DIAGNOSTIC REPORT

MC-7180

agilus diagnostics

PATIENT NAME : SIDDHESH BHURKE **REF. DOCTOR :** DR. GANESH BHAGWAT

CODE/NAME & ADDRESS : CS00008567 AGILUS DR PHADKE- PSC CAMLIN HOME 210,RAMBAUG BLDG, GROUND FLR, L.J.ROAD, MAHIMMUMBAI MUMBAI 400016 7304496384	ACCESSION NO : **5047ZA038021** PATIENT ID : SIDDM2508930 CLIENT PATIENT ID: SIDDM2508930 ABHA NO :	AGE/SEX :32 Years Male DRAWN :23/01/2026 10:08:01 RECEIVED :23/01/2026 10:55:55 REPORTED :23/01/2026 16:04:35

Test Report Status **Final**

HAEMATOLOGY - CBC

COMPLETE CARE ACTIVE MEN

BLOOD COUNTS, EDTA WHOLE BLOOD

BLOOD COUNTS, EDTA WHOLE BLOOD	Results	0043WK00134 04/11/23 11:47			Biological Reference Interval	Units
HEMOGLOBIN (HB) METHOD : SLS METHOD	16.0	15.5			13.0 - 17.0	g/dL
RED BLOOD CELL (RBC) COUNT METHOD : ELECTRICAL IMPEDANCE	5.02	4.99			4.50 - 5.50	mil/µL
WHITE BLOOD CELL (WBC) COUNT METHOD : FLOW CYTOMETRY	8.58	7.67			4 - 10	thou/µL
PLATELET COUNT METHOD : ELECTRICAL IMPEDANCE	214	276			150 - 410	thou/µL

RBC AND PLATELET INDICES	Results	0043WK00134 04/11/23 11:47			Biological Reference Interval	Units
HEMATOCRIT (PCV) METHOD : PULSE HEIGHT DETECTION	47.6	47.8			40.0 - 50.0	%
MEAN CORPUSCULAR VOLUME (MCV) METHOD : CALCULATED	94.8	95.8			83.0 - 101.0	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH) METHOD : CALCULATED	31.9	31.1			27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC) METHOD : CALCULATED	33.6	32.4			31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW)	12.9	12.0			11.6 - 14.0	%

DR. ALVIN ALVA (MD)
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ULR No.504700008483601-5047

PATIENT NAME : SIDDHESH BHURKE **REF. DOCTOR :** DR. GANESH BHAGWAT

CODE/NAME & ADDRESS : CS00008567 AGILUS DR PHADKE- PSC CAMLIN HOME 210,RAMBAUG BLDG, GROUND FLR, L.J.ROAD, MAHIMMUMBAI MUMBAI 400016 7304496384	ACCESSION NO : **5047ZA038021** PATIENT ID : SIDDM2508930 CLIENT PATIENT ID: SIDDM2508930 ABHA NO :	AGE/SEX :32 Years Male DRAWN :23/01/2026 10:08:01 RECEIVED :23/01/2026 10:55:55 REPORTED :23/01/2026 16:04:35

Test Report Status **Final**	Results	Biological Reference Interval	Units

METHOD : CALCULATED

MEAN PLATELET VOLUME (MPV)	10.7	9.6			6.80 - 10.90	fL

METHOD : CALCULATED

WBC DIFFERENTIAL COUNT	Results	0043WK00134 04/11/23 11:47			Biological Reference Interval	Units
NEUTROPHILS	44	43			40 - 80	%
METHOD : FLOW CYTOMETRY						
LYMPHOCYTES	41 H	48			20 - 40	%
METHOD : FLOW CYTOMETRY						
MONOCYTES	6	06			2 - 10	%
METHOD : FLOW CYTOMETRY						
EOSINOPHILS	8 H	03			1 - 6	%
METHOD : FLOW CYTOMETRY						
BASOPHILS	1	00			< 1 - 2	%
METHOD : FLOW CYTOMETRY						
ABSOLUTE NEUTROPHIL COUNT	3.78				2 - 7	thou/µL
METHOD : CALCULATED						
ABSOLUTE LYMPHOCYTE COUNT	3.51 H				1 - 3	thou/µL
METHOD : CALCULATED						
ABSOLUTE MONOCYTE COUNT	0.52				0.2 - 1	thou/µL
METHOD : CALCULATED						
ABSOLUTE EOSINOPHIL COUNT	0.66 H				0.02 - 0.50	thou/µL
METHOD : CALCULATED						
ABSOLUTE BASOPHIL COUNT	0.11 H				0 - 0.1	thou/µL
METHOD : CALCULATED						

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Test Report Status **Final**	Results	Biological Reference Interval	Units

MORPHOLOGY (MICROSCOPY)

WBC	EOSINOPHILIA PRESENT		

***This is a tabular depiction of test results illustrating values of the previous three reports of the patient which needs to be correlated with the original reports**

Interpretation(s)
RBC AND PLATELET INDICES-Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia(>13) from Beta thalassaemia trait (<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.
WBC DIFFERENTIAL COUNT-The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR < 3.3, COVID-19 patients tend to show mild disease. (Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients A.-P. Yang, et al. International Immunopharmacology 84 (2020) 106504
This ratio element is a calculated parameter and out of NABL scope.

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HAEMATOLOGY

COMPLETE CARE ACTIVE MEN

GLYCOSYLATED HEMOGLOBIN(HBA1C),EDTA WHOLE BLOOD	Results	0043WK00134 04/11/23 11:47			Biological Reference Interval	Units
HBA1C	5.3	5.2			Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 Therapeutic goals: < 7.0 Action suggested : > 8.0 (ADA Guideline 2021)	%
METHOD : HPLC						
ESTIMATED AVERAGE GLUCOSE(EAG)	105.4				< 116.0	mg/dL
METHOD : CALCULATED						

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Test Report Status **Final** **Results** **Biological Reference Interval** **Units**

BIOCHEMISTRY

COMPLETE CARE ACTIVE MEN

GLUCOSE FASTING,FLUORIDE PLASMA	**Results**	**0043WK00134** 04/11/23 11:47			**Biological Reference Interval**	**Units**
FBS (FASTING BLOOD SUGAR)	87	82			(Normal <110,Impaired fasting glucose:110 to 125,Diabetes mellitus:>=126(on more than 1 occasion)(ADA guidelines 2024)	mg/dL

METHOD : HEXOKINASE

KIDNEY FUNCTION TEST, SERUM	**Results**	**0043WK00134** 04/11/23 11:47			**Biological Reference Interval**	**Units**
BLOOD UREA NITROGEN	11	10			8 - 21	mg/dL

METHOD : UREASE KINETIC

CREATININE	0.81	0.76			0.7 - 1.4 Please note change in reference range	mg/dL

METHOD : JAFFE KINETIC METHOD

BUN/CREAT RATIO	13.58				10 - 20	

METHOD : CALCULATED

URIC ACID	7.3	7.0			4.0 - 8.6	mg/dL

METHOD : URICASE UV

TOTAL PROTEIN	7.4	7.0			6.3 - 8.6	g/dL

METHOD : BIURET

ALBUMIN	4.7	4.5			3.7 - 5.6	g/dL

METHOD : BCG

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210,RAMBAUG BLDG, GROUND FLR, L.J.ROAD, MAHIMMUMBAI
MUMBAI 400016
7304496384

ACCESSION NO : **5047ZA038021**
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Test Report Status **Final**	Results				Biological Reference Interval	Units
GLOBULIN METHOD : CALCULATED	2.7				1.5 - 3.5	g/dL
CALCIUM METHOD : NM-BAPTA	9.4	9.0			8.1 - 10.4	mg/dL
SODIUM, SERUM METHOD : ISE INDIRECT	145	141			135 - 145	mmol/L
POTASSIUM, SERUM METHOD : ISE INDIRECT	4.60	3.92			3.5 - 5.3	mmol/L
CHLORIDE, SERUM METHOD : ISE INDIRECT	104	104			97 - 110	mmol/L

LIVER FUNCTION PROFILE, SERUM	**Results**	**0043WK00134** 04/11/23 11:47			**Biological Reference Interval**	**Units**
BILIRUBIN, TOTAL METHOD : DIAZO METHOD	0.45				Upto 1.2	mg/dL
BILIRUBIN, DIRECT METHOD : DIAZO METHOD	0.13				0 - 0.6	mg/dL
BILIRUBIN, INDIRECT METHOD : CALCULATED	0.32				0 - 0.4	mg/dl
TOTAL PROTEIN METHOD : BIURET/ BROMOCRESOL GREEN/ CALCULATED	7.4				6.3 - 8.6	g/dL
ALBUMIN METHOD : BCG	4.7				3.7 - 5.6	g/dL
GLOBULIN METHOD : CALCULATED	2.7				1.5 - 3.5	g/dL
ALBUMIN/GLOBULIN RATIO METHOD : CALCULATED	1.7				0.90 - 2.00	RATIO

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ASPARTATE AMINOTRANSFERASE(AST/SGOT) METHOD : IFCC	34	15 - 45	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT) METHOD : IFCC	43	10 - 40	U/L
ALKALINE PHOSPHATASE METHOD : IFCC	58	40 - 129	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT) METHOD : G-GLUTAMYL-CARBOXY-NITROANILIDE-IFCC	21	8 - 78	U/L
LACTATE DEHYDROGENASE METHOD : UV- KINETIC METHOD	225	135 - 225	U/L

PHOSPHORUS, SERUM	**Results**	**0043WK00134** 04/11/23 11:47	**Biological Reference Interval**	**Units**
PHOSPHORUS METHOD : PHOSPHOMOLYBDATE METHOD	3.8	3.8	2.8 - 4.5	mg/dL

MAGNESIUM, SERUM	**Results**	**0043WK00134** 04/11/23 11:47	**Biological Reference Interval**	**Units**
MAGNESIUM, SERUM METHOD : COLORIMETIRC METHOD WITH CHLORO PHOSPHONAZO III	2.1		1.7 - 2.3	mg/dL

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Interpretation(s)
GLUCOSE FASTING (FBS), FLUORIDE PLASMA-**TEST DESCRIPTION**
Normally, the glucose concentration in extracellular fluid is closely regulated so that a source of energy is readily available to tissues and sothat no glucose is excreted in the urine.
Increased in:Diabetes mellitus, Cushing' s syndrome (10 – 15%), chronic pancreatitis (30%). Drugs:corticosteroids,phenytoin, estrogen, thiazides.
Decreased in :Pancreatic islet cell disease with increased insulin,insulinoma,adrenocortical insufficiency,hypopituitarism,diffuse liver disease, malignancy(adrenocortical,stomach,fibrosarcoma),infant of a diabetic mother,enzyme deficiency diseases(e.g.galactosemia),Drugs-insulin,ethanol,propranolol sulfonylureas,tolbutamide,and other oral hypoglycemic agents.
NOTE: While random serum glucose levels correlate with home glucose monitoring results (weekly mean capillary glucose values),there is wide fluctuation within individuals.Thus, glycosylated hemoglobin(HbA1c) levels are favored to monitor glycemic control.
High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment,Renal Glyosuria,Glycaemic index & response to food consumed,Alimentary Hypoglycemia,Increased insulin response & sensitivity etc.

Glucose fasting, plasma as per ADA Guideline
NORMAL RANGE: <100 mg/dl
PRE-DIABETIC RANGE: 100-125 mg/dl (Impaired Fasting Glucose)
DIABETIC RANGE: = 126 mg/dl
LIVER FUNCTION PROFILE, SERUM-
Bilirubin is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. Bilirubin is excreted in bile and urine, and elevated levels may give yellow discoloration in jaundice.**Elevated levels** results from increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Conjugated (direct) bilirubin is elevated more than unconjugated (indirect) bilirubin in Viral hepatitis, Drug reactions, Alcoholic liver disease Conjugated (direct) bilirubin is also elevated more than unconjugated (indirect) bilirubin when there is some kind of blockage of the bile ducts like in Gallstones getting into the bile ducts, tumors &Scarring of the bile ducts. Increased unconjugated (indirect) bilirubin may be a result of Hemolytic or pernicious anemia, Transfusion reaction & a common metabolic condition termed Gilbert syndrome, due to low levels of the enzyme that attaches sugar molecules to bilirubin.
AST is an enzyme found in various parts of the body. AST is found in the liver, heart, skeletal muscle, kidneys, brain, and red blood cells, and it is commonly measured clinically as a marker for liver health. AST levels increase during chronic viral hepatitis, blockage of the bile duct, cirrhosis of the liver,liver cancer,kidney failure,hemolytic anemia,pancreatitis,hemochromatosis. AST levels may also increase after a heart attack or strenuous activity.ALT test measures the amount of this enzyme in the blood.ALT is found mainly in the liver, but also in smaller amounts in the kidneys,heart,muscles, and pancreas.It is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health.AST levels increase during acute hepatitis,sometimes due to a viral infection,ischemia to the liver,chronic hepatitis,obstruction of bile ducts,cirrhosis.
ALP is a protein found in almost all body tissues.Tissues with higher amounts of ALP include the liver,bile ducts and bone.Elevated ALP levels are seen in Biliary obstruction, Osteoblastic bone tumors, osteomalacia, hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, Pagets disease,Rickets,Sarcoidosis etc. Lower-than-normal ALP levels seen in Hypophosphatasia,Malnutrition,Protein deficiency,Wilsons disease.
GGT is an enzyme found in cell membranes of many tissues mainly in the liver,kidney and pancreas.It is also found in other tissues including intestine,spleen,heart, brain and seminal vesicles.The highest concentration is in the kidney,but the liver is considered the source of normal enzyme activity.Serum GGT has been widely used as an index of liver dysfunction.Elevated serum GGT activity can be found in diseases of the liver,biliary system and pancreas.Conditions that increase serum GGT are obstructive liver disease,high alcohol consumption and use of enzyme-inducing drugs etc.
Total Protein also known as total protein,is a biochemical test for measuring the total amount of protein in serum.Protein in the plasma is made up of albumin and globulin.Higher-than-normal levels may be due to:Chronic inflammation or infection,including HIV and hepatitis B or C,Multiple myeloma,Waldenstroms disease.Lower-than-normal levels may be due to: Agammaglobulinemia,Bleeding (hemorrhage),Burns,Glomerulonephritis,Liver disease, Malabsorption,Malnutrition,Nephrotic syndrome,Protein-losing enteropathy etc.
Albumin is the most abundant protein in human blood plasma.It is produced in the liver.Albumin constitutes about half of the blood serum protein.Low blood albumin levels (hypoalbuminemia) can be caused by:Liver disease like cirrhosis of the liver, nephrotic syndrome,protein-losing enteropathy,Burns,hemodilution,increased vascular permeability or decreased lymphatic clearance,malnutrition and wasting etc
MAGNESIUM, SERUM-Description- Magnesium is primariliy an intracellular ion associated with GI absorption and renal excretion. Second most abundant ion in bone.It functions as co-factor in numerous enzymes e.g. ATPase . 65-70% of Mg is in ionized state and nearly 35% is protein bound.

Interpretation-
Increased in- Dehydration, Tissue trauma, Renal failure, Hypothyroidism, excessive intake of antacid.
Decrease in- Chronic diarrhea, Enteric fistula, Starvation, Chronic alcoholism, Total parenteral Nutrition, Diuretics.

Note- Hypomagnesemia is associated with weakness, tetany, disorientation and somnolence

Limitation-
• Hemolysis yields elevated levels of Mg being an intracellular ion.
• Serum magnesium levels may remain normal even when total body stores of magnesium are depleted upto 20%

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BIOCHEMISTRY - LIPID

COMPLETE CARE ACTIVE MEN

LIPID PROFILE WITH CALCULATED LDL,SERUM	Results	0043WK00134 04/11/23 11:47			Biological Reference Interval	Units
CHOLESTEROL, TOTAL METHOD : CHOD-POD	228	210			Desirable : < 200 Borderline : 200-239 High : > 240	mg/dL
TRIGLYCERIDES METHOD : GPO - PAP	321 H	209			< 160	mg/dL
HDL CHOLESTEROL METHOD : HOMOGENEOUS METHOD	37 L	46			LOW : < 40 HIGH : > 60	mg/dL
NON HDL CHOLESTEROL METHOD : CALCULATED	191 H				Optimal : <130 Desirable : 130 - 159 Borderline high : 159-189 High : 189 - 220 Very High : >=220	mg/dL
CHOL/HDL RATIO METHOD : CALCULATED	6.2 H				Less than 5	

Comments

Rechecked.

Kindly correlate clinically.

Interpretation(s)

Serum lipid profile is measured for cardiovascular risk prediction. Lipid Association of India recommends LDL-C as primary target and Non HDL-C as co-primary treatment target.

Risk Stratification for ASCVD (Atherosclerotic cardiovascular disease) by Lipid Association of India

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Risk Category	
Extreme risk group	A.CAD with > 1 feature of high risk group
	B. CAD with > 1 feature of Very high risk group or recurrent ACS (within 1 year) despite LDL-C < or = 50 mg/dl or polyvascular disease
Very High Risk	1. Established ASCVD 2. Diabetes with 2 major risk factors or evidence of end organ damage 3. Familial Homozygous Hypercholesterolemia
High Risk	1. Three major ASCVD risk factors. 2. Diabetes with 1 major risk factor or no evidence of end organ damage. 3. CKD stage 3B or 4. 4. LDL >190 mg/dl 5. Extreme of a single risk factor. 6. Coronary Artery Calcium - CAC >300 AU. 7. Lipoprotein a >/= 50mg/dl 8. Non stenotic carotid plaque
Moderate Risk	2 major ASCVD risk factors
Low Risk	0-1 major ASCVD risk factors

Major ASCVD (Atherosclerotic cardiovascular disease) Risk Factors	
1. Age > or = 45 years in males and > or = 55 years in females	3. Current Cigarette smoking or tobacco use
2. Family history of premature ASCVD	4. High blood pressure
5. Low HDL	

Newer treatment goals and statin initiation thresholds based on the risk categories proposed by LAI in 2020.

Risk Group	Treatment Goals		Consider Drug Therapy	
	LDL-C (mg/dl)	Non-HDL (mg/dl)	LDL-C (mg/dl)	Non-HDL (mg/dl)
Extreme Risk Group Category A	<50 (Optional goal < OR = 30)	< 80 (Optional goal <OR = 60)	>OR = 50	>OR = 80
Extreme Risk Group Category B	<OR = 30	<OR = 60	> 30	>60
Very High Risk	<50	<80	>OR= 50	>OR= 80
High Risk	<70	<100	>OR= 70	>OR= 100
Moderate Risk	<100	<130	>OR= 100	>OR= 130
Low Risk	<100	<130	>OR= 130*	>OR= 160

*After an adequate non-pharmacological intervention for at least 3 months.

References: Management of Dyslipidaemia for the Prevention of Stroke: Clinical Practice Recommendations from the Lipid Association of India. Current Vascular Pharmacology, 2022, 20, 134-155.

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DIRECT LDL CHOLESTEROL, SERUM

LDL CHOLESTEROL, DIRECT	155	OPTIMAL <100 NEAR OR ABOVE NORMAL 100-129 BORDERLINE HIGH 130-159 HIGH 160 - 189 VERY HIGH >190	mg/dL
METHOD : HOMOGENOUS DIRECT ENZYMATIC COLORIMETRIC			
DIRECT LDL/HDL RATIO	**4.2 High**	2.5 - 3.5	
METHOD : CALCULATED			

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DIAGNOSTIC REPORT

MC-7180

agilus diagnostics

PATIENT NAME : SIDDHESH BHURKE		**REF. DOCTOR :** DR. GANESH BHAGWAT
CODE/NAME & ADDRESS : CS00008567 AGILUS DR PHADKE- PSC CAMLIN HOME 210,RAMBAUG BLDG, GROUND FLR, L.J.ROAD, MAHIMMUMBAI MUMBAI 400016 7304496384	ACCESSION NO : **5047ZA038021** PATIENT ID : SIDDM2508930 CLIENT PATIENT ID: SIDDM2508930 ABHA NO :	AGE/SEX : 32 Years Male DRAWN : 23/01/2026 10:08:01 RECEIVED : 23/01/2026 10:55:55 REPORTED : 23/01/2026 16:04:35

Test Report Status **Final**	Results	Biological Reference Interval	Units

Interpretation(s)
DIRECT LDL CHOLESTEROL, SERUM-The small dense LDL test can be used to determine cardiovascular risk in individuals with metabolic syndrome or established/progressing coronary artery disease, individuals with triglyceride levels between 70 and 140 mg/dL, as well as individuals with a diet high in trans-fat or carbohydrates. Elevated sdLDL levels are associated with metabolic syndrome and an 'atherogenic lipoprotein profile', and are a strong, independent predictor of cardiovascular disease.
Elevated levels of LDL arise from multiple sources. A major factor is sedentary lifestyle with a diet high in saturated fat. Insulin-resistance and pre-diabetes have also been implicated, as has genetic predisposition. Measurement of sdLDL allows the clinician to get a more comprehensive picture of lipid risk factors and tailor treatment accordingly. Reducing LDL levels will reduce the risk of CVD and MI.

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Test Report Status **Final**

NEPHELOMETRY

COMPLETE CARE ACTIVE MEN

C-REACTIVE PROTEIN, SERUM (QUANTITATIVE)	Results	0043WK00134 04/11/23 11:47			Biological Reference Interval	Units
C-REACTIVE PROTEIN	2.0				0 - 5	mg/L

METHOD : IMMUNOTURBIDIMETRIC ASSAY

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Interpretation(s)
C-REACTIVE PROTEIN, SERUM (QUANTITATIVE)-**Test Description:**
A CRP test measures the amount of CRP in the blood to detect inflammation due to acute conditions or to monitor the severity of disease in chronic conditions. CRP is one of the proteins commonly referred to as acute phase reactants. CRP is distinguished by its rapid response to trauma or infection.Synthesis of CRP increases within 4-6 hours of onset of inflammation, reaching peak values within 1-2 days. CRP levels also fall quickly after resolution of inflammation since its half life is 6 hours.
This standard CRP test is not to be confused with a hs-CRP test. These are two different tests that measure CRP and each test measures a different range of CRP levels in the blood for different purposes. The standard CRP test measures high levels of protein observed in diseases that cause significant inflammation.
Test Interpretation:
Increased CRP level: Increasing amount of CRP in the blood suggests the presence of inflammation but will not identify its location or the cause.
Suspected bacterial infection: a high CRP level can confirm that you have a serious bacterial infection.
Chronic inflammatory disease: high levels of CRP suggest a flare-up if you have a chronic inflammatory disease or that treatment has not been effective.
Testing for CRP is indicated in the following clinical situations - monitoring recovery from surgery, myocardial infarction, transplantation, inflammatory bowel disease, rheumatic diseases and infectious diseases. Measuring and charting C-reactive protein values can also prove useful in determining disease progress or the effectiveness of treatments
CRP levels can be elevated in the later stages of pregnancy as well as with the use of birth control pills or hormone replacement therapy (i.e., estrogen). Higher levels of CRP have also been observed in people who are obese. CRP can also be increased in people who have cancer.
Recommendation: The hs-CRP test precisely detects lower levels of the protein than that measured by the standard CRP test and is also used to evaluate individuals for risk of cardiovascular disease. It measures CRP in the range from 0.15 to 20 mg/L.
Limitation:
CRP levels in autoimmune diseases may show little or no increase unless infection is present. Levels may not increase in conditions like pregnancy, angina, seizures, asthma, common cold. The main limitation of CRP is in its non-specific response and should not be interpreted without a complete clinical history and evaluation.

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Test Report Status **Final** | **Results** | **Biological Reference Interval** | **Units**

ENDOCRINOLOGY

COMPLETE CARE ACTIVE MEN

THYROID PANEL II (FT3,FT4,TSH) SERUM	Results	0043WK00134 04/11/23 11:47			Biological Reference Interval	Units
FREE TRIIODOTHYRONINE (FT3) METHOD : CMIA	3.08				1.58 - 3.91	pg/mL
FREE THYROXINE (FT4) METHOD : CMIA	1.08				0.70 - 1.48	ng/dL
TSH (ULTRASENSITIVE) METHOD : CMIA	2.580	2.400			Euthyroid : 0.35 - 4.94 Hypothyroid : > 4.94 Hyperthyroid : < 0.35	µIU/mL

Interpretation(s)

Sr. No.	TSH	FT4	FT3	Possible Conditions
1	High	Low	Low	(1) Primary Hypothyroidism (2) Chronic autoimmune Thyroiditis (3) Post Thyroidectomy (4) Post Radio-Iodine treatment
2	High	Normal	Normal	(1)Subclinical Hypothyroidism (2) Patient with insufficient thyroid hormone replacement therapy (3) In cases of Autoimmune/Hashimoto thyroiditis (4). Isolated increase in TSH levels can be due to Subclinical inflammation, drugs like amphetamines, Iodine containing drug and dopamine antagonist e.g. domperidone and other physiological reasons.
3	Normal/Low	Low	Low	(1) Secondary and Tertiary Hypothyroidism
4	Low	High	High	(1) Primary Hyperthyroidism (Graves Disease) (2) Multinodular Goitre (3)Toxic Nodular Goitre (4) Thyroiditis (5) Over treatment of thyroid hormone (6) Drug effect e.g. Glucocorticoids, dopamine, T4 replacement therapy (7) First trimester of Pregnancy
5	Low	Normal	Normal	(1) Subclinical Hyperthyroidism

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6	High	High	High	(1) TSH secreting pituitary adenoma (2) TRH secreting tumor
7	Low	Low	Low	(1) Central Hypothyroidism (2) Euthyroid sick syndrome (3) Recent treatment for Hyperthyroidism
8	Normal/Low	Normal	High	(1) T3 thyrotoxicosis (2) Non-Thyroidal illness
9	Low	High	Normal	(1) T4 Ingestion (2) Thyroiditis (3) Interfering Anti TPO antibodies

REF: 1. TIETZ Fundamentals of Clinical chemistry 2.Guidlines of the American Thyroid association duriing pregnancy and Postpartum, 2011.

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DIAGNOSTIC REPORT

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Test Report Status **Final**

SPECIALISED CHEMISTRY - ANEMIA

COMPLETE CARE ACTIVE MEN

IRON AND TIBC STUDIES,SERUM	Results	0043WK00134 04/11/23 11:47			Biological Reference Interval	Units
IRON	130				59 - 158	µg/dL
METHOD : FEROZINE						
TOTAL IRON BINDING CAPACITY	405				250 - 450	µg/dL
METHOD : CALCULATED						
% SATURATION	32				14 - 50	%
METHOD : CALCULATED						

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Interpretation(s)
IRON AND TIBC STUDIES,SERUM-Total iron binding capacity (TIBC) measures the blood's capacity to bind iron with transferrin and thus is an indirect way of assessing transferrin level.
Taken together with serum iron and percent transferrin saturation this test is performed when they is a concern about anemia, iron deficiency or iron deficiency anemia. However, because the liver produces transferrin, alterations in liver function (such as cirrhosis, hepatitis, or liver failure) must be considered when performing this test.
Increased in:
- iron deficiency
- acute and chronic blood loss
- acute liver damage
- progesterone birth control pills

Decreased in:
- hemochromatosis
- cirrhosis of the liver
- thalassemia
- anemias of infection and chronic diseases
- nephrosis
- hyperthyroidism

The percent Transferrin saturation = Serum Iron/TIBC x 100
Unsaturated Binding Capacity (UIBC)=TIBC - Serum Iron.
Limitations: Estrogens and oral contraceptives increase TIBC and Asparaginase, chloramphenicol, corticotropin, cortisone and testosterone decrease the TIBC level.

Reference:
1.Tietz Textbook of Clinical Chemistry and Molecular Diagnostics, edited by Carl A Burtis, Edward R.Ashwood, David E Bruns, 4th Edition, Elsevier publication, 2006, 563, 1314-1315.
2. Wallach's Interpretation of Diagnostic tests, 9th Edition, Ed Mary A Williamson and L Michael Snyder. Pub Lippincott Williams and Wilkins, 2011, 234-235.

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Test Report Status **Final** **Results** **Biological Reference Interval** **Units**

CLINICAL PATH - URINALYSIS

COMPLETE CARE ACTIVE MEN

PHYSICAL EXAMINATION, URINE

COLOR	PALE YELLOW
APPEARANCE	CLEAR

CHEMICAL EXAMINATION, URINE	Results	0043WK00134 04/11/23 11:47			Biological Reference Interval	Units
PH	5.5	5.5			4.6 - 8.0	
METHOD : DOUBLE INDICATOR PRINCIPLE						
SPECIFIC GRAVITY	1.015	1.015			1.003 - 1.035	
METHOD : AUTOMATED-REFRACTOMETRY						
PROTEIN	NOT DETECTED				NOT DETECTED	
METHOD : TETRA BROMOPHENOL BLUE/SULFOSALICYLIC ACID						
GLUCOSE	NOT DETECTED				NOT DETECTED	
METHOD : GOD-POD METHOD						
KETONES	NOT DETECTED				NOT DETECTED	
METHOD : NITROPRUSSIDE REACTION						
BLOOD	NOT DETECTED				NOT DETECTED	
METHOD : PEROXIDASE						
BILIRUBIN	NOT DETECTED				NOT DETECTED	
METHOD : AZO COUPLING METHOD						
UROBILINOGEN	NORMAL				NORMAL	
METHOD : AZO COUPLING METHOD						

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Test Report Status **Final**	Results	Biological Reference Interval	Units
NITRITE	NOT DETECTED	NOT DETECTED	
METHOD : GRIESS TEST			
LEUKOCYTE ESTERASE	NOT DETECTED	NOT DETECTED	
METHOD : STRIP HETROCYCLIC CARBOXYLIC ACID ESTER ,DIAZONIUM SALT			

MICROSCOPIC EXAMINATION, URINE

RED BLOOD CELLS	NOT DETECTED	0 - 2	/HPF
PUS CELL (WBCS)	1-2	0-5	/HPF
EPITHELIAL CELLS	0-1	0-5	/HPF
CASTS	NOT DETECTED		
CRYSTALS	NOT DETECTED		
BACTERIA	NOT DETECTED	NOT DETECTED	
YEAST	NOT DETECTED	NOT DETECTED	
REMARKS	Chemical Examination Done by Fully Automated Dipstick Method (CCD) Microscopic Examination Done by Fully Automated Machine Vision Technology		

Interpretation(s)

The following table describes the probable conditions, in which the analytes are present in urine

Presence of	Conditions
Proteins	Inflammation or immune illnesses
Pus (White Blood Cells)	Urinary tract infection, urinary tract or kidney stone, tumors or any kind of kidney impairment
Glucose	Diabetes or kidney disease
Ketones	Diabetic ketoacidosis (DKA), starvation or thirst
Urobilinogen	Liver disease such as hepatitis or cirrhosis
Blood	Renal or genital disorders/trauma
Bilirubin	Liver disease

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Erythrocytes	Urological diseases (e.g. kidney and bladder cancer, urolithiasis), urinary tract infection and glomerular diseases
Leukocytes	Urinary tract infection, glomerulonephritis, interstitial nephritis either acute or chronic, polycystic kidney disease, urolithiasis, contamination by genital secretions
Epithelial cells	Urolithiasis, bladder carcinoma or hydronephrosis, ureteric stents or bladder catheters for prolonged periods of time
Granular Casts	Low intratubular pH, high urine osmolality and sodium concentration, interaction with Bence-Jones protein
Hyaline casts	Physical stress, fever, dehydration, acute congestive heart failure, renal diseases
Calcium oxalate	Metabolic stone disease, primary or secondary hyperoxaluria, intravenous infusion of large doses of vitamin C, the use of vasodilator naftidrofuryl oxalate or the gastrointestinal lipase inhibitor orlistat, ingestion of ethylene glycol or of star fruit (Averrhoa carambola) or its juice
Uric acid	arthritis
Bacteria	Urinary infectionwhen present in significant numbers & with pus cells.
Trichomonas vaginalis	Vaginitis, cervicitis or salpingitis

Reference:

Henrys Clinical Diagnostics and Management by Laboratory Methods 21st edition (pg 410).

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Test Report Status **Final**

SPECIALISED CHEMISTRY - TUMOR MARKER

COMPLETE CARE ACTIVE MEN

PROSTATE SPECIFIC ANTIGEN(PSA TOTAL), SERUM	**Results**	**0043WK00134** 04/11/23 11:47			**Biological Reference Interval**	**Units**
PROSTATE SPECIFIC ANTIGEN	0.811				Normal : 0 - 4.0 Borderline : 4 - 10 High : >10	ng/mL

METHOD : CMIA

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Interpretation(s)
PROSTATE SPECIFIC ANTIGEN(PSA TOTAL), SERUM-- PSA is detected in the male patients with normal, benign hyperplastic and malignant prostate tissue and in patients with prostatitis.
- PSA is not detected (or detected at very low levels) in the patients without prostate tissue (because of radical prostatectomy or cystoprostatectomy) and also in the female patients.
- It a suitable marker for monitoring of patients with Prostate Cancer and it is better to be used in conjunction with other diagnostic procedures.
- Serial PSA levels can help determine the success of prostatectomy and the need for further treatment, such as radiation, endocrine or chemotherapy and useful in detecting residual disease and early recurrence of tumor.
- Elevated levels of PSA can be also observed in the patients with non-malignant diseases like Prostatitis and Benign Prostatic Hyperplasia.
- Specimens for total PSA assay should be obtained before biopsy, prostatectomy or prostatic massage, since manipulation of the prostate gland may lead to elevated PSA (false positive) levels persisting up to 3 weeks.
- As per American urological guidelines, PSA screening is recommended for early detection of Prostate cancer above the age of 40 years. Following Age specific reference range can be used as a guide lines.
- Measurement of total PSA alone may not clearly distinguish between benign prostatic hyperplasia (BPH) from cancer, this is especially true for the total PSA values between 4-10 ng/mL.
- Total PSA values determined on patient samples by different testing procedures cannot be directly compared with one another and could be the cause of erroneous medical interpretations. Recommended follow up on same platform as patient result can vary due to differences in assay method and reagent specificity.

References-
1. Burtis CA, Ashwood ER, Bruns DE. Teitz textbook of clinical chemistry and Molecular Diagnostics. 4th edition.
2. Williamson MA, Snyder LM. Wallach's interpretation of diagnostic tests. 9th edition.

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Test Report Status **Final**

SPECIALISED CHEMISTRY - VITAMIN

COMPLETE CARE ACTIVE MEN

25 - HYDROXYVITAMIN D(VITAMIN D TOTAL),SERUM	Results	0043WK00134 04/11/23 11:47			Biological Reference Interval	Units
25 - HYDROXYVITAMIN D	13.9 L				Deficiency(seriously deficient): <10 Insufficiency(deficient): 10-30 Sufficiency(adequately supplied) : 30 - 100 Toxicity > 100	ng/mL

METHOD : ECLIA

VITAMIN B12(CYANOCOBALAMINE), SERUM	Results	0043WK00134 04/11/23 11:47			Biological Reference Interval	Units
VITAMIN B12	146 L				187 - 883	pg/mL

METHOD : ECLIA

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Interpretation(s)
25 - HYDROXYVITAMIN D(VITAMIN D TOTAL),SERUM-**Test description**
Vitamin D has anti-inflammatory and immune-modulating properties and it works towards the bones, teeth, intestines, immune system, pancreas, muscles and brain. It helps to maintain normal calcium and phosphate levels.Vitamin D is a fat-soluble vitamin. Also called as "Sunshine Vitamin".Two main forms as Cholecalciferol (vitamin D3) which is synthesized in skin from 7-dehydrocholesterol in response to sunlight (Type B UV) exposure & Ergocalciferol (vitamin D2) present mainly in dietary sources.
Vit D25(OH)D deficiency is seen due to poor or inadequate sunlight exposure, Nutritional or dietary deficiency or fat malabsorption, Severe Hepatocellular disease, Secondary hyperparathyroidism, Hypocalcemia tetany which can cause involuntary contraction of muscles, leading to cramps and spasms, Rickets in children, Osteomalacia in adults- due to vitamin D deficiency mainly, Older adults- osteoporosis. (Increased risk of bone fractures)due to long-term effect of calcium and/or vitamin D deficiency, Other conditions that are precipitated by Vit D deficiency included increased cardiovascular risk, low immunity & chronic renal failure.
Elevated levels may be seen in patients taking supplements(hence recommended to repeat after 3 months for estimation of accurate levels), Vitamin D intoxication, sarcoidosis and malignancies containing non regulated 1-alpha hydroxylase in the lesion.
Recommendations
1.To prevent biotin interference the patient should be atleast 8 hours fasting before submitting the sample 2.25(OH)D is the analyte of choice for determination of the Vitamin D status as it is the major storage & active form of Vitamin D and has longer half-life. 3. Kidney Disease Outcomes Quality Initiatives (KDOQI) and Kidney Disease

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PATIENT NAME : SIDDHESH BHURKE		**REF. DOCTOR :** DR. GANESH BHAGWAT
CODE/NAME & ADDRESS : CS00008567 AGILUS DR PHADKE- PSC CAMLIN HOME 210,RAMBAUG BLDG, GROUND FLR, L.J.ROAD, MAHIMMUMBAI MUMBAI 400016 7304496384	ACCESSION NO : **5047ZA038021** PATIENT ID : SIDDM2508930 CLIENT PATIENT ID: SIDDM2508930 ABHA NO :	AGE/SEX : 32 Years Male DRAWN : 23/01/2026 10:08:01 RECEIVED : 23/01/2026 10:55:55 REPORTED : 23/01/2026 16:04:35

Test Report Status **Final**	Results	Biological Reference Interval	Units

Improving Global Outcomes (KDIGO) recommend activated vitamin D testing for CKD patients.
Note-Our Vitamin D assays is standardized to be in alignment with the ID-LC/MS/MS 25(OH)vitamin D Reference Method Procedure (RMP), the reference procedure for the Vitamin D Standardization Program (VDSP). The VDSP, a collaboration of the National Institutes of Health Office of Dietary Supplements, National Institute of Technology and Standards, Centers for Disease Control and Ghent University, is an initiative to standardize 25(OH)vitamin D measurement across methods.
Reference: 1.Wallach Interpretation of diagnostic test, 10th edition.
VITAMIN B12(CYANOCOBALAMINE), SERUM-**Test description**
1.Measures the amount of Vitamin B12/ Cyanocobalamin or Methyl cobalamin in blood.2. Done in Anemic conditions like Megaloblastic anemia, pernicious anemia, dietary folate deficiencies,3.Workup of neuropathies especially due to diabetes.4.Nerve health and it is monitored in treatment of nerve damage.5.Important vitamin for women of childbearing age and for older people.
1.Part of water-soluble B complex of vitamins. 2. It is essential in DNA synthesis, hematopoiesis & CNS integrity.3.Source for B12 is dietary foods like milk, yoghurt, eggs, meat, fortified cereals, bread. 4.Absorption depends on the HCl secreted by the stomach and occurs in intestines. 5. It is part of enterohepatic circulation, hence excreted in feces(approx. 0.1% per day)
Test interpretation
Higher than normal levels are in patients on Vitamin supplements or patients with COPD, CRF, Diabetes, Liver cell damage, Obesity, Polycythemia.
Decreased levels seen in
Inflammatory bowel disease, Pernicious anemia - genetic deficiency of intrinsic factor - necessary for Vit B12 absorption, Strict vegetarianslead to sub-clinical B12 deficiency- high among elderly patients, Malabsorption due to gastrectomy, smoking, pregnancy, multiple myeloma & hemodialysis, Alcohol & drugs like amino salicylic acid, anticonvulsants, cholestyramine, cimetidine, Hyperthyroidism (High levels of thyroid), Seen in mothers of children with (NTD) Neural tube defects- hence fortification and supplements are advised in expecting mothers
Recommendations-1.To prevent biotin interference the patient should be atleast 8 hours fasting before submitting the sample. 2. Vit B12 and Folic acid evaluated together in macrocytic anemias to avoid methyl folate trap. Carmel's composite criteria for inadequate Vit B12 status: Serum vitamin B12 < 148 pmol/L, or 148–258 pmol/L and MMA > 0.30µmol/L, or tHcy > 13 nmol/L (females) and >15 nmol/L (males).
Associated Test-Holo-TC: Marker of vitamin B12 status -specificity and sensitivity better than serum vitamin B12, hence recommended in boderline and deficient cases for confirmation.
References-O-Leary F, Samman S. Vitamin B12 in health and disease. Nutrients. 2010 Mar 2(3):299-316.

****End Of Report****
Please visit www.agilusdiagnostics.com for related Test Information for this accession

CONDITIONS OF LABORATORY TESTING & REPORTING

1. It is presumed that the test sample belongs to the patient named or identified in the test requisition form.
2. All tests are performed and reported as per the turnaround time stated in the AGILUS Directory of Services.
3. Result delays could occur due to unforeseen circumstances such as non-availability of kits / equipment breakdown / natural calamities / technical downtime or any other unforeseen event.
4. A requested test might not be performed if:
   i. Specimen received is insufficient or inappropriate
   ii. Specimen quality is unsatisfactory
   iii. Incorrect specimen type
   iv. Discrepancy between identification on specimen container label and test requisition form
5. AGILUS Diagnostics confirms that all tests have been performed or assayed with highest quality standards, clinical safety & technical integrity.
6. Laboratory results should not be interpreted in isolation; it must be correlated with clinical information and be interpreted by registered medical practitioners only to determine final diagnosis.
7. Test results may vary based on time of collection, physiological condition of the patient, current medication or nutritional and dietary changes. Please consult your doctor or call us for any clarification.
8. Test results cannot be used for Medico legal purposes.
9. In case of queries please call customer care (91115 91115) within 48 hours of the report.

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