

**Name** : MR NARINDER KUMAR NANGIA  
**Registration No** : MH008565418 RefHosp No. :  
ghzb-00000010554  
**Patient Episode** : H18000001214  
**Referred By** : HEALTH CHECK MGD  
**Receiving Date** : 25 Sep 2023 15:29

**Age** : 55 Yr(s) Sex :Male  
**Lab No** : 202309005460  
**Collection Date** : 25 Sep 2023 15:29  
**Reporting Date** : 25 Sep 2023 17:59

### CLINICAL PATHOLOGY

#### ROUTINE URINE ANALYSIS (Semi Automated)Specimen-Urine

##### MACROSCOPIC DESCRIPTION

Colour	PALE YELLOW	(Pale Yellow - Yellow)
<b>Appearance</b>	<b>SLIGHTLY TURBID</b>	
Reaction[pH]	6.5	(4.6-8.0)
Specific Gravity	1.010	(1.003-1.035)

##### CHEMICAL EXAMINATION

Protein/Albumin	Negative	(NEGATIVE)
Glucose	NIL	(NIL)
Ketone Bodies	Negative	(NEGATIVE)
Urobilinogen	Normal	(NORMAL)

##### MICROSCOPIC EXAMINATION(Automated/Manual)

Pus Cells	2-4 /hpf	(0-5/hpf)
RBC	0-1/hpf	(0-2/hpf)
Epithelial Cells	1-2 /hpf	
CASTS	NIL	
Crystals	NIL	
Bacteria	NIL	
OTHERS	NIL	

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**BIOCHEMISTRY**

TEST	RESULT	UNIT	BIOLOGICAL REFERENCE INTERVAL
<b>Serum LIPID PROFILE</b>			
Serum TOTAL CHOLESTEROL Method:Oxidase,esterase, peroxide	189	mg/dl	[<200] Moderate risk:200-239 High risk:>240
TRIGLYCERIDES (GPO/POD)	79	mg/dl	[<150] Borderline high:151-199 High: 200 - 499 Very high:>500
<b>HDL- CHOLESTEROL</b> Method : Enzymatic Immunoimhibition	<b>70.0 #</b>	<b>mg/dl</b>	<b>[35.0-65.0]</b>
VLDL- CHOLESTEROL (Calculated)	16	mg/dl	[0-35]
CHOLESTEROL, LDL, CALCULATED	103.0	mg/dl	[<120.0] Near/ Borderline High:130-159 High Risk:160-189
Above optimal-100-129			<4.0 Optimal 4.0-5.0 Borderline >6 High Risk
T.Chol/HDL.Chol ratio(Calculated)	2.7		
LDL.CHOL/HDL.CHOL Ratio(Calculated)	1.5		<3 Optimal 3-4 Borderline >6 High Risk

Note:  
Reference ranges based on ATP III Classifications.

Lipid profile is a panel of blood tests that serves as initial broad medical screening tool for abnormalities in lipids, the results of this tests can identify certain genetic diseases and determine approximate risks for cardiovascular disease, certain forms of pancreatitis and other diseases

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**BIOCHEMISTRY**

TEST	RESULT	UNIT	BIOLOGICAL REFERENCE INTERVAL
<b>KIDNEY PROFILE</b>			
Specimen: Serum			
UREA <i>Method: GLDH, Kinatic assay</i>	28.8	mg/dl	[15.0-40.0]
BUN, BLOOD UREA NITROGEN <i>Method: Calculated</i>	13.5	mg/dl	[8.0-20.0]
CREATININE, SERUM <i>Method: Jaffe rate-IDMS Standardization</i>	0.88	mg/dl	[0.70-1.20]
URIC ACID <i>Method:uricase PAP</i>	6.6	mg/dl	[4.0-8.5]
SODIUM, SERUM	140.00	mmol/L	[136.00-144.00]
POTASSIUM, SERUM	4.30	mmol/L	[3.60-5.10]
SERUM CHLORIDE <i>Method: ISE Indirect</i>	101.6	mmol/L	[101.0-111.0]
eGFR (calculated)	96.7	ml/min/1.73sq.m	[>60.0]

**Technical Note**

eGFR which is primarily based on Serum Creatinine is a derivation of CKD-EPI 2009 equation normalized to 1.73 sq.m BSA and is not applicable to individuals below 18 years. eGFR tends to be less accurate when Serum Creatinine estimation is indeterminate e.g. patients at extremes of muscle mass, on unusual diets etc. and samples with severe Hemolysis Icterus / Lipemia.

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TEST	RESULT	UNIT	BIOLOGICAL REFERENCE INTERVAL
<b>LIVER FUNCTION TEST</b>			
BILIRUBIN - TOTAL <i>Method: D P D</i>	0.45	mg/dl	[0.30-1.20]
BILIRUBIN - DIRECT <i>Method: DPD</i>	0.12	mg/dl	[0.00-0.30]
INDIRECT BILIRUBIN(SERUM) <i>Method: Calculation</i>	0.33	mg/dl	[0.10-0.90]
<b>TOTAL PROTEINS(SERUM)</b> <i>Method: BIURET</i>	<b>6.50 #</b>	<b>gm/dl</b>	<b>[6.60-8.70]</b>
ALBUMIN (SERUM) <i>Method: BCG</i>	4.27	g/dl	[3.50-5.20]
GLOBULINS (SERUM) <i>Method: Calculation</i>	2.20	gm/dl	[1.80-3.40]
PROTEIN SERUM (A-G) RATIO <i>Method: Calculation</i>	1.91		[1.00-2.50]
AST(SGOT) (SERUM) <i>Method: IFCC W/O P5P</i>	23.00	U/L	[0.00-40.00]
ALT(SGPT) (SERUM) <i>Method: IFCC W/O P5P</i>	26.50	U/L	[17.00-63.00]
Serum Alkaline Phosphatase <i>Method: AMP BUFFER IFCC)</i>	77.0	IU/L	[32.0-91.0]
GGT	13.0	U/L	[7.0-50.0]

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**BIOCHEMISTRY**

TEST	RESULT	UNIT	BIOLOGICAL REFERENCE INTERVAL
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Liver function test aids in diagnosis of various pre hepatic, hepatic and post hepatic causes of dysfunction like hemolytic anemia's, viral and alcoholic hepatitis and cholestasis of obstructive causes.

The test encompasses hepatic excretory, synthetic function and also hepatic parenchymal cell damage. LFT helps in evaluating severity, monitoring therapy and assessing prognosis of liver disease and dysfunction.

-----END OF REPORT-----



**Dr. Alka Dixit Vats**  
**Consultant Pathologist**

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**Patient Episode** : H1800001214  
**Referred By** : HEALTH CHECK MGD  
**Receiving Date** : 25 Sep 2023 10:11

**Age** : 55 Yr(s) Sex :Male  
**Lab No** : 202309005461  
**Collection Date** : 25 Sep 2023 10:11  
**Reporting Date** : 25 Sep 2023 15:41

**BIOCHEMISTRY**

TEST	RESULT	UNIT	BIOLOGICAL REFERENCE INTERVAL
<b>GLUCOSE-Fasting</b> Specimen: Plasma GLUCOSE, FASTING (F) Method: Hexokinase	94.0	mg/dl	[70.0-110.0]

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, fibro sarcoma), infant of a diabetic mother enzyme deficiency diseases(e.g.galactosemia),  
Drugs-  
insulin, ethanol, propranolol, sulfonylureas, tobutamide, and other oral hypoglycemic agents.

-----END OF REPORT-----

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**Reporting Date** : 25 Sep 2023 17:51

**BIOCHEMISTRY**

TEST	RESULT	UNIT	BIOLOGICAL REFERENCE INTERVAL
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**PLASMA GLUCOSE**

Specimen:Plasma

GLUCOSE, POST PRANDIAL (PP), 2 HOURS	103.0	mg/dl	[80.0-140.0]
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Method: Hexokinase

Note:

Conditions which can lead to lower postprandial glucose levels as compared to fasting glucose are excessive insulin release, rapid gastric emptying, brisk glucose absorption , post exercise

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