

C007183-Shiv Path Lab

Shop No.1 Opp. Water Tank Basti Road Indira Chowk Gajrola
AMROHAR, 244235
UTTAR PRADESH, India
Tel : 9760194969
Email : vaibhavgoyal0512@gmail.com

NAME : MR. SHYAM KUMAR BANSAL

AGE : 59 Years SEX : Male

 LAB REF NO.: **23976694**

 ACCESSION NO : **0027HI000558**

COLLECTED ON : 05/09/2019 00:00

REGISTERED ON : 06/09/2019 09:07

REPORTED ON: 06/09/2019 12:11

Report Status: Final
REFERRED BY : SELF

Tests	Results	Biological Reference Range	Units
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HEMATOLOGY
HEART CLINIC BASIC PACKAGE
COMPLETE BLOOD COUNT (CBC) WHOLE BLOOD

HEMOGLOBIN	14.3	13 - 17	g/dL
HEMATOCRIT	43.5	40 - 50	%
RBC COUNT	5.18	4.50 - 5.50	10 ⁶ /uL
MCV	84.0	83 - 101	fL
MCH	27.6	27 - 32	pg
MCHC	32.9	31.50 - 34.50	g/dL
RDW-CV	18.6	High 11.60 - 14.0	%
PLATELET COUNT	269	150 - 410	10 ³ /uL
TOTAL LEUCOCYTE COUNT	7.7	4 - 10	10 ³ /uL

DIFFERENTIAL LEUKOCYTE COUNT, WHOLE BLOOD

NEUTROPHILS	55.8	40 - 80	%
LYMPHOCYTES	37.3	20 - 40	%
MONOCYTES	5.3	2 - 10	%
EOSINOPHILS	1.2	1 - 6	%
BASOPHILS	0.4	<2.0	%
ABSOLUTE NEUTROPHIL COUNT	4.29	2 - 7	10 ³ /uL
ABSOLUTE LYMPHOCYTE COUNT	2.87	1 - 3	10 ³ /uL
ABSOLUTE MONOCYTE COUNT	0.41	0.20 - 1.0	10 ³ /uL
ABSOLUTE EOSINOPHIL COUNT	0.09	0.02 - 0.50	10 ³ /uL
ABSOLUTE BASOPHIL COUNT	0.03	0.02 - 0.10	10 ³ /uL

GLUCOSE FASTING, PLASMA

GLUCOSE FASTING	125.0	High 70 - 110	mg/dL
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LIPID PROFILE, SERUM			
CHOLESTEROL TOTAL	120.0	<200.0 DESIRABLE 200.0 - 239.0 BORDERLINE >=240.0 HIGH	mg/dL
METHOD : SPECTROPHOTOMETRY, CHOD- POD METHOD			
TRIGLYCERIDES	199.0	High <150 NORMAL 150 - 199 BORDERLINE 200 - 499 HIGH >= 500 VERY HIGH	mg/dL
METHOD : SPECTROPHOTOMETRY, GPO- POD METHOD			
HDL	41.0	<40.0 LOW 40.0 - 60.0 NORMAL >= 60.0 HIGH	mg/dL
METHOD : SPECTROPHOTOMETRY, DIRECT ENZYMATIC METHOD			
CHOLESTEROL LDL, CALCULATED	39.2	<100 OPTIMAL 100 - 129 NEAR OR ABOVE OPTIMAL 130 - 159 BORDERLINE HIGH 160 - 189 HIGH >=190 VERY HIGH	mg/dL
CHOLESTEROL VLDL, CALCULATED	39.8	High <= 30.0	mg/dL
CHOL / HDL RATIO	2.9	Low 3.3 - 4.4 LOW RISK 4.5 - 7.0 AVERAGE RISK 7.1 - 11.0 MODERATE RISK >11.0 HIGH RISK	Ratio
Comments			
KINDLY CORRELATE CLINICALLY. NOTE: 12 HRS FASTING IS MANDATORY BEFORE TESTING FOR LIPID PROFILE.			
BLOOD UREA NITROGEN (BUN), SERUM			
BLOOD UREA NITROGEN	14.00	7.0 - 18.0	mg/dL
METHOD : SPECTROPHOTOMETRY, UREASE-GLDH			
CREATININE, SERUM			
CREATININE	1.02	0.80 - 1.30	mg/dL
METHOD : SPECTROPHOTOMETRY, JAFFE-KINETIC			
BUN/CREATININE RATIO			
BUN/CREATININE RATIO	13.7		Ratio
URIC ACID, SERUM			
URIC ACID	4.1	3.5 - 7.2	mg/dL
METHOD : SPECTROPHOTOMETRY, URICASE			
CALCIUM, SERUM			
CALCIUM	9.60	8.5 - 10.1	mg/dL
METHOD : SPECTROPHOTOMETRY, O-CRESOLPHTHALEIN COMPLEXONE (OCPC) REACTION			



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Tests	Results	Biological Reference Range	Units
LIVER FUNCTION TEST, SERUM			
BILIRUBIN TOTAL	0.50	0.30 - 1.20	mg/dL
BILIRUBIN DIRECT	0.10	0.0 - 0.20	mg/dL
METHOD : SPECTROPHOTOMETRY, DIAZO METHOD			
BILIRUBIN INDIRECT	0.40	0.20 - 1.00	mg /dL
METHOD : CALCULATED			
ASPARTATE AMINOTRANSFERASE (SGOT)	29	15 - 37	U/L
ALANINE AMINOTRANSFERASE (SGPT)	44	16 - 63	U/L
METHOD : SPECTROPHOTOMETRY, UV WITH PYRIDOXAL-5-PHOSPHATE			
ALKALINE PHOSPHATASE	96	46.0 - 116.0	U/L
METHOD : SPECTROPHOTOMETRY, PNP AMP KINETIC			
GAMMA GLUTAMYL TRANSFERASE	54	15 - 85	U/L
METHOD : SPECTROPHOTOMETRY, G-GLUTAMYL-CARBOXY-NITROANILIDE			
PROTEIN TOTAL	7.4	6.4 - 8.2	g/dL
METHOD : SPECTROPHOTOMETRY, BIURET			
ALBUMIN	4.1	3.4 - 5.0	g/dL
METHOD : BROMCRESOL PURPLE (BCP)			
GLOBULIN	3.3	2.0 - 4.10	g/dL
A:G RATIO	1.24	1.0 - 2.1	Ratio



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THYROID PROFILE,TOTAL, SERUM

TRI-IODO THYRONIN, (T3)	87.70	60.0 - 181.0	ng/dL
THYROXIN, (T4)	5.80	3.20 - 12.6	µg/dL
THYROID STIMULATING HORMONE	5.48	0.35 - 5.50	µIU/mL

METHOD : CHEMILUMINESCENCE (CLIA)

Interpretation(s)

TSH stimulates the production and secretion of the metabolically active thyroid hormones, thyroxine (T4) and triiodothyronine (T3), by interacting with a specific receptor on the thyroid cell surface. The synthesis and secretion of TSH is stimulated by Thyrotropin releasing hormone (TRH), in response to low levels of circulating thyroid hormones. Elevated levels of T3 and T4 suppress the production of TSH via a classic negative feedback mechanism. Failure at any level of regulation of the hypothalamic-pituitary-thyroid axis will result in either underproduction (hypothyroidism) or overproduction (hyperthyroidism) of T4 and/or T3.

Limitations:

T3 and T4 circulates in reversibly bound form with Thyroid binding globulins (TBG), and to a lesser extent albumin and Thyroid binding Pre Albumin, so conditions in which TBG and protein levels alter such as pregnancy, excess estrogens, androgens, steroids may falsely affect the T3 and T4 levels. Normal levels of T4 can also be seen in Hyperthyroid patients with : T3 Thyrotoxicosis, hypoproteinemia or ingestion of certain drugs. Serum T4 levels in neonates and infants are higher than values in the normal adult, due to the increased concentration of TBG in neonate serum. TSH may be normal in central hypothyroidism, recent rapid correction of hyperthyroidism or hypothyroidism, pregnancy, phenytoin therapy. Autoimmune disorders may produce spurious results. Various drugs can interfere with the test result. TSH has a diurnal rhythm so values may vary if sample collection is done at different times of the day.

Reference intervals for T3, T4 & TSH from TIETZ Textbook of CLINICAL CHEMISTRY & MOLECULAR DIAGNOSTICS- 5th Edition

T3		T4		TSH	
Age	Reference Intervals (ng/dL)	Age	Reference Intervals (µg/dL)	Age	Reference Intervals (µIU/mL)
Children		Children		Children	
1 - 3 Days	100 - 740	1 - 3 Days	11.8 - 22.6	0 - 4 Days	1.0 - 39.0
1 - 11 Months	105 - 245	1 - 2 Week	9.9 - 16.6	2 weeks - 5 months	1.7 - 9.1
1 - 5 Years	105 - 269	1 - 4 Months	7.2 - 14.4	6 months - 20 Years	0.7 - 6.4
6 - 10 Years	94 - 241	4 Months - 1 Year	7.8 - 16.5	> 55 years	0.5 - 8.9
11 - 15 Years	82 - 213	1 - 5 Years	7.3 - 15.0	Pregnancy	Adolescents
	5- 10 Years 6.4 - 13.3	First Trimester	0.1 - 2.5	Second Trimester	0.2 - 3.0
15 - 20 years	80 - 210	11 - 15 Years	5.6 - 11.7	Third Trimester	0.3 - 3.0
Pregnancy					
First Trimester	81 - 190				
Second&Third Trimester	100-260				

*Pregnancy reference values for TSH provided as per recommendations by American Thyroid Association



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Gajraula. Mob no. 9837790322

Name	: Mr. SHYAM KUMAR BANSAL	Collected	: 7/5/2020 10:42:00AM
Lab No.	: 273629655	Received	: 7/5/2020 10:52:48AM
Age	: 59 Years	Reported	: 7/5/2020 4:04:05PM
Gender	: Male	Report Status	: Final
A/c Status	: P	Ref By	: Dr. SHIV PATH LAB

Test Name	Results	Units	Bio. Ref. Interval
LIPID SCREEN, SERUM (Spectrophotometry)			
Cholesterol, Total	143.40	mg/dL	<200.00
Triglycerides	267.00	mg/dL	<150.00
HDL Cholesterol	40.20	mg/dL	>40.00
LDL Cholesterol, Calculated	49.80	mg/dL	<100.00
VLDL Cholesterol, Calculated	53.40	mg/dL	<30.00
Non-HDL Cholesterol	103	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.

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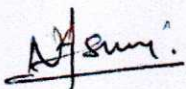
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- | Test Name | Results | Units | Bio. Ref. Interval |
|--|---------|-------|--------------------|
| 3. Friedewald equation to calculate LDL cholesterol is most accurate when Triglyceride level is < 400 mg/dL. Measurement of Direct LDL cholesterol is recommended when Triglyceride level is > 400 mg/dL | | | |
| 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



Dr Mohammad Naushad Ansari
 MD Pathology
 Chief of Laboratory
 Dr Lal PathLabs Ltd

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

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Test Name	Results	Units	Bio. Ref. Interval
COMPLETE BLOOD COUNT;CBC (Impedence, Photometry, Calculated, DHSS, Flow Cytometry & Cytochemistry)			
Hemoglobin	14.80	g/dL	13.00 - 17.00
Packed Cell Volume (PCV)	44.90	%	40.00 - 50.00
RBC Count	5.14	mill/mm3	4.50 - 5.50
MCV	87.00	fL	80.00 - 100.00
MCH	28.90	pg	27.00 - 32.00
MCHC	33.00	g/dL	32.00 - 35.00
Red Cell Distribution Width (RDW)	17.90	%	11.50 - 14.50
Total Leukocyte Count (TLC)	8.80	thou/mm3	4.00 - 10.00
Differential Leucocyte Count (DLC)			
Segmented Neutrophils	38.30	%	40.00 - 80.00
Lymphocytes	53.10	%	20.00 - 40.00
Monocytes	4.60	%	2.00 - 10.00
Eosinophils	4.00	%	1.00 - 6.00
Basophils	0.00	%	<2.00
Absolute Leucocyte Count			
Neutrophils	3.37	thou/mm3	2.00 - 7.00
Lymphocytes	4.67	thou/mm3	1.00 - 3.00
Monocytes	0.40	thou/mm3	0.20 - 1.00
Eosinophils	0.35	thou/mm3	0.02 - 0.50
Basophils	0.00	thou/mm3	0.01 - 0.10
Platelet Count	287.0	thou/mm3	150.00 - 450.00

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		Reported	: 7/5/2020 4:04:05PM

Test Name	Results	Units	Bio. Ref. Interval
HbA1c (GLYCOSYLATED HEMOGLOBIN), BLOOD (HPLC)			
HbA1c	7.2	%	
Estimated average glucose (eAG)	160	mg/dL	

Interpretation

As per American Diabetes Association (ADA)	
Reference Group	HbA1c in %
Non diabetic adults >=18 years	4.0 - 5.6
At risk (Prediabetes)	5.7 - 6.4
Diagnosing Diabetes	>= 6.5
Therapeutic goals for glycemic control	< 7.0

Note

1. Since HbA1c reflects long term fluctuations in the blood glucose concentration, a diabetic patient who is recently under good control may still have a high concentration of HbA1c. Converse is true for a diabetic previously under good control but now poorly controlled
2. Target goals of < 7.0 % may be beneficial in patients with short duration of diabetes, long life expectancy and no significant cardiovascular disease. In patients with significant complications of diabetes, limited life expectancy or extensive co-morbid conditions, targeting a goal of < 7.0 % may not be appropriate
3. Presence of Hemoglobin variants and/or conditions that affect red cell turnover must be considered, particularly when the A1C result does not correlate with the patient's blood glucose levels
4. In patients with HbA1c level between 7-8%, Glycemark (1,5 Anhydroglucitol) test may be done to identify those with more frequent and extreme hyperglycemic excursions

Comments

HbA1C reflects average glycemia over approximately 3 months, the test is the major tool for assessing glycemic control and has strong predictive value for diabetes complications. Thus, HbA1C testing should be performed routinely in all patients with diabetes - at initial assessment and as part of continuing care.

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A/c Status	: P	Ref By : Dr. SHIV PATH LAB	Reported	: 7/5/2020 4:04:05PM	
			Report Status	: Final	

Test Name	Results	Units	Bio. Ref. Interval
Measurement approximately every 3 months determines whether patients' glycemic targets have been reached and maintained. The frequency of A1C testing should depend on the clinical situation, the treatment regimen, and the clinician's judgement.			

ADA Recommendations for HbA1c testing

1. Perform the A1C test at least two times a year in patients who are meeting treatment goals (and who have stable glycemic control)
2. Perform the A1C test quarterly in patients whose therapy has changed or who are not meeting glycemic goals

Factors that Interfere with HbA1c Measurement: 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

Factors that affect interpretation of HbA1c Results: 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


Client
Meerut

Pathkind Diagnostic Pvt. Ltd.

8,9- Begum Bridge Road, Opposite City Center, Bacha Park,

Processed By
Pathkind Diagnostic Pvt. Ltd.

Plot No. 55-56, Udhog Vihar Ph-IV, Gurugram - 122015

Name : Mr. SHYAM KUMAR BANSAL	Billing Date : 31/12/2019 10:40:07
Age : 58 Yrs	Sample Collected on : 31/12/2019 10:41:52
Sex : Male	Sample Received on : 31/12/2019 14:58:30
P. ID No. : P110044470	Report Released on : 01/01/2020 13:29:09
Accession No : 110019000013536	Barcode No. : 7183502
Referring Doctor : DR.RAKESH KUMAR ARAN	
Reference By :	

Report Status - Final

Test Name	Result	Biological Ref. Interval	Unit
BIOCHEMISTRY			
HEALTHKIND TOTAL			
* TSH 3rd Generation <small>Sample: Serum Method: ECLIA</small>	2.690	0.270 - 4.200	µIU/mL

TSH 3rd Generation
Clinical Significance :

TSH levels are elevated in primary hypothyroidism and low in primary hyperthyroidism. Evaluation of TSH is useful in the differential diagnosis of primary from secondary and tertiary hypothyroidism. In primary hypothyroidism, TSH levels are elevated, while in secondary and tertiary hypothyroidism, TSH levels are low or normal. High TSH level in the presence of normal FT4 is called subclinical hypothyroidism and low TSH with normal FT4 is called subclinical hyperthyroidism. Sick, hospitalized patients may have falsely low or transiently elevated TSH. Significant diurnal variation is also seen in TSH levels.

Dr. Manesh Bagai

 MD (Pathology)
 Head - Reference Lab




8,9- Begum Bridge Road, Opposite City Center, Bacha Park, Meerut
 8,9- Begum Bridge Road, Opposite City Center, Bacha Park, Meerut- 250002, Contact No-7902101834,8448393145

Name : Mr. SHYAM KUMAR BANSAL
Age : 58 Yrs
Sex : Male
P ID No. : P11004470
Accession No : 110019000013536
Referring Doctor : DR. RAKESH KUMAR ARAN
Referred By :

Billing Date : 31/12/2019 10:40:07
Sample Collected on : 31/12/2019 10:41:52
Sample Received on : 31/12/2019 14:58:30
Report Released on : 01/01/2020 13:29:09
Barcode No. : 7183504

Report Status - Final

Test Name	Result	Biological Ref. Interval	Unit
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Lymphocytes
 Sample: Whole Blood EDTA
 Method: VCS Technology & Microscopy
 45 H 20 - 40 %

Eosinophils
 Sample: Whole Blood EDTA
 Method: VCS Technology & Microscopy
 03 01 - 06 %

Monocytes
 Sample: Whole Blood EDTA
 Method: VCS Technology & Microscopy
 04 02 - 10 %

Basophils
 Sample: Whole Blood EDTA
 Method: VCS Technology & Microscopy
 00 00 - 02 %

Absolute Neutrophil Count
 Sample: Whole Blood EDTA
 4752 2000 - 7000 /µL

Absolute Lymphocyte Count
 Sample: Whole Blood EDTA
 4455 H 1000 - 3000 /µL

Absolute Eosinophil Count
 Sample: Whole Blood EDTA
 297 20 - 500 /µL

Absolute Monocyte Count
 Sample: Whole Blood EDTA
 396 200 - 1000 /µL

Absolute Basophil Count
 Sample: Whole Blood EDTA
 00 L 20 - 100 /µL

PLC Performed By
 Sample: Whole Blood EDTA
 Automated
Platelet Count
 Sample: Whole Blood EDTA
 Method: Impedance
 303 150 - 410 thou/µL

MPV (Mean Platelet Volume)
 Sample: Whole Blood EDTA
 Method: Calculated
 8.3 6.8 - 10.9 fL

110019000013536 Mr. SHYAM KUMAR BANSAL



जांच सही तो इलाज सही





The Test/s marked with (#) is/are not accredited by NABL 110019000013536 Mr. SHYAM KUMAR BANSAL

Test Name	Result	Biological Ref. Interval	Unit
Fasting Plasma Glucose Sample: Fluoride Plasma - f Method: Hexokinase	151 H	Normal : 74 - 99 Impaired Fasting Glucose : 100 - 125 Diabetes : > 126	mg/dL
HbA1c (Glycosylated Hemoglobin) Sample: Whole Blood EDTA Method: High Performance Liquid Chromatography (HPLC)	7.8 H	Non Diabetic : < 5.7 % Prediabetic Range : 5.7 - 6.4 % Diabetic Range : >= 6.5 % Goal of Therapy : <7.0 % Action suggested : >8.0 %	%
# Mean Plasma Glucose Sample: Whole Blood EDTA Method: Calculated	177.2 H	<116.0	mg/dL
Total Cholesterol Sample: Serum Method: Spectrophotometry-Esterase/CO/Peroxidase	158	Desirable Level : < 200 Borderline : 200 - 239 High Risk : >= 240	mg/dL
Triglycerides Sample: Serum Method: Spectrophotometry-Enzymatic	288 H	Desirable : < 150 Borderline High : 150 - 199 High : 200 - 499 Very High : >= 500	mg/dL
LDL Cholesterol (Calculated) Sample: Serum Method: Calculated	54	Optimal : <100 mg/dL Near Optimal : 100 - 129 mg/dL Borderline High : 130 - 160 mg/dL High : 161 - 189 mg/dL Very High : >=190 mg/dL	mg/dL
HDL Cholesterol Sample: Serum Method: Spectrophotometry-Esterase/CO/Peroxidase	46	Low : < 40 Optimal : 40 - 60 High : > 60	mg/dL
VLDL Cholesterol Sample: Serum Method: Calculated	57.6 H	Desirable 10 - 35	mg/dL

BIOCHEMISTRY

Report Status - Final

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Accession No : 110019000013536
Referring Doctor : DR. RAKESH KUMAR ARAN
Referral By :
Billing Date : 31/12/2019 10:40:07
Sample Collected on : 31/12/2019 10:41:52
Sample Received on : 31/12/2019 14:58:30
Report Released on : 01/01/2020 13:29:09
Barcode No. : 7183503, 7183502, 7183504

8,9- Begum Bridge Road, Opposite City Center, Bacha Park, Meerut- 250002, Contact No-7902101834, 8448393145
8,9- Begum Bridge Road, Opposite City Center, Bacha Park, Meerut- 250002, Contact No-7902101834, 8448393145

Processed By
Pathkind Diagnostic Pvt. Ltd.





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Test Name	Result	Biological Ref. Interval	Unit
Total Cholesterol / HDL Ratio Sample: Serum Method: Calculated	3.43	Low Risk : 3.3 - 4.4 Average Risk : 4.5 - 7.0 Moderate Risk : 7.1 - 11.0 High Risk : > 11.0	
LDL / HDL Ratio Sample: Serum Method: Calculated	1.2	0.5 - 3.0	
Blood Urea Nitrogen (BUN) Sample: Serum Method: Spectrophotometry-Urease / GLDH	16.50	8.41 - 25.70	mg/dl
# Urea Sample: Serum Method: Urease/GLDH	35.31	18.00 - 55.00	mg/dl
Creatinine Sample: Serum Method: Spectrophotometry Alkaline Picrate	0.88	0.70 - 1.30	mg/dl
BUN Creatinine Ratio Sample: Serum Method: Calculated	19	10 - 20	
Uric Acid Sample: Serum Method: Urlicase Peroxidase	5.0	3.6 - 8.2	mg/dl
SGOT / AST Sample: Serum Method: Spectrophotometry-FCC Without Pyridoxal PO4	34 H	0 - 33	U/L
SGPT / ALT Sample: Serum Method: Spectrophotometry-FCC Without Pyridoxal PO4	33	0 - 41	U/L
Alkaline Phosphatase (ALP) Sample: Serum Method: Spectrophotometry-FCC Without Pyridoxal PO4	104	40 - 129	U/L

Low Risk : 0.5 - 3.0
Moderate Risk : 3.1 - 6.0
High Risk : > 6.0

Report Status - Final

Name : Mr. SHYAM KUMAR BANSAL
Age : 58 Yrs
Sex : Male
P. ID No. : P11004470
Accession No : 110019000013536
Referring Doctor : DR. RAKESH KUMAR ARAN
Referred By :
Billing Date : 31/12/2019 10:40:07
Sample Collected on : 31/12/2019 10:41:52
Sample Received on : 31/12/2019 14:58:30
Report Released on : 01/01/2020 13:29:09
Barcode No. : 7183503, 7183502, 7183504

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Customer Care: 1800-1-21-000

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Meerut- 250002, Contact No-7902101834, 8448393145

Name

Mr. SHYAM KUMAR BANSAL

Age

58 Yrs

Sex

Male

P. ID No.

P110044470

Accession No

110019000013536

Referring Doctor : DR. RAKESH KUMAR ARAN

Referred By :

Report Status - Final

Test Name	Result	Biological Ref. Interval	Unit
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CLINICAL PATHOLOGY

Urine Routine & Microscopic Examination

Method: Reflectance Photometry

Physical Examination

Colour
Sample: Urine
Method: Physical Examination

Pale Yellow

Appearance
Sample: Urine
Method: Physical Examination

Slightly Hazy

Specific Gravity
Sample: Urine
Method: Physical Examination

1.015

Method: pKa change of pretreated polyelectrolytes

pH
Sample: Urine
Method: Double indicator principle

5.0

Chemical Examination

Glucose
Sample: Urine
Method: Glucose oxidase/peroxidase

Detected (+++)

URINE GLUCOSE RECHECKED MANUALLY BY BENEDICT'S TEST.

Protein
Sample: Urine
Method: Protein-error-of-indicators principle

Not Detected

Ketones
Sample: Urine
Method: Sodium nitroprusside reaction

Not Detected

Blood
Sample: Urine
Method: Peroxidase

Not Detected

The Test/s marked with (#) is/are not accredited by NABL.



जाब सही तो इलाज सही





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HbA1c (Glycosylated Hemoglobin)

CER comprises of estimation of the cellular components of blood including RBCs, WBCs and Platelets. Mean corpuscular volume (MCV) is a measure of the size of the average RBC. MCH is a measure of the hemoglobin content of the average RBC and MCHC is the hemoglobin concentration per RBC. The red cell distribution width (RDW) is a measure of the degree of variation in RBC size (anisocytosis) and is helpful in distinguishing between some anemias. CBC examination is used as a screening tool to confirm a hematologic disorder, to establish or rule out a primary disorder of the cell-producing organs or an underlying disease. Results should be interpreted in conjunction with the patient's clinical picture and appropriate additional testing performed.

Complete Blood Count (CBC)

Platelets or thrombocytes are a cellular component of blood whose function is to stop bleeding by clumping or clotting blood vessel injuries. Low platelet count, also known as Thrombocytopenia, can be either due to less production or increased destruction of platelets. High platelet count or Thrombocytosis can be due to unregulated production, secondary to congenital, reactive or neoplastic conditions.

Platelet Count

Hemoglobin is the iron containing protein molecule in red blood cells that carries oxygen from the lungs to the body's tissues and returns carbon dioxide from the tissues back to the lungs. Decrease in Hemoglobin levels results in anaemia and very high Hemoglobin levels results in hemochromatosis. Hemocrit or Packed cell volume (PCV) is the proportion of blood volume occupied by red blood cells and is typically about three times the hemoglobin concentration.

PCV / Hematocrit

Hemoglobin is the iron containing protein molecule in red blood cells that carries oxygen from the lungs to the body's tissues and returns carbon dioxide from the tissues back to the lungs. Decrease in Hemoglobin levels results in anaemia and very high Hemoglobin levels results in hemochromatosis.

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Clinical Significance:

Blood Urea Nitrogen (BUN)

High-density lipoprotein (HDL) is an important tool used to assess risk of developing coronary heart disease. Increased levels are seen in persons with more physical activity. Very high levels are seen in case of metabolic response to medications like hormone replacement therapy. Raised levels are also seen in case of chronic intoxication with alcohol, heavy metals or industrial chemicals. Low HDL cholesterol correlates with increased risk for coronary heart disease (CHD). Very low levels are seen in Tangier disease, cholestatic liver disease and in association with decreased hepatocyte function.

Clinical Significance:

HDL Cholesterol

Triglycerides are partly synthesized in the liver and partly derived from the diet. Increased serum triglyceride levels are a risk factor for atherosclerosis. Hypertension may be inherited or may be due to conditions like biliary obstruction, diabetes mellitus, nephrotic syndrome, renal failure, certain metabolic disorders or drug induced.

Clinical Significance:

Triglycerides

Serum cholesterol is elevated in hereditary hyperlipoproteinemias and in other metabolic diseases. Moderate-to-markedly elevated values are also seen in cholestatic liver disease. Increased levels are a risk factor for cardiovascular disease. Low levels of cholesterol may be seen in disorders like hypothyroidism, malabsorption, and deficiencies of apolipoproteins.

Clinical Significance:

Total Cholesterol

Hemoglobin A1c (HbA1c) level reflects the mean glucose concentration over the previous period (approximately 8-12 weeks) and provides a much better indication of long-term glycemic control than blood and urinary glucose determinations. American Diabetes Association (ADA) include the use of HbA1c to diagnose diabetes, using a cutpoint of 6.5%. The ADA recommends measurement of HbA1c 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 assess whether a patient's metabolic control has remained continuously within the target range. Falsely low HbA1c results may be seen in conditions that shorten erythrocyte life span, and may not reflect glycemic control in these cases accurately.

Clinical Significance:

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Alkaline Phosphatase (ALP)

Clinical Significance:
 Elevated alanine aminotransferase (ALT) values are seen in parenchymal liver diseases characterized by a destruction of hepatocytes. Values are at least 10 times higher than normal range and may reach up to 100 times the upper reference limit. Commonly, values are seen to be 20 - 50 times higher than normal. In infectious hepatitis and other inflammatory conditions affecting the liver, ALT levels rise more than aspartate aminotransferase (AST), and the ALT/AST ratio, which is normally <1, is reversed and becomes >1. ALT levels usually rise before clinical signs and symptoms of disease appear.

SGPT / ALT

Clinical Significance:
 "Elevated aspartate aminotransferase (AST) values are seen most commonly in parenchymal liver diseases. Values can be elevated from 10 to 100 times the normal range, though commonly 20 to 50 times elevations are seen. AST levels are raised in infectious hepatitis and other inflammatory conditions affecting the liver along with ALT, though ALT levels are higher. The ALT:AST ratio which is normally <1 is reversed in these conditions and becomes >1. AST levels are usually raised before clinical signs and symptoms of disease appear. AST and ALT also rise in primary or metastatic carcinoma of the liver, with AST usually being higher than ALT. Elevated AST values may also be seen in disorders affecting the heart, skeletal muscle and kidney, such as myocardial infarction, muscular dystrophy, dermatomyositis, acute pancreatitis and crushed muscle injuries."

SGOT / AST

Clinical Significance:
 Serum creatinine is inversely correlated with glomerular filtration rate (GFR). Increased levels of Serum Creatinine is associated with renal dysfunction.

Creatinine

Increased blood urea nitrogen (BUN) may be due to prerenal causes (cardiac decompensation, water depletion due to decreased intake and excessive loss, increased protein catabolism, and high protein diet), renal causes (acute glomerulonephritis, chronic nephritis, polycystic kidney disease, nephrosclerosis, and tubular necrosis) and postrenal causes (eg, all types of obstruction of the urinary tract, such as stones, enlarged prostate gland, tumors).

Test Name	Result	Biological Ref. Interval	Unit
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Sex	: Male
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Name : Mr. SHYAM KUMAR BANSAL	Billing Date : 31/12/2019 10:40:07
Age : 58 Yrs	Sample Collected on : 31/12/2019 10:41:52
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Referring Doctor : DR.RAKESH KUMAR ARAN	
Referred By :	

Report Status - Final

Test Name	Result	Biological Ref. Interval	Unit
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Clinical Significance :

Alkaline Phosphatase levels can be elevated in both liver related as well as bone related conditions. ALP levels are raised (more than 3 fold) in extrahepatic biliary obstruction (eg, by stone or by cancer of the head of the pancreas) than in intrahepatic obstruction, and is directly proportional to the level of obstruction. Levels may rise up to 10 to 12 times the upper limit of normal range and returns to normal on surgical removal of the obstruction. ALP levels rise together with GGT levels and If both GGT and ALP are elevated, a liver source of the ALP is likely. Among bone diseases, ALP levels rise in Paget disease (up to 25 fold),osteomalacia,rickets,primary and secondary hyperparathyroidism and osteogenic bone cancer. Elevated ALP is seen in children following accelerated bone growth. Also, a 2 to 3fold elevation may be observed in women in the third trimester of pregnancy, although the interval is very wide and levels may not exceed the upper limit of the reference interval in some cases.

Bilirubin Total

Clinical Significance :

"Total Bilirubin is one of the most commonly used tests to assess liver function. A number of inherited and acquired diseases affect bilirubin production, metabolism, storage and excretion and causes hyperbilirubinemia resulting in jaundice.Hyperbilirubinemia may be due to increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Unconjugated hyperbilirubinemia is seen in newborn and known as physiological jaundice. Elevated unconjugated bilirubin in the neonatal period may result in brain damage (kernicterus).Crigler-Najjar syndromes type I and type II are also associated with elevated levels of indirect bilirubin.Both conjugated and unconjugated bilirubin are increased in hepatitis and space-occupying lesions of the liver; and obstructive lesions such as carcinoma of the head of the pancreas, common bile duct, or ampulla of Vater."

Bilirubin Direct

Clinical Significance :

"Direct bilirubin is a measurement of conjugated bilirubin.Jaundice can occur as a result of increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Inherited disorders in which direct bilirubin levels are increased are seen in Dubin-Johnson syndrome and Rotor syndrome,idiopathic neonatal hepatitis and biliary atresia. The most commonly occurring form of jaundice of the newborn called physiological jaundiceis due to increase in levels of indirect bilirubin.Both conjugated and unconjugated bilirubin are increased in hepatocellular diseases such as hepatitis and space-occupying lesions of the liver. bstructive lesions such as carcinoma of the head of the pancreas, common bile duct, or ampulla of Vater."

Bilirubin (Total, Direct & Indirect)





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Clinical Significance:
The most commonly occurring form of unconjugated hyperbilirubinemia is that seen in newborns and referred to as physiological jaundice. Elevated unconjugated bilirubin in the neonatal period may result in brain damage (kernicterus).

Clinical Significance:
High levels of Serum Total Protein is seen in increased acute phase reactants in inflammation, late-stage liver disease, infections, multiple myeloma and other malignant paraproteinemias. Hypoproteinemia is seen in hypogammaglobulinemia, nephrotic syndrome and protein-losing enteropathy.

Albumin

Clinical Significance:
Hypalbuminemia can be caused by impaired synthesis due to liver disease (primary) or due to diminished protein intake (secondary). Increased catabolism due to tissue damage and inflammation; malabsorption of amino acids; and increased renal excretion (eg, nephrotic syndrome). Hyperalbuminemia is seen in dehydration.

Urine Routine & Microscopic Examination

Clinical Significance:
Urine routine examination and microscopy comprises of a set of screening tests that can detect some common diseases like urinary tract infections, kidney disorders, liver problems, diabetes or other metabolic conditions. Physical characteristics (colour and appearance), chemical composition (glucose, protein, ketone, blood, bilirubin and urobilinogen) and microscopic content (pus cells, epithelial cells, RBCs, casts and crystals) are analysed and reported.

Marked tests are processed in our companion laboratories

** End of Report **

Dr. Shambhavi
 Dr. Shambhavi
 MD (Pathology)
 Pathologist

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