

REPORT

Name	: Dr. G. ADITHYA	Sample ID	: 24863893, 24863911
Age/Gender	: 36 Years/Male	Reg. No	: 0312404020022
Referred by	: Dr. SELF	SPP Code	: SPL-CV-172
Referring Customer	: V CARE MEDICAL DIAGNOSTICS	Collected On	: 02-Apr-2024 10:09 AM
Primary Sample	: Whole Blood	Received On	: 02-Apr-2024 12:16 PM
Sample Tested In	: Serum, Urine	Reported On	: 02-Apr-2024 03:11 PM
Client Address	: Kimtee colony ,Gokul Nagar, Tarnaka	Report Status	: Final Report

CLINICAL BIOCHEMISTRY

HEALTH PACKAGE - B

Test Name	Results	Units	Ref. Range	Method
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C-Reactive protein-(CRP)	9.21	mg/L	Upto:6.0	Immunoturbidimetry
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Interpretation:

C-reactive protein (CRP) is produced by the liver. The level of CRP rises when there is inflammation throughout the body. It is one of a group of proteins called acute phase reactants that go up in response to inflammation. The levels of acute phase reactants increase in response to certain inflammatory proteins called cytokines. These proteins are produced by white blood cells during inflammation.

A positive test means you have inflammation in the body. This may be due to a variety of conditions, including:

- Connective tissue disease
- Heart attack
- Infection
- Inflammatory bowel disease (IBD)
- Lupus
- Pneumonia
- Rheumatoid arthritis

Protein - Random Urine	63.63	mg/dL	1-14	Pyrogallol Red
Creatinine - Random Urine	209.66	mg/dL	24-392	kinetic Jaffe reaction.
Protein/Creatinine Ratio	0.3		< 0.20	Calculated

Interpretation:

The urine protein test measures the amount of protein being excreted in the urine. Proteinuria is frequently seen in chronic diseases, such as diabetes and hypertension, with increasing amounts of protein in the urine reflecting increasing kidney damage. With early kidney damage, the affected person is often asymptomatic. As damage progresses, or if protein loss is severe, the person may develop symptoms such as edema, shortness of breath, nausea, and fatigue. Excess protein overproduction, as seen with multiple myeloma, lymphoma, and amyloidosis, can also lead to proteinuria. Creatinine, a byproduct of muscle metabolism, is normally released into the urine at a constant rate.

Estimated Glomerular Filtration Rate (eGFR):

GFR by MDRD Formula	111	mL/min/1.73m ²	74 - 138	Calculated
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Dr. Vaishnavi
DR. VAISHNAVI
MD BIOCHEMISTRY

REPORT

Name	: Dr. G. ADITHYA	Sample ID	: 24863895
Age/Gender	: 36 Years/Male	Reg. No	: 0312404020022
Referred by	: Dr. SELF	SPP Code	: SPL-CV-172
Referring Customer	: V CARE MEDICAL DIAGNOSTICS	Collected On	: 02-Apr-2024 10:09 AM
Primary Sample	: Whole Blood	Received On	: 02-Apr-2024 12:16 PM
Sample Tested In	: Whole Blood EDTA	Reported On	: 02-Apr-2024 01:30 PM
Client Address	: Kimtee colony ,Gokul Nagar,Tarnaka	Report Status	: Final Report

HAEMATOLOGY

HEALTH PACKAGE - B

Test Name	Results	Units	Ref. Range	Method
Complete Blood Picture(CBP)				
Haemoglobin (Hb)	13.8	g/dL	13-17	Cynmeth Method
Haematocrit (HCT)	40.3	%	40-50	Calculated
RBC Count	4.43	10 ¹² /L	4.5-5.5	Cell Impedance
MCV	91	fl	81-101	Calculated
MCH	31.1	pg	27-32	Calculated
MCHC	34.2	g/dL	32.5-34.5	Calculated
RDW-CV	13.1	%	11.6-14.0	Calculated
Platelet Count (PLT)	242	10 ⁹ /L	150-410	Cell Impedance
Total WBC Count	6.7	10 ⁹ /L	4.0-10.0	Impedance
Differential Leucocyte Count (DC)				
Neutrophils	58	%	40-70	Cell Impedance
Lymphocytes	35	%	20-40	Cell Impedance
Monocytes	04	%	2-10	Microscopy
Eosinophils	03	%	1-6	Microscopy
Basophils	00	%	1-2	Microscopy
Absolute Neutrophils Count	3.89	10 ⁹ /L	2.0-7.0	Impedance
Absolute Lymphocyte Count	2.35	10 ⁹ /L	1.0-3.0	Impedance
Absolute Monocyte Count	0.27	10 ⁹ /L	0.2-1.0	Calculated
Absolute Eosinophils Count	0.2	10 ⁹ /L	0.02-0.5	Calculated
Absolute Basophil ICount	0.00	10 ⁹ /L	0.0-0.3	Calculated
Morphology	Normocytic normochromic blood picture.			PAPs Staining
Erythrocyte Sedimentation Rate (ESR)	9		10 or less	Westergren method

Comments : ESR is an acute phase reactant which indicates presence and intensity of an inflammatory process.It is never diagnostic of a specific disease. It is used to monitor the course or response to treatment of certain diseases. Extremely high levels are found in cases of malignancy, hematologic diseases, collagen disorders and renal diseases.



Swannabala - M
DR.SWARNA BALA
MD PATHOLOGY

REPORT

Name	: Dr. G. ADITHYA	Sample ID	: 24863896, 24863898, 248638
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Referring Customer	: V CARE MEDICAL DIAGNOSTICS	Collected On	: 02-Apr-2024 10:09 AM
Primary Sample	: Whole Blood	Received On	: 02-Apr-2024 12:16 PM
Sample Tested In	: Plasma-NaF(F), Plasma-NaF(PP),	Reported On	: 02-Apr-2024 03:48 PM
Client Address	: Kimtee colony ,Gokul Nagar, Tarnaka	Report Status	: Final Report

CLINICAL BIOCHEMISTRY

HEALTH PACKAGE - B

Test Name	Results	Units	Ref. Range	Method
Glycated Hemoglobin (HbA1c)	5.2	%	Non Diabetic:< 5.7 Pre diabetic: 5.7-6.4 Diabetic:>= 6.5	HPLC
Mean Plasma Glucose	102.54	mg/dL		Calculated

Interpretation:

- Glycated hemoglobins (GHb), also called glycohemoglobins, are substances formed when glucose binds to hemoglobin, and occur in amounts proportional to the concentration of serum glucose. Since red blood cells survive an average of 120 days, the measurement of GHb provides an index of a person's average blood glucose concentration (glycemia) during the preceding 2-3 months. Normally, only 4% to 6% of hemoglobin is bound to glucose, while elevated glycohemoglobin levels are seen in diabetes and other hyperglycemic states
- Mean Plasma Glucose(MPG):This Is Mathematical Calculations Where Glycated Hb Can Be Correlated With Daily Mean Plasma Glucose Level

Calcium	8.6	mg/dL	8.5-10.1	o-cresolphthalein complexone (OCPC)
Phosphorus(PO4)	3.2	mg/dL	2.5-4.9	Phosphomolybdate UV

Interpretation:

- This will give an idea of renal and bone diseases.

Increased Phosphorus Or Hyperphosphatemia:

- Renal diseases with increased blood urea (BUN) and creatinine.
- Hypoparathyroidism with raised phosphate and decreased calcium. But renal function will be normal.
- Liver diseases and cirrhosis.
- Acromegaly.
- Increased dietary intake.
- Sarcoidosis.
- Acidosis
- Hemolytic anemia.

Decreased Level Of Phosphorus Or Hypophosphatemia:

- Decreased intestinal absorption.
- Rickets (Vit.D deficiency)
- Vomiting and severe diarrhea
- Severe malnutrition and malabsorption.
- Acute alcoholism.



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CLINICAL BIOCHEMISTRY

HEALTH PACKAGE - B

Test Name	Results	Units	Ref. Range	Method
25 - Hydroxy Vitamin D	16.3	ng/mL	<20.0-Deficiency 20.0-<30.0-Insufficiency 30.0-100.0-Sufficiency >100.0-Potential Intoxication	CLIA

Interpretation:

1.Vitamin D helps your body absorb calcium and maintain strong bones throughout your entire life. Your body produces vitamin D when the sun's UV rays contact your skin. Other good sources of the vitamin include fish, eggs, and fortified dairy products. It's also available as a dietary supplement.

2.Vitamin D must go through several processes in your body before your body can use it. The first transformation occurs in the liver. Here, your body converts vitamin D to a chemical known as 25-hydroxyvitamin D, also called calcidiol.

3.The 25-hydroxy vitamin D test is the best way to monitor vitamin D levels. The amount of 25-hydroxyvitamin D in your blood is a good indication of how much vitamin D your body has. The test can determine if your vitamin D levels are too high or too low.

4.The test is also known as the 25-OH vitamin D test and the calcidiol 25-hydroxycholecalciferol test. It can be an important indicator of osteoporosis (bone weakness) and rickets (bone malformation).

Those who are at high risk of having low levels of vitamin D include:

- 1.people who don't get much exposure to the sun
- 2.older adults
- 3.people with obesity.
- 4.dietary deficiency

Increased Levels: Vitamin D Intoxication

Method : CLIA

Vitamin- B12 (cyanocobalamin)	228	pg/mL	211-911	CLIA
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Interpretation:

This test is most often done when other blood tests suggest a condition called megaloblastic anemia. Pernicious anemia is a form of megaloblastic anemia caused by poor vitamin B12 absorption. This can occur when the stomach makes less of the substance the body needs to properly absorb vitamin B12.

Causes of vitamin B12 deficiency include:Diseases that cause malabsorption

- 1.Lack of intrinsic factor, a protein that helps the intestine absorb vitamin B12
- 2.Above normal heat production (for example, with hyperthyroidism)

An increased vitamin B12 level is uncommon in:

- 1.Liver disease (such as cirrhosis or hepatitis)
- 2.Myeloproliferative disorders (for example, polycythemia vera and chronic myelogenous leukemia)

Result rechecked and verified for abnormal cases

*** End Of Report ***

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CLINICAL BIOCHEMISTRY

HEALTH PACKAGE - B

Test Name	Results	Units	Ref. Range	Method
Lipid Profile				
Cholesterol Total	124	mg/dL	< 200	CHOD-POD
Triglycerides-TGL	174	mg/dL	< 150	GPO-POD
Cholesterol-HDL	51	mg/dL	40-60	Direct
Cholesterol-LDL	38.2	mg/dL	< 100	Calculated
Cholesterol- VLDL	34.8	mg/dL	7-35	Calculated
Non HDL Cholesterol	73	mg/dL	< 130	Calculated
Cholesterol Total /HDL Ratio	2.43	%	0-4.0	Calculated
HDL / LDL Ratio	1.34			
LDL/HDL Ratio	0.75	%	0-3.5	Calculated

The National Cholesterol Education program's third Adult Treatment Panel (ATPIII) has issued its recommendations on evaluating and treating lipid disorders for primary and secondary.

NCEP Recommendations	Cholesterol Total in (mg/dL)	Triglycerides in (mg/dL)	HDL Cholesterol (mg/dL)	LDL Cholesterol in (mg/dL)	Non HDL Cholesterol in (mg/dL)
Optimal	Adult: < 200 Children: < 170	< 150	40-59	Adult:<100 Children: <110	<130
Above Optimal	-----	-----		100-129	130 - 159
Borderline High	Adult: 200-239 Children:171-199	150-199		Adult: 130-159 Children: 111-129	160 - 189
High	Adult:>or=240 Children:>or=200	200-499	≥ 60	Adult:160-189 Children:>or=130	190 - 219
Very High	-----	>or=500		Adult: >or=190 -----	>=220

Note: LDL cholesterol cannot be calculated if triglyceride is >400 mg/dL (Friedewald's formula). Calculated values not provided for LDL and VLDL



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HEALTH PACKAGE - B

Test Name	Results	Units	Ref. Range	Method
Kidney Profile-KFT				
Creatinine -Serum	0.72	mg/dL	0.70-1.30	Sarcosine oxidase
Urea-Serum	16.5	mg/dL	12.8-42.8	Glutamate dehydrogenase+Calculation
Blood Urea Nitrogen (BUN)	7.7	mg/dL	7.0-18.0	Calculated
BUN / Creatinine Ratio	10.69		6 - 22	
Uric Acid	4.25	mg/dL	3.5-7.2	Uricase
Sodium	142	mmol/L	136-145	ISE Direct
Potassium	3.9	mmol/L	3.5-5.1	ISE Direct
Chloride	102	mmol/L	98-108	ISE Direct
Liver Function Test (LFT)				
Bilirubin(Total)	0.9	mg/dL	0.3-1.2	Diazo
Bilirubin (Direct)	0.2	mg/dL	0.0 - 0.5	Diazo
Bilirubin (Indirect)	0.7	mg/dL	0.2-1.0	Calculated
Aspartate Aminotransferase (AST/SGOT)	19	U/L	5-40	IFCC with out (P-5-P)
Alanine Aminotransferase (ALT/SGPT)	11	U/L	0-55	IFCC with out (P-5-P)
Alkaline Phosphatase(ALP)	86	U/L	40-150	Kinetic PNPP-AMP
Gamma Glutamyl Transpeptidase (GGTP)	22	U/L	15-85	IFCC
Protein - Total	6.7	g/dL	6.4-8.2	Biuret
Albumin	3.9	g/dL	3.4-5.0	Bromocresol purple (BCP)
Globulin	2.8	g/dL	2.0-4.2	Calculated
A:G Ratio	1.39	%	0.8-2.0	Calculated
SGOT/SGPT Ratio	1.73			

Result rechecked and verified for abnormal cases

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CLINICAL BIOCHEMISTRY

HEALTH PACKAGE - B

Test Name	Results	Units	Ref. Range	Method
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Thyroid Profile-I(TFT)

T3 (Triiodothyronine)	119.23	ng/dL	70-204	CLIA
T4 (Thyroxine)	7.6	µg/dL	3.2-12.6	CLIA
TSH -Thyroid Stimulating Hormone	3.64	µIU/mL	0.35-5.5	CLIA

Pregnancy & Cord Blood

T3 (Triiodothyronine):	T4 (Thyroxine)	TSH (Thyroid Stimulating Hormone)
First Trimester : 81-190 ng/dL	15 to 40 weeks:9.1-14.0 µg/dL	First Trimester : 0.24-2.99 µIU/mL
Second&Third Trimester :100-260 ng/dL		Second Trimester: 0.46-2.95 µIU/mL
		Third Trimester : 0.43-2.78 µIU/mL
Cord Blood: 30-70 ng/dL	Cord Blood: 7.4-13.0 µg/dL	Cord Blood: : 2.3-13.2 µIU/mL

Interpretation:

- Thyroid gland is a butterfly-shaped endocrine gland that is normally located in the lower front of the neck. The thyroid's job is to make thyroid hormones, which are secreted into the blood and then carried to every tissue in the body. Thyroid hormones help the body use energy, stay warm and keep the brain, heart, muscles, and other organs working as they should.
- Thyroid produces two major hormones: triiodothyronine (T3) and thyroxine (T4). If thyroid gland doesn't produce enough of these hormones, you may experience symptoms such as weight gain, lack of energy, and depression. This condition is called hypothyroidism.
- Thyroid gland produces too many hormones, you may experience weight loss, high levels of anxiety, tremors, and a sense of being on a high. This is called hyperthyroidism.
- TSH interacts with specific cell receptors on the thyroid cell surface and exerts two main actions. The first action is to stimulate cell reproduction and hypertrophy. Secondly, TSH stimulates the thyroid gland to synthesize and secrete T3 and T4.
- The ability to quantitate circulating levels of TSH is important in evaluating thyroid function. It is especially useful in the differential diagnosis of primary (thyroid) from secondary (pituitary) and tertiary (hypothalamus) hypothyroidism. In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hypothyroidism, TSH levels are low.



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CLINICAL BIOCHEMISTRY

HEALTH PACKAGE - B

Test Name	Results	Units	Ref. Range	Method
Iron Profile-I				
Iron(Fe)	106.73	µg/dL	65-175	Ferene
Total Iron Binding Capacity (TIBC)	374	µg/dL	250-450	Ferene
Transferrin	261.54	mg/dL	215-365	Calculated
Iron Saturation((% Transferrin Saturation)	28.54	%	20-50	Calculated
Unsaturated Iron Binding Capacity (UIBC)	267	µg/dL	110 - 370	FerroZine

Interpretation:

- Serum transferrin (and TIBC) high, serum iron low, saturation low. Usual causes of depleted iron stores include blood loss, inadequate dietary iron. RBCs in moderately severe iron deficiency are hypochromic and microcytic. Stainable marrow iron is absent. Serum ferritin decrease is the earliest indicator of iron deficiency if inflammation is absent.
- **Anemia of chronic disease:** Serum transferrin (and TIBC) low to normal, serum iron low, saturation low or normal. Transferrin decreases with many inflammatory diseases. With chronic disease there is a block in movement to and utilization of iron by marrow. This leads to low serum iron and decreased erythropoiesis. Examples include acute and chronic infections, malignancy and renal failure.
- **Sideroblastic Anemia:** Serum transferrin (and TIBC) normal to low, serum iron normal to high, saturation high.
- **Hemolytic Anemia:** Serum transferrin (and TIBC) normal to low, serum iron high, saturation high.
- **Hemochromatosis:** Serum transferrin (and TIBC) slightly low, serum iron high, saturation very high.
- **Protein depletion:** Serum transferrin (and TIBC) may be low, serum iron normal or low (if patient also is iron deficient). This may occur as a result of malnutrition, liver disease, renal disease.
- **Liver disease:** Serum transferrin variable; with acute viral hepatitis, high along with serum iron and ferritin. With chronic liver disease (eg, cirrhosis), transferrin may be low. Patients who have cirrhosis and portacaval shunting have saturated TIBC/transferrin as well as high ferritin.



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Primary Sample	:	Received On	: 02-Apr-2024 03:37 PM
Sample Tested In	: Urine	Reported On	: 02-Apr-2024 05:15 PM
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CLINICAL PATHOLOGY

HEALTH PACKAGE - B

Test Name	Results	Units	Ref. Range	Method
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Complete Urine Analysis (CUE)

Physical Examination

Colour	Pale Yellow	Straw to light amber
Appearance	Clear	Clear

Chemical Examination

Glucose	Negative	Negative	Strip Reflectance
Protein	Absent	Negative	Strip Reflectance
Bilirubin (Bile)	Negative	Negative	Strip Reflectance
Urobilinogen	Negative	Negative	Ehrlichs reagent
Ketone Bodies	Negative	Negative	Strip Reflectance
Specific Gravity	1.015	1.000 - 1.030	Strip Reflectance
Blood	Negative	Negative	Strip Reflectance
Reaction (pH)	6.0	5.0 - 8.5	Reagent Strip Reflectance
Nitrites	Negative	Negative	Strip Reflectance
Leukocyte esterase	Negative	Negative	Reagent Strip Reflectance

Microscopic Examination (Microscopy)

PUS(WBC) Cells	02-03	/hpf	00-05	Microscopy
R.B.C.	Nil	/hpf	Nil	Microscopic
Epithelial Cells	01-02	/hpf	00-05	Microscopic
Casts	Absent	Absent	Absent	Microscopic
Crystals	Absent	Absent	Absent	Microscopic
Bacteria	Nil	Nil	Nil	
Budding Yeast Cells	Nil	Absent	Absent	Microscopy

Correlate Clinically.

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*** End Of Report ***



Swannabala - M
DR.SWARNA BALA
MD PATHOLOGY