

REPORT

Patient Name	: Mr. SHASHI PRAKASH	Reg. No.	: 00042209040086
Age and Sex	: 55 Yrs / Male	PCC Code	: PCL-UP-474
Referring Doctor	: NA	Sample Drawn Date	: 04-Sep-2022 12:00 AM
Referring Customer	: DR. ATUL MATHUR MD	Registration Date	: 04-Sep-2022 03:11 PM
Vial ID	: M0820584, M0820582, M0820581	Report Date	: 04-Sep-2022 05:21 PM
Sample Type	: Serum, Plasma-Sodium Fluoride	Report Status	: Final Report
Client Address	: G.t.road, Bamrauli, prayagraj		

CLINICAL BIOCHEMISTRY

Test Name	Obtained Value	Units	Bio. Ref. Intervals (Age/Gender specific)	Method
*Alanine Transaminase (ALT/SGPT)	67.92	U/L	0-55	NADH w/o P-5'-P

Comments:

- ALT is found in a variety of tissues but is mainly found in the Liver.
- Increased levels are found in Hepatitis, Cirrhosis, Obstructive Jaundice and other Hepatic Disease.
- Slight elevation of the enzymes is also seen in Myocardial Infarction.

*Bilirubin Total	0.56	mg/dL	0.2-1.2	Diazonium Salt
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Comments:

- Bilirubin is formed from the heme portion of aged or damaged RBCs.
- Bilirubin combines with Albumin to form a complex which is not water soluble it is referred as indirect or unconjugated Bilirubin. In the Liver, Bilirubin complex is combined with Glucuronic Acid to form water soluble conjugated or direct Bilirubin.
- Elevated levels of Bilirubin are found in Liver diseases (Hepatitis, Cirrhosis) excessive Hemolysis / destruction of RBC (Hemolytic Jaundice) obstruction of biliary tract (Obstructive Jaundice) and in drug induced reactions. The differentiation between the direct and indirect Bilirubin is important in diagnosing the cause of Hyperbilirubinemia.

*Urea	49.8	mg/dL	18.0-55.0	Calculated
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Comments:

- Urea is the end product of the Protein metabolism. It is synthesized in Liver from the Ammonia produced by the catabolism of amino acids.
- It is transported by the Blood to the 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	0.89	mg/dL	0.7-1.3	Kinetic Alkaline Picrate
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Comments:

- 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.



Neha

DR. NEHA SHARMA
MD - PATHOLOGY

REPORT

Patient Name : Mr. SHASHI PRAKASH Age and Sex : 55 Yrs / Male Referring Doctor : NA Referring Customer : DR.ATUL MATHUR MD Vial ID : M0820584, M0820582, M0820581 Sample Type : Serum, Plasma-Sodium Fluoride Client Address : G.t.road, Bamrauli, prayagraj	Reg. No. : 00042209040086 PCC Code : PCL-UP-474 Sample Drawn Date : 04-Sep-2022 12:00 AM Registration Date : 04-Sep-2022 03:11 PM Report Date : 04-Sep-2022 05:21 PM Report Status : Final Report
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CLINICAL BIOCHEMISTRY

Test Name	Obtained Value	Units	Bio. Ref. Intervals (Age/Gender specific)	Method
*Glucose-Blood-Fasting	85.2	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

*Glucose - Post Prandial(PP)	80.10	mg/dL	Normal: <140 Pre-Diabetic: 140-199 Diabetic: >=200	Hexokinase
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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

*Uric Acid	4.6	mg/dL	3.5 - 7.2	Uricase
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Comments:

- 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 the Liver.

Result rechecked and verified for abnormal cases.
 *** End Of Report ***



DR. NE
 MD - PA

Note: If the test results are alarming or unexpected, Client is advised to contact the laboratory immediately for possible remedial action.

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Age and Sex	55 Yrs / Male	PCC Code	PCL-UP-474
Referring Doctor	NA	Sample Drawn Date	04-Sep-2022 12:09 AM
Referring Customer	DR. ATUL MATHUR MD	Registration Date	04-Sep-2022 03:11 PM
Vial ID	M0820584	Report Date	04-Sep-2022 04:44 PM
Sample Type	Serum	Report Status	Final Report
Client Address	G.T. road, Bamrauli, prayagraj		

CLINICAL BIOCHEMISTRY

Test Name	Obtained Value	Units	Bio. Ref. Intervals (Age/Gender specific)	Method
Lipid Profile				
Cholesterol Total	215.33	mg/dL	< 200 - Desirable	CHOD PAP
Cholesterol HDL	52.1	mg / dL	40 - 60	Direct Homogenous
Cholesterol - LDL	124.09	mg/dL	<100 Optimal	Calculated
Cholesterol VLDL	39.14	mg/dL	7-40	Calculated
Non-HDL cholesterol	163.23	mg/dL	Optimal < 130	Calculated
Triglycerides	195.7	mg/dL	Normal: <150 Borderline High: 150-199 High: 200-499	Glycerol Phosphate Oxidase
Cholesterol Total/Cholesterol HDL Ratio	4.13		0 - 4.0	Calculated
Cholesterol LDL/Cholesterol HDL	2.38		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)	<60 - Low, >60 - High
LDL Cholesterol (mg/dL)	<100 - Optimal, [Primary Target of Therapy], 100-129 - Near Optimal/Above Optimal, 130-159 - Borderline High, 160-199 - 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 Institute Therapeutic Lifestyle Changes (TLC)	LDL Level at Which to Consider Drug Therapy
CHD or CHD Risk Equivalents (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%: >160 mg/dL
0-1 Risk Factor	<160 mg/dL	>160 mg/dL	>190 mg/dL (160-189 mg/dL: LDL-lowering drug optional)



Neha
DR. NEHA SH
MD - PATHOLOGY

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Patient Name : Mr. SHASHI PRAKASH
 Age and Sex : 55 Yrs / Male
 Referring Doctor : NA
 Referring Customer : DR. ATUL MATHUR MD
 Vial ID : M0820583
 Sample Type : WB-EDTA
 Client Address : G.T.road, Bamrauli, Prayagraj

Reg. No. : 00042209040086
 PCC Code : PCL-UP-474
 Sample Drawn Date : 04-Sep-2022 12:00 AM
 Registration Date : 04-Sep-2022 03:11 PM
 Report Date : 04-Sep-2022 05:53 PM
 Report Status : Final Report

HEMATOLOGY

Test Name	Obtained Value	Units	Bio. Ref. Intervals (Age/Gender specific)	Method
Complete Blood Count (CBC)				
Haemoglobin	11.4	g/dL	13-17	Colorimetric Method
RBC Count	3.9	$10^{12}/L$	4.5-5.5	Cell Impedance
Haematocrit (HCT)	35.4	%	40-50	Calculated
MCV	90.0	fL	81-101	Calculated
MCH	28.9	pg	27-32	Calculated
MCHC	32.1	g/dL	31.5-34.5	Calculated
RDW-CV	14.7	%	11.6-14.0	Cell Impedance
Platelet Count	145	$10^9/L$	150-410	Cell Impedance
WBC count, Total	7.7	$10^9/L$	4.0-10.0	Microscopy
Neutrophils	40.0	%	40-70	Calculated
Neutrophil-Absolute Count	3.08	$10^9/L$	2.0-7.0	Microscopy
Lymphocytes	54.0	%	20-40	Calculated
Lymphocytes-Absolute Count	4.16	$10^9/L$	1.0-3.0	Microscopy
Monocytes	2.0	%	2-10	Calculated
Monocytes-Absolute Count	0.15	$10^9/L$	0.2-1.0	Microscopy
Eosinophils	4.0	%	1-6	Calculated
Eosinophils-Absolute Count	0.31	$10^9/L$	0.02-0.5	Microscopy
Basophils	0.0	%	0-2	Calculated
Basophils-Absolute Count	0.00	$10^9/L$	0.0-0.3	Microscopy
Others	0.0	%	00	

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

***Erythrocyte Sedimentation Rate 48 (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, Waldenström Macroglobulinemia, Polymyalgia Rheumatica, Malignancy, Cancer, Chronic Infection, Hyperfibrinogenemia etc.



Neha
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 MD - PATHOLOGIST

DIAGNOSTIC REPORT



CLIENT CODE : C000119495

CLIENT'S NAME AND ADDRESS :
LUCKERGANJ COLLECTION CENTRE
136 LUCKERGANJ TEHSIL, SADAR PRAYAGRAJ,
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9551527737

SRL Ltd
43/1, Sardar Patel Marg, Civil Lines,
Allahabad, 211001
Uttar Pradesh, INDIA
Tel : 9111591115, Fax : CIN - U74899PB1995PLC045956

PATIENT NAME : SHASHI PRAKASH DHORE

PATIENT ID : SHASF818674910

ACCESSION NO : 0201VE004745 AGE : 52 Years SEX : Female

DRAWN : 17/05/2022 11:16

RECEIVED : 17/05/2022 12:56

REPORTED : 17/05/2022 17:05

REFERRING DOCTOR : SELF

CLIENT PATIENT ID :

Test Report Status	Final	Results	Biological Reference Interval	Units
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HEALTH SCREEN 4

GLYCOSYLATED HEMOGLOBIN, EDTA WHOLE BLOOD

GLYCOSYLATED HEMOGLOBIN (HBA1C)	4.8 ✓		Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 ADA Target: 7.0 Action suggested: > 8.0	%
MEAN PLASMA GLUCOSE	91.1 ✓		< 116.0	mg/dL
GLUCOSE, FASTING, PLASMA				
GLUCOSE, FASTING, PLASMA	85		74 - 99	mg/dL
CORONARY RISK PROFILE (LIPID PROFILE), SERUM				
CHOLESTEROL	214 ↗	High	Desirable: < 200 BorderlineHigh: 200 - 239 High: > or = 240	mg/dL
TRIGLYCERIDES	127		Desirable: < 150 BorderlineHigh: 150 - 199 High: 200 - 499 Very High: > or = 500	mg/dL
HDL CHOLESTEROL	51		Low < 40 High > or = 60	mg/dL
DIRECT LDL CHOLESTEROL	142	High	Optimal: < 100 NearOptimal/AboveOptimal: 100 - 129 BorderlineHigh: 130 - 159 High: 160 - 189 VeryHigh: = 190	mg/dL
NON HDL CHOLESTEROL	163	High	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
CHOL/HDL RATIO	4.2		3.3 - 4.4 Low Risk 4.5-7.0 Average Risk 7.1 - 11.0 Moderate Risk > 11.0 High Risk	
LDL/HDL RATIO	2.8		0.5 - 3.0 Desirable/ Low Risk 3.1-6.0 Borderline /Moderate Risk > 6.0 High Risk	
VERY LOW DENSITY LIPOPROTEIN	25.4 ✓		12 - 30	mg/dL
THYROID PANEL, SERUM				
T3	91.1 ✓		80.00 - 200.00	ng/dL
METHOD : ELECTROCHEMILUMINESCENCE IMMUNO ASSAY				
T4	7.53 ✓		5.10 - 14.10	µg/dL

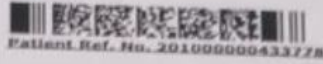


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43/1, Sardar Patel Marg, Civil Lines,
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Uttar Pradesh, INDIA
Tel : 9111591115, Fax : CIN : U74899PB1995PLC045956

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PATIENT ID : SHASPB18674910

ACCESSION NO : 0201VE004745 AGE : 52 Years SEX : Female

DRAWN : 17/05/2022 11:16

RECEIVED : 17/05/2022 12:56

REPORTED : 17/05/2022 17:05

REFERRING DOCTOR : SELF

CLIENT PATIENT ID :

Test Report Status	Final	Results	Biological Reference Interval	Units
TSH 3RD GENERATION		3.970	0.270 - 4.200	µIU/mL
METHOD : ELECTROCHEMILUMINESCENCE IMMUNO ASSAY				
SERUM BLOOD UREA NITROGEN		7	6 - 20	mg/dL
BLOOD UREA NITROGEN		7		
CREATININE, SERUM		0.63	0.60 - 1.10	mg/dL
CREATININE		0.63		
BUN/CREAT RATIO		11.11	5.0 - 15.0	
BUN/CREAT RATIO		11.11		
URIC ACID, SERUM		3.5	2.4 - 5.7	mg/dL
URIC ACID		3.5		
TOTAL PROTEIN, SERUM		7.2	6.4 - 8.3	g/dL
TOTAL PROTEIN		7.2		
ALBUMIN, SERUM		4.6	3.5 - 5.2	g/dL
ALBUMIN		4.6		
GLOBULIN		2.6	1.8 - 3.6	g/dL
GLOBULIN		2.6		
ELECTROLYTES (NA/K/CL), SERUM		143	137 - 145	mmol/L
SODIUM		143		mmol/L
POTASSIUM		4.60	3.6 - 5.0	mmol/L
CHLORIDE		104.2	98 - 107	mmol/L
BLOOD COUNTS, EDTA WHOLE BLOOD		10.8	Low 12.0 - 15.0	g/dL
HEMOGLOBIN		10.8		g/dL
RED BLOOD CELL COUNT		3.73	Low 3.8 - 4.8	mil/µL
WHITE BLOOD CELL COUNT		6.80	4.0 - 10.0	thou/µL
PLATELET COUNT		142	Low 150 - 410	thou/µL
RBC AND PLATELET INDICES		34.0	Low 36 - 46	%
HEMATOCRIT		34.0		%
MEAN CORPUSCULAR VOL		91.0	83 - 101	fL
MEAN CORPUSCULAR HGB		29.0	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION		31.9	31.5 - 34.5	g/dL
MENTZER INDEX		24.4		
RED CELL DISTRIBUTION WIDTH		14.3	High 11.6 - 14.0	%
MEAN PLATELET VOLUME		11.9	High 6.8 - 10.9	fL
WBC DIFFERENTIAL COUNT - NLR				

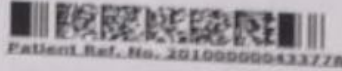


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 Tel : 9111591115, Fax : CN - U78999PB1995PLC045956

PATIENT NAME : SHASHI PRAKASH DHORE

PATIENT ID : SHASFB18674910

ACCESSION NO : 0201VE004745 AGE : 52 Years SEX : Female

DRAWN : 17/05/2022 11:16 RECEIVED : 17/05/2022 12:56 REPORTED : 17/05/2022 17:05

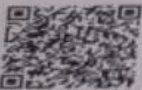
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CLIENT PATIENT ID :

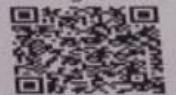
Test Report Status	Final	Results	Biological Reference Interval	Units
SEGMENTED NEUTROPHILS		58	40 - 80	%
ABSOLUTE NEUTROPHIL COUNT		3.94	2.0 - 7.0	thou/ μ L
LYMPHOCYTES		31	20 - 40	%
ABSOLUTE LYMPHOCYTE COUNT		2.11	1.0 - 3.0	thou/ μ L
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		30.5		
EOSINOPHILS		2	1 - 6	%
ABSOLUTE EOSINOPHIL COUNT		0.14	0.02 - 0.50	thou/ μ L
MONOCYTES		9	2 - 10	%
ABSOLUTE MONOCYTE COUNT		0.61	0.2 - 1.0	thou/ μ L
BASOPHILS		0	0 - 2	%
ABSOLUTE BASOPHIL COUNT		0	Low 0.02 - 0.10	thou/ μ L
DIFFERENTIAL COUNT PERFORMED ON:		EDTA SMEAR		
LIVER FUNCTION PROFILE, SERUM				
BILIRUBIN, TOTAL		0.51	Upto 1.2	mg/dL
BILIRUBIN, DIRECT		0.16	Upto 0.2	mg/dL
BILIRUBIN, INDIRECT		0.35	UPTO 0.6	mg/dL
TOTAL PROTEIN		7.2	6.4 - 8.3	g/dL
ALBUMIN		4.6	3.5 - 5.2	g/dL
GLOBULIN		2.6	1.8 - 3.6	g/dL
ALBUMIN/GLOBULIN RATIO		1.8		RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT)		23	0 - 32	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)		19	0 - 33	U/L
ALKALINE PHOSPHATASE		153	High 35 - 104	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)		13	5 - 36	U/L
LACTATE DEHYDROGENASE		267	High 135 - 214	U/L
PHYSICAL EXAMINATION, URINE				
COLOR		SAMPLE NOT RECEIVED		
METHOD : GROSS EXAMINATION				

Interpretation(s)

GLYCOSYLATED HEMOGLOBIN, EDTA WHOLE BLOOD- Glycosylated hemoglobin (Ghb) has been firmly established as an index of long-term blood glucose concentrations and as a measure of the risk for the development of complications in patients with diabetes mellitus. Formation of Ghb is essentially irreversible, and the concentration in the blood depends on both the life span of the red blood cell (average 120 days) and the blood glucose concentration. Because the rate of formation of Ghb is directly proportional to the concentration of glucose in the blood, the Ghb concentration represents the integrated values for glucose over the preceding 6-8 weeks.

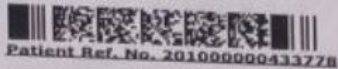


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ACCESSION NO : 0201VE004745 AGE : 52 Years SEX : Female

DRAWN : 17/05/2022 11:16

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Test Report Status	Final	Results	Biological Reference Interval	Units
S TYPHI 'O' ANTIGEN TITRE		1:160	< 1:80	TITER
S TYPHI 'H' ANTIGEN TITRE		1:80	< 1:80	TITER
S PARATYPHI 'AH' ANTIGEN		< 1:80	< 1:80	TITER
S PARATYPHI 'BH' ANTIGEN		< 1:80	< 1:80	TITER

Interpretation(s)

WIDAL TEST, SERUM-WIDAL TEST, SERUM

The Widal agglutination test is used for diagnosing Enteric Fever. The term enteric fever includes typhoid fever caused by Salmonella typhi, Salmonella paratyphi A, B and C. Though enteric fever is endemic in all parts of India, S.paratyphi C infections are uncommon and are not included in Widal testing.

Test Utility:

- The Widal test measures the antibodies against the flagellar & somatic antigens of typhoid and paratyphoid(A & B) bacilli in the patients sera. The test is performed in serially increasing dilutions.
- Diagnostic titre of Widal test varies highly between different geographical locations. It depends upon the baseline titre prevalent amongst the healthy individuals in that geographical area, which in turn is influenced by endemicity of typhoid in that region.
- The titre of the Widal test will depend on the stage of the disease. Antibodies usually appear by the beginning of second week of infection. Hence blood taken earlier may give a negative result. The titre increases steadily till the 3rd or 4th week after which it declines gradually.
- Cases treated early with antibiotics may show a poor antibody response.
- A single Widal test is of little clinical relevance due to the number of cross reacting infections, including malaria, tuberculosis, pneumonia, amoebiasis, rickettsial disease, rheumatoid arthritis, hepatitis B. A fourfold increase in the titer in paired sera in the course of the infection would be consistent with a typhoid infection.
- Persons who have suffered from enteric fever in the past may show agglutinins in moderate titre, even when suffering from other unrelated illness. Such anamnestic appearance may be differentiated by repeat testing after 7-10 days. Anamnestic response will show only a transient rise, while in enteric fever the rise will be sustained.
- TAB vaccinated patients may show a moderate rise in the titres against all three 'H', 'AH' & 'BH' antigens.

**** End Of Report ****

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

Yugank Anand
Dr. Yugank Anand
Consultant Pathologist

Neha
Dr. Neha Sharma
Locum Pathologist

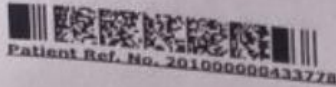


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 Tel : 9111591115, Fax : CIN - U74899PB1995PLC045956

PATIENT NAME : SHASHI PRAKASH DHORE

ACCESSION NO : **0201VE004745** AGE : 52 Years SEX : Female PATIENT ID : **SHASFB18674910**

DRAWN : 17/05/2022 11:16

RECEIVED : 17/05/2022 12:56

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Test Report Status	Final	Results	Biological Reference Interval	Units
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Any condition that alters the life span of the red blood cells has the potential to alter the Hb level. Samples from patients with hemolytic anemias will exhibit decreased glycated hemoglobin values due to the shortened life span of the red cells. This effect will depend upon the severity of the anemia. Samples from patients with polycythemia or post-splenectomy may exhibit increased glycated hemoglobin values due to a somewhat longer life span of the red cells. Glycosylated hemoglobins results from patients with HbSS, HbCC, and HbSC and HbD must be interpreted with caution, given the pathological processes, including anemia, increased red cell turnover, transfusion requirements, that adversely impact HbA1c as a marker of long-term glycemic control. In these conditions, alternative forms of testing such as glycated serum protein (fructosamine) should be considered. Targets should be individualized. More or less stringent glycemic goals may be appropriate for individual patients. Goals should be individualized based on duration of diabetes, age, life expectancy, comorbid conditions, known CVD or advanced microvascular complications, hypoglycemia unawareness, and individual patient considerations.

- References
1. Tietz Textbook of Clinical Chemistry and Molecular Diagnostics, edited by Carl A Burtis, Edward D. Ashwood, David E. Bruns, 4th Edition, Elsevier publication, 2006, 879-884.
 2. Forsham PH, Diabetes Mellitus: A rational plan for management. Postgrad Med 1982, 71, 139-154.
 3. Mayer TK, Freedman ZR: Protein glycosylation in Diabetes Mellitus: A review of laboratory measurements and their clinical utility. Clin Chim Acta 1983, 127, 147-184.

ADA 2021 guidelines for adults, after 8 hrs fasting is as follows:
 Pre-diabetic: 100 - 125 mg/dL
 Diabetic: > or = 126 mg/dL

CORONARY RISK PROFILE (LIPID PROFILE), SERUM-Serum cholesterol is a blood test that can provide valuable information for the risk of coronary artery disease. This test can help determine your risk of the build up of plaques in your arteries that can lead to narrowed or blocked arteries throughout your body (atherosclerosis). High cholesterol levels usually don't cause any signs or symptoms, so a cholesterol test is an important tool. High cholesterol levels often are a significant risk factor for heart disease and important for diagnosis of hyperlipoproteinemia, atherosclerosis, hepatic and thyroid diseases.

Serum Triglyceride are a type of fat in the blood. When you eat, your body converts any calories it doesn't need into triglycerides, which are stored in fat cells. High triglyceride levels are associated with several factors, including being overweight, eating too many sweets or drinking too much alcohol, smoking, being sedentary, or having diabetes with elevated blood sugar levels. Analysis has proven useful in the diagnosis and treatment of patients with diabetes mellitus, nephrosis, liver obstruction, other diseases involving lipid metabolism, and various endocrine disorders. In conjunction with high density lipoprotein and total serum cholesterol, a triglyceride determination provides valuable information for the assessment of coronary heart disease risk. It is done in fasting state.

High-density lipoprotein (HDL) cholesterol. This is sometimes called the "good" cholesterol because it helps carry away LDL cholesterol, thus keeping arteries open and blood flowing more freely. HDL cholesterol is inversely related to the risk for cardiovascular disease. It increases following regular exercise, moderate alcohol consumption and with oral estrogen therapy. Decreased levels are associated with obesity, stress, cigarette smoking and diabetes mellitus.

SERUM LDL The small dense LDL test can be used to determine cardiovascular risk in individuals with metabolic syndrome or established/progressing coronary artery disease. Individuals with triglyceride levels between 70 and 140 mg/dL, as well as individuals with a diet high in trans-fat or carbohydrates. Elevated sdLDL levels are associated with metabolic syndrome and an 'atherogenic lipoprotein profile', and are a strong, independent predictor of cardiovascular disease. Elevated levels of LDL arise from multiple sources. A major factor is sedentary lifestyle with a diet high in saturated fat. Insulin-resistance and pre-diabetes have also been implicated, as has genetic predisposition. Measurement of sdLDL allows the clinician to get a more comprehensive picture of lipid risk factors and tailor treatment accordingly. Reducing LDL levels will reduce the risk of CVD and MI.

Recommendations: Results of Lipids should always be interpreted in conjunction with the patient's medical history, clinical presentation and other findings.

NON FASTING LIPID PROFILE includes Total Cholesterol, HDL Cholesterol and calculated non-HDL Cholesterol. It does not include triglycerides and may be best used in patients for whom fasting is difficult.

THYROID PANEL, SERUM-Thyroid hormone, T3, is a thyroid hormone. It affects 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.

Thyroxine T4. Thyroxine's principal function is to stimulate the metabolism of all cells and tissues in the body. Excessive secretion of thyroxine in the body is hyperthyroidism, and deficient secretion is called 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.

In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hypothyroidism, TSH levels are low.

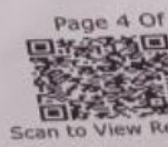
Below mentioned are the guidelines for Pregnancy related reference ranges for Total T4, TSH & Total T3

Levels in	TOTAL T4 (µg/dL)	TSH3G (µIU/mL)	TOTAL T3 (ng/dL)
Pregnancy	6.6 - 12.4	0.1 - 2.5	81 - 190
1st Trimester	6.6 - 15.5	0.2 - 3.0	100 - 260
2nd Trimester	6.6 - 15.5	0.3 - 3.0	100 - 260
3rd Trimester	6.6 - 15.5	0.3 - 3.0	100 - 260

Below mentioned are the guidelines for age related reference ranges for T3 and T4.

T3 (ng/dL)	T4 (µg/dL)
New Born: 75 - 260	1-3 day: 8.2 - 19.9
	1 Week: 6.0 - 15.9

NOTE: TSH concentrations in apparently normal euthyroid subjects are known to be highly skewed, with a strong tailed distribution towards higher TSH values. This is





Patient's Name : Shashi Prakash Age : Sex : Date :

Rx

Mo Bodyache
Nausea
Abdominal Discomfort

Pr. Cap Roversa - 1 daily
Tab olmitin Trio 1 daily
Tab PA-65 1 300mg
Tab - efg - 1 500mg
Cap Biolac - Z 1 daily
Sib etal UTE 2 TIF Zwater
Tab Eby - 2x 1120
Sib Becoban NC - 2 TIF 3x

Sp - 150/90 mmHg
PR - 139 mb
G/B नई.
Temp - 102° F

Adv
urinal test
USA Alderman
ECG
Urine CALE
U/S

1/R
28/3/2022



- डिजिटल एक्स-रे
 - पैथोलॉजी
 - ईएसीएजी
 - डिलेवरी
 - I.C.U.
 - N.I.C.U.
 - दूरबीन विधि एवं सभी प्रकार के आपरेशन
- 24 घन्टे आपातकालीन सेवा

कृपया अपनी सारी रिपोर्ट लेकर आएं

इमरजेन्सी फीस
रात्रि 12 से प्रातः 5 बजे तक
पर्व की वैधता 5 दि