

REPORT

| | | | |
|--------------------|--|-------------------|------------------------|
| Patient Name | : Ms. SHUCHI | Reg. No. | : 00152404270022 |
| Age and Sex | : 38 Yrs / Female | PCC Code | : PCL-HR-509 |
| Referring Doctor | : Self | Sample Drawn Date | : 27-Apr-2024 06:50 AM |
| Referring Customer | : N/A | Registration Date | : 27-Apr-2024 02:20 PM |
| Vial ID | : N4107560 | Report Date | : 27-Apr-2024 05:35 PM |
| Sample Type | : WB-EDTA | Report Status | : Final Report |
| Client Address | : Diagnostic Hub Opp.Grand Eva Sec 103 | | |

HEMATOLOGY

HEALTHCHECK PANEL

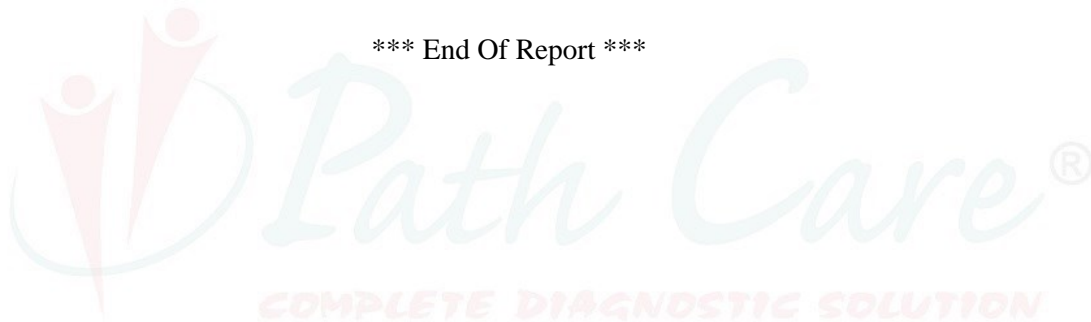
| Test Name | Obtained Value | Units | Bio. Ref. Intervals (Age/Gender specific) | Method |
|-----------|----------------|-------|--|--------|
|-----------|----------------|-------|--|--------|

| | | |
|---|----------------------|----------------------|
| *Erythrocyte Sedimentation Rate 08 (ESR) | mm in 1hr 12 or less | Westergren method |
|---|----------------------|----------------------|

Comment:

Conditions that may be associated with a highly elevated ESR include the Hypersensitivity Vasculitis, Giant Cell Arteritis, Waldenstrom Macroglobulinemia, Polymyalgia Rheumatic, Metastatic Cancer, Chronic infection, Hyperfibrogenemia etc.

*** End Of Report ***




DR. NEEMA NEHRA
MBBS; MD - PATHOLOGIST

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CLINICAL BIOCHEMISTRY

HEALTHCHECK PANEL

| Test Name | Obtained Value | Units | Bio. Ref. Intervals (Age/Gender specific) | Method |
|-------------------------------------|----------------|----------|--|------------|
| *Glycosylated Hemoglobin(GHb/HbA1c) | 5.0 | % | <5.7 Non diabetic, 5.7 – 6.4 Borderline diabetic, >6.4 Diabetic | HPLC |
| *Glycosylated Hemoglobin | 31.15 | mmol/mol | | Calculated |
| *Mean Blood Glucose | 96.80 | mg/dL | 90 - 120 : Excellent Control 121 - 150 : Good Control 151 - 180 : Average Control 181 - 210 : Action Suggested >211 :Panic Value | Calculated |

Comments:

- HbA1c is an indicator of glycemic control. HbA1c represents average Glycemia over the past six to eight weeks. Glycation of Hemoglobin occurs over the entire 120 day life span of the Red Blood Cell, but within this 120 days. Clinical studies suggest that a patient in stable control will have 50% of their HbA1c formed in the month before sampling, 25% in the month before that, and the remaining 25% in months two to four.
- Mean Plasma Glucose mg/dL = $28.7 \times \text{A1C} - 46.7$. Correlation between HbA1c and Mean Plasma Glucose (MPG) is not "perfect" but rather only this means that to predict or estimate average glucose from HbA1c or vice-versa is not "perfect" but gives a good working ballpark estimate.
- Afternoon and evening results correlate more closely to HbA1c than morning results, perhaps because morning fasting glucose levels vary much more than daytime Glucose levels, which are easier to predict and control. As per IFCC recommendations 2007, HbA1c being reported as above maintaining traceability to both IFCC (mmol/mol) & NGSP (%) units.
- Reference: ADA (American Diabetic Association) Guidelines 2023.

*** End Of Report ***




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| Vial ID | : N4107562 | Report Date | : 27-Apr-2024 03:57 PM |
| Sample Type | : Serum | Report Status | : Final Report |
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CLINICAL BIOCHEMISTRY

HEALTHCHECK PANEL

| Test Name | Obtained Value | Units | Bio. Ref. Intervals (Age/Gender specific) | Method |
|--------------------------------------|----------------|-------|--|------------|
| Iron Deficiency Profile-II | | | | |
| Iron | 48 | µg/dL | 50-170 | Ferene |
| Iron Binding Capacity - Total (TIBC) | 433 | ug/dL | 250-450 | Calculated |
| Transferrin | 302.8 | mg/dL | 176 - 280 | Calculated |
| % Iron Saturation | 11 | % | 20 - 50 | Calculated |

| | |
|-------------|---|
| Iron | Iron found in the blood is mainly present in the hemoglobin of the RBCs. Its role in the body is mainly in the transportation. Iron is absorbed in the Small Intestine, and bound to a globulin in the plasma called Transferrin and transported to the Bone Marrow for the formation of Hemoglobin. Increased serum levels are found in Hemolytic Anemias, Hepatitis, Lead and Iron poisoning. Decreased serum levels are found in Anemias caused by Iron Deficiency due to insufficient intake or absorption of Iron, chronic blood loss, late pregnancy and Cancer |
| TIBC | The serum TIBC varies in disorders of Iron metabolism. In Iron-deficiency Anemia the TIBC is elevated and the transferrin saturation is lowered to 15% or less. Low serum Iron associated with low TIBC is characteristic of the anemia of chronic disorders, malignant tumors, and infections. |




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| Vial ID | : N4107560 | Report Date | : 27-Apr-2024 03:03 PM |
| Sample Type | : WB-EDTA | Report Status | : Final Report |
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HEMATOLOGY
HEALTHCHECK PANEL

| Test Name | Obtained Value | Units | Bio. Ref. Intervals (Age/Gender specific) | Method |
|-----------------------------------|----------------|---------------------|--|---------------------------------|
| Complete Blood Count (CBC) | | | | |
| Haemoglobin | 12.8 | g/dL | 12.0-15.0 | Colorimetric |
| RBC Count | 4.9 | 10 ¹² /L | 3.8-4.8 | Electrical Impedance |
| Haematocrit (HCT) | 39.8 | % | 36-46 | Calculated |
| MCV | 80.5 | fl | 83-101 | RBC Histogram |
| MCH | 26.0 | pg | 27-32 | Calculated |
| MCHC | 32.2 | g/dL | 31.5-34.5 | Calculated |
| RDW-CV | 14.1 | % | 11.6-14.0 | RBC Histogram |
| Platelet Count | 224 | 10 ⁹ /L | 150-410 | Electrical Impedance/Microscopy |
| WBC count, Total | 4.5 | 10 ⁹ /L | 4.0-10.0 | Impedance |
| Neutrophils | 62.0 | % | 40-70 | Microscopy |
| Neutrophil-Absolute Count | 2.8 | 10 ⁹ /L | 2.0-7.0 | Calculated |
| Lymphocytes | 33.0 | % | 20-40 | Microscopy |
| Lymphocytes-Absolute Count | 1.5 | 10 ⁹ /L | 1.0-3.0 | Calculated |
| Monocytes | 3.0 | % | 2-10 | Microscopy |
| Monocytes-Absolute Count | 0.1 | 10 ⁹ /L | 0.2-1.0 | Calculated |
| Eosinophils | 2.0 | % | 1-6 | Microscopy |
| Eosinophils-Absolute Count | 0.1 | 10 ⁹ /L | 0.02-0.5 | Calculated |
| Basophils | 0.0 | % | 0-2 | Microscopy |
| Basophils-Absolute Count | 0.0 | 10 ⁹ /L | 0.0-0.3 | Calculated |
| Others | 0.0 | % | 00 | Microscopy |
| Remarks | - | | | |

Sample is Processed on Automated CBC Analyzer
Note: Haematocrit (HCT) is derived from calculated MCV based on RBC Histogram as per Manufacturer's Manual

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| Referring Customer | : N/A | Registration Date | : 27-Apr-2024 02:23 PM |
| Vial ID | : N4107559 | Report Date | : 27-Apr-2024 02:52 PM |
| Sample Type | : Plasma-Sodium Fluoride-Fasting | Report Status | : Final Report |
| Client Address | : Diagnostic Hub Opp.Grand Eva Sec 103 | | |

CLINICAL BIOCHEMISTRY

HEALTHCHECK PANEL

| Test Name | Obtained Value | Units | Bio. Ref. Intervals (Age/Gender specific) | Method |
|-----------------------|----------------|-------|---|------------|
| Glucose-Blood-Fasting | 90.0 | mg/dL | Normal < 100 Pre-diabetic 100-125 Diabetic >= 126 | Hexokinase |

Comments:

- Glucose is the major carbohydrate present in blood. Its oxidation in the cells is the source of energy for the body. Increased levels of Glucose are found in Diabetes Mellitus, Hyperparathyroidism, Pancreatitis and renal failure.
- Decreased levels are found in Insulinoma, Hypothyroidism, Hypopituitarism and extensive Liver disease

Biological Reference Interval : Source: American Diabetic Association, Diabetes Care 2018:41 (Suppl.1) S13-S27

Result rechecked and verified for abnormal cases.

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| Vial ID | : N4107562 | Report Date | : 27-Apr-2024 03:37 PM |
| Sample Type | : Serum | Report Status | : Final Report |
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CLINICAL BIOCHEMISTRY
HEALTHCHECK PANEL

| Test Name | Obtained Value | Units | Bio. Ref. Intervals (Age/Gender specific) | Method |
|---------------------------------------|----------------|--------|--|-------------------------------------|
| Kidney Function Test (KFT) - I | | | | |
| Creatinine | 0.6 | mg/dL | 0.6-1.1 | Kinetic Alkaline Picrate |
| Urea | 22.0 | mg/dL | 15.0-40.0 | Calculated |
| Uric Acid | 3.1 | mg/dL | 2.6-6.0 | Uricase |
| Sodium (Na) | 143 | mmol/L | 135-145 | Ion selective electrodes – Indirect |
| Potassium (K) | 3.81 | mmol/L | 3.8 - 5.2 | Ion selective electrodes – Indirect |
| Chloride(CL) | 107 | mmol/L | 98 - 108 | Ion selective electrodes – Indirect |

Urea is the end product of protein metabolism. It is synthesized in Liver from Ammonia produced by the catabolism of amino acids. It is transported by blood to Kidneys, from where it is excreted.

- Increased levels are found in renal diseases, urinary obstructions, shock, Congestive Heart Failure and burns.
- Decreased levels are found in Liver failure and pregnancy.

Creatinine is the catabolic product of Creatinine Phosphate, which is used by the skeletal Muscle.

- The daily production depends on muscular mass and it is excreted out of the body entirely by the Kidneys.
- Elevated levels are found in renal dysfunction, reduced renal blood flow shock, dehydration, Congestive Heart Failure, Diabetes Acromegaly. Decreased levels are found in Muscular Dystrophy.

Uric acid is the end product of purine metabolism.

- Uric acid is excreted to a large degree by the kidneys and to a smaller degree in the intestinal tract by microbial degradation.
- Increased levels are found in Gout, Arthritis, impaired renal functions and starvation.
- Decreased levels are found in Wilson's disease, Fanconis Syndrome and Yellow Atrophy of Liver.

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CLINICAL BIOCHEMISTRY
HEALTHCHECK PANEL

| Test Name | Obtained Value | Units | Bio. Ref. Intervals (Age/Gender specific) | Method |
|-----------------------------------|----------------|-------|--|-------------------------------------|
| Liver Function Test (LFT) | | | | |
| Bilirubin Total | 1.62 | mg/dL | 0.2-1.2 | Diazonium Salt |
| Bilirubin Direct | 0.45 | mg/dL | 0-0.5 | Diazo Reaction |
| Bilirubin Indirect | 1.17 | mg/dL | 0.2 - 1.0 | Calculated |
| Alkaline Phosphatase (ALP) | 77.0 | U/L | 40-150 | Para-Nitrophenyl-phosphate |
| Aspartate Aminotransferase (SGOT) | 20.0 | U/L | 11-34 | NADH w/o P-5'-P |
| Alanine Transaminase (ALT/SGPT) | 13.0 | U/L | 0-55 | NADH w/o P-5'-P |
| Gamma Glutamyl Transferase (GGT) | 25 | U/L | 9-36 | L-g-g-3-Carboxy-4-Nitroanilide subs |
| Protein Total | 6.3 | g/dL | 6.4-8.3 | Biuret |
| Albumin | 4.6 | g/dL | 3.5-5.2 | Bromocresol Green |
| Globulin | 1.7 | g/dl | 2.5 - 3.8 | Calculated |
| Albumin / Globulin Ratio | 2.7 | | 1.0 - 2.1 | Calculated |

SUGGESTED:

Please correlate clinically and with previous investigation if any and follow up.

*Liver function tests are blood tests used to help diagnose and monitor Liver disease or damage.

*Screen for Liver infections, such as Hepatitis, monitor possible side effects of medications

*Measure the severity of a disease, particularly scarring of the Liver (Cirrhosis)

***Alanine Transaminase (ALT)**- an enzyme found in the Liver that helps your body metabolize protein. When the Liver is damaged, ALT is released into the bloodstream and levels increase.

***Aspartate Transaminase (AST)**- an enzyme that helps metabolize Alanine, an amino acid. Like ALT, AST is normally present in blood at low levels. An increase in AST levels may indicate Liver damage or disease or Muscle damage.

***Alkaline Phosphatase (ALP)**- an enzyme in the Liver, bile ducts and bone. Higher-than-normal levels of ALP may indicate liver damage or disease, such as a blocked bile duct, or certain bone diseases.

***Albumin and Total Protein**- Albumin is one of several proteins made in the Liver. Your body needs these proteins to fight infections and to perform other functions. Lower-than-normal levels of albumin and total protein might indicate Liver damage or disease

***Bilirubin**- a substance produced during the normal breakdown of red blood cells. Bilirubin passes through the liver and is excreted in stool. Elevated levels of bilirubin (jaundice) might indicate liver damage or disease or certain types of anemia.

***Gamma-Glutamyltransferase (GGT)**- GGT is an enzyme in the blood. Higher-than-normal levels may indicate liver or bile duct damage.

Result rechecked and verified for abnormal cases.

*** End Of Report ***



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CLINICAL BIOCHEMISTRY

HEALTHCHECK PANEL

| Test Name | Obtained Value | Units | Bio. Ref. Intervals (Age/Gender specific) | Method |
|---|----------------|---------|---|----------------------------------|
| Lipid Profile | | | | |
| Cholesterol Total | 165 | mg/dL | Adult: Desirable<200 mg/dL, Borderline: 200 – 239 mg/dL, High:>240 mg/dL | Enzymatic |
| Cholesterol HDL | 47 | mg / dL | 40 - 60 | Direct Homogenous |
| Cholesterol - LDL | 97.6 | mg/dL | <100 Optimal | Calculated |
| Cholesterol VLDL | 20.4 | mg/dL | 7-40 | Calculated |
| Non-HDL cholesterol | 118 | mg/dL | Optimal < 130 | Calculated |
| Triglycerides | 102.0 | mg/dL | Normal: < 150~ Borderline High: 150 to 199~ High: 200 to 499~ Very High >= 500 | Glycerol Phosphate Oxidase |
| Cholesterol Total/Cholesterol HDL Ratio | 3.5 | | 0 - 4.0 | Calculated |
| Cholesterol LDL/Cholesterol HDL | 2.1 | | 0 - 3.5 | Calculated |

COMMENTS: Therapeutic target levels of lipids as per NCEP – ATP III recommendations:

| | |
|-----------------------------|---|
| Total Cholesterol (mg/dL) | <200 - Desirable, 200-239 - Borderline High, >240 - High |
| HDL Cholesterol (mg/dL) | <40 - Low, >60 - High |
| LDL Cholesterol (mg/dL) | <100 Optimal, [Primary Target of Therapy], 100-129 - Near Optimal/Above Optimal, 130-159 - Borderline High, 160-189 - High, >190 Very High |
| Serum Triglycerides (mg/dL) | <150 Normal, 150-199 Borderline High, 200-499 High, >500 Very High |

NCEP recommends lowering of LDL Cholesterol as the primary therapeutic target with Lipid lowering agents, however, if Triglycerides remain >200 mg/dL after LDL goal is reached, set secondary goal for non-HDL Cholesterol (total minus HDL) 30 mg/dL higher than LDL goal.

When Triglyceride level is > 400 mg/dL, Friedewald Equation is not applicable for calculation of LDL & VLDL. Hence the calculated values are not provided for such samples.

ATP III Guidelines:

| Risk Category | LDL Goal | LDL Level at Which to Initiate Therapeutic Lifestyle Changes (TLC) | LDL Level at Which to Consider Drug Therapy |
|---|------------|--|---|
| CHD or CHD RiskEquivalents(10-year risk >20%) | <100 mg/dL | >100 mg/dL | >130 mg/dL (100-129 mg/dL: drug optional)* |
| 2+ Risk Factors (10-year risk <20%) | <130 mg/dL | >130 mg/dL | 10-year risk 10-20%: >130 mg/dL 10-year risk <10%:>160mg/dL |
| 0-1 Risk Factor | <160 mg/dL | >160 mg/dL | >190 mg/dL (160-189 mg/dL: LDL-lowering drug optional) |


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CLINICAL BIOCHEMISTRY

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| Test Name | Obtained Value | Units | Bio. Ref. Intervals (Age/Gender specific) | Method |
|-----------|----------------|-------|--|-------------------------|
| Calcium | 9.00 | mg/dl | 8.4-10.2 | Arsenazo III Complex |

Interpretation:

| Category | Normal Ref. Range |
|----------------------|-------------------------|
| Premature | 6.2 mg/dL to 11.0 mg/dL |
| 0 to 10 days | 7.6 mg/dL to 10.4 mg/dL |
| 10 days to 24 months | 9.0 mg/dL to 11.0 mg/dL |
| Child 2 to 12 years | 8.8 mg/dL to 10.8 mg/dL |
| Adult | 8.4 mg/dL to 10.2 mg/dL |
| Male > 60 years | 8.8 mg/dL to 10.0 mg/dL |

Comments:

- * Calcium in the body is found mainly in the bones (approximately 99%). In serum, Calcium exists in a free ionised form and in bound form (with Albumin). Hence, a decrease in Albumin causes lower Calcium levels and vice-versa.
- * Calcium levels in serum depend on the Parathyroid Hormone.
- * Increased Calcium levels are found in Bone tumors, Hyperparathyroidism. decreased levels are found in Hypoparathyroidism, renal failure, Rickets.

*** End Of Report ***



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|-----------|----------------|-------|--|--------|

Thyroid Profile I

| | | | | |
|-----------------------------------|--------|--------|--|------|
| Tri-Iodothyronine Total (TT3) | 93.76 | ng/dL | 35-193 | CMIA |
| Thyroxine - Total (TT4) | 6.40 | µg/dL | 4.87-11.72 | CMIA |
| Thyroid Stimulating Hormone (TSH) | 1.2331 | µIU/mL | 0.35-4.94 (Test performed on 4th Generation TSH kit) | CMIA |

| Pregnancy | | | |
|-------------|-------------|------------|------------|
| | TSH(µIU/mL) | TT3(ng/dL) | TT4(µg/dL) |
| 1 Trimester | 0.10-2.50 | 89.9-196.6 | 4.4-11.5 |
| 2 Trimester | 0.2-3.00 | 86.1-217.4 | 4.9-12.2 |
| 3 Trimester | 0.3-3.00 | 79.9-186 | 5.1-13.2 |

Interpretation:

- Assay results should be interpreted in context to the clinical condition and associated results of other investigations.
- Previous treatment with corticosteroid therapy may result in lower TSH levels while Thyroid hormone levels are normal.
- Results are invalidated if the client has undergone a radionuclide scan within 7-14 days before the test.
- Abnormal thyroid test findings often found in critically ill clients should be repeated after the critical nature of the condition is resolved.
- The production, circulation, and disposal of Thyroid hormone are altered throughout the stages of pregnancy.
- Hyperthyroidism (overactive thyroid):**
Hyperthyroidism (overactive Thyroid) occurs when your thyroid gland produces too much of the hormone Thyroxine. Hyperthyroidism can accelerate your body's metabolism, causing unintentional weight loss and a rapid or irregular heartbeat.
- Hypothyroidism (underactive thyroid):**
Hypothyroidism (underactive thyroid) is a condition in which your Thyroid gland doesn't produce enough of certain crucial hormones. Hypothyroidism may not cause noticeable symptoms in the early stages. Over time, untreated Hypothyroidism can cause a number of health problems, such as obesity, joint pain, infertility and heart disease.

| | | | | |
|---------------|-----|-------|-----------|------|
| Vitamin - B12 | 796 | pg/mL | 187 - 833 | CMIA |
|---------------|-----|-------|-----------|------|

Comments:


- Vitamin B12 is essential in DNA synthesis Hematopoiesis, and Central Nervous System integrity.
- Its absorption depends on the presence of intrinsic factor (IF) and may be due to lack of IF secretion by gastric mucosa.
- Vitamin B12 deficiency frequently causes Macrocytic Anemia, Glossitis, Peripheral Neuropathy, Weakness, Hyperreflexia, Ataxia, Loss of Proprioception, poor coordination and effective behavioural changes. A significant increase in RBC MCV may be an important indicator of Vitamin B12 deficiency.

| | | | | |
|-------------------------------|------|-------|--|------|
| 25 - Hydroxy Vitamin D- Serum | 36.6 | ng/mL | Deficiency - < 20 Insufficiency - 20 -30 Sufficiency - 30 - 100 Toxicity - >100 | CMIA |
|-------------------------------|------|-------|--|------|

Comments:

- 25 OH Vitamin D is total of Vitamin D in Bone and mineral metabolism was recognized from its first identification as a factor that could cure rickets. However, Vitamin D is now recognized as a prohormone which has multiple roles in maintaining optimal health.
- Vitamin D toxicity is a recognized problem but a rare occurrence. Instead, a recent growing public health problem is Vitamin D insufficiency.


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| Rheumatoid Factor (RA test) - Serum | 8.4 | IU/mL | < 30 IU/mL, 30IU/mL – 50IU/mL weak | Immunoturbidometry |

Comments:

- Rheumatoid Factors are a heterogeneous group of auto antibodies directed against the antigenic determinants on the Fc- region of IgG molecules.
- They are useful in diagnosis of Rheumatoid Arthritis, but can also be found in other inflammatory diseases and in various non-rheumatic diseases. These occur in all the immunoglobulin classes, although the usual analytical methods are limited to the detection of Rheumatoid Factors of the IgM type. These are also found in clinically healthy persons over 60 yrs of age.

Correlate Clinically.

*** End Of Report ***


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