DIAGNOSTIC REPORT

agilus diagnostics

PATIENT NAME : CHANDNI SHUCHAK		**REF. DOCTOR :** SELF
CODE/NAME & ADDRESS : C000138364 ARCOFEMI HEALTHCARE LTD (MEDIWHEEL F-703, LADO SARAI, MEHRAULISOUTH WEST DELHI NEW DELHI 110030 8800465156	ACCESSION NO : **0321XD000095** PATIENT ID : CHANF030287246 CLIENT PATIENT ID: ABHA NO :	AGE/SEX : 37 Years Female DRAWN : RECEIVED : 01/04/2024 10:31:53 REPORTED : 02/04/2024 17:49:53

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	NORMAL SINUS RHYTHM		

MEDICAL HISTORY

RELEVANT PRESENT HISTORY	NOT SIGNIFICANT		
RELEVANT PAST HISTORY	P/HY/O FISTULA SURGERY 2023 C - SECTION JAN 2023		
RELEVANT PERSONAL HISTORY	NOT SIGNIFICANT		
MENSTRUAL HISTORY (FOR FEMALES)	REGULAR		
LMP (FOR FEMALES)	05/03/2024		
OBSTETRIC HISTORY (FOR FEMALES)	G1,P1,A0,L1		
LCB (FOR FEMALES)	2023		
RELEVANT FAMILY HISTORY	HYPERTENSION DIABETES		
OCCUPATIONAL HISTORY	NOT SIGNIFICANT		
HISTORY OF MEDICATIONS	NOT SIGNIFICANT		

ANTHROPOMETRIC DATA & BMI

HEIGHT IN METERS	1.61		mts
WEIGHT IN KGS.	95.5		Kgs
BMI	37	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

Dr.Sahil .N.Shah
Consultant Radiologist

Dr.Priyank Kapadia
Physician

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Patient Ref. No. 775000007024869

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GENERAL EXAMINATION

MENTAL / EMOTIONAL STATE	NORMAL		
PHYSICAL ATTITUDE	NORMAL		
GENERAL APPEARANCE / NUTRITIONAL STATUS	OBESE		
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		
TEMPERATURE	NORMAL		
PULSE	74/MIN		
RESPIRATORY RATE	NORMAL		

CARDIOVASCULAR SYSTEM

BP	99/74 MM HG (SITTING)		mm/Hg
PERICARDIUM	NORMAL		
APEX BEAT	NORMAL		
HEART SOUNDS	S1, S2 HEARD NORMALLY		
MURMURS	ABSENT		

RESPIRATORY SYSTEM

SIZE AND SHAPE OF CHEST	NORMAL		
MOVEMENTS OF CHEST	SYMMETRICAL		

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BREATH SOUNDS INTENSITY	NORMAL		
BREATH SOUNDS QUALITY	VESICULAR (NORMAL)		
ADDED SOUNDS	ABSENT		

PER ABDOMEN

APPEARANCE	NORMAL		
LIVER	NOT PALPABLE		
SPLEEN	NOT PALPABLE		

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

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

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SUMMARY

RELEVANT HISTORY	NOT SIGNIFICANT
RELEVANT GP EXAMINATION FINDINGS	NOT SIGNIFICANT
RELEVANT LAB INVESTIGATIONS	HEMOGLOBIN:- LOW, MCV:- LOW, MCH:- LOW FBS:- HIGH, HBA1C:- HIGH TRIGLYCERIDES:- HIGH, VLDL:- HIGH
RELEVANT NON PATHOLOGY DIAGNOSTICS	NO ABNORMALITIES DETECTED
REMARKS / RECOMMENDATIONS	1) HEMOGLOBIN:- LOW, MCV:- LOW, MCH:- LOW ADV:- TAKE MORE DIETARY IRON 2) FBS:- HIGH, HBA1C:- HIGH ADV:- REDUCE INTAKE OF SWEET, SUGAR, STARCH IN DIET, REGULAR PHYSICAL EXERCISE, REPEAT FBS, PPBS AND HBA1C AND DIABETOLOGIST OPINION 3) TRIGLYCERIDES:- HIGH, VLDL:- HIGH ADV:- LOW FAT DIET, REGULAR PHYSICAL EXERCISE

Comments

OUR PANEL DOCTORS FOR NON-PATHOLOGY TESTS:-

CHECK UP DONE BY:– DR. NAMRATA AGRAWAL (M.B.B.S)

REPORT REVIEWED BY:- DR. PRIYANK KAPADIYA (M.B.B.S DNB MEDICINE)

RADIOLOGIST:– DR. SAHIL N SHAH (M.D.RADIOLOGY)

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MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 50 FEMALE	RESULT PENDING	
ULTRASOUND ABDOMEN	RESULT PENDING	
TMT OR ECHO		
CLINICAL PROFILE		

TMT:- NORMAL

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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HAEMATOLOGY - CBC

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

BLOOD COUNTS,EDTA WHOLE BLOOD

HEMOGLOBIN (HB)	**9.2 Low**	12.0 - 15.0	g/dL
RED BLOOD CELL (RBC) COUNT	4.69	3.8 - 4.8	mil/µL
WHITE BLOOD CELL (WBC) COUNT	6.93	4.0 - 10.0	thou/µL
PLATELET COUNT	351	150 - 410	thou/µL

RBC AND PLATELET INDICES

HEMATOCRIT (PCV)	**30.1 Low**	36.0 - 46.0	%
MEAN CORPUSCULAR VOLUME (MCV)	**64.1 Low**	83.0 - 101.0	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	**19.5 Low**	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)	**30.4 Low**	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW)	**19.7 High**	11.6 - 14.0	%
MENTZER INDEX	13.7		
MEAN PLATELET VOLUME (MPV)	7.2	6.8 - 10.9	fL

WBC DIFFERENTIAL COUNT

NEUTROPHILS	41	40 - 80	%
LYMPHOCYTES	**48 High**	20 - 40	%
MONOCYTES	8	2.0 - 10.0	%
EOSINOPHILS	3	1.0 - 6.0	%
BASOPHILS	0	0 - 1	%
ABSOLUTE NEUTROPHIL COUNT	2.84	2.0 - 7.0	thou/µL
ABSOLUTE LYMPHOCYTE COUNT	**3.33 High**	1.0 - 3.0	thou/µL
ABSOLUTE MONOCYTE COUNT	0.55	0.2 - 1.0	thou/µL
ABSOLUTE EOSINOPHIL COUNT	0.21	0.02 - 0.50	thou/µL
ABSOLUTE BASOPHIL COUNT	**0.00 Low**	0.02 - 0.10	thou/µL
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	0.9		

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MORPHOLOGY

RBC	RBCs ARE MICROCYTIC HYPOCHROMIC WITH ANISOPOIKILOCYTOSIS. ELLIPTOCYTES AND TARGET CELLS PRESENT ON SMEAR.
WBC	NORMAL MORPHOLOGY
PLATELETS	ADEQUATE
IMPRESSION	MICROCYTIC ANEMIA ADVICE: HEMOGLOBIN STUDY BY HPLC/HB ELECTROPHORESIS
REMARKS	NO PREMATURE CELLS ARE SEEN. MALARIAL PARASITE NOT DETECTED.

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	**28 High**	0 - 20	mm at 1 hr
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD			
HBA1C	**5.8 High**	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 Therapeutic goals: < 7.0 Action suggested : > 8.0 (ADA Guideline 2021)	%
ESTIMATED AVERAGE GLUCOSE(EAG)	**119.8 High**	< 116.0	mg/dL

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 if anemic) and in second trimester (0-70 mm /hr(95 if anemic). ESR returns to normal 4th week post partum.
Decreased in: Polycythermia 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

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the adult reference range is "Practical Haematology by Dacie and Lewis,10th edition.
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 (Estimated 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 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 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 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
RH TYPE	POSITIVE

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 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

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GLUCOSE FASTING,FLUORIDE PLASMA			
FBS (FASTING BLOOD SUGAR)	**102 High**	74 - 99	mg/dL
GLUCOSE, POST-PRANDIAL, PLASMA			
PPBS(POST PRANDIAL BLOOD SUGAR)	86	70 - 140	mg/dL
LIPID PROFILE WITH CALCULATED LDL, SERUM			
CHOLESTEROL, TOTAL	177	Desirable: < 200 BorderlineHigh: 200 - 239 High: > or = 240	mg/dL
TRIGLYCERIDES	**198 High**	Desirable: < 150 BorderlineHigh: 150 - 199 High: 200 - 499 Very High: > or = 500	mg/dL
HDL CHOLESTEROL	**34 Low**	< 40 Low > or = 60 High	mg/dL
CHOLESTEROL LDL	**103 High**	Adult levels: Optimal < 100 Near optimal/above optimal: 100-129 Borderline high : 130-159 High : 160-189 Very high : = 190	mg/dL
NON HDL CHOLESTEROL	**143 High**	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
VERY LOW DENSITY LIPOPROTEIN	**39.6 High**	< or = 30	mg/dL
CHOL/HDL RATIO	**5.2 High**	3.3 - 4.4	

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Test Report Status **Preliminary**	Results	Biological Reference Interval	Units
LDL/HDL RATIO	3.0	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
LIVER FUNCTION PROFILE, SERUM			
BILIRUBIN, TOTAL	0.21	Upto 1.2	mg/dL
BILIRUBIN, DIRECT	0.13	Upto 0.2	mg/dL
BILIRUBIN, INDIRECT	0.08	0.00 - 1.00	mg/dL
TOTAL PROTEIN	6.9	6.4 - 8.3	g/dL
ALBUMIN	4.0	3.5 - 5.2	g/dL
GLOBULIN	2.9	2.0 - 4.1	g/dL
ALBUMIN/GLOBULIN RATIO	1.4	1.0 - 2.0	RATIO
ASPARTATE AMINOTRANSFERASE(AST/SGOT)	18	0 - 32	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)	9	0 - 33	U/L
ALKALINE PHOSPHATASE	95	35 - 104	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)	**47 High**	5 - 36	U/L
LACTATE DEHYDROGENASE	197	135 - 214	U/L
BLOOD UREA NITROGEN (BUN), SERUM			
BLOOD UREA NITROGEN	6	6 - 20	mg/dL
CREATININE, SERUM			
CREATININE	**0.58 Low**	0.60 - 1.10	mg/dL
BUN/CREAT RATIO			
BUN/CREAT RATIO	10.34	5.0 - 15.0	

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Patient Ref. No. 775000007024869

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URIC ACID, SERUM			
URIC ACID	3.9	2.4 - 5.7	mg/dL
TOTAL PROTEIN, SERUM			
TOTAL PROTEIN	6.9	6.4 - 8.3	g/dL
ALBUMIN, SERUM			
ALBUMIN	4.0	3.5 - 5.2	g/dL
GLOBULIN			
GLOBULIN	2.9	2.0 - 4.1	g/dL
ELECTROLYTES (NA/K/CL), SERUM			
SODIUM, SERUM	138.3	136 - 145	mmol/L
POTASSIUM, SERUM	3.90	3.3 - 5.1	mmol/L
CHLORIDE, SERUM	105.7	98 - 106	mmol/L

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.
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

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individuals.Thus, glycosylated 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 seen 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 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 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 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.
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, 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. **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.

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CLINICAL PATH - URINALYSIS

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

PHYSICAL EXAMINATION, URINE

COLOR	Yellow		
APPEARANCE	Clear		

CHEMICAL EXAMINATION, URINE

PH	7.5	4.7 - 7.5	
SPECIFIC GRAVITY	1.020	1.003 - 1.035	
PROTEIN	NOT DETECTED	NOT DETECTED	
GLUCOSE	NOT DETECTED	NEGATIVE	
KETONES	NOT DETECTED	NOT DETECTED	
BLOOD	NOT DETECTED	NEGATIVE	
BILIRUBIN	NOT DETECTED	NOT DETECTED	
UROBILINOGEN	NORMAL	NORMAL	
NITRITE	NOT DETECTED	NOT DETECTED	
LEUKOCYTE ESTERASE	NOT DETECTED	NOT DETECTED	

MICROSCOPIC EXAMINATION, URINE

RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
PUS CELL (WBC'S)	0-1	0-5	/HPF
EPITHELIAL CELLS	1-2	0-5	/HPF
CASTS	NOT DETECTED		
CRYSTALS	NOT DETECTED		
BACTERIA	NOT DETECTED	NOT DETECTED	
YEAST	NOT DETECTED	NOT DETECTED	
REMARKS	MICROSCOPIC EXAMINATION OF URINE IS CARRIED OUT ON CENTRIFUGED URINARY SEDIMENT.		

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DIAGNOSTIC REPORT

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CYTOLOGY

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

PAPANICOLAOU SMEAR

TEST METHOD	CONVENTIONAL GYNEC CYTOLOGY
SPECIMEN TYPE	TWO UNSTAINED CERVICAL SMEARS RECEIVED
REPORTING SYSTEM	2014 BETHESDA SYSTEM FOR REPORTING CERVICAL CYTOLOGY
SPECIMEN ADEQUACY	SMEARS ARE SATISFACTORY FOR EVALUATION.
MICROSCOPY	SMEARS SHOW PREDOMINANTLY SUPERFICIAL AND INTERMEDIATE SQUAMOUS CELLS AGAINST BACKGROUND OF MILD ACUTE INFLAMMATION. ENDOCERVICAL CELLS ARE NOT SEEN ON SMEARS. NO EVIDENCE OF DYSPLASIA OR MALIGNANT CELLS SEEN.
INTERPRETATION / RESULT	NEGATIVE FOR INTRAEPITHELIAL LESION OR MALIGNANCY

Comments

PAP SMEAR IS A SCREENING PROCEDURE FOR CERVICAL CANCER WITH INHERENT FALSE NEGATIVE RESULTS HENCE RESULTS SHOULD BE INTERPRETED WITH CAUTION.

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CLINICAL PATH - STOOL ANALYSIS

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 45F FEMALE	RESULT PENDING		
PHYSICAL EXAMINATION,STOOL	RESULT PENDING		
CHEMICAL EXAMINATION,STOOL	RESULT PENDING		
MICROSCOPIC EXAMINATION,STOOL	RESULT PENDING		

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SPECIALISED CHEMISTRY - HORMONE

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

THYROID PANEL, SERUM

T3	122.40	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	8.45	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)	1.660	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

****End Of Report****

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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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