

<b>Name :</b>	<b>Mr.AVTAR SINGH</b>	<b>Lab No. :</b>	<b>011604180034</b>
Age/Gender :	65 YRS/MALE	Privilege Card No :	N/A
Ref.By :	Dr. KAMAL GUPTA M.S.	Sample Received :	18/Apr/2016
Location :	N/A	Result Reported :	18/Apr/2016 03:41PM
Field Executive :	N/A	Client/Panel :	Standard
Sample Collected at/Sent By :	In Lab	Barcode No:	10003895

### WHOLE BODY CHECKUP

Test Name	Result	Unit	Status	Ref.Interval
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#### **Liver Function Test Panel 2**

<b>Bilirubin ( Total )</b>	0.79	mg/ dl	N	0.2-1.3
<b>Bilirubin (Direct)</b>	0.28	mg/ dl	N	0.0- 0.3
<b>Bilirubin ( Indirect )</b>	0.51	mg/ dl	N	0.1-1.0
<b>SGOT (AST)</b>	28.5	IU/ L	N	5 - 35
<b>SGPT (ALT)</b>	33.0	IU/ L	N	5 - 40
<b>Alk.Phosphatase</b>	82.0	IU/ L	N	38.0-156.0

#### **Comment :**

\*Alkaline phosphatases are found in liver, bone, intestine, and placenta.

\*It performs well in measuring the extent of bone metastases in prostate cancer.

\*Normal in osteoporosis.

\*Gamma glutamyl transpeptidase,(GGT),which increases in hepatobiliary disease but not in bone disease can be done to infer origin of increased alkaline phosphatase (ie, liver rather than bone).

**Increased in:** Obstructive hepatobiliary disease, bone disease (physiologic bone growth, Paget disease, osteomalacia, osteogenic sarcoma, bone metastases), hyperparathyroidism, rickets, benign familial hyperphosphatasemia, pregnancy (third trimester), GI disease (perforated ulcer or bowel infarct), hepatotoxic drugs.

**Decreased in:** Hypophosphatasia

<b>GGT</b>	49.7	IU/ L	N	5.0-73.0
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#### **Comment:-**

GGT is an enzyme present in liver, kidney, and pancreas.

It is induced by alcohol intake and is a sensitive indicator of liver disease, particularly alcoholic liver disease.

**Clinical utility**

- follow-up of alcoholics undergoing treatment since the test is sensitive to modest alcohol intake.
- confirmation of hepatic origin of elevated serum alkaline phosphatase.

**Increased in**

- Liver disease: acute viral or toxic hepatitis, chronic or subacute hepatitis, alcoholic hepatitis, cirrhosis, biliary tract obstruction (intrahepatic or extrahepatic), primary or metastatic liver neoplasm, and mononucleosis
- Drugs (by enzymeinduction): phenytoin, carbamazepine, barbiturates, alcohol

<b>T.Protein</b>	7.07	gm/ dl	N	06.0 - 8.0
<b>Albumin</b>	4.61	g/ dL	N	3.5 - 5.1
<b>Globulin</b>	2.46	gm/ dl	N	1.8 - 3.6
<b>A/G Ratio</b>	1.87		N	1.1 - 2.5

The liver filters and processes blood as it circulates through the body. It metabolizes nutrients, detoxifies harmful substances, makes blood clotting proteins, and performs many other vital functions. The cells in the liver contain proteins called enzymes that drive these chemical reactions.

When liver cells are damaged or destroyed, the enzymes in the cells leak out into the blood, where they can be measured by blood tests.If SGOT and SGPT are found together in elevated amounts in the blood, liver damage is most likely present.

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

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#### **Kidney Function Test 1**

<b>Urea, Serum</b>	28.5	mg/ dl	N	13.0-43.0
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**Comment**

- \* Urea is a nonprotein nitrogen compound formed in the liver from ammonia as an end product of protein metabolism.
- \* Blood urea nitrogen (BUN) levels reflect the balance between the production and excretion of urea.

**Clinical Utility**

- \*Evaluate renal function
- \*Assess nutritional support
- \*Evaluate hemodialysis therapy,hydration,liver function
- \*Evaluate patients with lymphoma after chemotherapy (tumor lysis)
- \*Monitor the effects of drugs known to be nephrotoxic or hepatotoxic

**Increased in:**

Acute renal failure ,chronic glomerulonephritis, congestive heart failure , decreased renal perfusion, diabetes, excessive protein ingestion, gastrointestinal (GI) bleeding, hyperalimentation, hypovolemia ,ketoacidosis ,muscle wasting from starvation, neoplasms, nephrotoxic agents, pyelonephritis, shock, urinary tract obstruction

**Decreased in:**

Inadequate dietary protein, low-protein/high-carbohydrate diet, malabsorption syndromes, pregnancy, severe liver disease  
Drugs- acetohydroxamic acid, chloramphenicol, fluorides, paramethasone, phenothiazine, and streptomycin.

<b>Creatinine, Serum</b>	1.10	mg/ dL	N	0.5-1.3
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**Comment :-**

Endogenous creatinine is excreted by filtration through the glomerulus and by tubular secretion. Creatinine clearance is an acceptable clinical measure of glomerular filtration rate (GFR) For each 50% reduction in GFR, serum creatinine approximately doubles.

**Increased in:** Acute or chronic renal failure, urinary tract obstruction, nephrotoxic drugs, hypothyroidism.

**Decreased in:** Reduced muscle mass.

**Note :**

- Serum creatinine levels frequently do not reflect decreased renal function because creatinine production rate is decreased with reduced lean body mass.
- Increased intravascular volume and increased volume of distribution associated with anasarca may also mask decreased renal function by reducing serum creatinine levels.
- Patients with diabetic ketoacidosis may have spuriously elevated creatinine.
- Cephalosporins may spuriously increase or decrease creatinine levels.
- Increased bilirubin may spuriously decrease creatinine.

<b>Uric Acid, Serum</b>	4.3	mg/ dl	N	3.5-7.3
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**Comment :-**

Before testing for uric acid levels in serum, Alcohol should be avoided, because it slows down the removal of uric acid from the body. Fasting, a starvation diet, and strenuous exercise all raise uric acid levels. Uric acid blood levels vary from day to day. The level is usually higher in the morning and lower in the evening. Blood uric acid levels that increase during pregnancy, even if the levels remain within the normal range, may help diagnose preeclampsia.

**High uric acid values may be caused by:**

1. Individual differences in the way your body produces or gets rid of uric acid.- Conditions, such as: Kidney disorder.
2. The increased breakdown of body cells that occurs with some types of cancer (including leukemia, lymphoma, and multiple myeloma) or cancer treatments, hemolytic anemia, sickle cell anemia, or heart failure.
3. Severe liver disease (acute hepatitis, cirrhosis, malignancy), hyperthyroidism, severe acute or chronic illness, malnutrition,malabsorption (eg, HIV), extensive burns, familial (Gaucher disease, Tangier disease), abetalipoproteinemia,

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intestinal lymphangiectasia.

4. Other disorders, such as alcohol dependence, preeclampsia, liver disease (cirrhosis), obesity, psoriasis, hypothyroidism, low blood levels of parathyroid hormone, Starvation, malnutrition, or lead poisoning.
5. Medicines, such as some diuretics, vitamin C (ascorbic acid), lower doses of aspirin (75 to 100 mg daily), niacin, warfarin (such as Coumadin), cyclosporine, levodopa, tacrolimus, and some medicines used to treat leukemia, lymphoma, or tuberculosis.
6. Eating foods that are very high in purines, such as organ meats (liver, brains), red meats (beef, lamb), game meat (deer, elk), some seafood (sardines, herring, scallops), and beer.

**Low uric acid values may be caused by:**

1. Severe liver disease, Wilson's disease, or some types of cancer, the syndrome of inappropriate antidiuretic hormone (SIADH).
2. Not eating enough protein, Sulfinpyrazone, large amounts of aspirin (1,500 mg or more daily), probenecid & allopurinol.

<b>BUN (Blood Urea Nitrogen )</b>	13.3	mg/ dl	N	6.0-20.0
<b>BUN CREATININE RATIO</b>	12.07		N	10 - 20 : 1

**Comment**

BUN:Creatinine	Location	
>20:1	Prerenal	Dehydration, Prerenal Disease
10-20:1	Normal or Postrenal	Normal range. Postrenal disease.
<10:1	Intrarenal	Renal Damage

\*The ratio may be used to determine the cause of acute kidney injury or dehydration.

**BUN Creatinine Ratio Increased-** In dehydration, gastrointestinal bleeding, increased catabolism and prerenal disease.

**BUN Creatinine Ratio Decreased** - In acute tubular necrosis advanced liver disease, low protein intake and following hemodialysis

<b>UREA CREATININE RATIO</b>	25.91		N	20 - 35 : 1
( Calculated Parameters )	-			

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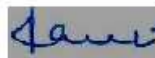
<u>Test Name</u>	<u>Result</u>	<u>Unit</u>	<u>Status</u>	<u>Ref.Interval</u>
<b><u>Electrolytes /Na+ K+ Ca(Ionic)Serum</u></b>				
<b>Sodium, Serum</b>	138.2	mmol/ L	N	135 - 150
<b>Potassium, Serum</b>	4.40	mmol/ L	N	3.50 - 5.50
<b>Calcium [Ionic]</b>	<b>0.92</b>	mmol/ L	L	1.0 - 1.3

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#### **DIABETIC SCREENING**

<b>Blood Sugar Fasting</b>	<b>134.0</b>	mg/ dL	H	70.0 - 110.0
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#### **Interpretation:-**

Fasting Plasma Glucose (mg/dl)	2 hr plasma Glucose (mg/dl)	Diagnosis
99 or below	139 or below	Normal
100 to 125	140 to 199	Pre-Diabetes (IGT)
126 or above	200 or above	Diabetes

\*Confirm by repeating the test on a different day

Impaired glucose tolerance (IGT) fasting, means a person has an increased risk of developing type 2 diabetes but does not have it yet. A level of 126 mg/dL or above, confirmed by repeating the test on another day, means a person has diabetes.

IGT (2 hrs Post meal ), means a person has an increased risk of developing type 2 diabetes but does not have it yet. A 2-hour glucose level of 200 mg/dL or above, confirmed by repeating the test on another day, means a person has diabetes.

Blood Glucose Goals	For people with Diabetes
Before meal	70-130 mg/dL
2 Hours after meal	Less than 180 mg/dL
HbA1c	Less than 7%

Ref : American Diabetes association standards of medical care.

<b>Hb A1c</b>	5.8	N	3.9 - 6.1%
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**Haemoglobin A1c** In the blood stream are the red blood cells, which are made of a molecule, haemoglobin. Glucose sticks to the haemoglobin to make a 'glycosylated haemoglobin molecule, called haemoglobinA1c or HbA1c. The more glucose in the blood, the more haemoglobin A1c or HbA1c will be present in the blood. HbA1C is an indicator of glycemic control. HbA1c represents average glycemia over the past six to eight weeks.

#### **Underlying Principle:**

In the normal 120-day life span of the RBC, glucose molecules join haemoglobin, forming glycosylated haemoglobin. In individuals with poorly controlled diabetes, increases in the quantities of this glycosylated haemoglobin are noted. Once a haemoglobin molecule is glycosylated, it remains that way. A buildup of glycosylated haemoglobin within the red cell reflects the average level of glucose to which the cell has been exposed during its life cycle. Measuring glycosylated haemoglobin assesses the effectiveness of therapy by monitoring long-term serum glucose regulation. HbA1c levels depend on the blood glucose concentration. That is, the higher the glucose concentration in blood, the higher of the level of HbA1c; and **is not influenced by daily fluctuation in the blood glucose concentration but reflects the average levels over the prior two or three months.** Therefore, HbA1c is a useful indicator of how well the blood glucose level has been controlled in the recent past and may be used to monitor the effects of diet, exercise and drug therapy on blood glucose in diabetic patients.

#### **Healthy HbA1c levels:**

**Target HbA1c levels may vary from person to person. A general range for HbA1c level is:**

- Between 4 % and 6% shows normal **non diabetic range.**
- Between 6 % and 7 % shows well **controlled diabetic range.**
- Between 7 % and 8% indicates **unsatisfactory control.**
- Above 8% indicates **poor control and need treatment by doctor.**

#### **Importance:-**

Patient's daily blood glucose tests provide only a snapshot of glycemic control at the moment you test. The HbA1c test, on the other hand, gives the big picture by showing how patient blood glucose control has been over the **past 2-3 months.** Over a longer period of

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time, consecutive HbA1c tests may provide an overall trend in your diabetic control.

**A major study, the UKPDS Study published in 2000, managed by quantify many of the benefits of reducing a high HbA1c level by just 1%.**

- A 16% decrease in risk of **heart failure**.
- A 14% decrease in risk of **fatal of nonfatal myocardial infarction(heart arrack)**
- A 12% decrease in risk of **fatal or nonfatal stroke**.
- A 21% decrease in risk of **diabetes-related death**.
- A 14% decrease in risk of **death from all causes**.
- A 43% decrease in risk of **ambulation**.
- A 37% decrease in risk of **small blood vessel disease (e.g. retinal blood vessel disease causing vision loss)**.

<b>Glycosylated Hb.-HbA1C(IFCC)</b>	36.1	mmol/ mol	N	20.0-53.0
<b>Estimated Average Blood Glucose (EAG)</b>	120.0	mg/ dL	N	70-140

**Note:-**

In Diabetics HbA1c should be routinely monitored every 3 months.

Advised repeat estimation every three months.

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#### ARTHRITIS SCREENING

<b>ESR (Erythrocyte Sedimentation Rate)-Westergrens Method</b>	4.0	mm	N	0.0 - 20
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This test can be used to monitor inflammatory diseases or cancer. It is a screening test. This means it cannot be used to diagnose a specific disorder. However, the test is useful for detecting and monitoring Autoimmune disorders, Bone infections, Certain forms of arthritis, Inflammatory diseases, Anaemia, Kidney diseases and Thyroid disorders.

<b>Calcium</b>	<b>7.4</b>	mg/ dl	L	8.5 - 10.5
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Calcium helps build strong bones and teeth. It is important for heart function, and helps with muscle contraction, nerve signaling, and blood clotting. Higher than normal levels may be due to a number of health conditions. Common causes include: Being on bed rest for a long time, Consuming too much calcium or vitamin D, HIV/AIDS, Hyperparathyroidism, or hyperractive thyroid gland (hyperthyroidism) or too much thyroid hormone replacement medication Lower than normal levels may be due to: Hypoparathyroidism, Kidney failure, Low blood level of albumin, Liver disease, Magnesium deficiency, Osteomalacia and Vitamin D deficiency

<b>CRP Qualitative</b>	NEGATIVE		N	NEGATIVE
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C-reactive protein (CRP) test is a blood test that measures the amount of a protein called C-reactive protein in blood. High levels of CRP are caused by infections and many long-term diseases. But a CRP test cannot show where the inflammation is located or what is causing it. Other tests are needed to find the cause and location of the inflammation

<b>Alkaline Phosphatase</b>	82.0	U/ L	N	40-150
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<b>RA Factor</b>	NEGATIVE			
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#### Comments :

\* RA factor has been demonstrated in approximately 80 % of patients with rheumatoid arthritis.

\* False positive results may occur in hepatitis, sarcoidosis, cirrhosis of liver Sjogren's syndrome, acut bacterial and viral infection.

Diagnosis of rheumatoid arthritis should be made in conjunction with complete clinical evaluation.

In many early cases of RA, clinical symptoms are milder and nonspecific, and patients will not fulfill ACR classification criteria for RA. Therefore, the detection of a disease-specific autoantibody like anti-CCP could be of great diagnostic and therapeutic importance. Anti-CCP antibodies may be detected in roughly 50-60% of patients with early RA at 'baseline. The specificity of anti-CCP is around 95-98% as regards undifferentiated forms of arthritis that do not develop into RA

ENA SCREEN test is also done for detection of IgG Antibodies to Extractable Nuclear Antigens (ENA). It is capable of detecting all anti-ENAs commonly tested for, such as those against Jo-1, Sm, Sm/RNP, SSA, SSB, and Scl-70. A single test therefore rules out the need for individual testing. ENA SCREEN is there fore a cost effective and quick test for screening rheumatic process.

"The test is validated and performed at third party lab"

<b>Uric Acid, Serum</b>	4.3	mg/ dl	N	3.5-7.3
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#### Comment :-

Before testing for uric acid levels in serum, Alcohol should be avoided, because it slows down the removal of uric acid from the body. Fasting, a starvation diet, and strenuous exercise all raise uric acid levels. Uric acid blood levels vary from day to day. The level is usually higher in the morning and lower in the evening. Blood uric acid levels that increase during pregnancy, even if the levels remain within the normal range, may help diagnose preeclampsia.

**High uric acid values may be caused by:**

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2. The increased breakdown of body cells that occurs with some types of cancer (including leukemia, lymphoma, and multiple myeloma) or cancer treatments, hemolytic anemia, sickle cell anemia, or heart failure.				
3. Severe liver disease (acute hepatitis, cirrhosis, malignancy), hyperthyroidism, severe acute or chronic illness, malnutrition,malabsorption (eg, HIV), extensive burns, familial (Gaucher disease, Tangier disease), abetalipoproteinemia, intestinal lymphangiectasia.				
4. Other disorders, such as alcohol dependence, preeclampsia, liver disease (cirrhosis), obesity, psoriasis, hypothyroidism, low blood levels of parathyroid hormone, Starvation, malnutrition, or lead poisoning.				
5. Medicines, such as some diuretics, vitamin C (ascorbic acid), lower doses of aspirin (75 to 100 mg daily), niacin,warfarin(such as Coumadin), cyclosporine, levodopa, tacrolimus, and some medicines used to treat leukemia, lymphoma,or tuberculosis.				
6. Eating foods that are very high in purines, such as organ meats (liver, brains), red meats (beef, lamb), game meat (deer, elk),some seafood (sardines, herring, scallops), and beer.				

**Low uric acid values may be caused by:**

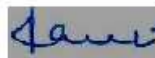
1. Severe liver disease, Wilson's disease, or some types of cancer, the syndrome of inappropriate antidiuretic hormone (SIADH).
2. Not eating enough protein,Sulfipyrazone, large amounts of aspirin (1,500 mg or more daily), probenecid & allopurinol.

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#### **STRONG BONES PROFILE**

<b>Calcium</b>	<b>7.4</b>	mg/ dL	L	8.5-11.0
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Calcium helps build strong bones and teeth. It is important for heart function, and helps with muscle contraction, nerve signaling, and blood clotting. Higher than normal levels may be due to a number of health conditions. Common causes include: Being on bed rest for a long time, Consuming too much calcium or vitamin D, HIV/AIDS, Hyperparathyroidism, or hyperractive thyroid gland (hyperthyroidism) or too much thyroid hormone replacement medication Lower than normal levels may be due to: Hypoparathyroidism, Kidney failure, Low blood level of albumin, Liver disease, Magnesium deficiency, Osteomalacia and Vitamin D deficiency

<b>Phosphorous</b>	<b>3.4</b>	mg/ dl	N	2.5-4.5
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Phosphate tests, which measure phosphate levels in the blood, are used to diagnose kidney problems and monitor dialysis. The normal range for this test is 2.4 to 4.1 mg/dL. Levels that are higher or lower-than-normal may indicate kidney disease.

<b>Magnesium</b>	<b>2.26</b>	mg/ dl	N	1.3-2.5
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#### **Lipid Profile Complete**

<b>Total Cholesterol</b>	<b>204</b>	mg/ dL	H	Desirable <200 Borderline 200-239 High Risk >240
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A complete cholesterol test (also called a lipid profile) measures the amount of "good" and "bad" cholesterol and the level of triglycerides in the blood. Cholesterol is a fat-like substance that the body needs to function properly. However, too much cholesterol can lead to heart disease, stroke, and atherosclerosis (a clogging or hardening of your arteries). It is important to have your cholesterol levels (lipid profile or panel) checked routinely. High cholesterol by itself usually has no signs or symptoms. Hence the importance of screening test. The body makes most of the cholesterol in the liver. For this reason, cholesterol levels are largely determined by genetics. Eating foods high in cholesterol, saturated fats, trans fats and total fat in the diet may also affect the cholesterol levels. Most of the cholesterol in the diet comes from animal products like meats, dairy fats and egg yolks.

<b>Triglycerides</b>	<b>187</b>	mg/ dL	H	40 - 160
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Triglycerides are blood lipids by esterification of glycerol and free fatty acids and are carried by their serum lipoproteins. The intestine processes the triglycerides from dietary fatty acid and they are transported in the blood stream as chylomicrons. A function of Triglycerides is to provide energy to heart and skeletal muscles. Triglycerides are major contributors to arterial diseases. As the concentration of triglycerides increases, so will the VLDL increase. A peak concentration of chylomicron associated triglycerides occurs within 3-6 hrs after ingestion of a fat-rich meal. Alcohol intake also causes a transient increase of serum TG level. If TG is more than 400 mg/dL, VLDL cannot be calculated. Conditions associated with increased TG levels: Hyperlipoproteinemia, stress, high carbohydrates or fatty diet, acute MI, Hypertension, Cerebral thrombosis, hypothyroidism, uncontrolled diabetes, pancreatitis, pregnancy etc. Conditions associated with decreased TG levels: Hyperthyroidism, Hyperparathyroidism, Lipoproteinemia, Protein malnutrition, exercise etc. People with increased levels are advised to undergo a lipid profile at regular intervals.

<b>HDL Cholesterol Direct</b>	<b>35</b>	mg/ dL	N	35 - 60
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<b>LDL Cholesterol</b>	<b>132</b>	mg/ dL	H	60 - 100
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LDL Cholesterol, or low-density lipoprotein, is also known as "bad" cholesterol due to the proven relationship between high LDL levels and heart disease. The main goal of any cholesterol treatment program is to lower the LDL cholesterol.

LDL Cholesterol Levels (mg/dL)

70 or below: lowest risk

100 or below: lower risk

101 to 129: moderate risk

130 or above: high risk

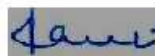
<b>V.L.D.L.</b>	<b>37.4</b>	mg/ dL	H	4.7 - 30.0
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<b>CHOLESTEROL / HDL RATIO</b>	<b>5.8</b>		H	Low Risk 3.3-4.4 Average Risk 4.4-7.1 Moderate Risk 7.1-11.0 High Risk >11.0
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<b>LDL / HDL RATIO</b>	<b>3.8</b>		H	0.1 - 3.0
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**Interpretation :** The National Cholesterol Education Program (NCEP) Adult Treatment Panel III (ATP-III) has classified lipid results and established guidelines for lipid testing and patient management.

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Age/Gender :	65 YRS/MALE	Privilege Card No :	N/A
Ref.By :	Dr. KAMAL GUPTA M.S.	Sample Received :	18/Apr/2016
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Field Executive :	N/A	Client/Panel :	Standard
Sample Collected at/Sent By :	In Lab	Barcode No:	10003895

### WHOLE BODY CHECKUP

Test Name                                      Result                                      Unit                                      Status    Ref.Interval

For adults (18 years and above)	
<b>Total Cholesterol</b> Desirable: <200 mg/dL Borderline high: 200-239 mg/dL High: > or =240 mg/dL	<b>Triglycerides</b> Normal: <150 mg/dL Borderline high: 150-199 mg/dL High: 200-499 mg/dL Very high: > or =500 mg/dL
<b>HDL Cholesterol</b> Low (removed HDL): <40 mg/dL Normal: 40-60 mg/dL High: >60 mg/dL	<b>LDL Cholesterol</b> Optimal: <100 mg/dL Near Optimal: 100-129 mg/dL Borderline high: 130-159 mg/dL High: 160-189 mg/dL Very high: > or =190 mg/dL
<b>Non HDL Cholesterol</b> Desirable: <130 mg/dL Borderline high: 130-159 mg/dL High: 160-189 mg/dL Very high: > or =190 mg/dL	

For individuals aged between 2 - 18 years	
<b>Total Cholesterol</b> Desirable: <170 mg/dL Borderline high: 170 -199 mg/dL High: > or =200 mg/dL	<b>Triglycerides</b> Normal: <90 mg/dL Borderline high: 90-129 mg/dL High: > or =130 mg/dL
<b>HDL Cholesterol</b> Low HDL: <40 mg/dL Borderline low: 40-59 mg/dL Normal: > or =60 mg/dL	<b>LDL Cholesterol</b> Desirable: <110 mg/dL Borderline high: 110-129 mg/dL High: > or =130 mg/dL

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

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### WHOLE BODY CHECKUP

Test Name	Result	Unit	Status	Ref.Interval
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#### **Anaemia Screening**

Iron, Serum	79.50	ug/ dL	N	35-160
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#### **Ref Range for Iron**

Adult Male	60-160	ug/dL
Adult Female	35-145	ug/dL
Child	50-120	ug/dL

#### **COMMENT:**

##### **Serum iron**

Serum iron measures the amount of circulating iron that is bound to transferrin. Clinicians order this laboratory test when they are concerned about iron deficiency, which can cause anemia and other problems.

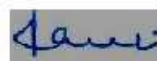
TIBC	324.20	ug/ dL	N	228.00 - 428.00
Transferin Saturation	24.50	%	N	20.00 - 55.00

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### WHOLE BODY CHECKUP

Test Name	Result	Unit	Status	Ref.Interval
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#### **CBC (Complete Blood Count)**

<b>Total Leucocyte Count(TLC)</b>	6.91	10 <sup>9</sup> / L	N	4.0-11.0
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Leukocytes or White Blood Cells, present in the blood are a part of the body's defense mechanism. They respond immediately to infections and foreign invaders by going to the affected site.

Purpose of this test is to determine the presence of an infection, to check different WBC values for diagnosing various problems

<b>Absolute Neutrophil Count</b>	4.29	10 <sup>9</sup> / L	N	2.0-7.5
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Increase in Number and repond rapidly in inflammatory process, tissues injury & bacterials infections, are first line of defence during an acute infection.

<b>Neutrophil</b>	62.10	%		
<b>Absolute Lymphocyte Count</b>	2.21	10 <sup>9</sup> / L	N	1.5-4.0

**Increased Levels:** are usually a sign of viral infections, like mumps, measles. also seen in - chronic bacterial infections, recovery from bacterial infections, infective hepatitis, infectious mononucleosis, lymphocytic leukemias, multiple myelomas.

**Decreased Levels:** seen in sepsis, immunosuppressive drugs, HIV infection, leukemia, radiation therapy/exposure, severe acute respiratory syndrome, autoimmune and connective tissue disease including SLE and rheumatoid arthritis, sarcoidosis, chronic renal failure, excess alcohol intake, older age and thymoma, some cases of mycobacterium infection, congenital lymphopenia, severe combined immunodeficiency and Di George syndrome.

<b>Lymphocytes</b>	32.00	%		
<b>Absolute Monocyte Count</b>	0.30	10 <sup>9</sup> / L	N	0.2-0.8

#### **Comment:**

\*Increased reactive levels are seen with chronic infections, inflammatory or granulomatous process, metastatic Carcinomas, lymphoma and radiation therapy.

\*Absolute monocytosis that is persistent indicates a myeloproliferative disorder like chronic myelomonocytic leukemia.

\* Decreased levels are seen with myocardial infarctions

<b>Monocytes %</b>	4.20	%	N	2.0-10.0
<b>Absolute Eosinophil Count</b>	0.09	10 <sup>9</sup> / L	N	0.04-0.4

Respond to parasitic infection & allergic conditions.

<b>Eosinophils</b>	1.30	%		
<b>Absolute Basophil Count</b>	0.02	10 <sup>9</sup> / L	N	0-0.1

#### **Comment:**

\*The count varies with age, gender and season.

\*A low basophil count does not indicate any specific disease and may be seen in normal individuals.

\*A high count may be seen in allergic reactions, rheumatoid arthritis, colitis, Polycythemia Vera, myeloid leukemia and some lymphomas.

<b>Basophils %</b>	0.40	%	N	0-1.0
<b>RBC Count</b>	5.5	x10(12)/ L	N	3.80 - 6.00

Decreased Level of RBC Indices Hemorrhage, Anemias, chronic Infections Leulemias, multiple myeloma, chronic renal failure, pregnancy, overhydration.

Increased Level Indices polycythemia vera, Dehydration, Cardiovascular disease

<b>Haemoglobin (Hb)</b>	15.30	gm/ dL	N	12.0-16.5
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### WHOLE BODY CHECKUP

Test Name	Result	Unit	Status	Ref.Interval
<b>MCH</b>	27.9	pg	N	27-32
<b>PCV</b>	<b>45.3</b>	%	H	35.0-45.0
<b>MCV</b>	82.5	fl	N	77-93

It indicates the size of RBC,  
Decreased MCV might be indicative of Iron-deficiency anemia, Microcytic anemia, Sickle cell anemia, Rheumatoid arthritis, and thalassaemia.  
Increased Level Indicative of Macrocytic anemia, Chronic liver disease, Hypothyroidism, Vit B12 deficiency.

<b>MCHC</b>	33.8	%	N	31-35
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It indicates the haemoglobin concentration per unit volume of RBCs. Decrease level indicates hypochromic anemia, iron deficiency anemia, Thalassaemia.

<b>RDW-CV</b>	13.9	%	N	11.50-14.50
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It is the size (Width) differences of RBCs . RDW is measurement of the width of the size distribution curve on a histogram. It is useful in predicting anemias early, before MCV changes and before signs and symptoms occur. An elevated RDW indicates iron deficiency, folic acid deficiency, and vitamin B12 deficiency anemias

<b>RDW-SD</b>	43.8	fl	N	37.0-46.0
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<b>Platelet Count</b>	228	10 <sup>9</sup> / L	N	150 - 400
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Platelets are basic elements in the blood that promote coagulation & formation of blood clots.

<b>MPV</b>	10.6	fl	N	8.0 - 12.0
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<b>PDW</b>	<b>16.2</b>	fl	H	9.0-14.0
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<b>PCT</b>	0.24			
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<b>Platelets Large Cell Concentration</b>	74.00			
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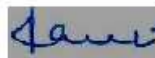
<b>Platelets Large Cell Ratio</b>	32.60			
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### WHOLE BODY CHECKUP

Test Name	Result	Unit	Status	Ref.Interval
<b>Thyroid Profile Total</b>				
<b>Triiodothyronine Total [T3]</b>	1.59	ng/ ml	N	0.58-1.81
<b>Thyroxine Total [T4]</b>	7.95	µg/ dl	N	4.87 - 11.72
<b>TSH</b>	1.17	µIU/ ml	N	0.35 - 5.50

#### Interpretation:-

TSH	T3	T4	Interpretation
High	Normal	Normal	Subclinical Hypothyroidism
Low	Normal	Normal	Subclinical Hyperthyroidism
High	High	High	Secondary Hyperthyroidism
Low	High/Normal	High/Normal	Hyperthyroidism
Low	Low/Normal	Low/Normal	Non Thyroidal Illness

#### Reference Range - Pregnancy

Pregnancy	TSH	T3	T4
1st Trimester	0.30 - 4.50	0.81 - 1.9	6.6 - 12.4
2nd Trimester	0.50 - 4.60	1.0 - 2.6	6.6 - 12.5
3rd Trimester	0.80 - 5.20	1.0 - 2.6	6.6 - 12.5

#### Reference Range - Age Related

Age	TSH	T3	T4
0-1 day /.(Cord Blood)	1.0 - 17.4	0.15 - 0.75	7.4 - 13.0
2day - 4days	1.0 - 39.0	1.0 - 7.4	14.0 - 28.4
2wks - 20wks	1.7 - 9.1	1.05 - 2.45	7.2 - 15.7
5mths - 24mths	0.8 - 8.2	1.05 - 2.69	7.2 - 15.7
2yrs - 7yrs	0.7 - 5.7	0.94 - 2.41	6.0 - 14.2
8yrs - 21yrs	0.7 - 5.7	0.8 - 2.0	4.7 - 12.4
Adults (> 21yrs)	0.35 - 4.94	0.58 - 1.81	4.87- 11.72

TSH levels are subjected to circadian variation, rising several hours before the onset of sleep, reaching peak levels between 11 pm and 6 am.

Nadir concentrations are observed during the afternoon. Diurnal variation in TSH levels is approx 50% +/-, hence time of the day can influence the measured serum concentration.


#### PSA (Prostate Specific Antigen) Profile - Cancer Markers

PROSTATIC SPECIFIC ANTIGEN                      1.04                      ng/ ml                      N                      0-4.0

PSA is present in the serum of males with normal, benign hyperplastic and malignant prostate tissue. PSA can be useful for determining residual disease and early recurrence after therapy when used in conjunction with other diagnostic indices. PSA levels increase in men with cancer of the prostate, and after radical prostatectomy PSA levels routinely fall to a very low level.

Serum PSA measurement is not an absolute test for malignancy. The PSA value should be used in conjunction with information available from clinical evaluation and other diagnostic procedures. Some cases of benign prostatic hypertrophy and prostatitis show elevation of PSA, but such increase are below those found with adenocarcinoma of prostate

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### WHOLE BODY CHECKUP

Test Name	Result	Unit	Status	Ref.Interval
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Note : Assay results should be interpreted only in context of other laboratory findings and the total clinical status of the patient.

<b><u>Vitamin B12 Level</u></b>	405.20	pg/ mL	N	New Born: 160-1300 Adult: 18-59 yrs: 200-835 >60 yrs: 110-800
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**CLINICAL SIGNIFICANCE :-**

Vitamin B12 or cynocobalamin, is a complex corrinoid compound found exclusively from animal dietary sources, such as meat, eggs and milk ,It is critical in normal DNA synthesis , which in turn affects erythrocyte maturation and in the formation of myelin sheath .Vitamin B12 is used to find out neurological abnormalities and impaired DNA synthesis associated with macrocytic naemias .

For diagnostic purpose ,results should always be assessed in conjunction with the patients medical history, clinical examination and other findings. Vitamin B 12 along with folate is essential for DNA synthesis and myelin formation.

Vitamin B 12 deficiency can be because of nutritional deficiency, malabsorption and other gastrointestinal causes The test is ordered primarily to help diagnose the cause of macrocytic/ megaloblastic anemia.

**Decreased** levels are seen in anaemia, normal near term pregnancy, vegetarianism, partial gastrectomy/ ileal damage, celiac disease, with oral contraceptive use, parasitic competition, pancreatic deficiency, treated epilepsy, smoking, hemodialysis and advancing age.

**Increased** levels are seen in renal failure, hepatocellular disorders, myeloproliferative disorders and at times with excess supplementation of vitamins pills

<b><u>Vitamin D , 25 Hydroxy</u></b>	<b>25.80</b>	ng/ mL	L	30.0-100.0
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NOTE:

1. 25 OH Vitamin D is considered the best indicator of Vitamin D nutritional status.
2. The assay measures both D2 (Ergocalciferol) and D3 (Cholecalciferol) metabolites of vitamin D.
3. 25 (OH)D is influenced by sunlight, latitude, skin pigmentation, sunscreen use and hepatic functions.

COMMENTS :

Vitamin D (Cholecalciferol) 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.

DECREASED LEVELS:

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

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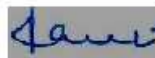
<u>Test Name</u>	<u>Result</u>	<u>Unit</u>	<u>Status</u>	<u>Ref.Interval</u>
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### WHOLE BODY CHECKUP

Test Name	Result	Unit	Status	Ref.Interval
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#### Urine Complete Examination

##### **Physical Examination**

Volume	20cc			
Colour	Pale Yellow			Pale Yellow
Appearance	Clear			Clear
Reaction	Acidic		N	5.80-7.50
SP.Gravity	1.015		N	1.003-1.030
pH	7.0		N	4.6-8.0

##### **Biochemical Examination**

Protein	Negative			NIL
Urine Glucose	Negative			NIL
Bilirubin	Negative			NIL
Ketones	Negative			NIL
Urobilinogen	3.20		N	0.2-3.2
Nitrite	Negative			NIL

##### **Cytological Examination**

Epithelial Cells	Few	/ HPF	N	0-5
Pus Cells.	1-2	HPF	N	0-4
Total RBC Count	NIL	cells/ mm		
Crystals	NIL	/ HPF		NIL
Casts	NIL			NIL
Bacteria	NIL	/ HPF		NIL
Yeast Cells	NIL	/ HPF		NIL
Mucous Threads	NIL			NIL
Trichomonas Vaginalis	NIL			NIL
Amorphous Material	NIL			NIL
Others	NIL			

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