PATIENT NAME : AVISHEK PAUL	**REF. DOCTOR :** SELF	
CODE/NAME & ADDRESS : C000138363 ACROFEMI HEALTHCARE LTD (MEDIWHEEL) F-703, LADO SARAI, MEHRAULISOUTH WEST DELHI NEW DELHI 110030 8800465156	ACCESSION NO : **0031WC024744** PATIENT ID : AVISM27128531 CLIENT PATIENT ID: ABHA NO :	AGE/SEX : 37 Years Male DRAWN : 30/03/2023 08:50:00 RECEIVED : 30/03/2023 08:56:58 REPORTED : 31/03/2023 13:36:29

Test Report Status **Final**	Results	Biological Reference Interval	Units
MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE			
XRAY-CHEST			
IMPRESSION	NO ABNORMALITY DETECTED		
TMT OR ECHO			
TMT OR ECHO	Echo done- Normal		
ECG			
ECG	WITHIN NORMAL LIMITS		
MEDICAL HISTORY			
RELEVANT PRESENT HISTORY	NOT SIGNIFICANT		
RELEVANT PAST HISTORY	Malaria, Jaundice		
RELEVANT PERSONAL HISTORY	Smoker - 10/day		
RELEVANT FAMILY HISTORY	Mother -HTN, Diabetes		
OCCUPATIONAL HISTORY	NOT SIGNIFICANT		
HISTORY OF MEDICATIONS	NOT SIGNIFICANT		
ANTHROPOMETRIC DATA & BMI			
HEIGHT IN METERS	1.66		mts
WEIGHT IN KGS.	108		Kgs
BMI	39	BMI & Weight Status as follows: Below 18.5: Underweight 18.5 - 24.9: Normal 25.0 - 29.9: Overweight 30.0 and Above: Obese	kg/sqmts
GENERAL EXAMINATION			
MENTAL / EMOTIONAL STATE	NORMAL		
PHYSICAL ATTITUDE	NORMAL		
GENERAL APPEARANCE / NUTRITIONAL STATUS	OBESE		
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		

Debika Roy

Dr. Debika Roy
MBBS Consultant Physician

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CIN - U74899PB1995PLC045956
Email : customercare.saltlake@srl.in

Patient Ref. No. 31000004661698

PATIENT NAME : AVISHEK PAUL	**REF. DOCTOR :** SELF	
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THYROID GLAND	NOT ENLARGED		
CAROTID PULSATION	NORMAL		
TEMPERATURE	NORMAL		
PULSE	78/min-REGULAR, ALL PERIPHERAL PULSES WELL FELT		
RESPIRATORY RATE	NORMAL		
CARDIOVASCULAR SYSTEM			
BP	120/80 mm Hg		mm/Hg
PERICARDIUM	NORMAL		
APEX BEAT	NORMAL		
HEART SOUNDS	S1, S2 HEARD NORMALLY		
MURMURS	ABSENT		
RESPIRATORY SYSTEM			
SIZE AND SHAPE OF CHEST	NORMAL		
MOVEMENTS OF CHEST	SYMMETRICAL		
BREATH SOUNDS INTENSITY	NORMAL		
BREATH SOUNDS QUALITY	VESICULAR (NORMAL)		
ADDED SOUNDS	ABSENT		
PER ABDOMEN			
APPEARANCE	NORMAL		
VENOUS PROMINENCE	ABSENT		
LIVER	NOT PALPABLE		
SPLEEN	NOT PALPABLE		
HERNIA	ABSENT		
CENTRAL NERVOUS SYSTEM			
HIGHER FUNCTIONS	NORMAL		
CRANIAL NERVES	NORMAL		
CEREBELLAR FUNCTIONS	NORMAL		
SENSORY SYSTEM	NORMAL		
MOTOR SYSTEM	NORMAL		
REFLEXES	NORMAL		
MUSCULOSKELETAL SYSTEM			
SPINE	NORMAL		

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JOINTS	NORMAL		
BASIC EYE EXAMINATION			
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			
RELEVANT HISTORY	NOT SIGNIFICANT		
RELEVANT GP EXAMINATION FINDINGS	Obese (108 kg)		
RELEVANT LAB INVESTIGATIONS	Raised FBS(140),PPBS(237),HbA1C(7.8),TGL(165), SGPT(219),SGOT(89),GGT(61),LDH(241), Low sodium(128),Low chloride(95)		
RELEVANT NON PATHOLOGY DIAGNOSTICS	Mild hepatomegaly with grade II Fatty change in USG.		

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REMARKS / RECOMMENDATIONS

On examination and investigations the candidate is found to be obese, diabetic and has raised FBS(140),PPBS(237),HbA1C(7.8),TGL (165),
SGPT(219),SGOT(89),GGT(61),LDH(241),Low sodium(128)and chloride (95)
Mild hepatomegaly with grade II Fatty change in USG

Should follow the given advice:
1. Avoid fat and oily diet
2. Diabetic diet
3. Estimated body weight should be : 66 kg
4. Regular physical exercise and walking
5. Drink sips of electral water
6. Dietician consultation
7. Stop smoking
8. Follow up with Diabetologist

Comments

MEDICAL EXAMINATION DONE BY:

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

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MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

ULTRASOUND ABDOMEN

ULTRASOUND ABDOMEN

Mild hepatomegaly with grade I fatty change

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

****

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MC-2396

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

HAEMATOLOGY - CBC

MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

BLOOD COUNTS,EDTA WHOLE BLOOD			
HEMOGLOBIN (HB) METHOD : SPECTROPHOTOMETRY	15.8	13.0 - 17.0	g/dL
RED BLOOD CELL (RBC) COUNT METHOD : ELECTRICAL IMPEDANCE	5.10	4.5 - 5.5	mil/µL
WHITE BLOOD CELL (WBC) COUNT METHOD : ELECTRICAL IMPEDANCE	9.59	4.0 - 10.0	thou/µL
PLATELET COUNT METHOD : ELECTRONIC IMPEDENCE & MICROSCOPY	155	150 - 410	thou/µL
RBC AND PLATELET INDICES			
HEMATOCRIT (PCV) METHOD : CALCULATED	46.2	40 - 50	%
MEAN CORPUSCULAR VOLUME (MCV) METHOD : ELECTRICAL IMPEDANCE	90.6	83 - 101	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH) METHOD : CALCULATED	31.1	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC) METHOD : CALCULATED	34.3	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW) METHOD : ELECTRICAL IMPEDANCE	**14.1 High**	11.6 - 14.0	%
MENTZER INDEX	17.8		
MEAN PLATELET VOLUME (MPV) METHOD : CALCULATED	**11.3 High**	6.8 - 10.9	fL
WBC DIFFERENTIAL COUNT			
NEUTROPHILS METHOD : FLOWCYTOMETRY, ELECTRONIC IMPEDANCE & MICROSCOPY.	41	40 - 80	%
LYMPHOCYTES METHOD : FLOWCYTOMETRY, ELECTRONIC IMPEDANCE & MICROSCOPY.	**44 High**	20 - 40	%
MONOCYTES METHOD : FLOWCYTOMETRY, ELECTRONIC IMPEDANCE & MICROSCOPY.	7	2 - 10	%
EOSINOPHILS	**8 High**	1 - 6	%
BASOPHILS	0	0 - 2	%

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METHOD : FLOWCYTOMETRY, ELECTRONIC IMPEDANCE & MICROSCOPY.			
ABSOLUTE NEUTROPHIL COUNT	3.93	2.0 - 7.0	thou/µL
METHOD : FLOWCYTOMETRY & CALCULATED			
ABSOLUTE LYMPHOCYTE COUNT	**4.22 High**	1 - 3	thou/µL
METHOD : FLOWCYTOMETRY & CALCULATED			
ABSOLUTE MONOCYTE COUNT	0.67	0.20 - 1.00	thou/µL
METHOD : FLOWCYTOMETRY & CALCULATED			
ABSOLUTE EOSINOPHIL COUNT	**0.77 High**	0.02 - 0.50	thou/µL
METHOD : FLOWCYTOMETRY & CALCULATED			
ABSOLUTE BASOPHIL COUNT	**0 Low**	0.02 - 0.10	thou/µL
METHOD : FLOWCYTOMETRY & CALCULATED			
MORPHOLOGY			
RBC	NORMOCYTIC NORMOCHROMIC		
METHOD : MICROSCOPIC EXAMINATION			
WBC	NORMAL MORPHOLOGY		
METHOD : MICROSCOPIC EXAMINATION			
PLATELETS	ADEQUATE & NORMAL		
METHOD : MICROSCOPIC EXAMINATION			

Interpretation(s)
BLOOD COUNTS,EDTA WHOLE BLOOD-The cell morphology is well preserved for 24hrs. However after 24-48 hrs a progressive increase in MCV and HCT is observed leading to a decrease in MCHC. A direct smear is recommended for an accurate differential count and for examination of RBC morphology.
RBC AND PLATELET INDICES-Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia(>13) from Beta thalassaemia trait
(<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.
WBC DIFFERENTIAL COUNT-The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR < 3.3, COVID-19 patients tend to show mild disease.
(Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients ; A.-P. Yang, et al.; International Immunopharmacology 84 (2020) 106504
This ratio element is a calculated parameter and out of NABL scope.

AChatterjee

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MC-2396

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HAEMATOLOGY

MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD			
E.S.R	5	0 - 14	mm at 1 hr

METHOD : AUTOMATED (PHOTOMETRICAL CAPILLARY STOPPED FLOW KINETIC ANALYSIS)"

Interpretation(s)
ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD-**TEST DESCRIPTION** :-
Erythrocyte sedimentation rate (ESR) is a test that indirectly measures the degree of inflammation present in the body. The test actually measures the rate of fall (sedimentation) of erythrocytes in a sample of blood that has been placed into a tall, thin, vertical tube. Results are reported as the millimetres of clear fluid (plasma) that are present at the top portion of the tube after one hour. Nowadays fully automated instruments are available to measure ESR.

ESR is not diagnostic; it is a non-specific test that may be elevated in a number of different conditions. It provides general information about the presence of an inflammatory condition.CRP is superior to ESR because it is more sensitive and reflects a more rapid change.
TEST INTERPRETATION
Increase in: Infections, Vasculities, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Tissue injury, Pregnancy, Estrogen medication, Aging.
Finding a very accelerated ESR**(>100 mm/hour)** in patients with ill-defined symptoms directs the physician to search for a systemic disease (Paraproteinemias, Disseminated malignancies, connective tissue disease, severe infections such as bacterial endocarditis).
In pregnancy BRI in first trimester is 0-48 mm/hr(62 if anemic) and in second trimester (0-70 mm /hr(95 if anemic). ESR returns to normal 4th week post partum.
Decreased in: Polycythermia vera, Sickle cell anemia

LIMITATIONS
False elevated ESR : Increased fibrinogen, Drugs(Vitamin A, Dextran etc), Hypercholesterolemia
False Decreased : Poikilocytosis,(SickleCells,spherocytes),Microcytosis, Low fibrinogen, Very high WBC counts, Drugs(Quinine, salicylates)

REFERENCE :
1. Nathan and Oski's Haematology of Infancy and Childhood, 5th edition;2. Paediatric reference intervals. AACC Press, 7th edition. Edited by S. Soldin;3. The reference for the adult reference range is "Practical Haematology by Dacie and Lewis,10th edition.

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MC-2396

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IMMUNOHAEMATOLOGY

MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

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

Interpretation(s)
ABO GROUP & RH TYPE, EDTA WHOLE BLOOD-
Blood group is identified by antigens and antibodies present in the blood. Antigens are protein molecules found on the surface of red blood cells. Antibodies are found in plasma. To determine blood group, red cells are mixed with different antibody solutions to give A,B,O or AB.

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

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

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

BIOCHEMISTRY

MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

GLUCOSE FASTING,FLUORIDE PLASMA

FBS (FASTING BLOOD SUGAR)	**140 High**	74 - 100	mg/dL
METHOD : ENZYMATIC (HEXOKINASE/G-6-PDH)			

GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

HBA1C	**7.8 High**	Non-diabetic Adult < 5.7 Pre-diabetes 5.7 - 6.4 Diabetes diagnosis: > or = 6.5 Therapeutic goals: < 7.0 Action suggested : > 8.0 (ADA Guideline 2021)	%
METHOD : HPLC			
ESTIMATED AVERAGE GLUCOSE(EAG)	**177.2 High**	< 116.0	mg/dL

Dr. Chaitali Ray, PhD
Chief Biochemist cum MRQA

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SRL LIMITED - KOLKATA REF. LAB
Bio-Rad Variant II Turbo CDM 5.4 S/N : 16043

PATIENT REP
V2TURBO_A1c

Patient Data

Sample ID: 3106849410
Patient ID:
Name:
Physician:
Sex:
DOB:

Comments:

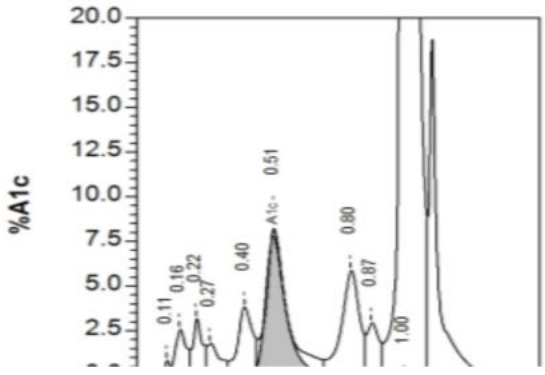
Analysis Data

Analysis Performed: 30/MAR/2023 12:38:10
Injection Number: 9799
Run Number: 455
Rack ID: 0007
Tube Number: 4
Report Generated: 30/MAR/2023 14:56:32
Operator ID:

Peak Name	NGSP %	Area %	Retention Time (min)	Peak Area
Unknown	---	0.1	0.111	2656
A1a	---	1.2	0.159	21686
A1b	---	1.3	0.220	23348
F	---	0.9	0.273	16934
LA1c	---	2.3	0.401	42364
A1c	7.8*	---	0.508	120583
P3	---	4.3	0.795	79618
P4	---	1.4	0.873	26142
Ao	---	82.0	0.997	1516672

*Values outside of expected ranges Total Area: 1,850,003

HbA1c (NGSP) = 7.8* %



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MC-2396

PATIENT NAME : AVISHEK PAUL		**REF. DOCTOR :** SELF
CODE/NAME & ADDRESS : C000138363 ACROFEMI HEALTHCARE LTD (MEDIWHEEL) F-703, LADO SARAI, MEHRAULISOUTH WEST DELHI NEW DELHI 110030 8800465156	ACCESSION NO : **0031WC024744** PATIENT ID : AVISM27128531 CLIENT PATIENT ID: ABHA NO :	AGE/SEX :37 Years Male DRAWN :30/03/2023 08:50:00 RECEIVED :30/03/2023 08:56:58 REPORTED :31/03/2023 13:36:29

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

Comments

FOR HbA1C
NOTE: INCREASED LEVELS OF GLYCOSYLATED HEMOGLOBIN MAY NEED CLINICAL CORRELATION . HIGH GLYCOSYLATED HEMOGLOBIN LEVELS MAY BE OBSERVED IN CONDITIONS SUCH AS UNCONTROLLED DIABETES, POOR COMPLIANCE WITH ANTIDIABETIC THERAPY, CHRONIC RENAL FAILURE, HYPERTRIGLYCERIDEMIA, IRON DEFICIENCY ANAEMIA, SALICYLATE THERAPY, HAEMOGLOBINOPATHIES LIKE THALASSAEMIA MAY ALSO SHOW HIGH GLYCOSYLATED HEMOGLOBIN LEVELS.

GLUCOSE, POST-PRANDIAL, PLASMA

PPBS(POST PRANDIAL BLOOD SUGAR)	**237 High**	140 Normal 140 - 199 Pre-diabetic > or = 200 Diabetic	mg/dL
METHOD : ENZYMATIC (HEXOKINASE/G-6-PDH)			

LIPID PROFILE, SERUM

CHOLESTEROL, TOTAL	172	< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
METHOD : ENZYMATIC ASSAY			
TRIGLYCERIDES	**165 High**	< 150 Normal 150 - 199 Borderline High 200 - 499 High >/=500 Very High	mg/dL
METHOD : GLYCEROL PHOSPHATE OXIDASE			
HDL CHOLESTEROL	42	Low : < 40 High : > / = 60	mg/dL
METHOD : ACCELERATOR SELECTIVE DETERGENT METHODOLOGY			
CHOLESTEROL LDL	97		mg/dL
NON HDL CHOLESTEROL	130	Desirable: Less than 130 Above Desirable: 130-159 Borderline High: 160-189 High: 190 -219 Very High: >or = 220	mg/dL
METHOD : CALCULATED			
VERY LOW DENSITY LIPOPROTEIN	33.0		mg/dL
CHOL/HDL RATIO	4.1		
LDL/HDL RATIO	2.3		

Interpretation(s)

Dr. Chaitali Ray, PhD
Chief Biochemist cum MRQA

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LIVER FUNCTION PROFILE, SERUM			
BILIRUBIN, TOTAL METHOD : DIAZONIUM SALT	0.72	0.2 - 1.2	mg/dL
BILIRUBIN, DIRECT METHOD : DIAZO REACTION	0.25	0.0 - 0.5	mg/dL
BILIRUBIN, INDIRECT METHOD : CALCULATED	0.47	0.1 - 1.0	mg/dL
TOTAL PROTEIN METHOD : BIURET	7.5	6.0 - 8.30	g/dL
ALBUMIN METHOD : COLORIMETRIC (BROMCRESOL GREEN)	4.5	3.5 - 5.2	g/dL
GLOBULIN	3.0	2.0 - 3.5	g/dL
ALBUMIN/GLOBULIN RATIO METHOD : CALCULATED PARAMETER	1.5	1 - 2.1	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT) METHOD : ENZYMATIC (NADH (WITHOUT P-5'-P)	**89 High**	5 - 34	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT) METHOD : ENZYMATIC (NADH (WITHOUT P-5'-P)	**219 High**	0 - 55	U/L
ALKALINE PHOSPHATASE METHOD : PARA-NITROPHENYL PHOSPHATE	87	40 - 150	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT) METHOD : L-GAMMA-GLUTAMYL-4-NITROANALIDE /GLYCYLGLYCINE KINETIC METHOD	**61 High**	11 - 59	U/L
LACTATE DEHYDROGENASE METHOD : IFCC LACTATE TO PYRUVATE	**241 High**	125 - 220	U/L
BLOOD UREA NITROGEN (BUN), SERUM			
BLOOD UREA NITROGEN METHOD : UREASE METHOD	**8 Low**	8.9 - 20.6	mg/dL
CREATININE, SERUM			
CREATININE METHOD : KINETIC ALKALINE PICRATE	0.89	0.60 - 1.2	mg/dL
BUN/CREAT RATIO			
BUN/CREAT RATIO	8.99	5.0 - 15.0	

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URIC ACID, SERUM			
URIC ACID METHOD : URICASE	5.6	3.5 - 7.2	mg/dL
TOTAL PROTEIN, SERUM			
TOTAL PROTEIN METHOD : BIURET	7.5	6.0 - 8.3	g/dL
ALBUMIN, SERUM			
ALBUMIN METHOD : COLORIMETRIC (BROMCRESOL GREEN)	4.5	3.5 - 5.2	g/dL
GLOBULIN			
GLOBULIN METHOD : CALCULATED PARAMETER	3.0	2.0 - 3.5	g/dL
ELECTROLYTES (NA/K/CL), SERUM			
SODIUM, SERUM METHOD : ION SELECTIVE ELECTRODE TECHNOLOGY INDIRECT	**128 Low**	136 - 145	mmol/L
POTASSIUM, SERUM METHOD : ION SELECTIVE ELECTRODE TECHNOLOGY INDIRECT	4.00	3.5 - 5.1	mmol/L
CHLORIDE, SERUM METHOD : ION SELECTIVE ELECTRODE TECHNOLOGY INDIRECT	**95 Low**	98 - 107	mmol/L

Interpretation(s)

Interpretation(s)
GLUCOSE FASTING,FLUORIDE PLASMA-**TEST DESCRIPTION**
Normally, the glucose concentration in extracellular fluid is closely regulated so that a source of energy is readily available to tissues and sothat no glucose is excreted in the urine.
Increased in:Diabetes mellitus, Cushing' s syndrome (10 – 15%), chronic pancreatitis (30%). Drugs:corticosteroids,phenytoin, estrogen, thiazides.
Decreased in :Pancreatic islet cell disease with increased insulin,insulinoma,adrenocortical insufficiency,hypopituitarism,diffuse liver disease, malignancy(adrenocortical,stomach,fibrosarcoma),infant of a diabetic mother,enzyme deficiency diseases(e.g.galactosemia),Drugs-insulin,ethanol,propranolol;sulfonylureas,tolbutamide,and other oral hypoglycemic agents.
NOTE: While random serum glucose levels correlate with home glucose monitoring results (weekly mean capillary glucose values),there is wide fluctuation within individuals.Thus, glycosylated hemoglobin(HbA1c) levels are favored to monitor glycemic control.
High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment,Renal Glyosuria,Glycaemic index & response to food consumed,Alimentary Hypoglycemia,Increased insulin response & sensitivity etc.

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GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD-**Used For**:

1. Evaluating the long-term control of blood glucose concentrations in diabetic patients.
2. Diagnosing diabetes.
3. Identifying patients at increased risk for diabetes (prediabetes).

The ADA recommends measurement of HbA1c (typically 3-4 times per year for type 1 and poorly controlled type 2 diabetic patients, and 2 times per year for well-controlled type 2 diabetic patients) to determine whether a patients metabolic control has remained continuously within the target range.

1. eAG (Estimated average glucose) converts percentage HbA1c to md/dl, to compare blood glucose levels.
2. eAG gives an evaluation of blood glucose levels for the last couple of months.
3. eAG is calculated as eAG (mg/dl) = 28.7 * HbA1c - 46.7

HbA1c Estimation can get affected due to :

1. Shortened Erythrocyte survival : Any condition that shortens erythrocyte survival or decreases mean erythrocyte age (e.g. recovery from acute blood loss,hemolytic anemia) will falsely lower HbA1c test results.Fructosamine is recommended in these patients which indicates diabetes control over 15 days.
2.Vitamin C & E are reported to falsely lower test results.(possibly by inhibiting glycation of hemoglobin.
3. Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia,uremia, hyperbilirubinemia, chronic alcoholism,chronic ingestion of salicylates & opiates addiction are reported to interfere with some assay methods,falsely increasing results.
4. Interference of hemoglobinopathies in HbA1c estimation is seen in

a) Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.
b) Heterozygous state detected (D10 is corrected for HbS & HbC trait.)
c) HbF > 25% on alternate paltform (Boronate affinity chromatography) is recommended for testing of HbA1c.Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy

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

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 is found mainly in the liver, but also in smaller amounts in the kidneys,heart,muscles, and pancreas.It is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health.AST levels increase during acute hepatitis,sometimes due to a viral infection,ischemia to the liver,chronic hepatitis,obstruction of bile ducts,cirrhosis.

ALP is a protein found in almost all body tissues.Tissues with higher amounts of ALP include the liver,bile ducts and bone.Elevated ALP levels are seen in Biliary obstruction, Osteoblastic bone tumors, osteomalacia, hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, Pagets disease,Rickets,Sarcoidosis etc. Lower-than-normal ALP levels seen in Hypophosphatasia,Malnutrition,Protein deficiency,Wilsons disease.

GGT is an enzyme found in cell membranes of many tissues mainly in the liver,kidney and pancreas.It is also found in other tissues including intestine,spleen,heart, brain and seminal vesicles.The highest concentration is in the kidney,but the liver is considered the source of normal enzyme activity.Serum GGT has been widely used as an index of liver dysfunction.Elevated serum GGT activity can be found in diseases of the liver,biliary system and pancreas.Conditions that increase serum GGT are obstructive liver disease,high alcohol consumption and use of enzyme-inducing drugs etc.

Total Protein also known as total protein,is a biochemical test for measuring the total amount of protein in serum.Protein in the plasma is made up of albumin and globulin.Higher-than-normal levels may be due to:Chronic inflammation or infection,including HIV and hepatitis B or C,Multiple myeloma,Waldenstroms disease.Lower-than-normal levels may be due to: Agammaglobulinemia,Bleeding (hemorrhage),Burns,Glomerulonephritis,Liver disease, Malabsorption,Malnutrition,Nephrotic syndrome,Protein-losing enteropathy etc.

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

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

Causes of decreased level include Liver disease, SIADH.

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

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

Lower than normal level may be due to:

• Myasthenia Gravis, Muscuophy

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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.

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CLINICAL PATH - URINALYSIS

MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

PHYSICAL EXAMINATION, URINE			
COLOR	PALE YELLOW		
APPEARANCE	CLEAR		
CHEMICAL EXAMINATION, URINE			
PH	6.0	4.7 - 7.5	
SPECIFIC GRAVITY METHOD : DIPSTICK	1.005	1.003 - 1.035	
PROTEIN METHOD : DIPSTICK	NOT DETECTED	NOT DETECTED	
GLUCOSE METHOD : DIPSTICK	NOT DETECTED	NOT DETECTED	
KETONES METHOD : DIPSTICK	NOT DETECTED	NOT DETECTED	
BLOOD METHOD : DIPSTICK	NOT DETECTED	NOT DETECTED	
BILIRUBIN METHOD : DIPSTICK	NOT DETECTED	NOT DETECTED	
UROBILINOGEN METHOD : DIPSTICK	NORMAL	NORMAL	
NITRITE METHOD : DIPSTICK	NOT DETECTED	NOT DETECTED	
LEUKOCYTE ESTERASE	NEGATIVE	NOT DETECTED	
MICROSCOPIC EXAMINATION, URINE			
RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
PUS CELL (WBC'S)	2-3	0-5	/HPF
EPITHELIAL CELLS	1-2	0-5	/HPF
CASTS	NOT DETECTED		
CRYSTALS	NOT DETECTED		
BACTERIA	NOT DETECTED	NOT DETECTED	
YEAST	NOT DETECTED	NOT DETECTED	

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

Interpretation(s)

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SPECIALISED CHEMISTRY - HORMONE

MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

THYROID PANEL, SERUM

T3	98.7	35 - 193	ng/dL
METHOD : TWO-STEP CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY			
T4	6.08	4.87 - 11.71	µg/dL
METHOD : TWO-STEP CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY			
TSH (ULTRASENSITIVE)	4.786	0.350 - 4.940	µIU/mL
METHOD : TWO-STEP CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY			

Interpretation(s)

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