

PATIENT NAME : NITIN DHYANI

REF. DOCTOR : SELF

CODE/NAME & ADDRESS : C000138379

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

ACCESSION NO : 0065WC002144

PATIENT ID : NITIM0806705047

CLIENT PATIENT ID:

ABHA NO :

AGE/SEX : 52 Years Male

DRAWN :

RECEIVED : 20/03/2023 08:38:05

REPORTED : 21/03/2023 15:43:27

Test Report Status	Final	Results	Biological Reference Interval	Units
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HAEMATOLOGY - CBC

MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE

BLOOD COUNTS, EDTA WHOLE BLOOD

HEMOGLOBIN (HB)	14.0	13.0 - 17.0	g/dL
METHOD : PHOTOMETRIC MEASUREMENT			
RED BLOOD CELL (RBC) COUNT	4.70	4.5 - 5.5	mil/ μ L
METHOD : COULTER PRINCIPLE			
WHITE BLOOD CELL (WBC) COUNT	6.70	4.0 - 10.0	thou/ μ L
METHOD : COULTER PRINCIPLE			
PLATELET COUNT	279	150 - 410	thou/ μ L
METHOD : ELECTRONIC IMPEDENCE & MICROSCOPY			

RBC AND PLATELET INDICES

HEMATOCRIT (PCV)	42.2	40.0 - 50.0	%
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR VOLUME (MCV)	89.7	83.0 - 101.0	fL
METHOD : DERIVED PARAMETER FROM RBC HISTOGRAM			
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	29.7	27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)	33.1	31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER			
RED CELL DISTRIBUTION WIDTH (RDW)	14.1 High	11.6 - 14.0	%
METHOD : DERIVED PARAMETER FROM RBC HISTOGRAM			
MENTZER INDEX	19.1		
MEAN PLATELET VOLUME (MPV)	9.1	6.8 - 10.9	fL
METHOD : DERIVED PARAMETER FROM PLATELET HISTOGRAM			

WBC DIFFERENTIAL COUNT

NEUTROPHILS	44	40 - 80	%
METHOD : VCSN TECHNOLOGY/ MICROSCOPY			
LYMPHOCYTES	40	20 - 40	%
METHOD : VCSN TECHNOLOGY/ MICROSCOPY			
MONOCYTES	10	2.0 - 10.0	%
METHOD : VCSN TECHNOLOGY/ MICROSCOPY			
EOSINOPHILS	5	1.0 - 6.0	%
METHOD : VCSN TECHNOLOGY/ MICROSCOPY			



Dr. Reena Mittal, MD
Senior Consultant
Hematopathologist



Dr. Sushant Chikane
Consultant Pathologist



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BASOPHILS		1	0 - 1	%
METHOD : VCSN TECHNOLOGY/ MICROSCOPY				
ABSOLUTE NEUTROPHIL COUNT		2.95	2.0 - 7.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE LYMPHOCYTE COUNT		2.70	1.0 - 3.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE MONOCYTE COUNT		0.67	0.2 - 1.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE EOSINOPHIL COUNT		0.34	0.02 - 0.50	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE BASOPHIL COUNT		0.07	0.02 - 0.10	thou/ μ L
METHOD : CALCULATED PARAMETER				
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		1.2		
METHOD : CALCULATED				

Interpretation(s)

BLOOD COUNTS, EDTA WHOLE BLOOD-The cell morphology is well preserved for 24hrs. However after 24-48 hrs a progressive increase in MCV and HCT is observed leading to a decrease in MCHC. A direct smear is recommended for an accurate differential count and for examination of RBC morphology.

RBC AND PLATELET INDICES-Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia (>13) from Beta thalassaemia trait

(<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.

WBC DIFFERENTIAL COUNT-The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR < 3.3, COVID-19 patients tend to show mild disease.

(Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients ; A.-P. Yang, et al.; International Immunopharmacology 84 (2020) 106504 This ratio element is a calculated parameter and out of NABL scope.



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HAEMATOLOGY

MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE

ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD

E.S.R **18 High** 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, 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

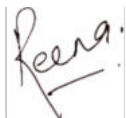
LIMITATIONS

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.



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IMMUNOHAEMATOLOGY

MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP

O

METHOD : HAEMAGGLUTINATION (AUTOMATED)

RH TYPE

POSITIVE

METHOD : HAEMAGGLUTINATION (AUTOMATED)

Interpretation(s)

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD-

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

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

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



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BIOCHEMISTRY

MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE

GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

HBA1C	5.7	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)
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METHOD : ION- EXCHANGE HPLC

ESTIMATED AVERAGE GLUCOSE(EAG)	116.9 High	< 116 mg/dL
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GLUCOSE FASTING,FLUORIDE PLASMA

FBS (FASTING BLOOD SUGAR)	92	Normal <100 mg/dL Impaired fasting glucose:100 to 125 Diabetes mellitus: > = 126 (on more than 1 occassion) (ADA guidelines 2021)
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METHOD : SPECTROPHOTOMETRY HEXOKINASE

GLUCOSE, POST-PRANDIAL, PLASMA

PPBS(POST PRANDIAL BLOOD SUGAR)	89	Normal <140 mg/dL Impaired glucose tolerance:140 to 199 Diabetes mellitus : > = 200 (on more than 1 occassion) ADA guideline 2021
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METHOD : SPECTROPHOTOMETRY HEXOKINASE

LIPID PROFILE, SERUM

CHOLESTEROL, TOTAL	218 High	Desirable : < 200 mg/dL Borderline : 200 - 239 High : > / = 240
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METHOD : SPECTROPHOTOMETRY, ENZYMATIC COLORIMETRIC - CHOLETSEROL OXIDASE, ESTERASE, PEROXIDASE

TRIGLYCERIDES	111	Normal: < 150 mg/dL Borderline high: 150 - 199 High: 200 - 499 Very High: >/= 500
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METHOD : SPECTROPHOTOMETRY, ENZYMATIC ENDPOINT WITH GLYCEROL BLANK

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HDL CHOLESTEROL **35 Low** At Risk: < 40 mg/dL
Desirable: > or = 60

METHOD : SPECTROPHOTOMETRY, HOMOGENEOUS DIRECT ENZYMATIC COLORIMETRIC

CHOLESTEROL LDL **161 High** Optimal : < 100 mg/dL
Near optimal/above optimal : 100-129
Borderline high : 130-159
High : 160-189
Very high : = 190

METHOD : CALCULATED PARAMETER

NON HDL CHOLESTEROL **183 High** Desirable : < 130 mg/dL
Above Desirable : 130 -159
Borderline High : 160 - 189
High : 190 - 219
Very high : > / = 220

METHOD : CALCULATED PARAMETER

VERY LOW DENSITY LIPOPROTEIN 22.0 < or = 30.0 mg/dL

METHOD : CALCULATED PARAMETER

CHOL/HDL RATIO **6.2 High** Low Risk : 3.3 - 4.4
Average Risk : 4.5 - 7.0
Moderate Risk : 7.1 - 11.0
High Risk : > 11.0

METHOD : CALCULATED PARAMETER

LDL/HDL RATIO **4.3 High** Desirable/Low Risk : 0.5 - 3.0
Borderline/Moderate Risk : 3.1 - 6.0
High Risk : > 6.0

METHOD : CALCULATED PARAMETER

Interpretation(s)

LIVER FUNCTION PROFILE, SERUM

BILIRUBIN, TOTAL 0.35 Upto 1.2 mg/dL
METHOD : SPECTROPHOTOMETRY, COLORIMETRIC -DIAZO METHOD

BILIRUBIN, DIRECT <0.09 < or = 0.3 mg/dL
METHOD : SPECTROPHOTOMETRY, JENDRASSIK & GROFF - DIAZOTIZATION

BILIRUBIN, INDIRECT NOT CALCULATED 0.0 - 0.9 mg/dL
METHOD : CALCULATED PARAMETER

TOTAL PROTEIN 7.1 6.0 - 8.0 g/dL

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METHOD : SPECTROPHOTOMETRY, COLORIMETRIC -BIURET, REAGENT BLANK, SERUM BLANK

ALBUMIN	4.4	3.97 - 4.94	g/dL
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METHOD : SPECTROPHOTOMETRY, BROMOCRESOL GREEN(BCG) - DYE BINDING

GLOBULIN	2.7	2.0 - 3.5	g/dL
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METHOD : CALCULATED PARAMETER

ALBUMIN/GLOBULIN RATIO	1.6	1.0 - 2.1	RATIO
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METHOD : CALCULATED PARAMETER

ASPARTATE AMINOTRANSFERASE (AST/SGOT)	23	Upto 40	U/L
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METHOD : SPECTROPHOTOMETRY, WITHOUT PYRIDOXAL PHOSPHATE ACTIVATION(P5P) - IFCC

ALANINE AMINOTRANSFERASE (ALT/SGPT)	32	Upto 41	U/L
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METHOD : SPECTROPHOTOMETRY, WITHOUT PYRIDOXAL PHOSPHATE ACTIVATION(P5P) - IFCC

ALKALINE PHOSPHATASE	64	40 - 129	U/L
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METHOD : SPECTROPHOTOMETRY, PNPP, AMP BUFFER - IFCC

GAMMA GLUTAMYL TRANSFERASE (GGT)	29	< 60	U/L
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METHOD : SPECTROPHOTOMETRY, ENZYMATIC COLORIMETRIC - G-GLUTAMYL-CARBOXY-NITROANILIDE - IFCC

LACTATE DEHYDROGENASE	207	< 232	U/L
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METHOD : SPECTROPHOTOMETRY, LACTATE TO PYRUVATE - UV-IFCC

Comments

NOTE : RECHECKED FOR SERUM DIRECT BILIRUBIN. SERUM DIRECT BILIRUBIN IS REPORTED AS 'LESS THAN 0.09 mg/dL', SINCE LOWER DETECTION RANGE FOR DIRECT BILIRUBIN IS 0.09 mg/dL. HENCE SERUM INDIRECT BILIRUBIN REPORT AS NOT CALCULATED.

BLOOD UREA NITROGEN (BUN), SERUM

BLOOD UREA NITROGEN	11	6 - 20	mg/dL
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METHOD : SPECTROPHOTOMETRY, UREASE -COLORIMETRIC

CREATININE, SERUM

CREATININE	0.93	0.90 - 1.30	mg/dL
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METHOD : SPECTROPHOTOMETRY, JAFFE'S ALKALINE PICRATE KINETIC - RATE BLANKED - IFCC-IDMS STANDARDIZED

BUN/CREAT RATIO

BUN/CREAT RATIO	11.50	8 - 15	
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METHOD : CALCULATED PARAMETER

URIC ACID, SERUM

URIC ACID	7.0	3.4 - 7.0	mg/dL
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METHOD : SPECTROPHOTOMETRY, ENZYMATIC COLORIMETRIC- URICASE

TOTAL PROTEIN, SERUM

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METHOD : SPECTROPHOTOMETRY, COLORIMETRIC -BIURET, REAGENT BLANK, SERUM BLANK

ALBUMIN, SERUM

ALBUMIN 4.4 3.97 - 4.94 g/dL
METHOD : SPECTROPHOTOMETRY, BROMOCRESOL GREEN(BCG) - DYE BINDING

GLOBULIN

GLOBULIN 2.7 2.0 - 3.5 g/dL
METHOD : CALCULATED PARAMETER

ELECTROLYTES (NA/K/CL), SERUM

SODIUM, SERUM 141 136 - 145 mmol/L
METHOD : ISE INDIRECT

POTASSIUM, SERUM 4.70 3.5 - 5.1 mmol/L
METHOD : ISE INDIRECT

CHLORIDE, SERUM 104 98 - 106 mmol/L
METHOD : ISE INDIRECT

Interpretation(s)

Sodium	Potassium	Chloride
Decreased in: CCF,cirrhosis, vomiting, diarrhea, excessive sweating, salt-losing nephropathy,adrenal insufficiency, nephrotic syndrome, water intoxication, SIADH. Drugs: thiazides, diuretics, ACE inhibitors, chlorpropamide,carbamazepine,anti depressants (SSRI), antipsychotics.	Decreased in: 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.	Decreased in: 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, adrenalinsufficiency, hyperaldosteronism,metabolic alkalosis. Drugs: chronic laxative,corticosteroids, diuretics.
Increased in: Dehydration (excessivesweating, severe vomiting or diarrhea),diabetes mellitus, diabetesinsipidus, hyperaldosteronism, inadequate water intake. Drugs: steroids, licorice,oral contraceptives.	Increased in: 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.	Increased in: 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.
Interferences: 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.	Interferences: 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.	Interferences: 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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ABHA NO :

AGE/SEX : 52 Years Male

DRAWN :

RECEIVED : 20/03/2023 08:38:05

REPORTED : 21/03/2023 15:43:27

Test Report Status	Final	Results	Biological Reference Interval	Units
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Interpretation(s)

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 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

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 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-

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.

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(Reg.no.MMC2012/06/1868)
Junior Biochemist



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CIN - U74899PB1995PLC045956



Patient Ref. No. 77500002660221

PATIENT NAME : NITIN DHYANI

REF. DOCTOR : SELF

CODE/NAME & ADDRESS : C000138379

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

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

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

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

Causes of decreased level include Liver disease, SIADH.

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

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

Lower than normal level may be due to:

- Myasthenia Gravis, Muscuophy

URIC ACID, SERUM- Causes of Increased levels: -Dietary (High Protein Intake, Prolonged Fasting, Rapid weight loss), Gout, Lesch nyhan syndrome, Type 2 DM, Metabolic syndrome **Causes of decreased levels:** -Low Zinc intake, OCP, Multiple Sclerosis

TOTAL PROTEIN, SERUM- is a biochemical test for measuring the total amount of protein in serum. Protein in the plasma is made up of albumin and globulin.

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

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

ALBUMIN, SERUM-

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

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CLINICAL PATH - URINALYSIS

MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE

PHYSICAL EXAMINATION, URINE

COLOR PALE YELLOW

APPEARANCE CLEAR

CHEMICAL EXAMINATION, URINE

PH	6.5	5.00 - 7.50
SPECIFIC GRAVITY	1.010	1.010 - 1.030
PROTEIN	NOT DETECTED	NOT DETECTED
GLUCOSE	NOT DETECTED	NOT DETECTED
KETONES	NOT DETECTED	NOT DETECTED
BLOOD	NOT DETECTED	NOT DETECTED
BILIRUBIN	NOT DETECTED	NOT DETECTED
UROBILINOGEN	NOT DETECTED	
NITRITE	NOT DETECTED	NOT DETECTED
LEUKOCYTE ESTERASE	NOT DETECTED	NOT DETECTED

MICROSCOPIC EXAMINATION, URINE

RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
PUS CELL (WBC'S)	0-1	0-5	/HPF
EPITHELIAL CELLS	0-1	0-5	/HPF
CASTS	NOT DETECTED		
CRYSTALS	NOT DETECTED		
BACTERIA	NOT DETECTED	NOT DETECTED	
YEAST	NOT DETECTED	NOT DETECTED	

METHOD : URINE ROUTINE & MICROSCOPY EXAMINATION BY INTEGRATED AUTOMATED SYSTEM

Interpretation(s)

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CLINICAL PATH - STOOL ANALYSIS

MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE

MICROSCOPIC EXAMINATION,STOOL

REMARK

TEST CANCELLED AS SPECIMEN NOT RECEIVED

Interpretation(s)



Dr. Ekta Patil
Microbiologist



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SPECIALISED CHEMISTRY - HORMONE

MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE

THYROID PANEL, SERUM

T3	100.0	80.0 - 200.0	ng/dL
METHOD : COMPETITIVE ELECTROCHEMILUMINESCENCE IMMUNOASSAY			
T4	6.88	5.10 - 14.10	µg/dL
METHOD : COMPETITIVE ELECTROCHEMILUMINESCENCE IMMUNOASSAY			
TSH (ULTRASENSITIVE)	3.140	0.270 - 4.200	µIU/mL
METHOD : SANDWICH ELECTROCHEMILUMINESCENCE IMMUNOASSAY			

Interpretation(s)

Triiodothyronine T3 , Thyroxine T4, and Thyroid Stimulating Hormone TSH are thyroid hormones which affect almost every physiological process in the body, including growth, development, metabolism, body temperature, and heart rate.

Production of T3 and its prohormone thyroxine (T4) is activated by thyroid-stimulating hormone (TSH), which is released from the pituitary gland. Elevated concentrations of T3, and T4 in the blood inhibit the production of TSH.

Excessive secretion of thyroxine in the body is hyperthyroidism, and deficient secretion is called hypothyroidism.

In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hyperthyroidism, TSH levels are low. Below mentioned are the guidelines for Pregnancy related reference ranges for Total T4, TSH & Total T3. Measurement of the serum TT3 level is a more sensitive test for the diagnosis of hyperthyroidism, and measurement of TT4 is more useful in the diagnosis of hypothyroidism. Most of the thyroid hormone in blood is bound to transport proteins. Only a very small fraction of the circulating hormone is free and biologically active. It is advisable to detect Free T3, FreeT4 along with TSH, instead of testing for albumin bound Total T3, Total T4.

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

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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.

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MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE

XRAY-CHEST

IMPRESSION NO ABNORMALITY DETECTED

TMT OR ECHO

TMT OR ECHO NEGATIVE

ECG

ECG DONE.

MEDICAL HISTORY

RELEVANT PRESENT HISTORY CVS 3RD DOSE.
RELEVANT PAST HISTORY NOT SIGNIFICANT
RELEVANT PERSONAL HISTORY ALCOHOL - OCC.
RELEVANT FAMILY HISTORY NOT SIGNIFICANT
HISTORY OF MEDICATIONS NOT SIGNIFICANT

ANTHROPOMETRIC DATA & BMI

HEIGHT IN METERS	1.72	mts
WEIGHT IN KGS.	88	Kgs
BMI	30	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 OVERWEIGHT
BUILT / SKELETAL FRAMEWORK AVERAGE
FACIAL APPEARANCE NORMAL
SKIN NORMAL
UPPER LIMB NORMAL
LOWER LIMB NORMAL
NECK NORMAL
NECK LYMPHATICS / SALIVARY GLANDS NOT ENLARGED OR TENDER
THYROID GLAND NOT ENLARGED



Dr. Rajesh Nayak
Consultant Radiologist



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CAROTID PULSATION	NORMAL			
TEMPERATURE	NORMAL			
PULSE	82/MIN, REGULAR, ALL PERIPHERAL PULSES WELL FELT, NO CAROTID BRUIT			
RESPIRATORY RATE	NORMAL			
CARDIOVASCULAR SYSTEM				
BP	120/80 MM HG (SUPINE)			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				
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

CORNEA

NORMAL

DISTANT VISION RIGHT EYE WITH GLASSES

REDUCE VISUAL ACUITY (6/9)

DISTANT VISION LEFT EYE WITH GLASSES

REDUCE VISUAL ACUITY (6/9)

NEAR VISION RIGHT EYE WITH GLASSES

WITHIN NORMAL LIMIT (N/8)

NEAR VISION LEFT EYE WITH GLASSES

WITHIN NORMAL LIMIT (N/8)

COLOUR VISION

OUT OF 17 NUMBERED PLATES 17

BASIC ENT EXAMINATION

EXTERNAL EAR CANAL

NORMAL

TYMPANIC MEMBRANE

NORMAL

NOSE

NO ABNORMALITY DETECTED

SINUSES

NORMAL

THROAT

NO ABNORMALITY DETECTED

TONSILS

NOT ENLARGED

SUMMARY

RELEVANT HISTORY

CVS 3RD DOSE DONE

RELEVANT GP EXAMINATION FINDINGS

OVER WEIGHT
REDUCE VISUAL ACUITY DISTANT VISION BOTH EYES WITH GLASSES (6/9)

RELEVANT LAB INVESTIGATIONS

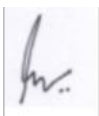
RAISED ESR (18)
RAISED TOTAL CHOLESTEROL (218)
LOW HDL CHOLESTEROL (35)
RAISED NON HDL CHOLESTEROL (183)
RAISED LDL CHOLESTEROL (161)
RAISED EAG (116.9)

RELEVANT NON PATHOLOGY DIAGNOSTICS

SONO - BORDERLINE PROSTATOMEGALY

REMARKS / RECOMMENDATIONS

REGULAR PHYSICAL EXERCISES
LOW CALORIC DIET
REDUCE FATTY AND PROCESSED FOOD IN DIET



Dr. Rajesh Nayak
Consultant Radiologist



View Details



View Report

PERFORMED AT :

SRL Ltd
PLOT No. 88, ROAD No. 15, MIDC ESTATE, ANDHERI (EAST)
MUMBAI, 400093
MAHARASHTRA, INDIA
Tel : 09152729959/9111591115, Fax :
CIN - U74899PB1995PLC045956



Patient Ref. No. 775000002660221

PATIENT NAME : NITIN DHYANI

REF. DOCTOR : SELF

CODE/NAME & ADDRESS : C000138379

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

ACCESSION NO : 0065WC002144

PATIENT ID : NITIM0806705047

CLIENT PATIENT ID:

ABHA NO :

AGE/SEX : 52 Years Male

DRAWN :

RECEIVED : 20/03/2023 08:38:05

REPORTED : 21/03/2023 15:43:27

Test Report Status	Final	Results	Biological Reference Interval	Units
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MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE

ULTRASOUND ABDOMEN

ULTRASOUND ABDOMEN

BORDERLINE PROSTATOMEGALY.

Interpretation(s)

MEDICAL

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

****End Of Report****

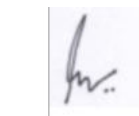
Please visit www.srlworld.com for related Test Information for this accession

CONDITIONS OF LABORATORY TESTING & REPORTING

- | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ol style="list-style-type: none"> 1. It is presumed that the test sample belongs to the patient named or identified in the test requisition form. 2. All tests are performed and reported as per the turnaround time stated in the SRL Directory of Services. 3. Result delays could occur due to unforeseen circumstances such as non-availability of kits / equipment breakdown / natural calamities / technical downtime or any other unforeseen event. 4. A requested test might not be performed if: <ol style="list-style-type: none"> 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 | <ol style="list-style-type: none"> 5. SRL confirms that all tests have been performed or assayed with highest quality standards, clinical safety & technical integrity. 6. Laboratory results should not be interpreted in isolation; it must be correlated with clinical information and be interpreted by registered medical practitioners only to determine final diagnosis. 7. Test results may vary based on time of collection, physiological condition of the patient, current medication or nutritional and dietary changes. Please consult your doctor or call us for any clarification. 8. Test results cannot be used for Medico legal purposes. 9. In case of queries please call customer care (91115 91115) within 48 hours of the report. |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

SRL Limited

Fortis Hospital, Sector 62, Phase VIII,
Mohali 160062



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Consultant Radiologist



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