

**REPORT**

Name	: Mr. G NARENDRA	Sample ID	: A0643548
Age/Gender	: 43 Years/Male	Reg. No	: 0312406240048
Referred by	: Dr. SELF	SPP Code	: SPL-CV-172
Referring Customer	: V CARE MEDICAL DIAGNOSTICS	Collected On	: 24-Jun-2024 12:01 PM
Primary Sample	: Whole Blood	Received On	: 24-Jun-2024 12:56 PM
Sample Tested In	: Whole Blood EDTA	Reported On	: 24-Jun-2024 01:45 PM
Client Address	: Kimtee colony ,Gokul Nagar,Tarnaka	Report Status	: Final Report

**HAEMATOLOGY**

**HEALTH PROFILE A-3 PACKAGE**

Test Name	Results	Units	Ref. Range	Method
<b>COMPLETE BLOOD COUNT (CBC)</b>				
Haemoglobin (Hb)	13.8	g/dL	13-17	Cynmeth Method
RBC Count	4.68	10 <sup>12</sup> /L	4.5-5.5	Cell Impedance
Haematocrit (HCT)	40.9	%	40-50	Calculated
MCV	88	fl	81-101	Calculated
MCH	29.4	pg	27-32	Calculated
MCHC	33.7	g/dL	32.5-34.5	Calculated
RDW-CV	13.0	%	11.6-14.0	Calculated
Platelet Count (PLT)	213	10 <sup>9</sup> /L	150-410	Cell Impedance
Total WBC Count	7.1	10 <sup>9</sup> /L	4.0-10.0	Impedance
Neutrophils	52	%	40-70	Cell Impedance
Absolute Neutrophils Count	3.69	10 <sup>9</sup> /L	2.0-7.0	Impedance
Lymphocytes	38	%	20-40	Cell Impedance
Absolute Lymphocyte Count	2.7	10 <sup>9</sup> /L	1.0-3.0	Impedance
Monocytes	06	%	2-10	Microscopy
Absolute Monocyte Count	0.43	10 <sup>9</sup> /L	0.2-1.0	Calculated
Eosinophils	04	%	1-6	Microscopy
Absolute Eosinophils Count	0.28	10 <sup>9</sup> /L	0.02-0.5	Calculated
Basophils	00	%	1-2	Microscopy
Absolute Basophil ICount	0.00	10 <sup>9</sup> /L	0.0-0.3	Calculated
<b>Morphology</b>				
WBC	Within Normal Limits			
RBC	Normocytic normochromic			
Platelets	Adequate.			Microscopy

\*\*\* End Of Report \*\*\*

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Swarnabala - M  
DR.SWARNA BALA  
MD PATHOLOGY

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**HAEMATOLOGY**

**HEALTH PROFILE A-3 PACKAGE**

Test Name	Results	Units	Ref. Range	Method
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<b>Erythrocyte Sedimentation Rate (ESR)</b>	6		10 or less	Westergren method
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**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.

\*\*\* End Of Report \*\*\*

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Swannabala - M  
DR.SWARNA BALA  
MD PATHOLOGY

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Sample Tested In	: Whole Blood EDTA, Serum	Reported On	: 24-Jun-2024 07:33 PM
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**CLINICAL BIOCHEMISTRY**


Test Name	Results	Units	Ref. Range	Method
Glycated Hemoglobin (HbA1c)	7.6	%	Non Diabetic:< 5.7 Pre diabetic: 5.7-6.4 Diabetic:>= 6.5	HPLC
Mean Plasma Glucose	171.42	mg/dL		Calculated

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

**NOTE: The above Given Risk Level Interpretation is not age specific and is an information resource only and is not to be used or relied on for any diagnostic or treatment purposes and should not be used as a substitute for professional diagnosis and treatment. Kindly Correlate clinically.**

**INTERPRETATION**

Method: Analyzer Fully automated HPLC platform.

Average Blood Glucose(eAG) (mg/dL)	Level of Control	Hemoglobin A1c (%)	
421		14%	
386		13%	
350		12%	
314		11%	
279		10%	
243		9%	
208		8%	
172		POOR	7%
136		GOOD	6%
101		EXCELLENT	5%

HbA1c values of 5.0- 6.5 percent indicate good control or an increased risk for developing diabetes mellitus. HbA1c values greater than 6.5 percent are diagnostic of diabetes mellitus. Diagnosis should be confirmed by repeating the HbA1c test.

NOTE: Hb F higher than 10 percent of total Hb may yield falsely low results. Conditions that shorten red cell survival, such as the presence of unstable hemoglobins like Hb SS, Hb CC, and Hb SC, or other causes of hemolytic anemia may yield falsely low results. Iron deficiency anemia may yield falsely high results.

Rheumatoid Factor, RA 5.38 IU/mL <20.0 Immunoturbidometry

**Interpretation:**

- This test detects evidence of rheumatoid factor (RF), which is a type of autoantibody. An antibody is a protective protein that forms in the blood in response to a foreign material, known as an antigen (for example a bacterial protein). Autoantibodies, however, are antibodies that attack one's own proteins rather than foreign protein. Rheumatoid factors are autoantibodies directed against the class of immunoglobulins known as IgG and are members of a class of proteins that become elevated in states of inflammation. Rheumatoid factor is elevated in many patients with both chronic and acute inflammation; it may be used to monitor the level of inflammation associated with rheumatoid arthritis (RA). Other markers such as CRP are considered more accurate for disease monitoring. Experts still do not understand exactly how RF is formed or why, but it is believed that RF probably does not directly cause joint damage but that it helps to promote the body's inflammation reaction, which contributes to the tissue destruction seen in rheumatoid arthritis.



*Dr. Vaishnavi*  
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**MD BIOCHEMISTRY**



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**CLINICAL BIOCHEMISTRY**

Test Name	Results	Units	Ref. Range	Method
25 - Hydroxy Vitamin D	21.03	ng/mL	<20.0-Deficiency 20.0-<30.0-Insufficiency 30.0-100.0-Sufficiency >100.0-Potential Intoxication	CLIA

**Interpretation:**

- 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.
- 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.
- 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.
- 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:**

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

**Increased Levels:** Vitamin D Intoxication

Method : CLIA

Vitamin- B12 (cyanocobalamin)	374	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**

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

**An increased vitamin B12 level is uncommon in:**

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



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**CLINICAL BIOCHEMISTRY**

Test Name	Results	Units	Ref. Range	Method
Testosterone Total	508.11	ng/dL	Refer Table	CLIA

**Interpretation:** (Testosterone Reference Ranges)

Age	Reference Range Male(ng/dL)	Reference Range Female(ng/dL)
Newborn(1-15days)	75-400	20-64
1-5 Months	1-177	1-5
6-11 Months	2-7	2-5
<b>Children:</b>		
1-5 Year	2-25	2-10
6-9 Year	3-30	2-20
<b>Puberty Tanner Stage</b>		
1	2-23	2-10
2	5-70	5-30
3	15-280	10-30
4	105-545	15-40
5	265-800	10-40
Adult	241-827	14-76

• Testosterone is a steroid hormone (androgen) made by the testes in males. Its production is stimulated and controlled by luteinising hormone (LH), which is manufactured in the pituitary gland. In males, testosterone stimulates development of secondary sex characteristics, including enlargement of the penis, growth of body hair and muscle, and a deepening voice. It is present in large amounts in males during puberty and in adult males to regulate the sex drive and maintain muscle mass. Testosterone is also produced by the adrenal glands in both males and females and, in small amounts, by the ovaries in females. The body can convert testosterone to oestradiol, the main sex hormone in females. There is great variability in testosterone levels between men and it is normal for testosterone levels to decline as men get older. Hypogonadism in a male refers to a reduction in sperm and/or testosterone production.

Result rechecked and verified for abnormal cases

\*\*\* End Of Report \*\*\*

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**CLINICAL BIOCHEMISTRY**

Test Name	Results	Units	Ref. Range	Method
<b>Lipid Profile</b>				
Cholesterol Total	203	mg/dL	< 200	CHOD-POD
Triglycerides-TGL	116	mg/dL	< 150	GPO-POD
Cholesterol-HDL	48	mg/dL	40-60	Direct
Cholesterol-LDL	131.8	mg/dL	< 100	Calculated
Cholesterol- VLDL	23.2	mg/dL	7-35	Calculated
Non HDL Cholesterol	155	mg/dL	< 130	Calculated
Cholesterol Total /HDL Ratio	4.23	%	0-4.0	Calculated
HDL / LDL Ratio	0.36			
LDL/HDL Ratio	2.75	%	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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**CLINICAL BIOCHEMISTRY**

Test Name	Results	Units	Ref. Range	Method
<b>Prostate-specific Antigen (PSA)</b>	0.01	ng/mL	0.0-4.0	CLIA

**Interpretation:**

- PSA is a glycoprotein present in the cytoplasm of the epithelial cells and ducts of the prostate and in the prostatic carcinoma.

**Increase PSA has been seen in:**

- Prostatic cancers.
- Benign prostatic hyperplasia.
- Prostatitis.
- Prostatic infarction.
- In the case of rectal manipulation of the prostate

**Note:**This interval is not intended to be used as a reference for posttreatment follow-up and monitoring of patients.

Result rechecked and verified for abnormal cases

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**CLINICAL BIOCHEMISTRY**

**HEALTH PROFILE A-3 PACKAGE**

Test Name	Results	Units	Ref. Range	Method
<b>Kidney Profile-KFT</b>				
Creatinine -Serum	0.73	mg/dL	0.70-1.30	Sarcosine oxidase
Urea-Serum	17.0	mg/dL	12.8-42.8	Glutamate dehydrogenase+Calculation
Blood Urea Nitrogen (BUN)	7.94	mg/dL	7.0-18.0	Calculated
BUN / Creatinine Ratio	10.88		6 - 22	
Uric Acid	<b>7.9</b>	mg/dL	3.5-7.2	Uricase
Sodium	140	mmol/L	136-145	ISE Direct
Potassium	3.8	mmol/L	3.5-5.1	ISE Direct
Chloride	100	mmol/L	98-108	ISE Direct

**Interpretation:**

- The kidneys, located in the retroperitoneal space in the abdomen, are vital for patient health. They process several hundred liters of fluid a day and remove around two liters of waste products from the bloodstream. The volume of fluid that passes through the kidneys each minute is closely linked to cardiac output. The kidneys maintain the body's balance of water and concentration of minerals such as sodium, potassium, and phosphorus in blood and remove waste by-products from the blood after digestion, muscle activity and exposure to chemicals or medications. They also produce renin which helps regulate blood pressure, produce erythropoietin which stimulates red blood cell production, and produce an active form of vitamin D, needed for bone health.

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**CLINICAL BIOCHEMISTRY**

**HEALTH PROFILE A-3 PACKAGE**

Test Name	Results	Units	Ref. Range	Method
<b>Liver Function Test (LFT)</b>				
Bilirubin(Total)	0.7	mg/dL	0.3-1.2	Diazo
Bilirubin (Direct)	0.1	mg/dL	0.0 - 0.2	Diazo
Bilirubin (Indirect)	0.6	mg/dL	0.2-1.0	Calculated
Aspartate Aminotransferase (AST/SGOT)	33	U/L	5-40	IFCC with out (P-5-P)
Alanine Aminotransferase (ALT/SGPT)	51	U/L	0-55	IFCC with out (P-5-P)
Alkaline Phosphatase(ALP)	75	U/L	30-120	Kinetic PNPP-AMP
Gamma Glutamyl Transpeptidase (GGTP)	24	U/L	15-85	IFCC
Protein - Total	6.4	g/dL	6.4-8.2	Biuret
Albumin	4.0	g/dL	3.4-5.0	Bromocresol Green (BCG)
Globulin	2.4	g/dL	2.0-4.2	Calculated
A:G Ratio	1.67	%	0.8-2.0	Calculated
SGOT/SGPT Ratio	0.65			

**Alanine Aminotransferase(ALT)** is an enzyme found in liver and kidneys cells. ALT helps create energy for liver cells. Damaged liver cells release ALT into the bloodstream, which can elevate ALT levels in the blood.

**Aspartate Aminotransferase (AST)** is an enzyme in the liver and muscles that helps metabolizes amino acids. Similarly to ALT, elevated AST levels may be a sign of liver damage or liver disease.

**Alkaline phosphate (ALP)** is an enzyme present in the blood. ALP contributes to numerous vital bodily functions, such as supplying nutrients to the liver, promoting bone growth, and metabolizing fat in the intestines.

**Gamma-glutamyl Transpeptidase (GGTP)** is an enzyme that occurs primarily in the liver, but it is also present in the kidneys, pancreas, gallbladder, and spleen. Higher than normal concentrations of GGTP in the blood may indicate alcohol-related liver damage. Elevated GGTP levels can also increase the risk of developing certain types of cancer.

**Bilirubin** is a waste product that forms when the liver breaks down red blood cells. Bilirubin exits the body as bile in stool. High levels of bilirubin can cause jaundice - a condition in which the skin and whites of the eyes turn yellow- and may indicate liver damage.

**Albumin** is a protein that the liver produces. The liver releases albumin into the bloodstream, where it helps fight infections and transport vitamins, hormones, and enzymes throughout the body. Liver damage can cause abnormally low albumin levels.

\*\*\* End Of Report \*\*\*

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**CLINICAL BIOCHEMISTRY**

**HEALTH PROFILE A-3 PACKAGE**

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

<b>T3 (Triiodothyronine)</b>	114.36	ng/dL	70-204	CLIA
<b>T4 (Thyroxine)</b>	9.5	µg/dL	3.2-12.6	CLIA
<b>TSH -Thyroid Stimulating Hormone</b>	1.12	µIU/mL	0.35-5.5	CLIA

**Pregnancy & Cord Blood**

<b>T3 (Triiodothyronine):</b>	<b>T4 (Thyroxine)</b>	<b>TSH (Thyroid Stimulating Hormone)</b>
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 PROFILE A-3 PACKAGE**

Test Name	Results	Units	Ref. Range	Method
<b>Iron Profile-I</b>				
Iron(Fe)	75	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)	20.05	%	20-50	Calculated
Unsaturated Iron Binding Capacity (UIBC)	299	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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**REPORT**

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Age/Gender	: 43 Years/Male	Reg. No	: 0312406240048
Referred by	: Dr. SELF	SPP Code	: SPL-CV-172
Referring Customer	: V CARE MEDICAL DIAGNOSTICS	Collected On	: 24-Jun-2024 12:01 PM
Primary Sample	:	Received On	: 24-Jun-2024 12:45 PM
Sample Tested In	: Urine	Reported On	: 24-Jun-2024 01:07 PM
Client Address	: Kimtee colony ,Gokul Nagar,Tarnaka	Report Status	: Final Report

**CLINICAL PATHOLOGY**

**HEALTH PROFILE A-3 PACKAGE**

Test Name	Results	Units	Ref. Range	Method
<b>Complete Urine Analysis (CUE)</b>				
<b>Physical Examination</b>				
Colour	Pale Yellow		Straw to light amber	
Appearance	Clear		Clear	
<b>Chemical Examination</b>				
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	1.030		1.000 - 1.030	Strip Reflectance
Blood	Negative		Negative	Strip Reflectance
Reaction (pH)	6.5		5.0 - 8.5	Reagent Strip Reflectance
Nitrites	Negative		Negative	Strip Reflectance
Leukocyte esterase	Negative		Negative	Reagent Strip Reflectance
<b>Microscopic Examination (Microscopy)</b>				
PUS(WBC) Cells	03-04	/hpf	00-05	Microscopy
R.B.C.	Nil	/hpf	Nil	Microscopic
Epithelial Cells	02-03	/hpf	00-05	Microscopic
Casts	Absent		Absent	Microscopic
Crystals	Absent		Absent	Microscopic
Bacteria	Nil		Nil	
Budding Yeast Cells	Nil		Absent	Microscopy

Correlate Clinically.

Laboratory is NABL Accredited

\*\*\* End Of Report \*\*\*



Swannabala - M  
DR.SWARNA BALA  
MD PATHOLOGY