PT. NAME	**:- MR. WILLIAM EKKA**	**Sample Collected On**	:- 15/09/2024
PT. AGE/SEX	:- 62 Y / M	**Report Released On**	:- 16/09/2024
MOBILE NO	:-	**Accession On**	:- 10
Ref. By.	**:- SELF**	**Patient Unique ID No.**	**:- 10291**
Company	**:- ARCOFEMI HEALTH CARE LTD.**	**TPA**	**:- MEDIWHEEL**

BIO CHEMISTRY

Description	Result	Unit	Biological Ref. Range
FASTING BLOOD SUGAR	**88.0**	mg/dL	70 - 110
POST PRANDIAL BLOOD SUGAR	**115.2**	mg/dl	70 - 140
Cholesterol	162.0	mg/dl	Desirable : <200 Borderline :200 - 239 High : >=240
Triglycerides	110.7	mg/dl	<150 : Normal 150-199 : Borderline - High 200-499 : High >500 : Very High
HDL	43.2	mg/dl	<40 : Low 40-60 :Optimal >60 : Desirable
LDL	**96.66**	mg/dl	<100 : Normal 100-129 : Desirable 130-159 : Borderling-High 160-189 : High >190 : Very High
VLDL	22.14	mg/dl	7 - 40
Cholesterol/HDL Ratio	3.75		0 - 5.0
LDL/HDL Ratio	2.23	ratio	0 - 3.5

Clinical Significance :
Total Cholesterol
Serum cholesterol is elevated in hereditary hyperlipoproteinemias and in other metabolic diseases. Moderate-to-markedly elevated values are also seen in cholestatic liver disease, risk factor for cardiovascular disease. Low levels of cholesterol may be seen in disorders like hyperthyroidism, malabsorption, and deficiencies of apolipoproteins.
Triglycerides
Increased serum triglyceride levels are a risk factor for atherosclerosis. Hyperlipidemia may be inherited or may be due to conditions like biliary obstruction, diabetes mellitus, nephrotic syndrome, renal failure,certain metabolic disorders or drug induced.
LDL Cholesterol (Direct) - LDL Cholesterol is directly associated with increased incidence of coronary heart disease , familial hyperlipidemias, fat rich diet intake, hypothyroidism, Diabetes mellitus, multiple myeloma and porphyrias. Decreased LDL levels are seen in hypolipoproteinemias , hyperthyroidism, chronic anaemia,and Reye's syndrome.
Undetectable LDL levels indicate abetalipoproteinemia
HDL Cholestero - High-density lipoprotein (HDL) is an important tool used to assess risk of developing coronary heart disease.Increased levels are seen in persons with more physical activity. Very high levels are seen in case of metabolic response to medications like hormone replacement therapy ..Low HDL cholesterol correlates with increased risk for coronary heart disease (CHD). Very low levels are seen in Tangier disease , cholestatic liver disease and in association with decreased hepatocyte function.

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Bilirubin - Total	0.63	mg/dl	0.2 - 1.3
Bilirubin - Direct	0.19	mg/dl	0 - 0.3
Bilirubin (Indirect)	0.44	mg/dl	0 - 1.1
SGOT (AST)	29.1	U/L	17 - 59
SGPT (ALT)	35.3	U/L	21 - 72
Alkaline phosphatase (ALP)	105.7	U/L	38 - 126
Total Proteins	6.9	g/dl	6.3 - 8.2
Albumin	4.1	g/dl	3.5 - 5.0
Globulin	**2.80**	g/dl	2.3 - 3.6
A/G Ratio	1.46		1.1 - 2.0
Gamma GT	25.0	U/L	<55

Clinical Significance :
Alanine transaminase (ALT)
ALT is an enzyme found in the liver that helps your body metabolize protein . When the liver is damaged, ALT is released into the bloodstream and levels increase .
Aspartate transaminase (AST)
AST is an enzyme that helps metabolize alanine, an amino acid. Like ALT, AST is normally present in blood at low levels. An increase in AST levels may indicate liver damage or disease or muscle damage.
Alkaline phosphatase (ALP)
ALP is an enzyme in the liver, bile ducts and bone. Higher-than-normal levels of ALP may indicate liver damage or disease , such as a blocked bile duct, or certain bone diseases.
Albumin and total protein
Albumin is one of several proteins made in the liver. Your body needs these proteins to fight infections and to perform other functions . Lower-than-normal levels of albumin and total protein might indicate liver damage or disease.
Bilirubin.
Bilirubin is a substance produced during the normal breakdown of red blood cells. Bilirubin passes through the liver and is excreted in stool. Elevated levels of bilirubin (jaundice) might indicate liver damage or disease or certain types of anemia.

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Urea	28.3	mg/dL	10 - 50
Creatinine	**0.89**	mg/dL	0.66 - 1.25
Uric Acid	4.5	mg/dL	3.5 - 8.5
Sodium (Na)	**139.2**	mmol/L	137 - 145
Pottasium (K)	**4.3**	mmol/L	3.5 - 5.1

Clinical Significance :
SERUM UREA
Serum urea concentration reflects the balance between urea production in the liver and urea elimination by the kidneys, in urine; so increased serum urea can be caused by increased urea production, decreased urea elimination, or a combination of the two.
CREATININE
Creatinine is a nitrogenous waste product formed in muscle from creatine phosphate. Endogenous production of creatinine is proportional to muscle mass and body weight. Exogenous creatinine (from ingestion of meat) has little effect on daily creatinine excretion .Serum creatinine is inversely correlated with glomerular filtration rate (GFR). Increased levels of Serum Creatinine is associated with renal dysfunction.
URIC ACID
The uric acid blood test is used to detect high levels of this compound in the blood in order to help diagnose gout. The test is also used to monitor uric acid levels in people undergoing chemotherapy or radiation treatment for cancer. Rapid cell turnover from such treatment can result in an increased uric acid level.The uric acid urine test is used to help diagnose the cause of recurrent kidney stones and to monitor people with gout for stone formation.
SODIUM
It may also be elevated in the urine when the body is losing too much sodium; in this case, the blood level would be normal to low. Decreased urinary sodium levels may indicate dehydration, congestive heart failure, liver disease, or nephrotic syndrome. Increased urinary sodium levels may indicate diuretic use or Addison disease .
POTASSIUM
If blood potassium levels are low due to insufficient intake , then urine concentrations will also be low .Decreased urinary potassium levels may be due to certain drugs such as NSAIDs, beta blockers, and lithium or due to the adrenal glands producing too little of the hormone aldosterone.Increased urinary potassium levels may be due to kidney disease, eating disorders such as anorexia, or muscle damage.

T3 (Triiodothyronine)	**147.52**	ng/dl	80 - 253 : 1yr - 10 Yr 76 - 199 11 Yr - 15 Yr 69 - 201 : 16 Yr - 18 Yr 60 - 181 : > 18 Yrs
T4 (Thyroxine)	6.88	ug/dl	4.6 - 12.5
TSH	1.43	uiU/mL	0.52 -16.0 1 Day - 30 Days 0.55-7.10 1 mon-5yrs 0.37 -6.00 : 6 Yrs - 18 Yrs 0.35 - 5.50 18 Yrs - 55 Yrs 0.50 - 8.90 : > 55 Yrs

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CLINICAL PATHOLOGY

Description	Result	Unit	Biological Ref. Range
	URINE R/M		
Appearance	Clear		Clear
Specific Gravity	1.015		1.003 - 1.030
Urine Glucose(Sugar)	**Nil**		Not Detected
Microscopic Examination			
Epithelial cells	1-2	/HPF	0 - 5
PUS CELLS	2-3	/HPF	0 - 5
RBC (Urine)	Absent	/HPF	0 - 3
Casts	**Absent**		Not Detected
Crystals	**Absent**		Not Detected
Bacteria	**Absent**		Not Detected
Reaction (pH)	**Acidic**		
Chemical Examination			
Others	**Not detected**		
Physical Examination			
Colour	Pale Yellow		Pale Yellow
Urine Protein(Albumin)	**Nil**		Not Detected

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HAEMATOLOGY

Description	Result	Unit	Biological Ref. Range
	BLOOD GROUP		
BLOOD GROUP	" B "		
Rh	Positive		

NOTE :- This technique is used for preliminary ABO grouping spcimen should Be Further Tested by Tube Method For Confirmation.

W.B.C. Indices			
TOTAL WBC COUNT	6000	/cumm	4000 - 11000
NEUTROPHILS	60	%	40 - 70
LYMPHOCYTES	32	%	20 - 52
MONOCYTES	05	%	4 - 12
EOSINOPHILS	03	%	1 - 6
BASOPHILS	00	%	0 - 1
R.B.C. Indices			
HAEMOGLOBIN	14.8	gm/dL	12.5 - 16.5
RBC COUNT	5.11	Mill/cumm	4.2 - 5.5
HEMATOCRIT (PCV)	42.1	%	37.5 - 49.5
MCV	82.4	fL	80 - 95
MCH	28.9	pg	26 - 32
MCHC	35.15	g/dl	32 - 36
RDW-CV	13.1	%	11.5 - 16.5
Platelet Indices			
PLATELET COUNT	172000	/µL	150000-400000
MPV	10.8	fl	7.0 - 11.0
PDW	16.2	%	12 - 18
P-LCR	34.0	%	13 - 43
ESR	10	after 1 hr	0 - 15
Advice			Correlate Clinically

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HbA1C-Glycosylated Haemoglobin	**5.3**	%	Normal Range : <6% Good Control : 6 - 7% Fair Control : 7 - 8% Unsatistactory Control : 8 -10% Poor Control : >10%

Clinical Significance :
Hemoglobin A1c (HbA1c) level reflects the mean glucose concentration over the previous period (approximately 8-12 weeks) and provides a much better indication of long-term glycemic control than blood and urinary glucose determinations. American Diabetes Association (ADA) include the use of HbA1c to diagnose diabetes, using a cutpoint of 6.5%. The ADA recommends measurement of HbA1c 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 assess whether a patient's metabolic control has remained continuously within the target range. Falsely low HbA1c results may be seen in conditions that shorten erythrocyte life span. and may not reflect glycemic control in these cases accurately.

--- End Of Report ---

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