DIAGNOSTIC REPORT

agilus diagnostics

PATIENT NAME : MAYURI JAYESH KALAV		REF. DOCTOR : SELF
CODE/NAME & ADDRESS :C000138394 ARCOFEMI HEALTHCARE LTD (MEDIWHEEL F-703, F-703, LADO SARAI, MEHRAULISOUTH- WEST DELHI NEW DELHI 110030 8800465156	ACCESSION NO : 0181XB000963 PATIENT ID : MAYUF180990181 CLIENT PATIENT ID: ABHA NO :	AGE/SEX :33 Years Female DRAWN : RECEIVED : 19/02/2024 08:42:01 REPORTED :22/02/2024 17:28:51

Test Report Status **Preliminary**	Results	Biological Reference Interval	Units

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

XRAY-CHEST

IMPRESSION	NO ABNORMALITY DETECTED

ECG

ECG	WITHIN NORMAL LIMITS

MEDICAL HISTORY

RELEVANT PRESENT HISTORY	NOT SIGNIFICANT
RELEVANT PAST HISTORY	PAST H/O ANAEMIA.
RELEVANT PERSONAL HISTORY	MARRIED / MIXED DIET / NO ALLERGIES / NO SMOKING / NO ALCOHOL.
LMP (FOR FEMALES)	05/02/2024.
OBSTETRIC HISTORY (FOR FEMALES)	1FTNDA0L1.
RELEVANT FAMILY HISTORY	NOT SIGNIFICANT
HISTORY OF MEDICATIONS	NOT SIGNIFICANT

ANTHROPOMETRIC DATA & BMI

HEIGHT IN METERS	1.58		mts
WEIGHT IN KGS.	55		Kgs
BMI	22	BMI & Weight Status as follows: Below 18.5: Underweight 18.5 - 24.9: Normal 25.0 - 29.9: Overweight 30.0 and Above: Obese	kg/sqmts

GENERAL EXAMINATION

MENTAL / EMOTIONAL STATE	NORMAL
PHYSICAL ATTITUDE	NORMAL

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Agilus Diagnostics Ltd.
S.K. Tower,Hari Niwas, Lbs Marg
Thane, 400602
Maharashtra, India
Tel : 9111591115, Fax : CIN - U74899PB1995PLC045956

Patient Ref. No. 775000006479423

agilus diagnostics

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GENERAL APPEARANCE / NUTRITIONAL STATUS	HEALTHY		
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		
CAROTID PULSATION	NORMAL		
TEMPERATURE	NORMAL		
PULSE	60/MIN.REGULAR, ALL PERIPHERAL PULSES WELL FELT, NO CAROTID BRUIT		
RESPIRATORY RATE	NORMAL		
CARDIOVASCULAR SYSTEM			
BP	110/70 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		

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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
JOINTS	NORMAL
BASIC EYE EXAMINATION	
CONJUNCTIVA	NORMAL
EYELIDS	NORMAL
EYE MOVEMENTS	NORMAL
CORNEA	NORMAL
DISTANT VISION RIGHT EYE WITHOUT GLASSES	WITHIN NORMAL LIMIT

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DISTANT VISION LEFT EYE WITHOUT GLASSES	WITHIN NORMAL LIMIT		
NEAR VISION RIGHT EYE WITHOUT GLASSES	WITHIN NORMAL LIMIT		
NEAR VISION LEFT EYE WITHOUT GLASSES	WITHIN NORMAL LIMIT		
COLOUR VISION	NORMAL		

SUMMARY

RELEVANT HISTORY	NOT SIGNIFICANT
RELEVANT GP EXAMINATION FINDINGS	NOT SIGNIFICANT
REMARKS / RECOMMENDATIONS	TO DO S.IRON. IRON RICH DIET ADVISED. ADD GREEN LEAFY VEGETABLES, DATES BEETROOT TO THE DAILY DIET. PHYSICIAN'S CONSULT FOR TREATMENT OF ANAEMIA. ANNUAL USG ABDOMEN TO MONITOR GALL BLADDER POLYP.

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MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

ULTRASOUND ABDOMEN

ULTRASOUND ABDOMEN

GALL BLADDER POLYP.

TMT OR ECHO

CLINICAL PROFILE

NEGATIVE

Interpretation(s)

MEDICAL

HISTORY-**********

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

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End Of Report

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

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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.

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HAEMATOLOGY - CBC

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

BLOOD COUNTS,EDTA WHOLE BLOOD

HEMOGLOBIN (HB)	9.7 Low	12.0 - 15.0	g/dL
METHOD : SLS- HEMOGLOBIN DETECTION METHOD			
RED BLOOD CELL (RBC) COUNT	4.38	3.8 - 4.8	mil/µL
METHOD : HYDRODYNAMIC FOCUSING BY DC DETECTION			
WHITE BLOOD CELL (WBC) COUNT	9.21	4.0 - 10.0	thou/µL
METHOD : FLUORESCENCE FLOW CYTOMETRY			
PLATELET COUNT	313	150 - 410	thou/µL
METHOD : HYDRODYNAMIC FOCUSING BY DC DETECTION			

RBC AND PLATELET INDICES

HEMATOCRIT (PCV)	32.6 Low	36.0 - 46.0	%
METHOD : CUMULATIVE PULSE HEIGHT DETECTION METHOD			
MEAN CORPUSCULAR VOLUME (MCV)	74.4 Low	83.0 - 101.0	fL
METHOD : CALCULATED FROM RBC & HCT			
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	22.1 Low	27.0 - 32.0	pg
METHOD : CALCULATED FROM THE RBC & HGB			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)	29.8 Low	31.5 - 34.5	g/dL
METHOD : CALCULATED FROM THE HGB & HCT			
RED CELL DISTRIBUTION WIDTH (RDW)	16.2 High	11.6 - 14.0	%
METHOD : CALCULATED FROM RBC SIZE DISTRIBUTION CURVE			
MENTZER INDEX	17.0		
MEAN PLATELET VOLUME (MPV)	11.2 High	6.8 - 10.9	fL
METHOD : CALCULATED FROM PLATELET COUNT & PLATELET HEMATOCRIT			

WBC DIFFERENTIAL COUNT

NEUTROPHILS	57	40 - 80	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
LYMPHOCYTES	33	20 - 40	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
MONOCYTES	6	2 - 10	%

Dr.(Mrs)Neelu K Bhojani
Lab Head

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METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
EOSINOPHILS	4	1 - 6	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
BASOPHILS	0	0 - 1	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
ABSOLUTE NEUTROPHIL COUNT	5.25	2.0 - 7.0	thou/µL
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
ABSOLUTE LYMPHOCYTE COUNT	3.02 High	1.0 - 3.0	thou/µL
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
ABSOLUTE MONOCYTE COUNT	0.55	0.2 - 1.0	thou/µL
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
ABSOLUTE EOSINOPHIL COUNT	0.37	0.02 - 0.50	thou/µL
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
ABSOLUTE BASOPHIL COUNT	0 Low	0.02 - 0.10	thou/µL
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	1.7		

MORPHOLOGY

RBC	MICROCYTOSIS AND ANISOCYTOSIS
WBC	NORMAL MORPHOLOGY
METHOD : MICROSCOPIC EXAMINATION	
PLATELETS	ADEQUATE

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.

Dr.(Mrs)Neelu K Bhojani
Lab Head

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HAEMATOLOGY

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

ERYTHROCYTE SEDIMENTATION RATE (ESR),EDTA BLOOD			
E.S.R	6	0 - 20	mm
METHOD : MODIFIED WESTERGREN			
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD			
HBA1C	5.5	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)	%
METHOD : HPLC			
ESTIMATED AVERAGE GLUCOSE(EAG)	111.2	< 116.0	mg/dL
METHOD : CALCULATED PARAMETER			

Interpretation(s)
ERYTHROCYTE SEDIMENTATION RATE (ESR),EDTA 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, 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 in anemic) and in second trimester (0-70 mm /hr(95 in 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.

Dr.(Mrs)Neelu K Bhojani
Lab Head

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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 (Estimatec 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 recommendec ir 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 addiction 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 paltform (Boronate affinity chromatography) is recommendec 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 AB**		
METHOD : GEL COLUMN AGGLUTINATION METHOD.			
RH TYPE	**POSITIVE**		
METHOD : GEL COLUMN AGGLUTINATION METHOD.			

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 rec blood cells. Antibodies are found in plasma. To determine blood group, red cells are mixec 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 womer 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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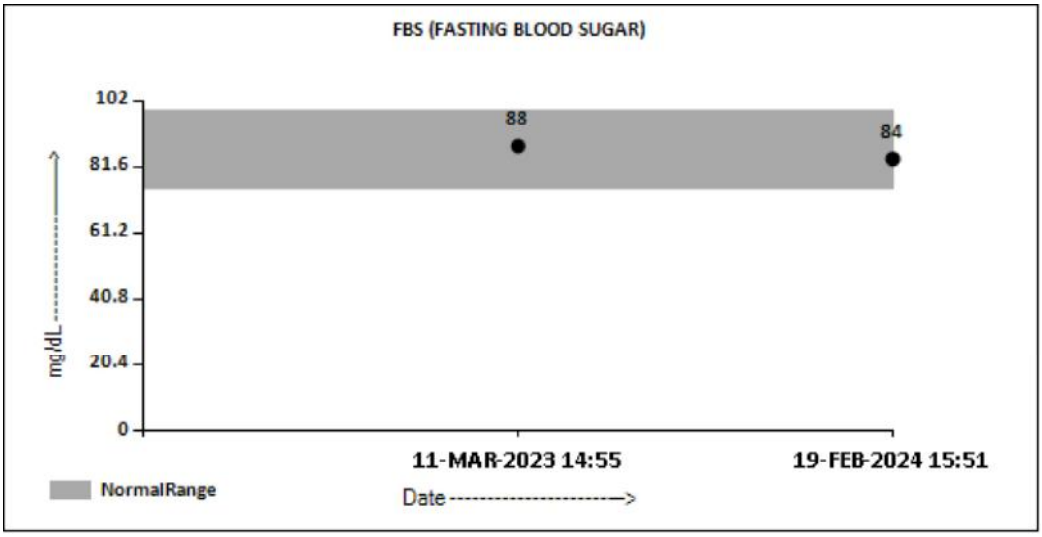
BIOCHEMISTRY

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

GLUCOSE FASTING,FLUORIDE PLASMA

FBS (FASTING BLOOD SUGAR)	84	Normal 75 - 99 Pre-diabetics: 100 – 125 Diabetic: > or = 126	mg/dL

METHOD : ENZYMATIC REFERENCE METHOD WITH HEXOKINASE



GLUCOSE, POST-PRANDIAL, PLASMA

PPBS(POST PRANDIAL BLOOD SUGAR)	93	70 - 139	mg/dL

METHOD : ENZYMATIC REFERENCE METHOD WITH HEXOKINASE

Dr. Ushma Wartikar
Consultant Pathologist

Dr.Priyal Chinchkhede
Consultant Pathologist

Dr.(Mrs)Neelu K Bhojani
Lab Head

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Mulund Goregoan Link Road
Mumbai, 400078
Maharashtra, India
Fax :
CIN - U74899PB1995PLC045956

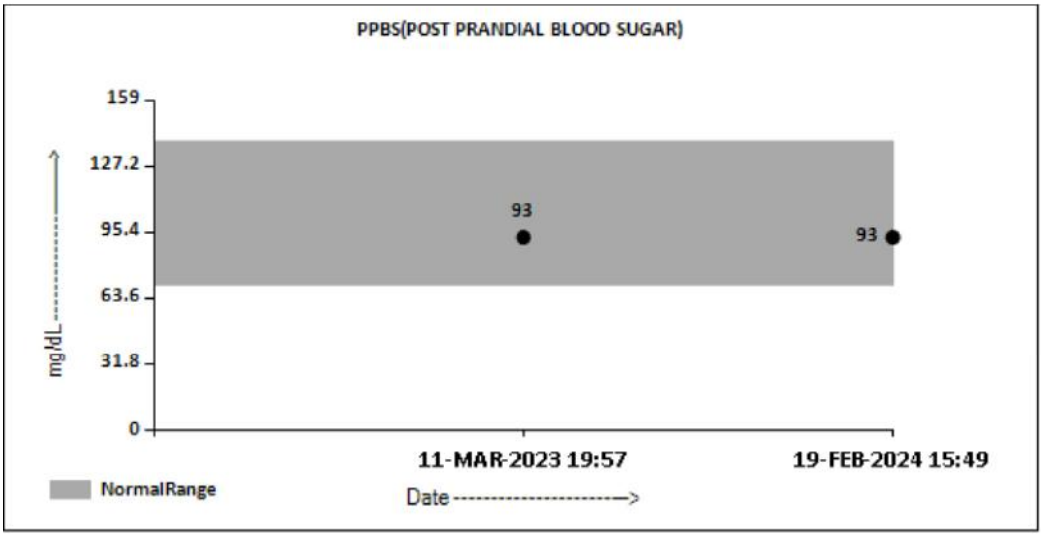
Patient Ref. No. 775000006479423

DIAGNOSTIC REPORT

agilus diagnostics

PATIENT NAME : MAYURI JAYESH KALAV		REF. DOCTOR : SELF
CODE/NAME & ADDRESS :C000138394 ARCOFEMI HEALTHCARE LTD (MEDIWHEEL F-703, F-703, LADO SARAI, MEHRAULISOUTH- WEST DELHI NEW DELHI 110030 8800465156	ACCESSION NO : 0181XB000963 PATIENT ID : MAYUF180990181 CLIENT PATIENT ID: ABHA NO :	AGE/SEX :33 Years Female DRAWN : RECEIVED : 19/02/2024 08:42:01 REPORTED : 22/02/2024 17:28:51

Test Report Status **Preliminary**	Results	Biological Reference Interval	Units



LIPID PROFILE WITH CALCULATED LDL

CHOLESTEROL, TOTAL	133	Desirable : < 200 Borderline : 200 - 239 High : > / = 240	mg/dL
METHOD : ENZYMATIC COLORIMETRIC ASSAY			
TRIGLYCERIDES	67	Normal: < 150 Borderline high: 150 - 199 High: 200 - 499 Very High: >/= 500	mg/dL
METHOD : ENZYMATIC COLORIMETRIC ASSAY			
HDL CHOLESTEROL	56	At Risk: < 40 Desirable: > or = 60	mg/dL
METHOD : ENZYMATIC, COLORIMETRIC			
CHOLESTEROL LDL	64	Adult levels: Optimal < 100 Near optimal/above optimal: 100-129 Borderline high : 130-159 High : 160-189 Very high : = 190	mg/dL
METHOD : ENZYMATIC COLORIMETRIC ASSAY			

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NON HDL CHOLESTEROL	77	Desirable : < 130 Above Desirable : 130 -159 Borderline High : 160 - 189 High : 190 - 219 Very high : > / = 220	mg/dL
VERY LOW DENSITY LIPOPROTEIN	13.4	< OR = 30.0	mg/dL
CHOL/HDL RATIO	2.4 Low	Low Risk : 3.3 - 4.4 Average Risk : 4.5 - 7.0 Moderate Risk : 7.1 - 11.0 High Risk : > 11.0	
LDL/HDL RATIO	1.1	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	

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**	
	LDL-C (mg/dl)	**Non-HDL (mg/dl)**	**LDL-C (mg/dl)**	**Non-HDL (mg/dl)**
Extreme Risk Group Category A	<50 (Optional goal < OR = 30)	< 80 (Optional goal <OR = 60)	>OR = 50	>OR = 80

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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

BILIRUBIN, TOTAL METHOD : COLORIMETRIC DIAZO	0.84	Upto 1.2	mg/dL
BILIRUBIN, DIRECT METHOD : DIAZO METHOD	0.30	< 0.30	mg/dL
BILIRUBIN, INDIRECT	0.54	0.1 - 1.0	mg/dL
TOTAL PROTEIN METHOD : COLORIMETRIC	6.5	6.0 - 8.0	g/dL
ALBUMIN METHOD : COLORIMETRIC	4.0	3.97 - 4.94	g/dL
GLOBULIN	2.5	2.0 - 3.5	g/dL
ALBUMIN/GLOBULIN RATIO	1.6	1.0 - 2.1	RATIO
ASPARTATE AMINOTRANSFERASE(AST/SGOT) METHOD : UV ABSORBANCE	15	< OR = 35	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT) METHOD : UV ABSORBANCE	11	< OR = 35	U/L
ALKALINE PHOSPHATASE METHOD : COLORIMETRIC	63	35 - 104	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT) METHOD : ENZYMATIC, COLORIMETRIC	18	0 - 40	U/L
LACTATE DEHYDROGENASE METHOD : UV ABSORBANCE	141	125 - 220	U/L

BLOOD UREA NITROGEN (BUN), SERUM

BLOOD UREA NITROGEN METHOD : ENZYMATIC ASSAY	13	6 - 20	mg/dL

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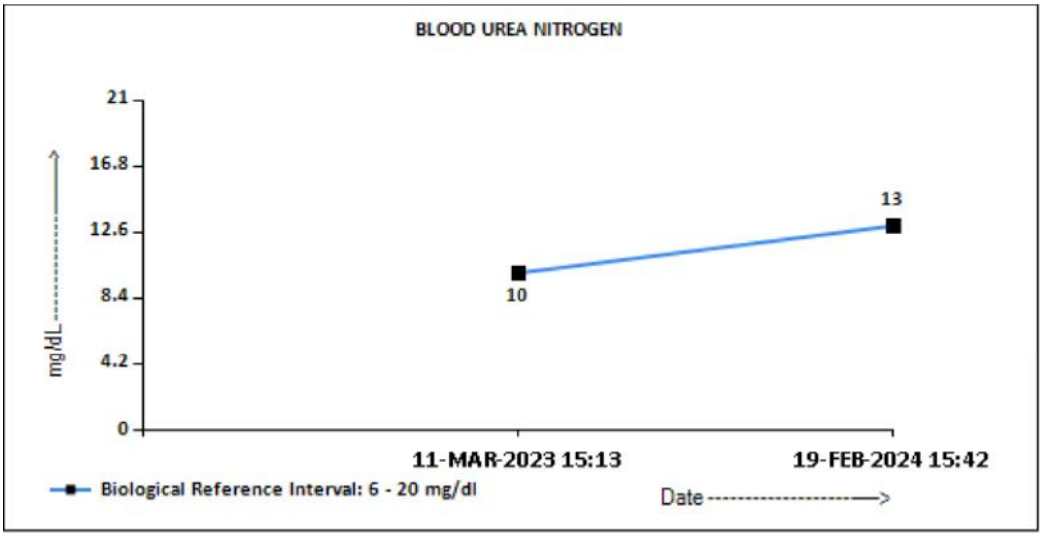

CREATININE, SERUM

CREATININE	0.64	0.5 - 0.9	mg/dL

METHOD : COLORIMETRIC

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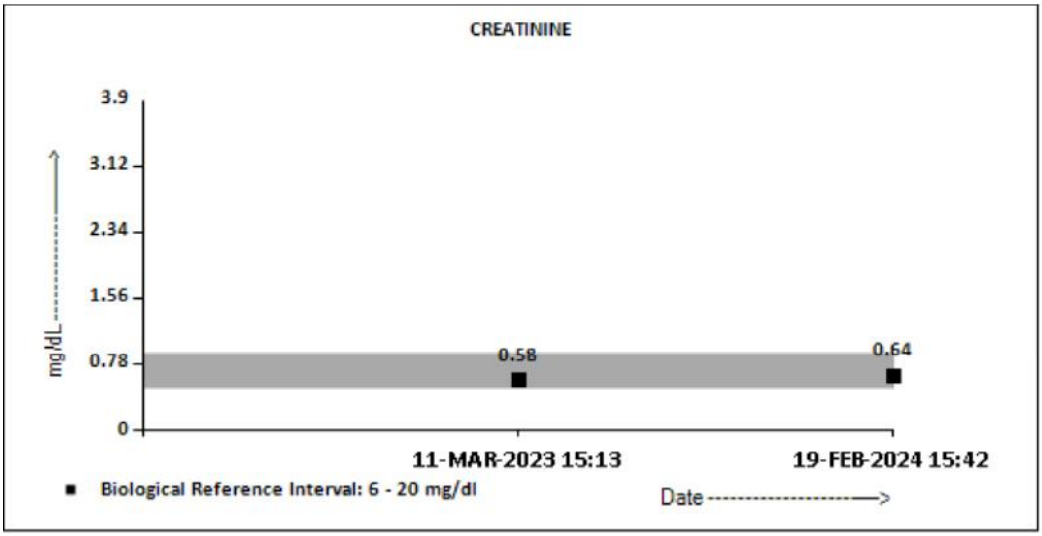

BUN/CREAT RATIO

BUN/CREAT RATIO	20.31 High	8.0 - 15.0	

URIC ACID, SERUM

URIC ACID	4.3	2.4 - 5.7	mg/dL

METHOD : ENZYMATIC COLORIMETRIC ASSAY

TOTAL PROTEIN, SERUM

TOTAL PROTEIN	6.5	6.0 - 8.0	g/dL

METHOD : COLORIMETRIC

ALBUMIN, SERUM

ALBUMIN	4.0	3.97 - 4.94	g/dL

METHOD : COLORIMETRIC

GLOBULIN

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GLOBULIN	**2.5**	**2.0 - 3.5**	g/dL
ELECTROLYTES (NA/K/CL), SERUM			
SODIUM, SERUM	**138**	**136 - 145**	mmol/L
METHOD : ION SELECTIVE ELECTRODE TECHNOLOGY			
POTASSIUM, SERUM	**4.90**	**3.5 - 5.1**	mmol/L
METHOD : ION SELECTIVE ELECTRODE TECHNOLOGY			
CHLORIDE, SERUM	**104**	**98 - 107**	mmol/L
METHOD : ION SELECTIVE ELECTRODE TECHNOLOGY			

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)

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 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.

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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, glycosylatec 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 Glyosuria,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 seer due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glyosuria, 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 increasec bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Conjugatec (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 termec 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 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 founc in diseases of the liver,biliary system and pancreas.Conditions that increase serum GGT are obstructive liver disease,high alcohol consumption anc 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 anc 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,increasec 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, Increasec 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 blooc flow, Loss of body fluic (dehydration), Muscle problems, such as breakdown of muscle fibers, Problems during pregnancy, such as seizures (eclampsia)), or high blooc 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,Rapic 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 ir the plasma is made up of albumin and globulin.
Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV anc 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. Albumir 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 decreasec lymphatic clearance,malnutrition and wasting etc.

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CLINICAL PATH - URINALYSIS

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

PHYSICAL EXAMINATION, URINE

COLOR	PALE YELLOW		
METHOD : MICROSCOPIC EXAMINATION			
APPEARANCE	CLEAR		
METHOD : MICROSCOPIC EXAMINATION			

CHEMICAL EXAMINATION, URINE

PH	7.5	4.6 - 8.0	
METHOD : METHYL RED & BROMOTHYMOL BLUE			
SPECIFIC GRAVITY	1.010	1.003 - 1.035	
PROTEIN	NOT DETECTED	NOT DETECTED	
METHOD : TETRA BROMOPHENOL BLUE/SULFOSALICYLIC ACID			
GLUCOSE	NOT DETECTED	NOT DETECTED	
METHOD : GLUCOSE OXIDASE / PEROXIDASE (GOD – POD) METHOD			
KETONES	NOT DETECTED	NOT DETECTED	
METHOD : SODIUM NITROPRUSSIDE REACTION			
BLOOD	NOT DETECTED	NOT DETECTED	
METHOD : STRIP TEST - DIAZONIUM SALT COUPLING			
UROBILINOGEN	NORMAL	NORMAL	
METHOD : CAFFEINE BENZOATE			
NITRITE	NOT DETECTED	NOT DETECTED	
METHOD : STRIP NAPHTHOETHYLENEDIAMINE HYDROCHOLORIDE,TATTANIC ACID			
LEUKOCYTE ESTERASE	NOT DETECTED	NOT DETECTED	
METHOD : STRIP HETROCYCLIC CARBOXYLIC ACID ESTER ,DIAZONIUM SALT			

MICROSCOPIC EXAMINATION, URINE

RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
METHOD : MICROSCOPIC EXAMINATION			
PUS CELL (WBC'S)	1-2	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION			
EPITHELIAL CELLS	1-2	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION			

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CODE/NAME & ADDRESS :C000138394 ARCOFEMI HEALTHCARE LTD (MEDIWHEEL F-703, F-703, LADO SARAI, MEHRAULISOUTH- WEST DELHI NEW DELHI 110030 8800465156	ACCESSION NO : 0181XB000963 PATIENT ID : MAYUF180990181 CLIENT PATIENT ID: ABHA NO :	AGE/SEX :33 Years Female DRAWN : RECEIVED : 19/02/2024 08:42:01 REPORTED : 22/02/2024 17:28:51

Test Report Status **Preliminary**	Results	Biological Reference Interval	Units
CASTS METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED		
CRYSTALS METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED		
BACTERIA METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED	NOT DETECTED	
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

Dr.Priyal Chinchkhede
Consultant Pathologist

Dr. Ushma Wartikar
Consultant Pathologist

Dr.(Mrs)Neelu K Bhojani
Lab Head

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PERFORMED AT :
Agilus Diagnostics Ltd.
Mulund Goregoan Link Road
Mumbai, 400078
Maharashtra, India
Fax :
CIN - U74899PB1995PLC045956

Patient Ref. No. 775000006479423

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Uric acid	arthritis
Bacteria	Urinary infectionwhen present in significant numbers & with pus cells.
Trichomonas vaginalis	Vaginitis, cervicitis or salpingitis

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DIAGNOSTIC REPORT

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Test Report Status **Preliminary**	Results	Biological Reference Interval	Units

CYTOLOGY

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40 FEMALE	RESULT PENDING
PAPANICOLAOU SMEAR	RESULT PENDING
LETTER	RESULT PENDING

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CLINICAL PATH - STOOL ANALYSIS

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

MICROSCOPIC EXAMINATION,STOOL	
REMARK	SAMPLE NOT RECEIVED

Ssawant

Dr. Sheetal Sawant
Consultant Microbiologist

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SPECIALISED CHEMISTRY - HORMONE

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

THYROID PANEL, SERUM

T3	139.0	Non-Pregnant Women 80.0 - 200.0 Pregnant Women 1st Trimester:105.0 - 230.0 2nd Trimester:129.0 - 262.0 3rd Trimester:135.0 - 262.0	ng/dL
T4	8.39	Non-Pregnant Women 5.10 - 14.10 Pregnant Women 1st Trimester: 7.33 - 14.80 2nd Trimester: 7.93 - 16.10 3rd Trimester: 6.95 - 15.70	µg/dL
TSH (ULTRASENSITIVE)	4.170	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

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