

PATIENT NAME : SWETA MUND

REF. DOCTOR : DR. ACROFEMI HEALTHCARE LTD  
( MEDIWHEEL )

CODE/NAME & ADDRESS : C000138398 ARCOFEMI HEALTHCARE LTD (MEDIWHEEL F-703, F-703, LADO SARAI, MEHRAULISOUTH WEST DELHI NEW DELHI 110030 8800465156	ACCESSION NO : <b>0194WF001977</b> PATIENT ID : SWETF200986194 CLIENT PATIENT ID: ABITA NO :	AGE/SEX : 36 Years Female DRAWN : RECEIVED : 23/06/2023 09:38:38 REPORTED : 24/06/2023 18:47:51
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Test Report Status	Final	Results	Biological Reference Interval	Units
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**MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40FEMALE****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
>>>	BOTH THE DOMES OF THE DIAPHRAM ARE NORMAL
>>>	VISUALIZED BONY THORAX IS NORMAL
IMPRESSION	NO ABNORMALITY DETECTED

**ECG**

ECG WITHIN NORMAL LIMITS

**MAMMOGRAPHY (BOTH BREASTS)**MAMMOGRAPHY BOTH BREASTS  
1. FIBROADENOSIS CHANGES  
2. FIBROADENOMA IN LEFT BREAST**MEDICAL HISTORY**

RELEVANT PRESENT HISTORY	NOT SIGNIFICANT
RELEVANT PAST HISTORY	NOT SIGNIFICANT
RELEVANT PERSONAL HISTORY	NOT SIGNIFICANT
RELEVANT FAMILY HISTORY	FATHER HAS DM+
OCCUPATIONAL HISTORY	NOT SIGNIFICANT
HISTORY OF MEDICATIONS	NOT SIGNIFICANT

**ANTHROPOMETRIC DATA & BMI**

HEIGHT IN METERS	1.58	mts
WEIGHT IN KGS.	70	Kgs
BMI	28	kg/sqmts

BMI & Weight Status as follows  
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


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Consultant Pathologist

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Patient Ref. No. 775000003653012

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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	REGULAR, ALL PERIPHERAL PULSES WELL FELT, NO CAROTID BRUIT			
RESPIRATORY RATE	NORMAL			

**CARDIOVASCULAR SYSTEM**

BP	110/60 MM HG (SITTING)		mm/Hg
PERICARDIUM	NORMAL		
APEX BEAT	NORMAL		
HEART SOUNDS	NORMAL		
MURMURS	ABSENT		

**RESPIRATORY SYSTEM**

SIZE AND SHAPE OF CHEST	NORMAL		
MOVEMENTS OF CHEST	SYMMETRICAL		
BREATH SOUNDS INTENSITY	NORMAL		
BREATH SOUNDS QUALITY	VESICULAR (NORMAL)		
ADDED SOUNDS	ABSENT		

**PER ABDOMEN**

APPEARANCE	NORMAL		
VENOUS PROMINENCE	ABSENT		
LIVER	NOT PALPABLE		
SPLEEN	NOT PALPABLE		
HERNIA	ABSENT		

**CENTRAL NERVOUS SYSTEM**

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HIGHER FUNCTIONS	NORMAL
CRANIAL NERVES	NORMAL
CEREBELLAR FUNCTIONS	NORMAL
SENSORY SYSTEM	NORMAL
MOTOR SYSTEM	NORMAL
REFLEXES	NORMAL
<b>MUSCULOSKELETAL SYSTEM</b>	
SPINE	NORMAL
JOINTS	NORMAL
<b>BASIC EYE EXAMINATION</b>	
CONJUNCTIVA	NORMAL
EYELIDS	NORMAL
EYE MOVEMENTS	NORMAL
CORNEA	NORMAL
DISTANT VISION RIGHT EYE WITHOUT GLASSES	WITHIN NORMAL LIMIT
DISTANT VISION LEFT EYE WITHOUT GLASSES	WITHIN NORMAL LIMIT
NEAR VISION RIGHT EYE WITHOUT GLASSES	WITHIN NORMAL LIMIT
NEAR VISION LEFT EYE WITHOUT GLASSES	WITHIN NORMAL LIMIT
COLOUR VISION	NORMAL
<b>BASIC ENT EXAMINATION</b>	
EXTERNAL EAR CANAL	NORMAL
TYMPANIC MEMBRANE	NORMAL
NOSE	NO ABNORMALITY DETECTED
SINUSES	CLEAR
THROAT	NO ABNORMALITY DETECTED
TONSILS	NOT ENLARGED
<b>BASIC DENTAL EXAMINATION</b>	
TEETH	NORMAL
GUMS	HEALTHY
<b>SUMMARY</b>	
RELEVANT HISTORY	NOT SIGNIFICANT

*U. Arunajyothi*

**Dr. Uram Aruna Jyothi**  
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RELEVANT GP EXAMINATION FINDINGS	NOT SIGNIFICANT
RELEVANT LAB INVESTIGATIONS	WITHIN NORMAL LIMITS
RELEVANT NON PATHOLOGY DIAGNOSTICS	NO ABNORMALITIES DETECTED
REMARKS / RECOMMENDATIONS	ADVICE TO FOLLOW UP WITH PHYSICIAN FOR ANEMIA AND ELEVATED HBA1C.  ADVICE TO FOLLOW UP WITH SURGEON FOR FIBROADENOMA LEFT BREST.
<b>FITNESS STATUS</b>	
FITNESS STATUS	FIT (WITH MEDICAL ADVICE) (AS PER REQUESTED PANEL OF TESTS)



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Table with 3 columns: CODE/NAME & ADDRESS, ACCESSION NO, AGE/SEX. Includes patient details like ARCOFEMI HEALTHCARE LTD, SWETA MUND, and test results like 36 Years Female.

Table with 4 columns: Test Report Status (Final), Results, Units.

MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40FEMALE

ULTRASOUND ABDOMEN

ULTRASOUND ABDOMEN

- 1.BULKY UTERUS
2.THICKENED ENDOMETRIUM.
TMT OR ECHO

TMT OR ECHO

TRIVIAL TR,NO PAH

Interpretation(s)

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

FITNESS STATUS-Conclusion on an individual's Fitness, which is commented upon mainly for Pre employment cases, is based on multi factorial findings and does not depend on any one single parameter. The final Fitness assigned to a candidate will depend on the Physician's findings and overall judgement on a case to case basis, details of the candidate's past and personal history as well as the comprehensiveness of the diagnostic panel which has been requested for .These are then further correlated with details of the job under consideration to eventually fit the right man to the right job.

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## HAEMATOLOGY - CBC

**MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40FEMALE****BLOOD COUNTS, EDTA WHOLE BLOOD**

HEMOGLOBIN (HB)	<b>10.7 Low</b>	12.0 - 15.0	g/dL
RED BLOOD CELL (RBC) COUNT	4.76	3.8 - 4.8	mil/ $\mu$ L
WHITE BLOOD CELL (WBC) COUNT	6.20	4.0 - 10.0	thou/ $\mu$ L
PLATELET COUNT	229	150 - 410	thou/ $\mu$ L

**RBC AND PLATELET INDICES**

HEMATOCRIT (PCV)	<b>35.3 Low</b>	36 - 46	%
MEAN CORPUSCULAR VOLUME (MCV)	<b>74.0 Low</b>	83 - 101	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	<b>22.5 Low</b>	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)	<b>30.4 Low</b>	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW)	<b>16.8 High</b>	11.6 - 14.0	%
MENTZER INDEX	15.6		
MEAN PLATELET VOLUME (MPV)	9.2	6.8 - 10.9	fL

**WBC DIFFERENTIAL COUNT**

NEUTROPHILS	69	40 - 80	%
LYMPHOCYTES	20	20 - 40	%
MONOCYTES	8	2 - 10	%
EOSINOPHILS	3	1 - 6	%
BASOPHILS	0	0 - 2	%
ABSOLUTE NEUTROPHIL COUNT	4.28	2.0 - 7.0	thou/ $\mu$ L
ABSOLUTE LYMPHOCYTE COUNT	1.24	1.0 - 3.0	thou/ $\mu$ L
ABSOLUTE MONOCYTE COUNT	0.50	0.2 - 1.0	thou/ $\mu$ L
ABSOLUTE EOSINOPHIL COUNT	0.19	0.02 - 0.50	thou/ $\mu$ L
ABSOLUTE BASOPHIL COUNT	<b>0.00 Low</b>	0.02 - 0.10	thou/ $\mu$ L
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	3.5		

**MORPHOLOGY**

RBC	MICROCYTIC HYPOCHROMIC CELLS.
WBC	NORMAL COUNT & DISTRIBUTION ,NO ABNORMAL CELLS / IMMATURE CELLS.


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PLATELETS  
IMPRESSIONADEQUATE & DISCRETELY PRESENT. NO HAEMOPARASITES SEEN.  
MICROCYTIC HYPOCHROMIC ANEMIA.**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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**ADMTA NO :**

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**HAEMATOLOGY**

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

**ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD**

E.S.R	20	0 - 20	mm at 1 hr
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**GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD**

HBA1C	<b>6.6 High</b>	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 ADA Target: 7.0 Action suggested: > 8.0	%
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METHOD : IMMUNOTURBIDIMETRIC ASSAY

ESTIMATED AVERAGE GLUCOSE(EAG)	<b>142.7 High</b>	< 116.0	mg/dL
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**Comments**

NOTE:KINDLY CORRELATE THE GLYCOSYLATED HEMOGLOBIN RESULT CLINICALLY.

**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, 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. 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:



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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 addition 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 platform (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 ABOVE 40FEMALE****ABO GROUP & RH TYPE, EDTA WHOLE BLOOD**

ABO GROUP	TYPE B
RH TYPE	POSITIVE

**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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**ADMIT NO :**

**AGE/SEX :** 36 Years Female  
**DRAWN :**  
**RECEIVED :** 23/06/2023 09:38:38  
**REPORTED :** 24/06/2023 18:47:51

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

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

**GLUCOSE FASTING,FLUORIDE PLASMA**

**FBS (FASTING BLOOD SUGAR)** **117 High** Normal : < 100 mg/dL  
Pre-diabetes: 100-125  
Diabetes: >/=126

METHOD : HEXOKINASE

**GLUCOSE, POST-PRANDIAL, PLASMA**

**PPBS(POST PRANDIAL BLOOD SUGAR)** **171 High** 70 - 140 mg/dL

METHOD : HEXOKINASE

**LIPID PROFILE, SERUM**

**CHOLESTEROL, TOTAL** 168 < 200 Desirable mg/dL  
200 - 239 Borderline High  
>/= 240 High

METHOD : CHOLESTEROL OXIDASE, ESTERASE,PEROXIDASE

**TRIGLYCERIDES** 82 < 150 Normal mg/dL  
150 - 199 Borderline High  
200 - 499 High  
>/=500 Very High

METHOD : ENZYMATIC ASSAY

**HDL CHOLESTEROL** 40 < 40 Low mg/dL  
>/=60 High

METHOD : DIRECT MEASURE - PEG

**CHOLESTEROL LDL** **112 High** < 100 Optimal mg/dL  
100 - 129  
Near optimal/ above optimal  
130 - 159  
Borderline High  
160 - 189 High  
>/= 190 Very High

**NON HDL CHOLESTEROL** 128 Desirable: Less than 130 mg/dL  
Above Desirable: 130 - 159  
Borderline High: 160 - 189  
High: 190 - 219  
Very high: > or = 220

**VERY LOW DENSITY LIPOPROTEIN** 16.4 </= 30.0 mg/dL

*U. Arunajyothi*

**Dr. Uram Aruna Jyothi**  
**Consultant Pathologist**



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Email : customercare.vizag@agilus.in



**Patient Ref. No. 775000003653012**

**PATIENT NAME : SWETA MUND**

**REF. DOCTOR : DR. ACROFEMI HEALTHCARE LTD ( MEDIWHEEL )**

<b>CODE/NAME &amp; ADDRESS :</b> C000138398 ARCOFEMI HEALTHCARE LTD (MEDIWHEEL F-703, F-703, LADO SARAI, MEHRAULISOUTH WEST DELHI NEW DELHI 110030 8800465156	<b>ACCESSION NO :</b> 0194WF001977 <b>PATIENT ID :</b> SWETF200986194 <b>CLIENT PATIENT ID:</b> ABITA NO :	<b>AGE/SEX :</b> 36 Years Female <b>DRAWN :</b> <b>RECEIVED :</b> 23/06/2023 09:38:38 <b>REPORTED :</b> 24/06/2023 18:47:51
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CHOL/HDL RATIO		4.2	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		2.8	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	

**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
Moderate Risk	<100	<130	>OR= 100	>OR= 130

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Low Risk	<100	<130	>OR= 130*	>OR= 160
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\*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 METHOD : JENDRASSIK AND GROFF	0.30	0.2 - 1.0	mg/dL
BILIRUBIN, DIRECT METHOD : DIAZOTIZATION	0.10	0.0 - 0.2	mg/dL
BILIRUBIN, INDIRECT METHOD : CALCULATED PARAMETER	0.20	0.1 - 1.0	mg/dL
TOTAL PROTEIN	7.9	6.4 - 8.2	g/dL
ALBUMIN	4.2	3.4 - 5.0	g/dL
GLOBULIN	3.7	2.0 - 4.1	g/dL
ALBUMIN/GLOBULIN RATIO	1.1	1.0 - 2.1	RATIO
ASPARTATE AMINOTRANSFERASE(AST/SGOT)	22	15 - 37	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)	26	< 34.0	U/L
ALKALINE PHOSPHATASE	78	30 - 120	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)	24	5 - 55	U/L
LACTATE DEHYDROGENASE	152	100 - 190	U/L

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

BLOOD UREA NITROGEN METHOD : UREASE - UV	8	6 - 20	mg/dL
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**CREATININE, SERUM**

CREATININE METHOD : ALKALINE PICRATE	0.73	0.60 - 1.10	mg/dL
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**BUN/CREAT RATIO**

BUN/CREAT RATIO	10.96	5.00 - 15.00
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**URIC ACID, SERUM**

URIC ACID METHOD : URICASE UV	4.8	2.6 - 6.0	mg/dL
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**TOTAL PROTEIN, SERUM**

TOTAL PROTEIN METHOD : BIURET	7.9	6.4 - 8.2	g/dL
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**ALBUMIN, SERUM**

ALBUMIN 4.2 3.4 - 5.0 g/dL  
METHOD : BROMOCRESOL PURPLE

**GLOBULIN**

GLOBULIN 3.7 2.0 - 4.1 g/dL

**ELECTROLYTES (NA/K/CL), SERUM**

SODIUM, SERUM 143 137 - 145 mmol/L  
METHOD : ION-SELECTIVE ELECTRODE

POTASSIUM, SERUM 4.0 3.6 - 5.0 mmol/L  
METHOD : ION-SELECTIVE ELECTRODE

CHLORIDE, SERUM 105 98 - 107 mmol/L  
METHOD : ION-SELECTIVE ELECTRODE

**Comments**

TEST IS OUT SOURCED TO MUMBAI SRL.

**Interpretation(s)**

Sodium	Potassium	Chloride
<b>Decreased in:</b> CCF, cirrhosis, vomiting, diarrhea, excessive sweating, salt-losing nephropathy, adrenal insufficiency, nephrotic syndrome, water intoxication, SIADH. Drugs: thiazides, diuretics, ACE inhibitors, chlorpropamide, carbamazepine, antidepressants (SSRI), antipsychotics.	<b>Decreased in:</b> 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.	<b>Decreased in:</b> 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, adrenal insufficiency, hyperaldosteronism, metabolic alkalosis. Drugs: chronic laxative, corticosteroids, diuretics.
<b>Increased in:</b> Dehydration (excessive sweating, severe vomiting or diarrhea), diabetes mellitus, diabetes insipidus, hyperaldosteronism, inadequate water intake. Drugs: steroids, licorice, oral contraceptives.	<b>Increased in:</b> 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.	<b>Increased in:</b> 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.

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<b>Interferences:</b> 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.	<b>Interferences:</b> 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.	<b>Interferences:</b> 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)
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**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 so that no glucose is excreted in the urine.

**Increased in:** Diabetes mellitus, Cushing's syndrome (10 – 15%), chronic pancreatitis (30%). Drugs: corticosteroids, phenytoin, estrogen, thiazides.

**Decreased in :** Pancreatic islet cell disease with increased insulin, insulinoma, adrenocortical insufficiency, hypopituitarism, diffuse liver disease, malignancy (adrenocortical, stomach, fibrosarcoma), infant of a diabetic mother, enzyme deficiency diseases (e.g. galactosemia), Drugs- insulin, ethanol, propranolol, sulfonylureas, tolbutamide, and other oral hypoglycemic agents.

**NOTE:** While random serum glucose levels correlate with home glucose monitoring results (weekly mean capillary glucose values), there is wide fluctuation within individuals. Thus, glycosylated hemoglobin (HbA1c) levels are favored to monitor glycemic control.

High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glycosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.

**GLUCOSE, POST-PRANDIAL, PLASMA-High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glycosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc. Additional test HbA1c LIVER FUNCTION PROFILE, SERUM-**

**Bilirubin** is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. Bilirubin is excreted in bile and urine, and elevated levels may give yellow discoloration in jaundice. **Elevated levels** results from increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Conjugated (direct) bilirubin is elevated more than unconjugated (indirect) bilirubin in Viral hepatitis, Drug reactions, Alcoholic liver disease. Conjugated (direct) bilirubin is also elevated more than unconjugated (indirect) bilirubin when there is some kind of blockage of the bile ducts like in Gallstones getting into the bile ducts, tumors & Scarring of the bile ducts. Increased unconjugated (indirect) bilirubin may be a result of Hemolytic or 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 (Maligancy, 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

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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 CHECKUP ABOVE 40FEMALE**

**PHYSICAL EXAMINATION, URINE**

**COLOR** Yellow  
METHOD : MANUAL

**APPEARANCE** CLEAR  
METHOD : MANUAL

**CHEMICAL EXAMINATION, URINE**

**PH** 6.0 4.7 - 7.5  
METHOD : REFLECTANCE SPECTROPHOTOMETRY

**SPECIFIC GRAVITY** 1.010 1.003 - 1.035  
METHOD : REFLECTANCE SPECTROPHOTOMETRY

**PROTEIN** NOT DETECTED NEGATIVE  
METHOD : REFLECTANCE SPECTROPHOTOMETRY

**GLUCOSE** NOT DETECTED NOT DETECTED  
METHOD : REFLECTANCE SPECTROPHOTOMETRY

**KETONES** NOT DETECTED NOT DETECTED  
METHOD : REFLECTANCE SPECTROPHOTOMETRY

**BLOOD** NOT DETECTED NOT DETECTED  
METHOD : REFLECTANCE SPECTROPHOTOMETRY

**BILIRUBIN** NOT DETECTED NOT DETECTED  
METHOD : REFLECTANCE SPECTROPHOTOMETRY

**UROBILINOGEN** NORMAL NORMAL  
METHOD : REFLECTANCE SPECTROPHOTOMETRY

**NITRITE** NOT DETECTED NOT DETECTED  
METHOD : REFLECTANCE SPECTROPHOTOMETRY

**LEUKOCYTE ESTERASE** NOT DETECTED NOT DETECTED

**MICROSCOPIC EXAMINATION, URINE**

**RED BLOOD CELLS** NOT DETECTED NOT DETECTED /HPF  
METHOD : MICROSCOPIC EXAMINATION

**PUS CELL (WBC'S)** 2-3 0-5 /HPF  
METHOD : MICROSCOPIC EXAMINATION

**EPITHELIAL CELLS** 3-5 0-5 /HPF  
METHOD : MICROSCOPIC EXAMINATION

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CASTS METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED			
CRYSTALS METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED			
BACTERIA METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED	NOT DETECTED		
YEAST	NOT DETECTED	NOT DETECTED		

**Interpretation(s)**

The following table describes the probable conditions, in which the analytes are present in urine

Presence of	Conditions
Proteins	Inflammation or immune illnesses
Pus (White Blood Cells)	Urinary tract infection, urinary tract or kidney stone, tumors or any kind of kidney impairment
Glucose	Diabetes or kidney disease
Ketones	Diabetic ketoacidosis (DKA), starvation or thirst
Urobilinogen	Liver disease such as hepatitis or cirrhosis
Blood	Renal or genital disorders/trauma
Bilirubin	Liver disease
Erythrocytes	Urological diseases (e.g. kidney and bladder cancer, urolithiasis), urinary tract infection and glomerular diseases
Leukocytes	Urinary tract infection, glomerulonephritis, interstitial nephritis either acute or chronic, polycystic kidney disease, urolithiasis, contamination by genital secretions
Epithelial cells	Urolithiasis, bladder carcinoma or hydronephrosis, ureteric stents or bladder catheters for prolonged periods of time
Granular Casts	Low intratubular pH, high urine osmolality and sodium concentration, interaction with Bence-Jones protein
Hyaline casts	Physical stress, fever, dehydration, acute congestive heart failure, renal diseases
Calcium oxalate	Metabolic stone disease, primary or secondary hyperoxaluria, intravenous infusion of large doses of vitamin C, the use of vasodilator naftidrofuryl oxalate or the gastrointestinal lipase inhibitor orlistat, ingestion of ethylene glycol or of star fruit (Averrhoa carambola) or its juice
Uric acid	arthritis

*U. Arunajyothi*

**Dr. Uram Aruna Jyothi**  
**Consultant Pathologist**



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 Flat No. 104-106, Animishai Pearl, Collectorate Junction  
 Visakhapatnam, 530002  
 Andhra Pradesh, India  
 Tel : 9111591115, Fax : CIN - U74899PB1995PLC045956  
 Email : customercare.vizag@agilus.in



**Patient Ref. No. 775000003653012**

PATIENT NAME : SWETA MUND

REF. DOCTOR : DR. ACROFEMI HEALTHCARE LTD  
( MEDIWHEEL )

CODE/NAME & ADDRESS : C000138398 ARCOFEMI HEALTHCARE LTD (MEDIWHEEL F-703, F-703, LADO SARAI, MEHRAULISOUTH WEST DELHI NEW DELHI 110030 8800465156	ACCESSION NO : <b>0194WF001977</b> PATIENT ID : SWETF200986194 CLIENT PATIENT ID: ABITA NO :	AGE/SEX : 36 Years Female DRAWN : RECEIVED : 23/06/2023 09:38:38 REPORTED : 24/06/2023 18:47:51
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Bacteria	Urinary infection when present in significant numbers & with pus cells.
Trichomonas vaginalis	Vaginitis, cervicitis or salpingitis



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**CLINICAL PATH - STOOL ANALYSIS**

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

**PHYSICAL EXAMINATION,STOOL**

COLOUR	SAMPLE NOT RECEIVED	
CONSISTENCY	SAMPLE NOT RECEIVED	
MUCUS	SAMPLE NOT RECEIVED	NOT DETECTED



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 F-703, F-703, LADO SARAI, MEHRAULISOUTH WEST  
 DELHI  
 NEW DELHI 110030  
 8800465156

**ACCESSION NO : 0194WF001977**  
**PATIENT ID : SWETF200986194**  
**CLIENT PATIENT ID:**  
**ADMIT NO :**

**AGE/SEX : 36 Years Female**  
**DRAWN :**  
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**SPECIALISED CHEMISTRY - HORMONE**

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

**THYROID PANEL, SERUM**

T3	169.60	Non-Pregnant Women 80.0 - 200.0 Pregnant Women 1st Trimester:105.0 - 230.0 2nd Trimester:129.0 - 262.0 3rd Trimester:135.0 - 262.0	ng/dL
T4	9.85	Non-Pregnant Women 5.10 - 14.10 Pregnant Women 1st Trimester: 7.33 - 14.80 2nd Trimester: 7.93 - 16.10 3rd Trimester: 6.95 - 15.70	µg/dL
TSH (ULTRASENSITIVE)	2.110	Non Pregnant Women 0.27 - 4.20 Pregnant Women 1st Trimester: 0.33 - 4.59 2nd Trimester: 0.35 - 4.10 3rd Trimester: 0.21 - 3.15	µIU/mL

**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

*U. Arunajyothi*

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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 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.

**\*\*End Of Report\*\***

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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.

#### Agilus Diagnostics Ltd

Fortis Hospital, Sector 62, Phase VIII,  
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