

Patient Name	: Mr. SARJE MAHENDRAKUMAR NAGORAO	Age/Gender	: 35 Y/M
UHID/MR No.	: CVIM.0000238550	OP Visit No	: CVIMOPV599570
Sample Collected on	:	Reported on	: 03-04-2024 11:53
LRN#	: RAD2291398	Specimen	:
Ref Doctor	: SELF		
Emp/Auth/TPA ID	: UBOIE4893		

DEPARTMENT OF RADIOLOGY

X-RAY CHEST PA

NOT DONE

X-RAY CHEST PA

Trachea appears normal.

Both the lung fields are clear.

Cardiac shadows appear apparently normal.


Both domes of diaphragm appear normal.

Both costophrenic angles are clear.

Bony thoracic cage shows no deformity. Visualised bones appear normal.

Soft tissues appear normal.

Impression: Essentially Normal Study.


Dr. PREETI P KATHE
DMRE, MD, DNB
Radiology

Patient Name : Mr.SARJE MAHENDRAKUMAR NAGORAO	Collected : 02/Apr/2024 02:26PM
Age/Gender : 35 Y 0 M 9 D/M	Received : 02/Apr/2024 04:38PM
UHID/MR No : CVIM.0000238550	Reported : 02/Apr/2024 05:44PM
Visit ID : CVIMOPV599570	Status : Final Report
Ref Doctor : Dr.SELF	Sponsor Name : ARCOFEMI HEALTHCARE LIMITED
Emp/Auth/TPA ID : UBOIE4893	

DEPARTMENT OF HAEMATOLOGY

ARCOFEMI - MEDIWHEEL - FULL BODY STANDARD PLUS MALE - PAN INDIA - FY2324

PERIPHERAL SMEAR , WHOLE BLOOD EDTA

RBC Predominantly Normocytic Normochromic with Microcytes+
WBC are normal in number and morphology
Platelets are Adequate
No hemoparasite seen.



DR.Sanjay Ingle
M.B.B.S,M.D(Pathology)
Consultant Pathologist

SIN No:BED240092209

This test has been performed at Apollo Health and Lifestyle Ltd- Sadashiv Peth Pune, Diagnostics Lab

Apollo Health and Lifestyle Limited (CIN - U85110TG2000PLC115819)

Regd. Office: 1-10-60/62, Ashoka Raghupathi Chambers, 5th Floor, Begumpet, Hyderabad, Telangana - 500 016 |
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APOLLO CLINICS NETWORK

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Nyati Millenium Premises, Cooperative Society Limited, Shop No.S1 & Stilt Floor, Building "C", Viman Nagar, Pune, Maharashtra, India - 411014

Certificate No: MC-5697

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DEPARTMENT OF HAEMATOLOGY

ARCOFEMI - MEDIWHEEL - FULL BODY STANDARD PLUS MALE - PAN INDIA - FY2324

Test Name	Result	Unit	Bio. Ref. Range	Method
HEMOGRAM , WHOLE BLOOD EDTA				
HAEMOGLOBIN	15.1	g/dL	13-17	Spectrophotometer
PCV	44.40	%	40-50	Electronic pulse & Calculation
RBC COUNT	5.3	Million/cu.mm	4.5-5.5	Electrical Impedence
MCV	83.8	fL	83-101	Calculated
MCH	28.6	pg	27-32	Calculated
MCHC	34.1	g/dL	31.5-34.5	Calculated
R.D.W	16.7	%	11.6-14	Calculated
TOTAL LEUCOCYTE COUNT (TLC)	7,040	cells/cu.mm	4000-10000	Electrical Impedence
DIFFERENTIAL LEUCOCYTIC COUNT (DLC)				
NEUTROPHILS	52.8	%	40-80	Electrical Impedence
LYMPHOCYTES	34.5	%	20-40	Electrical Impedence
EOSINOPHILS	4	%	1-6	Electrical Impedence
MONOCYTES	8.4	%	2-10	Electrical Impedence
BASOPHILS	0.3	%	<1-2	Electrical Impedence
ABSOLUTE LEUCOCYTE COUNT				
NEUTROPHILS	3717.12	Cells/cu.mm	2000-7000	Calculated
LYMPHOCYTES	2428.8	Cells/cu.mm	1000-3000	Calculated
EOSINOPHILS	281.6	Cells/cu.mm	20-500	Calculated
MONOCYTES	591.36	Cells/cu.mm	200-1000	Calculated
BASOPHILS	21.12	Cells/cu.mm	0-100	Calculated
Neutrophil lymphocyte ratio (NLR)	1.53		0.78- 3.53	Calculated
PLATELET COUNT	330000	cells/cu.mm	150000-410000	Electrical impedence
ERYTHROCYTE SEDIMENTATION RATE (ESR)	2	mm at the end of 1 hour	0-15	Modified Westergren
PERIPHERAL SMEAR				

RBC Predominantly Normocytic Normochromic with Microcytes+
WBC are normal in number and morphology
Platelets are Adequate

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M.B.B.S, M.D (Pathology)
Consultant Pathologist

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No hemoparasite seen.



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DEPARTMENT OF HAEMATOLOGY

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Test Name	Result	Unit	Bio. Ref. Range	Method
BLOOD GROUP ABO AND RH FACTOR , WHOLE BLOOD EDTA				
BLOOD GROUP TYPE	O			Microplate Hemagglutination
Rh TYPE	Positive			Microplate Hemagglutination

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Sneha Shah
Dr Sneha Shah
MBBS, MD (Pathology)
Consultant Pathologist

SIN No:BED240092209

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DEPARTMENT OF BIOCHEMISTRY

ARCOFEMI - MEDIWHEEL - FULL BODY STANDARD PLUS MALE - PAN INDIA - FY2324

Test Name	Result	Unit	Bio. Ref. Range	Method
GLUCOSE, FASTING , NAF PLASMA	107	mg/dL	70-100	HEXOKINASE

Comment:

As per American Diabetes Guidelines, 2023

Fasting Glucose Values in mg/dL	Interpretation
70-100 mg/dL	Normal
100-125 mg/dL	Prediabetes
≥126 mg/dL	Diabetes
<70 mg/dL	Hypoglycemia

Note:

- The diagnosis of Diabetes requires a fasting plasma glucose of > or = 126 mg/dL and/or a random / 2 hr post glucose value of > or = 200 mg/dL on at least 2 occasions.
- Very high glucose levels (>450 mg/dL in adults) may result in Diabetic Ketoacidosis & is considered critical.

Test Name	Result	Unit	Bio. Ref. Range	Method
GLUCOSE, POST PRANDIAL (PP), 2 HOURS , SODIUM FLUORIDE PLASMA (2 HR)	124	mg/dL	70-140	HEXOKINASE

Comment:

It is recommended that FBS and PPBS should be interpreted with respect to their Biological reference ranges and not with each other.

Conditions which may lead to lower postprandial glucose levels as compared to fasting glucose levels may be due to reactive hypoglycemia, dietary meal content, duration or timing of sampling after food digestion and absorption, medications such as insulin preparations, sulfonylureas, amylin analogues, or conditions such as overproduction of insulin.

Test Name	Result	Unit	Bio. Ref. Range	Method
HBA1C (GLYCATED HEMOGLOBIN) , WHOLE BLOOD EDTA				
HBA1C, GLYCATED HEMOGLOBIN	5.9	%		HPLC
ESTIMATED AVERAGE GLUCOSE (eAG)	123	mg/dL		Calculated

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ARCOFEMI - MEDIWHEEL - FULL BODY STANDARD PLUS MALE - PAN INDIA - FY2324

Comment:

Reference Range as per American Diabetes Association (ADA) 2023 Guidelines:

REFERENCE GROUP	HBA1C %
NON DIABETIC	<5.7
PREDIABETES	5.7 – 6.4
DIABETES	≥ 6.5
DIABETICS	
EXCELLENT CONTROL	6 – 7
FAIR TO GOOD CONTROL	7 – 8
UNSATISFACTORY CONTROL	8 – 10
POOR CONTROL	>10

Note: Dietary preparation or fasting is not required.

- HbA1C is recommended by American Diabetes Association for Diagnosing Diabetes and monitoring Glycemic Control by American Diabetes Association guidelines 2023.
- Trends in HbA1C values is a better indicator of Glycemic control than a single test.
- Low HbA1C in Non-Diabetic patients are associated with Anemia (Iron Deficiency/Hemolytic), Liver Disorders, Chronic Kidney Disease. Clinical Correlation is advised in interpretation of low Values.
- Falsely low HbA1c (below 4%) may be observed in patients with clinical conditions that shorten erythrocyte life span or decrease mean erythrocyte age. HbA1c may not accurately reflect glycemic control when clinical conditions that affect erythrocyte survival are present.
- In cases of Interference of Hemoglobin variants in HbA1C, alternative methods (Fructosamine) estimation is recommended for Glycemic Control
 - A: HbF >25%
 - B: Homozygous Hemoglobinopathy.
 (Hb Electrophoresis is recommended method for detection of Hemoglobinopathy)



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DEPARTMENT OF BIOCHEMISTRY

ARCOFEMI - MEDIWHEEL - FULL BODY STANDARD PLUS MALE - PAN INDIA - FY2324

Test Name	Result	Unit	Bio. Ref. Range	Method
LIPID PROFILE , SERUM				
TOTAL CHOLESTEROL	158	mg/dL	<200	CHO-POD
TRIGLYCERIDES	87	mg/dL	<150	GPO-POD
HDL CHOLESTEROL	35	mg/dL	40-60	Enzymatic Immunoinhibition
NON-HDL CHOLESTEROL	122	mg/dL	<130	Calculated
LDL CHOLESTEROL	104.9	mg/dL	<100	Calculated
VLDL CHOLESTEROL	17.41	mg/dL	<30	Calculated
CHOL / HDL RATIO	4.46		0-4.97	Calculated
ATHEROGENIC INDEX (AIP)	0.03		<0.11	Calculated

Comment:

Reference Interval as per National Cholesterol Education Program (NCEP) Adult Treatment Panel III Report.

	Desirable	Borderline High	High	Very High
TOTAL CHOLESTEROL	< 200	200 - 239	≥ 240	
TRIGLYCERIDES	<150	150 - 199	200 - 499	≥ 500
LDL	Optimal < 100; Near Optimal 100-129	130 - 159	160 - 189	≥ 190
HDL	≥ 60			
NON-HDL CHOLESTEROL	Optimal <130; Above Optimal 130-159	160-189	190-219	>220
ATHEROGENIC INDEX(AIP)	<0.11	0.12 – 0.20	>0.21	

Note:

- 1) Measurements in the same patient on different days can show physiological and analytical variations.
- 2) NCEP ATP III identifies non-HDL cholesterol as a secondary target of therapy in persons with high triglycerides.
- 3) Primary prevention algorithm now includes absolute risk estimation and lower LDL Cholesterol target levels to determine



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SIN No:SE04685741

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DEPARTMENT OF BIOCHEMISTRY

ARCOFEMI - MEDIWHEEL - FULL BODY STANDARD PLUS MALE - PAN INDIA - FY2324

eligibility of drug therapy.

- 4) Low HDL levels are associated with coronary heart disease due to insufficient HDL being available to participate in reverse cholesterol transport, the process by which cholesterol is eliminated from peripheral tissues.
- 5) As per NCEP guidelines, all adults above the age of 20 years should be screened for lipid status. Selective screening of children above the age of 2 years with a family history of premature cardiovascular disease or those with at least one parent with high total cholesterol is recommended.
- 6) VLDL, LDL Cholesterol Non-HDL Cholesterol, CHOL/HDL RATIO, LDL/HDL RATIO are calculated parameters when Triglycerides are below 400 mg/dl. When Triglycerides are more than 400 mg/dl LDL cholesterol is a direct measurement.
- 7) Triglycerides and HDL-cholesterol in Atherogenic index (AIP) reflect the balance between the atherogenic and protective lipoproteins. Clinical studies have shown that AIP (log (TG/HDL) & values used are in mmol/L) predicts cardiovascular risk and a useful measure of response to treatment (pharmacological intervention).



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Test Name	Result	Unit	Bio. Ref. Range	Method
LIVER FUNCTION TEST (LFT) , SERUM				
BILIRUBIN, TOTAL	0.81	mg/dL	0.3-1.2	DPD
BILIRUBIN CONJUGATED (DIRECT)	0.16	mg/dL	<0.2	DPD
BILIRUBIN (INDIRECT)	0.65	mg/dL	0.0-1.1	Dual Wavelength
ALANINE AMINOTRANSFERASE (ALT/SGPT)	37.62	U/L	<50	IFCC
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	25.2	U/L	<50	IFCC
ALKALINE PHOSPHATASE	67.13	U/L	30-120	IFCC
PROTEIN, TOTAL	7.24	g/dL	6.6-8.3	Biuret
ALBUMIN	4.31	g/dL	3.5-5.2	BROMO CRESOL GREEN
GLOBULIN	2.93	g/dL	2.0-3.5	Calculated
A/G RATIO	1.47		0.9-2.0	Calculated

Comment:

LFT results reflect different aspects of the health of the liver, i.e., hepatocyte integrity (AST & ALT), synthesis and secretion of bile (Bilirubin, ALP), cholestasis (ALP, GGT), protein synthesis (Albumin)

Common patterns seen:

1. Hepatocellular Injury:

- AST – Elevated levels can be seen. However, it is not specific to liver and can be raised in cardiac and skeletal injuries.
- ALT – Elevated levels indicate hepatocellular damage. It is considered to be most specific lab test for hepatocellular injury. Values also correlate well with increasing BMI. • Disproportionate increase in AST, ALT compared with ALP. • Bilirubin may be elevated.
- AST: ALT (ratio) – In case of hepatocellular injury AST: ALT > 1 In Alcoholic Liver Disease AST: ALT usually >2. This ratio is also seen to be increased in NAFLD, Wilson's's diseases, Cirrhosis, but the increase is usually not >2.

2. Cholestatic Pattern:

- ALP – Disproportionate increase in ALP compared with AST, ALT.
- Bilirubin may be elevated. • ALP elevation also seen in pregnancy, impacted by age and sex.
- To establish the hepatic origin correlation with GGT helps. If GGT elevated indicates hepatic cause of increased ALP.

3. Synthetic function impairment: • Albumin- Liver disease reduces albumin levels. • Correlation with PT (Prothrombin Time) helps.



DR.Sanjay Ingle
M.B.B.S,M.D(Pathology)
Consultant Pathologist

SIN No:SE04685741

This test has been performed at Apollo Health and Lifestyle Ltd- Sadashiv Peth Pune, Diagnostics Lab

Apollo Health and Lifestyle Limited (CIN - U85110TG2000PLC115819)

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Certificate No: MC-5697

Patient Name : Mr.SARJE MAHENDRAKUMAR NAGORAO	Collected : 02/Apr/2024 02:26PM
Age/Gender : 35 Y 0 M 9 D/M	Received : 02/Apr/2024 04:39PM
UHID/MR No : CVIM.0000238550	Reported : 02/Apr/2024 05:05PM
Visit ID : CVIMOPV599570	Status : Final Report
Ref Doctor : Dr.SELF	Sponsor Name : ARCOFEMI HEALTHCARE LIMITED
Emp/Auth/TPA ID : UBOIE4893	

DEPARTMENT OF BIOCHEMISTRY

ARCOFEMI - MEDIWHEEL - FULL BODY STANDARD PLUS MALE - PAN INDIA - FY2324

Test Name	Result	Unit	Bio. Ref. Range	Method
RENAL PROFILE/KIDNEY FUNCTION TEST (RFT/KFT) , SERUM				
CREATININE	0.77	mg/dL	0.72 – 1.18	Modified Jaffe, Kinetic
UREA	32.32	mg/dL	17-43	GLDH, Kinetic Assay
BLOOD UREA NITROGEN	15.1	mg/dL	8.0 - 23.0	Calculated
URIC ACID	6.05	mg/dL	3.5–7.2	Uricase PAP
CALCIUM	9.10	mg/dL	8.8-10.6	Arsenazo III
PHOSPHORUS, INORGANIC	2.96	mg/dL	2.5-4.5	Phosphomolybdate Complex
SODIUM	142.85	mmol/L	136–146	ISE (Indirect)
POTASSIUM	3.8	mmol/L	3.5–5.1	ISE (Indirect)
CHLORIDE	105.29	mmol/L	101–109	ISE (Indirect)
PROTEIN, TOTAL	7.24	g/dL	6.6-8.3	Biuret
ALBUMIN	4.31	g/dL	3.5-5.2	BROMO CRESOL GREEN
GLOBULIN	2.93	g/dL	2.0-3.5	Calculated
A/G RATIO	1.47		0.9-2.0	Calculated

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DEPARTMENT OF BIOCHEMISTRY

ARCOFEMI - MEDIWHEEL - FULL BODY STANDARD PLUS MALE - PAN INDIA - FY2324

Test Name	Result	Unit	Bio. Ref. Range	Method
GAMMA GLUTAMYL TRANSPEPTIDASE (GGT) , SERUM	42.47	U/L	<55	IFCC



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Patient Name : Mr.SARJE MAHENDRAKUMAR NAGORAO	Collected : 02/Apr/2024 02:26PM
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UHID/MR No : CVIM.0000238550	Reported : 02/Apr/2024 05:30PM
Visit ID : CVIMOPV599570	Status : Final Report
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Emp/Auth/TPA ID : UBOIE4893	

DEPARTMENT OF IMMUNOLOGY

ARCOFEMI - MEDIWHEEL - FULL BODY STANDARD PLUS MALE - PAN INDIA - FY2324

Test Name	Result	Unit	Bio. Ref. Range	Method
THYROID PROFILE TOTAL (T3, T4, TSH) , SERUM				
TRI-IODOTHYRONINE (T3, TOTAL)	1.28	ng/mL	0.7-2.04	CLIA
THYROXINE (T4, TOTAL)	14.33	µg/dL	5.48-14.28	CLIA
THYROID STIMULATING HORMONE (TSH)	2.058	µIU/mL	0.34-5.60	CLIA

Comment:

For pregnant females	Bio Ref Range for TSH in uIU/ml (As per American Thyroid Association)
First trimester	0.1 - 2.5
Second trimester	0.2 - 3.0
Third trimester	0.3 - 3.0

- TSH is a glycoprotein hormone secreted by the anterior pituitary. TSH activates production of T3 (Triiodothyronine) and its prohormone T4 (Thyroxine). Increased blood level of T3 and T4 inhibit production of TSH.
- TSH is elevated in primary hypothyroidism and will be low in primary hyperthyroidism. Elevated or low TSH in the context of normal free thyroxine is often referred to as sub-clinical hypo- or hyperthyroidism respectively.
- Both T4 & T3 provides limited clinical information as both are highly bound to proteins in circulation and reflects mostly inactive hormone. Only a very small fraction of circulating hormone is free and biologically active.
- Significant variations in TSH can occur with circadian rhythm, hormonal status, stress, sleep deprivation, medication & circulating antibodies.

TSH	T3	T4	FT4	Conditions
High	Low	Low	Low	Primary Hypothyroidism, Post Thyroidectomy, Chronic Autoimmune Thyroiditis
High	N	N	N	Subclinical Hypothyroidism, Autoimmune Thyroiditis, Insufficient Hormone Replacement Therapy.
N/Low	Low	Low	Low	Secondary and Tertiary Hypothyroidism
Low	High	High	High	Primary Hyperthyroidism, Goitre, Thyroiditis, Drug effects, Early Pregnancy
Low	N	N	N	Subclinical Hyperthyroidism
Low	Low	Low	Low	Central Hypothyroidism, Treatment with Hyperthyroidism
Low	N	High	High	Thyroiditis, Interfering Antibodies
N/Low	High	N	N	T3 Thyrotoxicosis, Non thyroidal causes
High	High	High	High	Pituitary Adenoma; TSHoma/Thyrotropinoma

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Certificate No: MC-5697

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DEPARTMENT OF CLINICAL PATHOLOGY

ARCOFEMI - MEDIWHEEL - FULL BODY STANDARD PLUS MALE - PAN INDIA - FY2324

Test Name	Result	Unit	Bio. Ref. Range	Method
COMPLETE URINE EXAMINATION (CUE) , URINE				
PHYSICAL EXAMINATION				
COLOUR	PALE YELLOW		PALE YELLOW	Visual
TRANSPARENCY	TURBID		CLEAR	Visual
pH	<5.5		5-7.5	DOUBLE INDICATOR
SP. GRAVITY	>1.025		1.002-1.030	Bromothymol Blue
BIOCHEMICAL EXAMINATION				
URINE PROTEIN	NEGATIVE		NEGATIVE	PROTEIN ERROR OF INDICATOR
GLUCOSE	NEGATIVE		NEGATIVE	GLUCOSE OXIDASE
URINE BILIRUBIN	NEGATIVE		NEGATIVE	AZO COUPLING REACTION
URINE KETONES (RANDOM)	NEGATIVE		NEGATIVE	SODIUM NITRO PRUSSIDE
UROBILINOGEN	NORMAL		NORMAL	MODIFIED EHRlich REACTION
NITRITE	NEGATIVE		NEGATIVE	Diazotization
LEUCOCYTE ESTERASE	NEGATIVE		NEGATIVE	LEUCOCYTE ESTERASE
CENTRIFUGED SEDIMENT WET MOUNT AND MICROSCOPY				
PUS CELLS	2 - 3	/hpf	0-5	Microscopy
EPITHELIAL CELLS	1 - 2	/hpf	<10	MICROSCOPY
RBC	NIL	/hpf	0-2	MICROSCOPY
CASTS	NIL		0-2 Hyaline Cast	MICROSCOPY
CRYSTALS	ABSENT		ABSENT	MICROSCOPY

*** End Of Report ***

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Consultant Pathologist

SIN No: UR2323904

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