



MC-5749

<b>PATIENT NAME : UMA ARORA</b>		<b>REF. DOCTOR : SELF</b>	
<b>CODE/NAME &amp; ADDRESS :</b> C000138383 ARCOFEMI HEALTHCARE LTD (MEDIWHEEL F-703, LADO SARAI, MEHRAULISOUTH WEST DELHI NEW DELHI 110030 8800465156	<b>ACCESSION NO :</b> 0080XC002859	<b>AGE/SEX :</b> 36 Years Female	<b>RECEIVED :</b> 09/03/2024 09:16:50
	<b>PATIENT ID :</b> UMAAF25068780	<b>DRAWN :</b>	<b>REPORTED :</b> 10/03/2024 14:59:41
	<b>CLIENT PATIENT ID:</b>		
	<b>ABHA NO :</b>		

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

**MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE**

**BLOOD COUNTS,EDTA WHOLE BLOOD**

HEMOGLOBIN (HB)	12.6	12.0 - 15.0	g/dL
METHOD : CYANMETHEMOGLOBIN METHOD			
RED BLOOD CELL (RBC) COUNT	<b>4.84 High</b>	3.8 - 4.8	mil/ $\mu$ L
METHOD : ELECTRICAL IMPEDANCE			
WHITE BLOOD CELL (WBC) COUNT	5.17	4.0 - 10.0	thou/ $\mu$ L
METHOD : ELECTRICAL IMPEDANCE			
PLATELET COUNT	199	150 - 410	thou/ $\mu$ L
METHOD : ELECTRICAL IMPEDANCE			

**RBC AND PLATELET INDICES**

HEMATOCRIT (PCV)	37.0	36 - 46	%
METHOD : ELECTRICAL IMPEDANCE			
MEAN CORPUSCULAR VOLUME (MCV)	<b>76.5 Low</b>	83 - 101	fL
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	<b>26.0 Low</b>	27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)	33.9	31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER			
RED CELL DISTRIBUTION WIDTH (RDW)	<b>15.2 High</b>	11.6 - 14.0	%
METHOD : CALCULATED PARAMETER			
MENTZER INDEX	15.8		
MEAN PLATELET VOLUME (MPV)	<b>13.8 High</b>	6.8 - 10.9	fL
METHOD : CALCULATED PARAMETER			

**WBC DIFFERENTIAL COUNT**

NEUTROPHILS	65	40 - 80	%
METHOD : LIGHT ABSORBANCE OF CYTOCHEMICAL STAINED CELLS IMPEDANCE			
LYMPHOCYTES	27	20 - 40	%
METHOD : LIGHT ABSORBANCE OF CYTOCHEMICAL STAINED CELLS IMPEDANCE			
MONOCYTES	6	2 - 10	%

*Chandni Garg*

*Pranjali Vasishth*

**DR.CHANDNI GARG**  
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**Dr.Pranjali Vasishth**  
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Agilus Diagnostics Ltd.  
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Punjab, India  
Tel : 9111591115, Fax :  
CIN - U74899PB1995PLC045956



**Patient Ref. No. 77500006737706**



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METHOD : LIGHT ABSORBANCE OF CYTOCHEMICAL STAINED CELLS IMPEDANCE				
EOSINOPHILS	2	1 - 6		%
BASOPHILS	0	0 - 2		%
METHOD : LIGHT ABSORBANCE OF CYTOCHEMICAL STAINED CELLS IMPEDANCE				
ABSOLUTE NEUTROPHIL COUNT	3.36	2.0 - 7.0		thou/μL
ABSOLUTE LYMPHOCYTE COUNT	1.40	1 - 3		thou/μL
ABSOLUTE MONOCYTE COUNT	0.31	0.20 - 1.00		thou/μL
METHOD : CALCULATED PARAMETER				
ABSOLUTE EOSINOPHIL COUNT	0.10	0.02 - 0.50		thou/μL
ABSOLUTE BASOPHIL COUNT	<b>0.00 Low</b>	0.02 - 0.10		thou/μL
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	2.4			
METHOD : CALCULATED PARAMETER				

**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 CHECKUP BELOW 40FEMALE

## ERYTHROCYTE SEDIMENTATION RATE (ESR), EDTA BLOOD

E.S.R **30 High** 0 - 20 mm at 1 hr

METHOD : MODIFIED WESTERGREIN

## GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

HBA1C 5.2 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)

ESTIMATED AVERAGE GLUCOSE(EAG) 102.5 &lt; 116.0 mg/dL

## &lt;b&gt;Interpretation(s)&lt;/b&gt;

ERYTHROCYTE SEDIMENTATION RATE (ESR), EDTA BLOOD -&lt;b&gt;TEST DESCRIPTION&lt;/b&gt; :-

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.

## &lt;b&gt;TEST INTERPRETATION&lt;/b&gt;

<b>Increase</b> 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.

<b>Decreased</b> in: Polycythemia vera, Sickle cell anemia

## &lt;b&gt;LIMITATIONS&lt;/b&gt;

<b>False elevated</b> ESR : Increased fibrinogen, Drugs (Vitamin A, Dextran etc), Hypercholesterolemia

<b>False Decreased</b> : Poikilocytosis, (Sickle Cells, spherocytes), Microcytosis, Low fibrinogen, Very high WBC counts, Drugs (Quinine,

salicylates)

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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. GLYCOSYLATED HEMOGLOBIN(HbA1C), EDTA WHOLE BLOOD-<b>Used For</b>:

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 patient's metabolic control has remained continuously within the target range.

1. eAG (Estimated average glucose) converts percentage HbA1c to mg/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  $eAG (mg/dl) = 28.7 * HbA1c - 46.7$

<b>HbA1c Estimation can get affected due to :</b>

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

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### IMMUNOHAEMATOLOGY

#### MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

#### ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP

TYPE O

METHOD : SLIDE AGGLUTINATION

RH TYPE

POSITIVE

METHOD : SLIDE AGGLUTINATION

&lt;b&gt;Interpretation(s)&lt;/b&gt;

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 CHECKUP BELOW 40FEMALE**

**GLUCOSE FASTING,FLUORIDE PLASMA**

**FBS (FASTING BLOOD SUGAR)** 90 74 - 106 mg/dL  
METHOD : HEXOKINASE

**GLUCOSE, POST-PRANDIAL, PLASMA**

**PPBS(POST PRANDIAL BLOOD SUGAR)** 112 Non-Diabetes mg/dL  
70 - 140  
METHOD : HEXOKINASE

**LIPID PROFILE WITH CALCULATED LDL**

**CHOLESTEROL, TOTAL** **210 High** < 200 Desirable mg/dL  
200 - 239 Borderline High  
>= 240 High  
METHOD : CHOLESTEROL OXIDASE, ESTERASE,PEROXIDASE

**TRIGLYCERIDES** 122 < 150 Normal mg/dL  
150 - 199 Borderline High  
200 - 499 High  
>= 500 Very High  
METHOD : ENZYMATIC ASSAY

**HDL CHOLESTEROL** 45 < 40 Low mg/dL  
>=60 High

**CHOLESTEROL LDL** **141 High** < 100 Optimal mg/dL  
100 - 129  
Near or above optimal  
130 - 159  
Borderline High  
160 - 189  
High  
>= 190  
Very High  
METHOD : CHOLESTEROL OXIDASE, ESTERASE,PEROXIDASE

**NON HDL CHOLESTEROL** 45 Desirable: Less than 130 mg/dL  
Above Desirable: 130 - 159

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METHOD : CALCULATED PARAMETER			Borderline High: 160 - 189	
<b>VERY LOW DENSITY LIPOPROTEIN</b>	<b>24.4</b>		High: 190 - 219	
			Very high: > or = 220	
METHOD : CALCULATED PARAMETER			Desirable value :	mg/dL
<b>CHOL/HDL RATIO</b>	<b>4.7 High</b>		10 - 35	
			3.3-4.4 Low Risk	
			4.5-7.0 Average Risk	
			7.1-11.0 Moderate Risk	
			> 11.0 High Risk	
METHOD : CALCULATED PARAMETER			0.5 - 3.0 Desirable/Low Risk	
<b>LDL/HDL RATIO</b>	<b>3.1 High</b>		3.1 - 6.0 Borderline/Moderate Risk	
			>6.0 High Risk	
METHOD : CALCULATED PARAMETER				

**Interpretation(s)**

Serum lipid profile is measured for cardiovascular risk prediction. Lipid Association of India recommends LDL-C as primary target and Non HDL-C as co-primary treatment target.

**Risk Stratification for ASCVD (Atherosclerotic cardiovascular disease) by Lipid Association of India**

Risk Category	
Extreme risk group	A.CAD with > 1 feature of high risk group
	B. CAD with > 1 feature of Very high risk group or recurrent ACS (within 1 year) despite LDL-C < or = 50 mg/dl or polyvascular disease
Very High Risk	1. Established ASCVD 2. Diabetes with 2 major risk factors or evidence of end organ damage 3. Familial Homozygous Hypercholesterolemia
High Risk	1. Three major ASCVD risk factors. 2. Diabetes with 1 major risk factor or no evidence of end organ damage. 3. CKD stage 3B or 4. 4. LDL >190 mg/dl 5. Extreme of a single risk factor. 6. Coronary Artery Calcium - CAC >300 AU. 7. Lipoprotein a >/= 50mg/dl 8. Non stenotic carotid plaque
Moderate Risk	2 major ASCVD risk factors
Low Risk	0-1 major ASCVD risk factors
Major ASCVD (Atherosclerotic cardiovascular disease) Risk Factors	
1. Age > or = 45 years in males and > or = 55 years in females	3. Current Cigarette smoking or tobacco use
2. Family history of premature ASCVD	4. High blood pressure
5. Low HDL	

**Newer treatment goals and statin initiation thresholds based on the risk categories proposed by LAI in 2020.**

Risk Group	Treatment Goals	Consider Drug Therapy
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	<b>LDL-C (mg/dl)</b>	<b>Non-HDL (mg/dl)</b>	<b>LDL-C (mg/dl)</b>	<b>Non-HDL (mg/dl)</b>
Extreme Risk Group Category A	<50 (Optional goal < OR = 30 )	< 80 (Optional goal <OR = 60)	>OR = 50	>OR = 80
Extreme Risk Group Category B	<OR = 30	<OR = 60	> 30	>60
Very High Risk	<50	<80	>OR= 50	>OR= 80
High Risk	<70	<100	>OR= 70	>OR= 100
Moderate Risk	<100	<130	>OR= 100	>OR= 130
Low Risk	<100	<130	>OR= 130*	>OR= 160

\*After an adequate non-pharmacological intervention for at least 3 months.

**References:** Management of Dyslipidaemia for the Prevention of Stroke: Clinical Practice Recommendations from the Lipid Association of India. Current Vascular Pharmacology, 2022, 20, 134-155.

**LIVER FUNCTION PROFILE, SERUM**

<b>BILIRUBIN, TOTAL</b> METHOD : DIAZONIUM ION, BLANKED (ROCHE)	0.51	UPTO 1.2	mg/dL
<b>BILIRUBIN, DIRECT</b> METHOD : DIAZOTIZATION	0.16	0.00 - 0.30	mg/dL
<b>BILIRUBIN, INDIRECT</b> METHOD : CALCULATED PARAMETER	0.35	0.00 - 0.60	mg/dL
<b>TOTAL PROTEIN</b> METHOD : BIURET	6.9	6.6 - 8.7	g/dL
<b>ALBUMIN</b> METHOD : BROMOCRESOL GREEN	<b>5.0 High</b>	3.97 - 4.94	g/dL
<b>GLOBULIN</b> METHOD : CALCULATED PARAMETER	<b>1.9 Low</b>	2.0 - 4.0 Neonates - Pre Mature: 0.29 - 1.04	g/dL
<b>ALBUMIN/GLOBULIN RATIO</b> METHOD : CALCULATED PARAMETER	<b>2.6 High</b>	1.0 - 2.0	RATIO
<b>ASPARTATE AMINOTRANSFERASE (AST/SGOT)</b>	16	0 - 32	U/L
<b>ALANINE AMINOTRANSFERASE (ALT/SGPT)</b> METHOD : UV WITHOUT PYRIDOXAL-5 PHOSPHATE	9	0 - 31	U/L
<b>ALKALINE PHOSPHATASE</b> METHOD : PNPP - AMP BUFFER	103	35 - 105	U/L
<b>GAMMA GLUTAMYL TRANSFERASE (GGT)</b> METHOD : GAMMA GLUTAMYL CARBOXY 4NITROANILIDE	12	5 - 36	U/L
<b>LACTATE DEHYDROGENASE</b> METHOD : LACTATE -PYRUVATE	165	135 - 214	U/L

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**BLOOD UREA NITROGEN (BUN), SERUM**

BLOOD UREA NITROGEN	8	6 - 20	mg/dL
METHOD : UREASE - UV			

**CREATININE, SERUM**

CREATININE	0.89	0.50 - 0.90	mg/dL
METHOD : ALKALINE PICRATE-KINETIC			

**BUN/CREAT RATIO**

BUN/CREAT RATIO	8.99	5.00 - 15.00	
METHOD : CALCULATED PARAMETER			

**URIC ACID, SERUM**

URIC ACID	4.8	2.4 - 5.7	mg/dL
METHOD : URICASE, COLORIMETRIC			

**TOTAL PROTEIN, SERUM**

TOTAL PROTEIN	6.9	6.6 - 8.7	g/dL
METHOD : BIURET			

**ALBUMIN, SERUM**

ALBUMIN	5.0 High	3.97 - 4.94	g/dL
METHOD : BROMOCRESOL GREEN			

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

**ACCESSION NO :** 0080XC002859  
**PATIENT ID :** UMAAF25068780  
**CLIENT PATIENT ID:**  
**ABHA NO :**

**AGE/SEX :** 36 Years Female  
**DRAWN :**  
**RECEIVED :** 09/03/2024 09:16:50  
**REPORTED :** 10/03/2024 14:59:41

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

GLOBULIN	<b>1.9 Low</b>	2.0 - 4.0 Neonates - Pre Mature: 0.29 - 1.04	g/dL
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METHOD : CALCULATED PARAMETER

**ELECTROLYTES (NA/K/CL), SERUM**

SODIUM, SERUM METHOD : ISE INDIRECT	140	136 - 145	mmol/L
POTASSIUM, SERUM METHOD : ISE INDIRECT	5.09	3.5 - 5.1	mmol/L
CHLORIDE, SERUM METHOD : ISE INDIRECT	105	98 - 107	mmol/L

**Interpretation(s)**

Sodium	Potassium	Chloride
<b>Decreased in:</b> 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.	<b>Decreased in:</b> 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.	<b>Decreased in:</b> 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.
<b>Increased in:</b> Dehydration (excessivesweating, severe vomiting or diarrhea),diabetes mellitus, diabetesinsipidus, hyperaldosteronism, inadequate water intake. Drugs: steroids, licorice,oral contraceptives.	<b>Increased in:</b> 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.	<b>Increased in:</b> 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.

**Dr.Pranjali Vasishth**  
**LAB HEAD**

**DR.CHANDNI GARG**  
**CONSULTANT PATHOLOGIST**



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24 Sco, Sector 11 D  
Chandigarh, 160011  
Punjab, India  
Tel : 9111591115, Fax :  
CIN - U74899PB1995PLC045956





**PATIENT NAME : UMA ARORA** **REF. DOCTOR : SELF**  
**CODE/NAME & ADDRESS : C000138383** **ACCESSION NO : 0080XC002859** **AGE/SEX : 36 Years Female**  
 ARCOFEMI HEALTHCARE LTD (MEDIWHEEL) **PATIENT ID : UMAAF25068780** **DRAWN :**  
 F-703, LADO SARAI, MEHRAULISOUTH WEST DELHI **CLIENT PATIENT ID :** **RECEIVED : 09/03/2024 09:16:50**  
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<p><b>Interferences:</b> 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.</p>	<p><b>Interferences:</b> 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.</p>	<p><b>Interferences:</b> 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)</p>
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**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 so that no glucose is excreted in the urine.  
**Increased:** Diabetes mellitus, Cushing's syndrome (10 – 15%), chronic pancreatitis (30%). Drugs: corticosteroids, phenytoin, estrogen, thiazides.  
**Decreased:** 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.  
**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.  
**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-  
**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 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.

**Dr. Pranjali Vasishth**  
LAB HEAD

**DR. CHANDNI GARG**  
CONSULTANT PATHOLOGIST



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 Punjab, India  
 Tel : 9111591115, Fax :  
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MC-5749

<b>PATIENT NAME : UMA ARORA</b>		<b>REF. DOCTOR : SELF</b>	
<b>CODE/NAME &amp; ADDRESS</b> : C000138383 ARCOFEMI HEALTHCARE LTD (MEDIWHEEL F-703, LADO SARAI, MEHRAULISOUTH WEST DELHI NEW DELHI 110030 8800465156	<b>ACCESSION NO</b> : <b>0080XC002859</b>	<b>AGE/SEX</b> : 36 Years Female	
	<b>PATIENT ID</b> : UMAAF25068780	<b>DRAWN</b> :	
	<b>CLIENT PATIENT ID</b> :	<b>RECEIVED</b> : 09/03/2024 09:16:50	
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<b>Higher-than-normal levels may be due to:</b> Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma,Waldenstroms disease.  
 <b>Lower-than-normal levels may be due to:</b> 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. <b>Low blood albumin levels (hypoalbuminemia) can be caused by:</b> 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.

**Dr.Pranjali Vasisht**  
**LAB HEAD**

**DR.CHANDNI GARG**  
**CONSULTANT PATHOLOGIST**



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**CLINICAL PATH - URINALYSIS**

**MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE**

**PHYSICAL EXAMINATION, URINE**

COLOR	PALE YELLOW
APPEARANCE	CLEAR

**CHEMICAL EXAMINATION, URINE**

PH	6.0	4.7 - 7.5
METHOD : REFLECTANCE SPECTROPHOTOMETRY- DOUBLE INDICATOR METHOD		
SPECIFIC GRAVITY	1.005	1.003 - 1.035
METHOD : REFLECTANCE SPECTROPHOTOMETRY (PKA CHANGE OF PRETREATED POLY ELECTROLYTES)		
PROTEIN	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY (PROTEIN-ERROR-OF-INDICATORS PRINCIPLE)		
GLUCOSE	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY(GLUCOSE OXIDAE/PEROXIDASE METHOD)		
KETONES	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY (SODIUM NITROPRUSSIDE REACTION)		
BLOOD	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY (PEROXIDASE METHOD)		
BILIRUBIN	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY (DIAZO REACTION)		
UROBILINOGEN	NORMAL	NORMAL
METHOD : REFLECTANCE SPECTROPHOTOMETRY - EHRlich REACTION		
NITRITE	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY, CONVERSION OF NITRATE TO NITRITE		
LEUKOCYTE ESTERASE	NOT DETECTED	NOT DETECTED

**MICROSCOPIC EXAMINATION, URINE**

RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
METHOD : MICROSCOPIC EXAMINATION			
PUS CELL (WBC'S)	2-3	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION			
EPITHELIAL CELLS	5-7	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION			

**Dr. Pranjali Vasisht**  
LAB HEAD

**DR. CHANDNI GARG**  
CONSULTANT PATHOLOGIST



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MC-5749

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**CODE/NAME & ADDRESS : C000138383** **ACCESSION NO : 0080XC002859** **AGE/SEX : 36 Years Female**  
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CASTS		NOT DETECTED		
CRYSTALS		NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION				
BACTERIA		NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION				
YEAST		NOT DETECTED	NOT DETECTED	

**Interpretation(s)**

The following table describes the probable conditions, in which the analytes are present in urine

Presence of	Conditions
Proteins	Inflammation or immune illnesses
Pus (White Blood Cells)	Urinary tract infection, urinary tract or kidney stone, tumors or any kind of kidney impairment
Glucose	Diabetes or kidney disease
Ketones	Diabetic ketoacidosis (DKA), starvation or thirst
Urobilinogen	Liver disease such as hepatitis or cirrhosis
Blood	Renal or genital disorders/trauma
Bilirubin	Liver disease
Erythrocytes	Urological diseases (e.g. kidney and bladder cancer, urolithiasis), urinary tract infection and glomerular diseases
Leukocytes	Urinary tract infection, glomerulonephritis, interstitial nephritis either acute or chronic, polycystic kidney disease, urolithiasis, contamination by genital secretions
Epithelial cells	Urolithiasis, bladder carcinoma or hydronephrosis, ureteric stents or bladder catheters for prolonged periods of time
Granular Casts	Low intratubular pH, high urine osmolality and sodium concentration, interaction with Bence-Jones protein
Hyaline casts	Physical stress, fever, dehydration, acute congestive heart failure, renal diseases
Calcium oxalate	Metabolic stone disease, primary or secondary hyperoxaluria, intravenous infusion of large doses of vitamin C, the use of vasodilator naftidrofuryl oxalate or the gastrointestinal lipase inhibitor orlistat, ingestion of ethylene glycol or of star fruit (Averrhoa carambola) or its juice
Uric acid	arthritis

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Bacteria	Urinary infection when present in significant numbers & with pus cells.
Trichomonas vaginalis	Vaginitis, cervicitis or salpingitis

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**CYTOLOGY**

**MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE**

**PAPANICOLAOU SMEAR**

TEST METHOD SAMPLE NOT RECEIVED

*Chandni Garg*

**DR.CHANDNI GARG**  
**CONSULTANT PATHOLOGIST**

*Pranjali Vasisht*

**Dr.Pranjali Vasisht**  
**LAB HEAD**



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PATIENT NAME : UMA ARORA

REF. DOCTOR : SELF

CODE/NAME &amp; ADDRESS : C000138383

ARCOFEMI HEALTHCARE LTD (MEDIWHEEL  
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ABHA NO :

AGE/SEX : 36 Years Female

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Test Report Status **Final**

Results

Biological Reference Interval Units

## SPECIALISED CHEMISTRY - HORMONE

## MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

## THYROID PANEL, SERUM

T3	90.58	80.00 - 200.00	ng/dL
METHOD : COMPETITIVE (ECLIA)			
T4	7.42	5.10 - 14.10	µg/dL
METHOD : COMPETITIVE (ECLIA)			
TSH (ULTRASENSITIVE)	3.150	Non Pregnant Women 0.27 - 4.20 Pregnant Women (As per American Thyroid Association) 1st Trimester 0.100 - 2.500 2nd Trimester 0.200 - 3.000 3rd Trimester 0.300 - 3.000	µIU/mL

METHOD : SANDWICH (ECLIA)

## 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

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Tel : 9111591115, Fax :  
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Patient Ref. No. 77500006737706



MC-5749

**PATIENT NAME : UMA ARORA**

**REF. DOCTOR : SELF**

**CODE/NAME & ADDRESS : C000138383**

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**AGE/SEX : 36 Years Female**

**DRAWN :**

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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
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. Guidelines of the American Thyroid association during pregnancy and Postpartum, 2011.

**NOTE: It is advisable to detect Free T3, Free T4 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.**

**\*\*End Of Report\*\***

**Please visit [www.agilusdiagnostics.com](http://www.agilusdiagnostics.com) for related Test Information for this accession**

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CLIENT PATIENT ID:

ABHA NO :

AGE/SEX : 36 Years Female

DRAWN :

RECEIVED : 09/03/2024 09:16:50

REPORTED : 10/03/2024 14:59:41

Test Report Status **Final**

Results

Biological Reference Interval Units

### CONDITIONS OF LABORATORY TESTING & REPORTING

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 AGILUS 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:
  - 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
5. AGILUS Diagnostics 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.

#### Agilus Diagnostics Ltd

Fortis Hospital, Sector 62, Phase VIII,  
Mohali 160062

Dr. Pranjali Vasisht  
LAB HEAD

DR. CHANDNI GARG  
CONSULTANT PATHOLOGIST



View Details



View Report

#### PERFORMED AT :

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Chandigarh, 160011  
Punjab, India  
Tel : 9111591115, Fax :  
CIN - U74899PB1995PLC045956



Patient Ref. No. 77500006737706