DIAGNOSTIC REPORT

Patient Ref. No. 28000001079219

SRL Diagnostics

CLIENT CODE : C000138361

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
E-368, LGF, Nirman Vihar,Near Nirman Vihar Metro
NEW DELHI, 110092
NEW DELHI, INDIA
Tel : 9111591115,
CIN - U74899PB1995PLC045956
Email : wellness.eastdelhi@srl.in

PATIENT NAME : YASHPAL SINGH PATIENT ID : **YASHM20128328**

ACCESSION NO : **0028WA000718** AGE : 39 Years SEX : Male ABHA NO :

DRAWN : RECEIVED : 28/01/2023 09:10 REPORTED : 30/01/2023 11:24

REFERRING DOCTOR : SELF CLIENT PATIENT ID :

Test Report Status **Final**	Results		Biological Reference Interval	Units
MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE				
BLOOD COUNTS,EDTA WHOLE BLOOD				
HEMOGLOBIN (HB)	13.7		13.0 - 17.0	g/dL
METHOD : SPECTROPHOTOMETRY				
RED BLOOD CELL (RBC) COUNT	4.57		4.5 - 5.5	mil/µL
METHOD : ELECTRICAL IMPEDANCE				
WHITE BLOOD CELL (WBC) COUNT	8.50		4.0 - 10.0	thou/µL
METHOD : ELECTRICAL IMPEDANCE				
PLATELET COUNT	154		150 - 410	thou/µL
METHOD : ELECTRICAL IMPEDANCE				
RBC AND PLATELET INDICES				
HEMATOCRIT (PCV)	41.2		40.0 - 50.0	%
METHOD : CALCULATED PARAMETER				
MEAN CORPUSCULAR VOLUME (MCV)	90.1		83.0 - 101.0	fL
METHOD : DERIVED/COULTER PRINCIPLE				
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	29.9		27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER				
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)	33.3		31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER				
RED CELL DISTRIBUTION WIDTH (RDW)	13.7		11.6 - 14.0	%
METHOD : DERIVED/COULTER PRINCIPLE				
MENTZER INDEX	19.7			
METHOD : CALCULATED PARAMETER				
MEAN PLATELET VOLUME (MPV)	**11.8**	**High**	6.8 - 10.9	fL
METHOD : DERIVED/COULTER PRINCIPLE				
WBC DIFFERENTIAL COUNT				
NEUTROPHILS	67		40 - 80	%
METHOD : VCS TECHNOLOGY/ MICROSCOPY				
LYMPHOCYTES	23		20 - 40	%
METHOD : VCS TECHNOLOGY/ MICROSCOPY				
MONOCYTES	6		2.0 - 10.0	%
METHOD : VCS TECHNOLOGY/ MICROSCOPY				
EOSINOPHILS	4		1.0 - 6.0	%
METHOD : VCS TECHNOLOGY/ MICROSCOPY				
BASOPHILS	00		0 - 1	%
METHOD : VCS TECHNOLOGY/ MICROSCOPY				

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ABSOLUTE NEUTROPHIL COUNT	5.70		2.0 - 7.0	thou/µL
METHOD : CALCULATED PARAMETER				
ABSOLUTE LYMPHOCYTE COUNT	1.90		1.0 - 3.0	thou/µL
METHOD : CALCULATED PARAMETER				
ABSOLUTE MONOCYTE COUNT	0.50		0.2 - 1.0	thou/µL
METHOD : CALCULATED PARAMETER				
ABSOLUTE EOSINOPHIL COUNT	0.30		0.02 - 0.50	thou/µL
METHOD : CALCULATED PARAMETER				
ABSOLUTE BASOPHIL COUNT	**0**	**Low**	0.02 - 0.10	thou/µL
METHOD : CALCULATED PARAMETER				
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	3.0			
METHOD : CALCULATED PARAMETER				
ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD				
E.S.R	**16**	**High**	< 15	mm at 1 hr
METHOD : MODIFIED WESTERGREN METHOD BY AUTOMATED ANALYSER				
GLUCOSE FASTING,FLUORIDE PLASMA				
FBS (FASTING BLOOD SUGAR)	**128**	**High**	74 - 106	mg/dL
METHOD : HEXOKINASE				
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD				
HBA1C	5.6		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)	114.0		< 116.0	mg/dL
GLUCOSE, POST-PRANDIAL, PLASMA				
PPBS(POST PRANDIAL BLOOD SUGAR)	**155**	**High**	Non-Diabetes 70 - 140	mg/dL
METHOD : HEXOKINASE				
LIPID PROFILE, SERUM				
CHOLESTEROL, TOTAL	175		< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
METHOD : CHOLESTEROL OXIDASE, ESTERASE,PEROXIDASE				

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TRIGLYCERIDES	**163**	**High**	< 150 Normal 150 - 199 Borderline High 200 - 499 High >/= 500 Very High	mg/dL
METHOD : ENZYMATIC, END POINT				
HDL CHOLESTEROL	**36**	**Low**	< 40 Low >/=60 High	mg/dL
METHOD : DIRECT MEASURE POLYMER-POLYANION				
CHOLESTEROL LDL	**106**	**High**	< 100 Optimal 100 - 129 Near or above optimal 130 - 159 Borderline High 160 - 189 High >/= 190 Very High	mg/dL
NON HDL CHOLESTEROL	**139**	**High**	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
METHOD : CALCULATED PARAMETER				
VERY LOW DENSITY LIPOPROTEIN	32.6		Desirable value : 10 - 35	mg/dL
CHOL/HDL RATIO	**4.9**	**High**	3.3-4.4 Low Risk 4.5-7.0 Average Risk 7.1-11.0 Moderate Risk > 11.0 High Risk	
LDL/HDL RATIO	2.9		0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
Interpretation(s)				
LIVER FUNCTION PROFILE, SERUM				
BILIRUBIN, TOTAL	**1.35**	**High**	UPTO 1.2	mg/dL
METHOD : DIAZONIUM ION, BLANKED (ROCHE)				
BILIRUBIN, DIRECT	**0.35**	**High**	0.00 - 0.30	mg/dL
METHOD : DIAZOTIZATION				
BILIRUBIN, INDIRECT	**1.00**	**High**	0.00 - 0.60	mg/dL
METHOD : CALCULATED PARAMETER				
TOTAL PROTEIN	8.0		6.6 - 8.7	g/dL
METHOD : BIURET,SERUM BLANK,ENDPOINT				
ALBUMIN	**5.1**	**High**	3.97 - 4.94	g/dL
METHOD : BROMOCRESOL GREEN				

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GLOBULIN	2.9		2.0 - 4.0 Neonates - Pre Mature: 0.29 - 1.04	g/dL
METHOD : CALCULATED PARAMETER				
ALBUMIN/GLOBULIN RATIO	1.8		1.0 - 2.0	RATIO
METHOD : CALCULATED PARAMETER				
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	30		0 - 40	U/L
METHOD : UV WITHOUT P5P				
ALANINE AMINOTRANSFERASE (ALT/SGPT)	37		0 - 41	U/L
METHOD : UV WITHOUT P5P				
ALKALINE PHOSPHATASE	83		40 - 129	U/L
METHOD : PNPP, AMP BUFFER-IFCC				
GAMMA GLUTAMYL TRANSFERASE (GGT)	23		8 - 61	U/L
METHOD : G-GLUTAMYL-CARBOXY-NITROANILIDE-IFCC				
LACTATE DEHYDROGENASE	190		135 - 225	U/L
METHOD : L TO P, IFCC				
BLOOD UREA NITROGEN (BUN), SERUM				
BLOOD UREA NITROGEN	8		6 - 20	mg/dL
METHOD : UREASE - UV				
CREATININE, SERUM				
CREATININE	1.02		0.70 - 1.20	mg/dL
METHOD : ALKALINE PICRATE-KINETIC				
BUN/CREAT RATIO				
BUN/CREAT RATIO	7.84		5.00 - 15.00	
METHOD : CALCULATED PARAMETER				
URIC ACID, SERUM				
URIC ACID	5.7		3.4 - 7.0	mg/dL
METHOD : URICASE, COLORIMETRIC				
TOTAL PROTEIN, SERUM				
TOTAL PROTEIN	8.0		6.6 - 8.7	g/dL
METHOD : BIURET,SERUM BLANK,ENDPOINT				
ALBUMIN, SERUM				
ALBUMIN	**5.1**	**High**	3.97 - 4.94	g/dL
METHOD : BROMOCRESOL GREEN				
GLOBULIN				

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GLOBULIN	2.9	2.0 - 4.0 Neonates - Pre Mature: 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	3.97	3.5 - 5.1	mmol/L
METHOD : ISE INDIRECT			
CHLORIDE, SERUM	98	98 - 107	mmol/L
METHOD : ISE INDIRECT			
Interpretation(s)			
PHYSICAL EXAMINATION, URINE			
COLOR	PALE YELLOW		
METHOD : VISUAL			
APPEARANCE	CLEAR		
METHOD : VISUAL			
CHEMICAL EXAMINATION, URINE			
PH	6.0	4.7 - 7.5	
METHOD : DOUBLE INDICATOR PRINCIPLE			
SPECIFIC GRAVITY	1.010	1.003 - 1.035	
METHOD : PKA CHANGE OF PRETREATED POLYELECTROLYTES			
PROTEIN	NOT DETECTED	NOT DETECTED	
METHOD : PROTEIN- ERROR INDICATOR			
GLUCOSE	NOT DETECTED	NOT DETECTED	
METHOD : OXIDASE-PEROXIDASE REACTION			
KETONES	NOT DETECTED	NOT DETECTED	
METHOD : ACETOACETIC REACTION WITH NITROPRUSSIDE			
BLOOD	NOT DETECTED	NOT DETECTED	
METHOD : PEROXIDASE-LIKE ACTIVITY OF HEMOGLOBIN			
BILIRUBIN	NOT DETECTED	NOT DETECTED	
METHOD : DIAZOTIZATION			
UROBILINOGEN	NORMAL	NORMAL	
METHOD : MODIFIED EHRLICH REACTION			
NITRITE	NOT DETECTED	NOT DETECTED	
METHOD : CONVERTION OF NITRATE TO NITRITE			
LEUKOCYTE ESTERASE	NOT DETECTED	NOT DETECTED	

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METHOD : ESTERASE HYDROLYSIS ACTIVITY				
MICROSCOPIC EXAMINATION, URINE				
RED BLOOD CELLS	NOT DETECTED		NOT DETECTED	/HPF
METHOD : MICROSCOPIC EXAMINATION				
PUS CELL (WBC'S)	0-1		0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION				
EPITHELIAL CELLS	0-1		0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION				
CASTS	NOT DETECTED			
METHOD : MICROSCOPIC EXAMINATION				
CRYSTALS	NOT DETECTED			
METHOD : MICROSCOPIC EXAMINATION				
BACTERIA	NOT DETECTED		NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION				
YEAST	NOT DETECTED		NOT DETECTED	
REMARKS	MICROSCOPIC EXAMINATION DONE ON CENTRIFUGED URINE PLEASE NOTE THAT GRADING OF BACTERIA NEEDS TO BE CORELATED WITH THE CULTURE IN CASE FOUND SIGNIFICANT CLINICALLY. OCCASIONAL BACTERIA/YEAST CELLS SEEN IN MICROSCOPY CAN BE A PART OF SURROUNDING SKIN FLORA ALSO.			
METHOD : MANUAL				
Interpretation(s)				
THYROID PANEL, SERUM				
T3	112.7		80.00 - 200.00	ng/dL
METHOD : ECLIA				
T4	6.58		5.10 - 14.10	µg/dL
METHOD : ECLIA				
TSH (ULTRASENSITIVE)	**4.500**	**High**	0.270 - 4.200	µIU/mL
METHOD : ECLIA				
Interpretation(s)				
PHYSICAL EXAMINATION,STOOL				
COLOUR	BROWN			
METHOD : GUAIAC METHOD				
CONSISTENCY	SEMI FORMED			
METHOD : MANUAL				
MUCUS	ABSENT		NOT DETECTED	

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METHOD : MANUAL			
VISIBLE BLOOD	ABSENT	ABSENT	
METHOD : MANUAL			
ADULT PARASITE	NOT DETECTED		
METHOD : CONCENTRATION AND MICROSCOPY			
CHEMICAL EXAMINATION,STOOL			
STOOL PH	6.0		
MICROSCOPIC EXAMINATION,STOOL			
PUS CELLS	0-1		/hpf
RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
METHOD : CONCENTRATION AND MICROSCOPY			
CYSTS	NOT DETECTED	NOT DETECTED	
METHOD : CONCENTRATION AND MICROSCOPY			
OVA	NOT DETECTED		
METHOD : CONCENTRATION AND MICROSCOPY			
LARVAE	NOT DETECTED	NOT DETECTED	
METHOD : CONCENTRATION AND MICROSCOPY			
TROPHOZOITES	NOT DETECTED	NOT DETECTED	
METHOD : CONCENTRATION AND MICROSCOPY			
FAT	ABSENT		
VEGETABLE CELLS	ABSENT		
CHARCOT LEYDEN CRYSTALS	ABSENT		
CONCENTRATION METHOD	OVA OR CYSTS NOT SEEN		
REMARK	YEAST CELLS SEEN		
METHOD : CONCENTRATION AND MICROSCOPY			
Interpretation(s)			
ABO GROUP & RH TYPE, EDTA WHOLE BLOOD			
ABO GROUP	TYPE AB		
METHOD : COLUMN AGGLUTINATION TECHOLOGY			
RH TYPE	POSITIVE		
METHOD : COLUMN AGGLUTINATION TECHOLOGY			
XRAY-CHEST			
»»	BOTH THE LUNG FIELDS ARE CLEAR		
»»	BOTH THE COSTOPHRENIC AND CARIOPHRENIC ANGELS ARE CLEAR		
»»	BOTH THE HILA ARE NORMAL		
»»	CARDIAC AND AORTIC SHADOWS APPEAR NORMAL		

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»»	BOTH THE DOMES OF THE DIAPHRAM ARE NORMAL		
»»	VISUALIZED BONY THORAX IS NORMAL		
IMPRESSION	NORMAL		
TMT OR ECHO			
TMT OR ECHO	2D ECHO DONE		
ECG			
ECG	SHORT PR INTERVAL		
MEDICAL HISTORY			
RELEVANT PRESENT HISTORY	NOT SIGNIFICANT		
RELEVANT PAST HISTORY	NOT SIGNIFICANT		
RELEVANT PERSONAL HISTORY	MARRIED 2 CHILD NON VEG AND VEG		
RELEVANT FAMILY HISTORY	MOTHER DIABETES		
OCCUPATIONAL HISTORY	JOB		
HISTORY OF MEDICATIONS	NOT SIGNIFICANT		
ANTHROPOMETRIC DATA & BMI			
HEIGHT IN METERS	1.69		mts
WEIGHT IN KGS.	75		Kgs
BMI	26	BMI & Weight Status as follows: kg/sqmts Below 18.5: Underweight 18.5 - 24.9: Normal 25.0 - 29.9: Overweight 30.0 and Above: Obese	
GENERAL EXAMINATION			
MENTAL / EMOTIONAL STATE	NORMAL		
PHYSICAL ATTITUDE	NORMAL		
GENERAL APPEARANCE / NUTRITIONAL STATUS	HEALTHY		
BUILT / SKELETAL FRAMEWORK	AVERAGE		
FACIAL APPEARANCE	NORMAL		
SKIN	NORMAL		
UPPER LIMB	NORMAL		
LOWER LIMB	NORMAL		
NECK	NORMAL		
NECK LYMPHATICS / SALIVARY GLANDS	NOT ENLARGED OR TENDER		
THYROID GLAND	NOT ENLARGED		
CAROTID PULSATION	NORMAL		

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TEMPERATURE	NORMAL		
PULSE	82/MINUTE, REGULAR, ALL PERIPHERAL PULSES WELL FELT, NO CAROTID BRUIT		
RESPIRATORY RATE	NORMAL		
CARDIOVASCULAR SYSTEM			
BP	135/91		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			
CONJUNCTIVA	NORMAL		
EYELIDS	NORMAL		

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Test Report Status **Final**	Results	Biological Reference Interval	Units
EYE MOVEMENTS	NORMAL		
CORNEA	NORMAL		
DISTANT VISION RIGHT EYE WITH GLASSES	NORMAL		
DISTANT VISION LEFT EYE WITH GLASSES	NORMAL		
NEAR VISION RIGHT EYE WITH GLASSES	NORMAL		
NEAR VISION LEFT EYE WITH GLASSES	NORMAL		
COLOUR VISION	NORMAL		
BASIC ENT EXAMINATION			
EXTERNAL EAR CANAL	NORMAL		
TYMPANIC MEMBRANE	NORMAL		
NOSE	NO ABNORMALITY DETECTED		
SINUSES	CLEAR		
THROAT	NO ABNORMALITY DETECTED		
TONSILS	NOT ENLARGED		
SUMMARY			
RELEVANT HISTORY	NOT SIGNIFICANT		
RELEVANT GP EXAMINATION FINDINGS	NOT SIGNIFICANT		
RELEVANT LAB INVESTIGATIONS	WITHIN NORMAL LIMITS		
RELEVANT NON PATHOLOGY DIAGNOSTICS	NO ABNORMALITIES DETECTED		
REMARKS / RECOMMENDATIONS	"NO ABNORMALITY FOUND OUT OF THE DIAGNOSTIC PACKAGE REQUESTED. GENERAL PHYSICAL EXAMINATION IS NORMAL."		

Interpretation(s)
BLOOD COUNTS,EDTA WHOLE BLOOD-The cell morphology is well preserved for 24hrs. However after 24-48 hrs a progressive increase in MCV and HCT is observed leading to a decrease in MCHC. A direct smear is recommended for an accurate differential count and for examination of RBC morphology.
RBC AND PLATELET INDICES-Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia(>13) from Beta thalassaemia trait
(<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.
WBC DIFFERENTIAL COUNT-The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR < 3.3, COVID-19 patients tend to show mild disease.
(Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients ; A.-P. Yang, et al.; International Immunopharmacology 84 (2020) 106504
This ratio element is a calculated parameter and out of NABL scope.
ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD-**TEST DESCRIPTION** :-
Erythrocyte sedimentation rate (ESR) is a test that indirectly measures the degree of inflammation present in the body. The test actually measures the rate of fall (sedimentation) of erythrocytes in a sample of blood that has been placed into a tall, thin, vertical tube. Results are reported as the millimetres of clear fluid (plasma) that are present at the top portion of the tube after one hour. Nowadays fully automated instruments are available to measure ESR.

ESR is not diagnostic; it is a non-specific test that may be elevated in a number of different conditions. It provides general information about the presence of an

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

SRL Ltd
E-368, LGF, Nirman Vihar,Near Nirman Vihar Metro
NEW DELHI, 110092
NEW DELHI, INDIA
Tel : 9111591115,
CIN - U74899PB1995PLC045956
Email : wellness.eastdelhi@srl.in

PATIENT NAME : YASHPAL SINGH PATIENT ID : **YASHM20128328**

ACCESSION NO : **0028WA000718** AGE : 39 Years SEX : Male ABHA NO :

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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.
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 :
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 addiction 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 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

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ACROFEMI HEALTHCARE LTD (MEDIWHEEL)
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SOUTH WEST DELHI
NEW DELHI 110030
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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 INVIOLABLE FEATURE OF OUR LAB MANAGEMENT SOFTWARE. HOWEVER, ALL EXAMINATIONS AND INVESTIGATIONS HAVE BEEN CONDUCTED BY OUR PANEL OF DOCTORS.

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DIAGNOSTIC REPORT

Patient Ref. No. 28000001079219

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SOUTH WEST DELHI
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MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

ULTRASOUND ABDOMEN

ULTRASOUND ABDOMEN

SPLENOMEGALY

****End Of Report****
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Dr. Neena Verma, MD (Pathology)
Deputy Lab Head

Dr. Anu Gupta, MD
Associate Consultant

Dr. Shyla Goel,M.B.B.S ,DCP
Sr.Pathologist

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