L71 - NAGRA COLLECTION CENTRE
NA,NAGRA SIKANDARPUR ROAD ,NEAR TB HOSPITAL,NAGRA
Maunath Bhanjan 221711

Name	: **Ms. RAMAVATI**			**Collected**	: **17/4/2022 2:39:00PM**
Lab No.	: **324542309**	**Age: 64 Years**	**Gender: Female**	**Received**	: **17/4/2022 2:41:15PM**
				Reported	: **20/4/2022 6:54:49AM**
A/c Status	: **P**	**Ref By : SELF**		**Report Status**	: **Final**

SWASTHFIT COMPLETE HEALTH CHECK

Test Name	Results	Units	Bio. Ref. Interval
HEMOGRAM (Electrical Impedence,Manual,Westergr)			
Hemoglobin	**11.90**	g/dL	12.00 - 15.00
Packed Cell Volume (PCV)	37.50	%	36.00 - 46.00
RBC Count	4.14	mill/mm3	3.80 - 4.80
MCV	91.00	fL	83.00 - 101.00
MCH	28.70	pg	27.00 - 32.00
MCHC	31.70	g/dL	31.50 - 34.50
Red Cell Distribution Width (RDW)	**15.80**	%	11.60 - 14.00
Total Leukocyte Count (TLC)	9.30	thou/mm3	4.00 - 10.00
Differential Leucocyte Count (DLC)			
Segmented Neutrophils	69.80	%	40.00 - 80.00
Lymphocytes	28.10	%	20.00 - 40.00
Monocytes	**0.90**	%	2.00 - 10.00
Eosinophils	**0.70**	%	1.00 - 6.00
Basophils	0.50	%	<2.00
Absolute Leucocyte Count			
Neutrophils	6.49	thou/mm3	2.00 - 7.00
Lymphocytes	2.61	thou/mm3	1.00 - 3.00
Monocytes	**0.08**	thou/mm3	0.20 - 1.00
Eosinophils	0.07	thou/mm3	0.02 - 0.50
Basophils	0.05	thou/mm3	0.02 - 0.10
Platelet Count	**120.0**	thou/mm3	150.00 - 410.00
Mean Platelet Volume	**13.2**	fL	6.5 - 12.0

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Test Name	Results	Units	Bio. Ref. Interval
ESR	**74**	mm/hr	0.00 - 30.00

Note

1. As per the recommendation of International council for Standardization in Hematology, the differential leucocyte counts are additionally being reported as absolute numbers of each cell in per unit volume of blood

2. Test conducted on EDTA whole blood

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Test Name	Results	Units	Bio. Ref. Interval
AMYLASE, SERUM (IFCC)	48.00	U/L	<100

Comments

Amylase is produced in the Pancreas and most of the elevation in serum is due to increased rate of Amylase entry into the blood stream / decreased rate of clearance or both. Serum Amylase rises within 6 to 48 hours of onset of Acute pancreatitis in 80% of patients, but is not proportional to the severity of the disease. Activity usually returns to normal in 3-5 days in patients with milder edematous form of the disease. Values persisting longer than this period suggest continuing necrosis of pancreas or Pseudocyst formation. Approximately 20% of patients with Pancreatitis have normal or near normal activity. Hyperlipemic patients with Pancreatitis also show spuriously normal Amylase levels due to suppression of Amylase activity by triglyceride. Low Amylase levels are seen in Chronic Pancreatitis, Congestive Heart failure, 2nd & 3rd trimesters of pregnancy, Gastrointestinal cancer & bone fractures.

GLUCOSE, FASTING (F), PLASMA (Hexokinase)	**117.00**	mg/dL	70.00 - 100.00
CARDIO C-REACTIVE PROTEIN (hsCRP), SERUM (Immunoturbidimetry)	**4.18**	mg/L	<1.00

Interpretation

CARDIO CRP IN mg/L	CARDIOVASCULAR RISK
< 1.00	Low
1.00 - 3.00	Average
> 3.00	High

Note: To assess vascular risk, it is recommended to test hsCRP levels 2 or more weeks apart and calculate the average

Comments

High sensitivity C Reactive Protein (hsCRP) significantly improves cardiovascular risk assessment as it is a strongest predictor of future coronary events. It reveals the risk of future Myocardial infarction and Stroke among healthy men and women, independent of traditional risk factors. It identifies patients at risk of first Myocardial infarction even with low to moderate lipid levels. The risk of recurrent cardiovascular events also correlates well with hsCRP levels. It is a powerful independent risk determinant in the prediction of incident Diabetes.

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Test Name	Results	Units	Bio. Ref. Interval
APOLIPOPROTEINS A1 & B, SERUM** (Immunoturbidimetry)			
Apolipoprotein (Apo A1)**	172	mg/dL	76.00 - 214.00
Apolipoprotein (Apo B)**	104	mg/dL	46.00 - 142.00
Apo B / Apo A1 Ratio**	0.60		0.35 - 0.98

Comments

Apolipoprotein B is a more powerful independent predictor of Coronary Heart Disease (CAD) than LDL Cholesterol. It is useful in assessing the risk of CAD and to classify Hyperlipidemias. Apolipoprotein studies help in monitoring coronary bypass surgery patients with regard to risk and severity of re-stenosis. They are also useful in assessing risk of re-infarction in patients of Myocardial infarction.

Apolipoprotein A1 is one of the apoproteins of high density lipoproteins (HDL) which is inversely related to the risk of CAD. Individuals with Tangier disease have < 1% of normal Apo A1. Levels <90mg/dL indicate increased risk of Atherosclerotic disease.

As per recommendations of National Cholesterol Education Program (NCEP) the clinical significance of results is as follows:

Apolipoprotein B

RESULT IN mg/dL	REMARKS
<23	Abetalipoproteinemia/Hypobetalipoproteinemia
23-45	Hypobetalipoproteinemia
46-135	Normal
>135	Hyperapobetalipoproteinemia/Increased CAD risk

Apo B to A1 Ratio

RATIO	REMARKS
0.35-0.98	Desirable
>0.98	Increased CAD risk

IRON STUDIES, SERUM

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Test Name	Results	Units	Bio. Ref. Interval
(ImmunoCAP,FEIA)			
Iron	75.67	µg/dL	37.00 - 145.00
Total Iron Binding Capacity (TIBC)	299.67	µg/dL	228.00 - 428.00
Transferrin Saturation	25.25	%	15.00 - 50.00
UIBC	224.00	µg/dL	112.00 - 346.00

Comments

Iron is an essential trace mineral element which forms an important component of hemoglobin, metallocompounds and Vitamin A. Deficiency of iron, leads to microcytic hypochromic anemia. The toxic effects of iron are deposition of iron in various organs of the body and hemochromatosis.

Total Iron Binding capacity (TIBC) is a direct measure of the protein Transferrin which transports iron from the gut to storage sites in the bone marrow. In iron deficiency anemia, serum iron is reduced and TIBC increases.

Transferrin Saturation occurs in Idiopathic hemochromatosis and Transfusional hemosiderosis where no unsaturated iron binding capacity is available for iron mobilization. Similar condition is seen in congenital deficiency of Transferrin.

VITAMIN B12; CYANOCOBALAMIN, SERUM (ECLIA)	**1003.00**	pg/mL	211.00 - 946.00

Notes

1. Interpretation of the result should be considered in relation to clinical circumstances.
2. It is recommended to consider supplementary testing with plasma Methylmalonic acid (MMA) or plasma homocysteine levels to determine biochemical cobalamin deficiency in presence of clinical suspicion of deficiency but indeterminate levels. Homocysteine levels are more sensitive but MMA is more specific
3. False increase in Vitamin B12 levels may be observed in patients with intrinsic factor blocking antibodies, MMA measurement should be considered in such patients
4. The concentration of Vitamin B12 obtained with different assay methods cannot be used interchangeably due to differences in assay methods and reagent specificity

VITAMIN D, 25 - HYDROXY, SERUM (ECLIA)	**33.33**	nmol/L	75.00 - 250.00

Interpretation

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Test Name	Results	Units	Bio. Ref. Interval

LEVEL	REFERENCE RANGE IN nmol/L	COMMENTS
Deficient	< 50	High risk for developing bone disease
Insufficient	50-74	Vitamin D concentration which normalizes Parathyroid hormone concentration
Sufficient	75-250	Optimal concentration for maximal health benefit
Potential intoxication	>250	High risk for toxic effects

Note

- The assay measures both D2 (Ergocalciferol) and D3 (Cholecalciferol) metabolites of vitamin D.
- 25 (OH)D is influenced by sunlight, latitude, skin pigmentation, sunscreen use and hepatic function.
- Optimal calcium absorption requires vitamin D 25 (OH) levels exceeding 75 nmol/L.
- It shows seasonal variation, with values being 40-50% lower in winter than in summer.
- Levels vary with age and are increased in pregnancy.
- A new test Vitamin D, Ultrasensitive by LC-MS/MS is also available

Comments

Vitamin D promotes absorption of calcium and phosphorus and mineralization of bones and teeth. Deficiency in children causes Rickets and in adults leads to Osteomalacia. It can also lead to Hypocalcemia and Tetany. Vitamin D status is best determined by measurement of 25 hydroxy vitamin D, as it is the major circulating form and has longer half life (2-3 weeks) than 1,25 Dihydroxy vitamin D (5-8 hrs).

Decreased Levels

- Inadequate exposure to sunlight
- Dietary deficiency
- Vitamin D malabsorption
- Severe Hepatocellular disease
- Drugs like Anticonvulsants
- Nephrotic syndrome

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Increased levels

Vitamin D intoxication

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Test Name	Results	Units	Bio. Ref. Interval
LIVER & KIDNEY PANEL, SERUM (Reflectance Photometry,Direct ISE)			
Bilirubin Total	0.38	mg/dL	<1.10
Bilirubin Direct	0.09	mg/dL	<0.20
Bilirubin Indirect	0.29	mg/dL	<1.10
AST (SGOT)	19.2	U/L	<32
ALT (SGPT)	20.5	U/L	<33
GGTP	20.0	U/L	<42.00
Alkaline Phosphatase (ALP)	108.00	U/L	<141
Total Protein	7.98	g/dL	6.40 - 8.30
Albumin	4.66	g/dL	3.97 - 4.94
A : G Ratio	1.40		0.90 - 2.00
Urea	**48.30**	mg/dL	21.00 - 43.00
Creatinine	**0.92**	mg/dL	<0.90
Uric Acid	4.10	mg/dL	2.4 - 5.7

Regd. Office/National Reference Lab: Dr Lal PathLabs Ltd, Block-E, Sector-18, Rohini, New Delhi-110085
Web: www.lalpathlabs.com, **CIN No.:** L74899DL1995PLC065388

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Test Name	Results	Units	Bio. Ref. Interval
Calcium, Total	9.82	mg/dL	8.8 - 10.2
Phosphorus	4.48	mg/dL	2.6 - 4.5
Sodium	141.00	mEq/L	136.00 - 145.00
Potassium	**6.41**	mEq/L	3.5 - 5.1
Chloride	103.70	mEq/L	97 - 107

ADVICE: CKD RISK MAP
KDIGO guideline, 2012 recommends Chronic Kidney disease (CKD) should be classified based on cause, GFR category and albuminuria (ACR) category. GFR & ACR category combined together reflect risk of progression and helps clinician to identify individuals who are progressing at more rapid rate than anticipated

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Test Name	Results	Units	Bio. Ref. Interval

GFR category and albuminuria (ACR) category. GFR & ACR category combined together reflect risk of progression and helps clinician to identify individuals who are progressing at more rapid rate than anticipated

ADVICE: CKD RISK MAP

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Test Name	Results	Units	Bio. Ref. Interval
URINE EXAMINATION, ROUTINE; URINE, R/E (Automated Strip Test, Microscopy)			
Physical			
Colour	Pale Yellow		Pale yellow
Specific Gravity	1.015		1.001 - 1.030
pH	5		5.0 - 8.0
Chemical			
Proteins	**Present 1+(30.0 mg/dL)**		Negative
Glucose	Negative		Negative
Ketones	Negative		Negative
Bilirubin	Negative		Negative
Urobilinogen	Negative		Negative
Leucocyte Esterase	**Positive**		Negative
Nitrite	Negative		Negative
Microscopy			
R.B.C.	0-1 RBC/HPF		0.0 - 2.0 RBC/hpf
Pus Cells	**40 - 60 WBC/HPF**		0-5 WBC / hpf
Epithelial Cells	2-3 Epi Cells/hpf		0.0 - 5.0 Epi cells/hpf
Casts	Hyaline+		None seen/Lpf
Crystals	Negative		None seen
Others	Bacteria		

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Test Name	Results	Units	Bio. Ref. Interval
HbA1c (GLYCOSYLATED HEMOGLOBIN), BLOOD (HPLC, NGSP certified)			
HbA1c	**8.0**	%	4.00 - 5.60
Estimated average glucose (eAG)	183	mg/dL	

Interpretation
HbA1c result is suggestive of Diabetes/ Higher than glycemic goal in a known Diabetic patient.

Please note, Glycemic goal should be individualized based on duration of diabetes, age/life expectancy, comorbid conditions, known CVD or advanced microvascular complications, hypoglycaemia unawareness, and individual patient considerations

Result Rechecked,
Please Correlate Clinically.

Note: Presence of Hemoglobin variants and/or conditions that affect red cell turnover must be considered, particularly when the HbA1C result does not correlate with the patient's blood glucose levels.

FACTORS THAT INTERFERE WITH HbA1C MEASUREMENT	FACTORS THAT AFFECT INTERPRETATION OF HBA1C RESULTS
Hemoglobin variants,elevated fetal hemoglobin (HbF) and chemically modified derivatives of hemoglobin (e.g. carbamylated Hb in patients with renal failure) can affect the accuracy of HbA1c measurements	Any condition that shortens erythrocyte survival or decreases mean erythrocyte age (e.g.,recovery from acute blood loss, hemolytic anemia, HbSS, HbCC, and HbSC) will falsely lower HbA1c test results regardless of the assay method used.Iron deficiency anemia is associated with higher HbA1c

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Test Name	Results	Units	Bio. Ref. Interval
THYROID PROFILE,TOTAL, SERUM (ECLIA)			
T3, Total	**0.55**	ng/mL	0.80 - 2.00
T4, Total	6.10	µg/dL	5.10 - 14.10
TSH	1.61	µIU/mL	0.27 - 4.20

Note

1. TSH levels are subject to circadian variation, reaching peak levels between 2 - 4.a.m. and at a minimum between 6-10 pm . The variation is of the order of 50% . hence time of the day has influence on the measured serum TSH concentrations.
2. Alteration in concentration of Thyroid hormone binding protein can profoundly affect Total T3 and/or Total T4 levels especially in pregnancy and in patients on steroid therapy.
3. Unbound fraction (Free,T4 /Free,T3) of thyroid hormone is biologically active form and correlate more closely with clinical status of the patient than total T4/T3 concentration
4. Values <0.03 uIU/mL need to be clinically correlated due to presence of a rare TSH variant in some individuals

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Test Name	Results	Units	Bio. Ref. Interval
LIPID SCREEN, SERUM (CHO-POD)			
Cholesterol, Total	**211.20**	mg/dL	<200
Triglycerides	**247.30**	mg/dL	<150.00
HDL Cholesterol	60.00	mg/dL	>50
LDL Cholesterol, Calculated	**101.74**	mg/dL	<100.00
VLDL Cholesterol,Calculated	**49.46**	mg/dL	<30.00
Non-HDL Cholesterol	**151**	mg/dL	<130

Interpretation

REMARKS	TOTAL CHOLESTEROL in mg/dL	TRIGLYCERIDE in mg/dL	LDL CHOLESTEROL in mg/dL	NON HDL CHOLESTEROL in mg/dL
Optimal	<200	<150	<100	<130
Above Optimal	-	-	100-129	130 - 159
Borderline High	200-239	150-199	130-159	160 - 189
High	>=240	200-499	160-189	190 - 219
Very High	-	>=500	>=190	>=220

Note

1. Measurements in the same patient can show physiological & analytical variations. Three serial samples 1 week apart are recommended for Total Cholesterol, Triglycerides, HDL& LDL Cholesterol.
2. NLA-2014 recommends a complete lipoprotein profile as the initial test for evaluating cholesterol.
3. Friedewald equation to calculate LDL cholesterol is most accurate when Triglyceride level is < 400 mg/dL. Measurement of Direct LDL cholesterol is recommended when Triglyceride level is > 400 mg/dL

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Test Name	Results	Units	Bio. Ref. Interval

4. NLA-2014 identifies Non HDL Cholesterol(an indicator of all atherogeniclipoproteins such as LDL , VLDL, IDL, Lpa, Chylomicron remnants)along with LDL-cholesterol as co- primary target for cholesterol lowering therapy. Note that major risk factors can modify treatment goals for LDL &Non HDL.
5. Apolipoprotein B is an optional, secondary lipid target for treatment once LDL & Non HDL goals have been achieved
6. Additional testing for Apolipoprotein B, hsCRP,Lp(a) & LP-PLA2 should be considered among patients with moderate risk for ASCVD for risk refinement

Treatment Goals as per Lipid Association of India 2016

RISK CATEGORY	TREATMENT GOAL		CONSIDER THERAPY	
	LDL CHOLESTEROL (LDL-C)(mg/dL)	NON HDL CHLOESTEROL (NON HDL-C) (mg/dL)	LDL CHOLESTEROL (LDL-C)(mg/dL)	NON HDL CHLOESTEROL (NON HDL-C) (mg/dL)
Very High	<50	<80	>=50	>=80
High	<70	<100	>=70	>=100
Moderate	<100	<130	>=100	>=130
Low	<100	<130	>=130*	>=160*

*In low risk patient, consider therapy after an initial non-pharmacological intervention for at least 3 months

L71 - NAGRA COLLECTION CENTRE
NA,NAGRA SIKANDARPUR ROAD ,NEAR TB HOSPITAL,NAGRA
Maunath Bhanjan 221711

Name	: Ms. RAMAVATI			**Collected**	: 17/4/2022 2:39:00PM
Lab No.	: 324542309	**Age:** 64 Years	**Gender:** Female	**Received**	: 17/4/2022 2:41:15PM
				Reported	: 20/4/2022 6:54:49AM
A/c Status	: P	**Ref By :** SELF		**Report Status**	: Final

Test Name	Results	Units	Bio. Ref. Interval

Dr C K Tyagi
MD, Pathology
Chief of Laboratory
Dr Lal PathLabs Ltd

Dr Praveen Kumar
MD, Pathology
Chief of Laboratory
Dr Lal PathLabs Ltd

Dr Himangshu Mazumdar
MD, Biochemistry
Sr. Consultant Biochemist
NRL - Dr Lal PathLabs Ltd

Dr.Kamal Modi
MD, Biochemistry
Consultant Biochemist
NRL - Dr Lal PathLabs Ltd

Dr Nishant Bhagoliwal
DCP, Pathology
Consultant Pathologist
Dr Lal PathLabs Ltd

Dr Nimmi Kansal
MD, Biochemistry
Technical Director - Clinical Chemistry & Biochemical Genetics
NRL - Dr Lal PathLabs Ltd

Dr Priyanka Rai
MD, Pathology
Consultant Pathologist
Dr Lal PathLabs Ltd

----------End of report ----------

** Test conducted under NABL scope MC-2113,LPL-NATIONAL REFERENCE LAB at NEW DELHI

IMPORTANT INSTRUCTIONS

•Test results released pertain to the specimen submitted.•All test results are dependent on the quality of the sample received by the Laboratory.•Laboratory investigations are only a tool to facilitate in arriving at a diagnosis and should be clinically correlated by the Referring Physician.•Sample repeats are accepted on request of Referring Physician within 7 days post reporting.•Report delivery may be delayed due to unforeseen circumstances. Inconvenience is regretted.•Certain tests may require further testing at additional cost for derivation of exact value. Kindly submit request within 72 hours post reporting.•Test results may show interlaboratory variations.•The Courts/Forum at Delhi shall have exclusive jurisdiction in all disputes/claims concerning the test(s) & or results of test(s).•Test results are not valid for medico legal purposes.•Contact customer care Tel No. +91-11-39885050 for all queries related to test results.
(#) Sample drawn from outside source.