - 5.2	g/dL
METHOD : COLORIMETRIC (BROMCRESOL GREEN)				
GLOBULIN				
GLOBULIN		3.3	2.0 - 3.5	g/dL
METHOD : CALCULATED PARAMETER				
ELECTROLYTES (NA/K/CL), SERUM				
SODIUM, SERUM		135	Low 136 - 145	mmol/L
METHOD : ION SELECTIVE ELECTRODE TECHNOLOGY INDIRECT				
POTASSIUM, SERUM		4.20	3.5 - 5.1	mmol/L
METHOD : ION SELECTIVE ELECTRODE TECHNOLOGY INDIRECT				
CHLORIDE, SERUM		101	98 - 107	mmol/L
METHOD : ION SELECTIVE ELECTRODE TECHNOLOGY INDIRECT				





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PHYSICAL EXAMINATION, URINE

COLOR PALE YELLOW
APPEARANCE SLIGHTLY HAZY

CHEMICAL EXAMINATION, URINE

PH	6.0	4.7 - 7.5	
SPECIFIC GRAVITY	1.005	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	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	DETECTED (+)	NOT DETECTED	

MICROSCOPIC EXAMINATION, URINE

RED BLOOD CELLS	2 - 3	NOT DETECTED	/HPF
PUS CELL (WBC'S)	8-10	0-5	/HPF
EPITHELIAL CELLS	3-5	0-5	/HPF
CASTS	NOT DETECTED		
CRYSTALS	NOT DETECTED		
BACTERIA	NOT DETECTED	NOT DETECTED	
YEAST	NOT DETECTED	NOT DETECTED	

Comments

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

THYROID PANEL, SERUM

T3	96.2	35 - 193	ng/dL
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METHOD : TWO-STEP CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY



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T4	6.50	4.87 - 11.71	µg/dL
METHOD : TWO-STEP CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY			
TSH 3RD GENERATION	3.915	0.350 - 4.940	µIU/mL
METHOD : TWO-STEP CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY			

Interpretation(s)

Triiodothyronine T3, Thyroxine T4, and Thyroid Stimulating Hormone TSH are thyroid hormones which affect almost every physiological process in the body, including growth, development, metabolism, body temperature, and heart rate. Production of T3 and its prohormone thyroxine (T4) is activated by thyroid-stimulating hormone (TSH), which is released from the pituitary gland. Elevated concentrations of T3, and T4 in the blood inhibit the production of TSH. Excessive secretion of thyroxine in the body is hyperthyroidism, and deficient secretion is called hypothyroidism. In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hyperthyroidism, TSH levels are low. Below mentioned are the guidelines for Pregnancy related reference ranges for Total T4, TSH & Total T3. Measurement of the serum TT3 level is a more sensitive test for the diagnosis of hyperthyroidism, and measurement of TT4 is more useful in the diagnosis of hypothyroidism. Most of the thyroid hormone in blood is bound to transport proteins. Only a very small fraction of the circulating hormone is free and biologically active. It is advisable to detect Free T3, FreeT4 along with TSH, instead of testing for albumin bound Total T3, Total T4.

Sr. No.	TSH	Total T4	FT4	Total T3	Possible Conditions
1	High	Low	Low	Low	(1) Primary Hypothyroidism (2) Chronic autoimmune Thyroiditis (3) Post Thyroidectomy (4) Post Radio-Iodine treatment
2	High	Normal	Normal	Normal	(1) Subclinical Hypothyroidism (2) Patient with insufficient thyroid hormone replacement therapy (3) In cases of Autoimmune/Hashimoto thyroiditis (4). Isolated increase in TSH levels can be due to Subclinical inflammation, drugs like amphetamines, Iodine containing drug and dopamine antagonist e.g. domperidone and other physiological reasons.
3	Normal/Low	Low	Low	Low	(1) Secondary and Tertiary Hypothyroidism
4	Low	High	High	High	(1) Primary Hyperthyroidism (Graves Disease) (2) Multinodular Goitre (3) Toxic Nodular Goitre (4) Thyroiditis (5) Over treatment of thyroid hormone (6) Drug effect e.g. Glucocorticoids, dopamine, T4 replacement therapy (7) First trimester of Pregnancy
5	Low	Normal	Normal	Normal	(1) Subclinical Hyperthyroidism
6	High	High	High	High	(1) TSH secreting pituitary adenoma (2) TRH secreting tumor
7	Low	Low	Low	Low	(1) Central Hypothyroidism (2) Euthyroid sick syndrome (3) Recent treatment for Hyperthyroidism
8	Normal/Low	Normal	Normal	High	(1) T3 thyrotoxicosis (2) Non-Thyroidal illness
9	Low	High	High	Normal	(1) T4 Ingestion (2) Thyroiditis (3) Interfering Anti TPO antibodies

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

NOTE: It is advisable to detect Free T3, 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.

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP

TYPE A

METHOD : TUBE AGGLUTINATION





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RH TYPE

POSITIVE

METHOD : TUBE AGGLUTINATION

XRAY-CHEST

IMPRESSION

NO ABNORMALITY DETECTED

TMT OR ECHO

TMT OR ECHO

ECHO DONE INSTEAD OF TMT
ECHO - NORMAL STUDY.

ECG

ECG

SINUS BRADYCARDIA
LOW VOLTAGE QRS- TO BE CORRELATED

MEDICAL HISTORY

RELEVANT PRESENT HISTORY

NOT SIGNIFICANT

RELEVANT PAST HISTORY

NOT SIGNIFICANT

RELEVANT PERSONAL HISTORY

NOT SIGNIFICANT

MENSTRUAL HISTORY (FOR FEMALES)

REGULAR

LMP (FOR FEMALES)

29/10/22

RELEVANT FAMILY HISTORY

FATHER : DIABETIC

OCCUPATIONAL HISTORY

NOT SIGNIFICANT

HISTORY OF MEDICATIONS

NOT SIGNIFICANT

ANTHROPOMETRIC DATA & BMI

HEIGHT IN METERS

1.55

mts

WEIGHT IN KGS.

60

Kgs

BMI

25

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



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NECK LYMPHATICS / SALIVARY GLANDS

NOT ENLARGED OR TENDER

THYROID GLAND

NOT ENLARGED

CAROTID PULSATION

NORMAL

TEMPERATURE

NORMAL

PULSE

60/MINS

RESPIRATORY RATE

NORMAL

CARDIOVASCULAR SYSTEM

BP

116/53

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

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

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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NEW DELHI 110030
DELHI INDIA
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SRL Ltd
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KOLKATA, 700016
WEST BENGAL, INDIA
Tel : 033-22267333,46019048, Fax : 033-22271324
CIN - U74899PB1995PLC045956

PATIENT NAME : SUSHMITA MANDAL

PATIENT ID : SUSHF27129182

ACCESSION NO : 0082VK000228 AGE : 30 Years SEX : Female

ABHA NO :

DRAWN : 08/11/2022 08:50

RECEIVED : 08/11/2022 08:58

REPORTED : 09/11/2022 18:22

REFERRING DOCTOR : DR. ACROFEMI HEALTHCARE LTD (MEDIWHEEL)

CLIENT PATIENT ID :

Test Report Status	Final	Results	Biological Reference Interval	Units
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CONJUNCTIVA	NORMAL
EYELIDS	NORMAL
EYE MOVEMENTS	NORMAL
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

REMARKS / RECOMMENDATIONS

Mrs. MANDAL CAME FOR ANNUAL HEALTH CHECK-UP. ON EXAMINATION AND INVESTIGATIONS SHE IS FOUND TO BE IN GOOD HEALTH.

Comments

MEDICAL EXAMINATION DONE BY:
DR. B. N. JANA, MBBS, DCH
CONSULTANT
WELLNESS CLINIC
PARK STREET, KOLKATA

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.



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(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,(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. AACCC 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 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:

Hypoglycemia is defined as a glucoseof < 50 mg/dL in men and< 40 mg/dL in women.

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 :

I.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.

II.Vitamin C & E are reported to falsely lower test results.(possibly by inhibiting glycation of hemoglobin.

III.Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia,uremia, hyperbilirubinemia, chronic alcoholism,chronic ingestion of salicylates & opiates addition are reported to interfere with some assay methods,falsely increasing results.

IV.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

LIVER FUNCTION PROFILE, SERUM-

LIVER FUNCTION PROFILE

Bilirubin is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. Bilirubin is excreted in bile and urine, and elevated levels may give



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yellow discoloration in jaundice. Elevated levels results from increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Conjugated (direct) bilirubin is elevated more than unconjugated (indirect) bilirubin in Viral hepatitis, Drug reactions, Alcoholic liver disease. Conjugated (direct) bilirubin is also elevated more than unconjugated (indirect) bilirubin when there is some kind of blockage of the bile ducts like in Gallstones getting into the bile ducts, tumors & Scarring of the bile ducts. Increased unconjugated (indirect) bilirubin may be a result of Hemolytic or pernicious anemia, Transfusion reaction & a common metabolic condition termed Gilbert syndrome, due to low levels of the enzyme that attaches sugar molecules to bilirubin.

AST is an enzyme found in various parts of the body. AST is found in the liver, heart, skeletal muscle, kidneys, brain, and red blood cells, and it is commonly measured clinically as a marker for liver health. AST levels increase during chronic viral hepatitis, blockage of the bile duct, cirrhosis of the liver, liver cancer, kidney failure, hemolytic anemia, pancreatitis, hemochromatosis. AST levels may also increase after a heart attack or strenuous activity. ALT test measures the amount of this enzyme in the blood. ALT is found mainly in the liver, but also in smaller amounts in the kidneys, heart, muscles, and pancreas. It is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health. AST levels increase during acute hepatitis, sometimes due to a viral infection, ischemia to the liver, chronic hepatitis, obstruction of bile ducts, cirrhosis.

ALP is a protein found in almost all body tissues. Tissues with higher amounts of ALP include the liver, bile ducts and bone. Elevated ALP levels are seen in Biliary obstruction, Osteoblastic bone tumors, osteomalacia, hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, Paget's disease, Rickets, Sarcoidosis etc. Lower-than-normal ALP levels seen in Hypophosphatasia, Malnutrition, Protein deficiency, Wilson's disease. GGT is an enzyme found in cell membranes of many tissues mainly in the liver, kidney and pancreas. It is also found in other tissues including intestine, spleen, heart, brain and seminal vesicles. The highest concentration is in the kidney, but the liver is considered the source of normal enzyme activity. Serum GGT has been widely used as an index of liver dysfunction. Elevated serum GGT activity can be found in diseases of the liver, biliary system and pancreas. Conditions that increase serum GGT are obstructive liver disease, high alcohol consumption and use of enzyme-inducing drugs etc. Serum total protein, also known as total protein, is a biochemical test for measuring the total amount of protein in serum. Protein in the plasma is made up of albumin and globulin. Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma, Waldenstrom's disease. Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage), Burns, Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome, Protein-losing enteropathy etc. Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. Low blood albumin levels (hypoalbuminemia) can be caused by: Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance, malnutrition and wasting etc.

BLOOD UREA NITROGEN (BUN), SERUM- Causes of Increased levels include Pre renal (High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal), Renal Failure, Post Renal (Malignancy, Nephrolithiasis, Prostatism)
 Causes of decreased level include Liver disease, SIADH.

CREATININE, SERUM- Higher than normal level may be due to:

- Blockage in the urinary tract
- Kidney problems, such as kidney damage or failure, infection, or reduced blood flow
- Loss of body fluid (dehydration)
- Muscle problems, such as breakdown of muscle fibers
- Problems during pregnancy, such as seizures (eclampsia), or high blood pressure caused by pregnancy (preeclampsia)

Lower than normal level may be due to:

- Myasthenia Gravis
- Muscular dystrophy

URIC ACID, SERUM-

Causes of Increased levels- Dietary (High Protein Intake, Prolonged Fasting, Rapid weight loss), Gout, Lesch nyhan syndrome, Type 2 DM, Metabolic syndrome

Causes of decreased levels- Low Zinc intake, OCP, Multiple Sclerosis

TOTAL PROTEIN, SERUM-

Serum total protein, also known as total protein, is a biochemical test for measuring the total amount of protein in serum. Protein in the plasma is made up of albumin and globulin

Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma, Waldenstrom's disease

Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage), Burns, Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome, Protein-losing enteropathy etc.

ALBUMIN, SERUM-

Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. Low blood albumin levels (hypoalbuminemia) can be caused by: Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance, malnutrition and wasting etc.

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD-

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

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

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

MEDICAL

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





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

1. GRADE I FATTY LIVER
2. RETROVERTED UTERUS

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

Dr. B. N. Jana, MBBS, DCH
Consultant

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.

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