Name	: **Mr. ANUBHAV KRISHNA**	**Age**	: **27 Years**
Lab No.	: **462175941**	**Gender**	: **Male**
Ref By	: **SELF**	**Reported**	: **25/1/2024 3:45:31PM**
Collected	: **25/1/2024 9:12:00AM**	**Report Status**	: **Final**
A/c Status	: **P**	**Processed at**	: **LPL-VASANT KUNJ LAB NELSON MANDELA MARG, BUILDING No.1 L.S.C., SECTOR-B, POCKET-7, VASANT KU NEW DELHI-110070**
Collected at	: **NFC-II HOME COLLECTION C-655, Ground Floor New Friends Colony, New Delhi-110025**		

MC-2011

Test Report

SWASTHFIT COMPLETE PACKAGE

Test Name	Results	Units	Bio. Ref. Interval
HEMOGRAM (Photometry, Electrical Impedance, VCS technology, calculated and Capillary photometry)			
Hemoglobin	15.10	g/dL	13.00 - 17.00
Packed Cell Volume (PCV)	44.80	%	40.00 - 50.00
RBC Count	4.97	mill/mm3	4.50 - 5.50
MCV	90.10	fL	83.00 - 101.00
MCH	30.40	pg	27.00 - 32.00
MCHC	33.70	g/dL	31.50 - 34.50
Red Cell Distribution Width (RDW)	14.00	%	11.60 - 14.00
Total Leukocyte Count (TLC)	7.20	thou/mm3	4.00 - 10.00
Differential Leucocyte Count (DLC)			
Segmented Neutrophils	60.40	%	40.00 - 80.00
Lymphocytes	21.30	%	20.00 - 40.00
Monocytes	**10.40**	%	2.00 - 10.00
Eosinophils	**7.70**	%	1.00 - 6.00
Basophils	0.20	%	<2.00
Absolute Leucocyte Count			
Neutrophils	4.35	thou/mm3	2.00 - 7.00
Lymphocytes	1.53	thou/mm3	1.00 - 3.00
Monocytes	0.75	thou/mm3	0.20 - 1.00
Eosinophils	**0.55**	thou/mm3	0.02 - 0.50
Basophils	**0.01**	thou/mm3	0.02 - 0.10
Platelet Count	217	thou/mm3	150.00 - 410.00
Mean Platelet Volume	11.6	fL	6.5 - 12.0

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MC-2011

Test Report

Test Name	Results	Units	Bio. Ref. Interval
E.S.R.	2	mm/hr	0 - 15

Note

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

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MC-2011

Test Report

Test Name	Results	Units	Bio. Ref. Interval
GLUCOSE, FASTING (F), PLASMA (Hexokinase)	88.00	mg/dL	70 - 100
CARDIO C-REACTIVE PROTEIN (hsCRP), SERUM (Immunoturbidimetry)	0.32	mg/L	<1.00

Interpretation

CARDIO CRP IN mg/L	CARDIOVASCULAR RISK
<1	Low
1-3	Average
3-10	High
>10	Persistent elevation may represent Non cardiovascular inflammation

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

Comments

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

APOLIPOPROTEINS A1 & B, SERUM (Immunoturbidometry)			
Apolipoprotein (Apo A1)	100	mg/dL	79 - 169
Apolipoprotein (Apo B)	72	mg/dL	46.00 - 174.00
Apo B / Apo A1 Ratio	0.72		0.35 - 0.98

Comments

Apolipoprotein B is a more powerful independent predictor of Coronary Heart Disease (CAD) than LDL Cholesterol. It is useful in assessing the risk of CAD and to classify Hyperlipidemias. Apolipoprotein studies

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MC-2011

Test Report

Test Name	Results	Units	Bio. Ref. Interval

help in monitoring coronary bypass surgery patients with regard to risk and severity of re-stenosis. They are also useful in assessing risk of re-infarction in patients of Myocardial infarction.

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

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

Apolipoprotein B

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

Apo B to A1 Ratio

RATIO	REMARKS
0.35-0.98	Desirable
>0.98	Increased CAD risk

VITAMIN B12; CYANOCOBALAMIN, SERUM (CLIA)	277.00	pg/mL	211.00 - 911.00

Notes

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

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MC-2011

Test Report

Test Name	Results	Units	Bio. Ref. Interval
interchangeably due to differences in assay methods and reagent specificity			
VITAMIN D, 25 - HYDROXY, SERUM (CLIA)	**12.00**	nmol/L	75.00 - 250.00
Result Rechecked, Please Correlate Clinically.			

Interpretation

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

Note

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

Comments

Vitamin D promotes absorption of calcium and phosphorus and mineralization of bones and teeth. Deficiency in children causes Rickets and in adults leads to Osteomalacia. It can also lead to Hypocalcemia and Tetany. Vitamin D status is best determined by measurement of 25 hydroxy vitamin D, as it is the major

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MC-2011

Test Report

Test Name	Results	Units	Bio. Ref. Interval

circulating form and has longer half life (2-3 weeks) than 1,25 Dihydroxy vitamin D (5-8 hrs).

Decreased Levels

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

Increased levels

Vitamin D intoxication

Interpretation

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

Note

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MC-2011

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Comments

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

Decreased Levels

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

Increased levels

Vitamin D intoxication

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Test Report

Test Name	Results	Units	Bio. Ref. Interval
AMYLASE, SERUM (Ethylidene Blocked-pNPG7)	**143.00**	U/L	30.00 - 118.00

Comments

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

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MC-2011

Test Report

Test Name	Results	Units	Bio. Ref. Interval
LIVER & KIDNEY PANEL, SERUM			
Creatinine (Modified Jaffe,Kinetic)	0.90	mg/dL	0.70 - 1.30
GFR Estimated	118	mL/min/1.73m2	>59
GFR Category	G1		
Urea (Urease UV,Calculated)	23.00	mg/dL	17.00 - 43.00
Urea Nitrogen Blood	10.74	mg/dL	6.00 - 20.00
BUN/Creatinine Ratio	12		
Uric Acid (Uricase)	5.80	mg/dL	3.50 - 7.20
AST (SGOT) (IFCC)	28.0	U/L	15.00 - 40.00
ALT (SGPT) (IFCC)	32.0	U/L	10.00 - 49.00
GGTP (IFCC)	18.0	U/L	0 - 73
Alkaline Phosphatase (ALP) (IFCC-AMP)	78.00	U/L	30.00 - 120.00
Bilirubin Total (Oxidation)	**2.24**	mg/dL	0.30 - 1.20
Bilirubin Direct (Oxidation)	**0.80**	mg/dL	<0.3
Bilirubin Indirect (Calculated)	**1.44**	mg/dL	<1.10
Total Protein (Biuret)	7.40	g/dL	5.70 - 8.20
Albumin (BCG)	4.80	g/dL	3.20 - 4.80
A : G Ratio (Calculated)	1.85		0.90 - 2.00
Globulin(Calculated)	2.60	gm/dL	2.0 - 3.5
Calcium, Total (Arsenazo III)	9.30	mg/dL	8.70 - 10.40

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MC-2011

Test Report

Test Name	Results	Units	Bio. Ref. Interval
Phosphorus (Phosphomolybdate UV)	3.90	mg/dL	2.40 - 5.10
Sodium (Indirect ISE)	139.50	mEq/L	136.00 - 145.00
Potassium (Indirect ISE)	4.55	mEq/L	3.50 - 5.10
Chloride (Indirect ISE)	103.60	mEq/L	98.00 - 107.00

Note

1. Estimated GFR (eGFR) calculated using the 2021 CKD-EPI creatinine equation and GFR Category reported as per KDIGO guideline 2012.
2. eGFR category G1 or G2 does not fulfil the criteria for CKD, in the absence of evidence of kidney damage
3. The BUN-to-creatinine ratio is used to differentiate prerenal and postrenal azotemia from renal azotemia. Because of considerable variability, it should be used only as a rough guide. Normally, the BUN/creatinine ratio is about 10:1

LIPID SCREEN, SERUM
(Spectrophotometry)

Cholesterol, Total	146.00	mg/dL	<200.00
Triglycerides	93.00	mg/dL	<150.00
HDL Cholesterol	**39.20**	mg/dL	>40.00
LDL Cholesterol, Calculated	88.20	mg/dL	<100.00
VLDL Cholesterol,Calculated	18.60	mg/dL	<30.00
Non-HDL Cholesterol	107	mg/dL	<130

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. 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
3. Lipid Association of India (LAI) recommends screening of all adults above the age of 20 years for

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MC-2011

Test Report

Test Name	Results	Units	Bio. Ref. Interval

Atherosclerotic Cardiovascular Disease (ASCVD) risk factors especially lipid profile. This should be done earlier if there is family history of premature heart disease, dyslipidemia, obesity or other risk factors

4. Indians tend to have higher triglyceride levels & Lower HDL cholesterol combined with small dense LDL particles, a pattern known as atherogenic dyslipidemia
5. Non HDL Cholesterol comprises the cholesterol carried by all atherogenic particles, including LDL, IDL, VLDL & VLDL remnants, Chylomicron remnants & Lp(a)
6. LAI recommends LDL cholesterol as primary target and Non HDL cholesterol as co-primary treatment target
7. Apolipoprotein B is an, secondary lipid target for treatment once LDL & Non HDL goals have been achieved
8. 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 2020

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)
Extreme Risk Group Category A	<50 (Optional goal ≤30)	<80 (Optional goal ≤60)	≥50	≥80
Extreme Risk Group Category A	≤30	≤60	>30	>60
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

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MC-2011

Test Report

Test Name	Results	Units	Bio. Ref. Interval
HbA1c (GLYCOSYLATED HEMOGLOBIN), BLOOD (HPLC, NGSP certified)			
HbA1c	4.9	%	4.00 - 5.60
Estimated average glucose (eAG)	94	mg/dL	

Interpretation

HbA1c result is suggestive of non diabetic adults (>=18 years)/ well controlled Diabetes in a known Diabetic

Interpretation as per American Diabetes Association (ADA) Guidelines

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

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

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

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MC-2011

Test Report

Test Name	Results	Units	Bio. Ref. Interval
THYROID PROFILE,TOTAL, SERUM (Chemiluminescent Immunoassay)			
T3, Total	0.62	ng/mL	0.60 - 1.81
T4, Total	**4.10**	µg/dL	4.50 - 11.60
TSH	1.92	µIU/mL	0.550 - 4.780

Note

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

IRON STUDIES, SERUM (Ferrozine)			
Iron	135.00	ug/dL	65.00 - 175.00
Total Iron Binding Capacity (TIBC)	336.55	µg/dL	250 - 425
Transferrin Saturation	40.11	%	20.00 - 50.00

Comments

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

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

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MC-2011

Test Report

Test Name	Results	Units	Bio. Ref. Interval

increases.

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

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Ref By	: **SELF**	**Gender**	: **Male**
Collected	: **25/1/2024 9:12:00AM**	**Reported**	: **25/1/2024 3:45:31PM**
A/c Status	: **P**	**Report Status**	: **Final**
Collected at	: **NFC-II HOME COLLECTION C-655, Ground Floor New Friends Colony, New Delhi-110025**	**Processed at**	: **LPL-VASANT KUNJ LAB NELSON MANDELA MARG, BUILDING No.1, L.S.C., SECTOR-B, POCKET-7, VASANT KUNJ, NEW DELHI-110070**

MC-2011

Test Report

Test Name	Results	Units	Bio. Ref. Interval
URINE EXAMINATION, ROUTINE; URINE, R/E (Automated Strip Test, Microscopy)			
Physical			
Colour	Slight Lemon Yellow		Pale yellow
Specific Gravity	1.020		1.001 - 1.030
pH	6		5.0 - 8.0
Chemical			
Proteins	Negative		Negative
Glucose	Negative		Negative
Ketones	Negative		Negative
Bilirubin	Negative		Negative
Urobilinogen	Negative		Negative
Leucocyte Esterase	Negative		Negative
Nitrite	Negative		Negative
Microscopy			
R.B.C.	Negative		0.0 - 2.0 RBC/hpf
Pus Cells	Negative		0-5 WBC / hpf
Epithelial Cells	0-1 Epi Cells/hpf		0.0 - 5.0 Epi cells/hpf
Casts	None seen		None seen/Lpf
Crystals	None seen		None seen
Others	None seen		None seen

Name	: **Mr. ANUBHAV KRISHNA**		
Lab No.	: **462175941**	**Age**	: **27 Years**
Ref By	: **SELF**	**Gender**	: **Male**
Collected	: **25/1/2024 9:12:00AM**	**Reported**	: **25/1/2024 3:45:31PM**
A/c Status	: **P**	**Report Status**	: **Final**
Collected at	: **NFC-II HOME COLLECTION C-655, Ground Floor New Friends Colony, New Delhi-110025**	**Processed at**	: **LPL-VASANT KUNJ LAB NELSON MANDELA MARG, BUILDING No.1, L.S.C., SECTOR-B, POCKET-7, VASANT KUNJ, NEW DELHI-110070**

MC-2011

Test Report

Test Name	Results	Units	Bio. Ref. Interval

DMC-38596

Dr. Kusha Gupta
MD, Pathology
Chief of Laboratory
Dr Lal PathLabs Ltd

DMC-5243

Dr Rachna Malik
MD, Pathology
Consultant Pathologist
Dr Lal PathLabs Ltd

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

IMPORTANT INSTRUCTIONS

•Test results released pertain to the specimen submitted.•All test results are dependent on the quality of the sample received by the Laboratory.•Laboratory investigations are only a tool to facilitate in arriving at a diagnosis and should be clinically correlated by the Referring Physician .•Report delivery may be delayed due to unforeseen circumstances. Inconvenience is regretted.•Certain tests may require further testing at additional cost for derivation of exact value. Kindly submit request within 72 hours post reporting.•Test results may show interlaboratory variations.•The Courts/Forum at Delhi shall have exclusive jurisdiction in all disputes/claims concerning the test(s) & or results of test(s).•Test results are not valid for medico legal purposes.•This is computer generated medical diagnostic report that has been validated by Authorized Medical Practitioner/Doctor.•The report does not need physical signature.

(#) Sample drawn from outside source.

If Test results are alarming or unexpected, client is advised to contact the Customer Care immediately for possible remedial action.

Tel: +91-11-49885050,Fax: - +91-11-2788-2134, E-mail: lalpathlabs@lalpathlabs.com