MC-6146

Patient Name	: Mr.RAGHAVENDRA	Collected	: 23/Sep/2024 08:18PM
Age/Gender	: 30 Y 0 M 0 D /M	Received	: 24/Sep/2024 11:19AM
UHID/MR No	: DSDU.0000002492	Reported	: 24/Sep/2024 11:30AM
Visit ID	: DSDUOPV5555	Status	: Final Report
Ref Doctor	: ANJANADRI DIAGNOSTICS KARATAGI	Client Name	: PCC SINDHANUR
IP/OP NO	:	Center location	: Sindhanur,Sindhanur

DEPARTMENT OF HAEMATOLOGY

Test Name	Result	Unit	Bio. Ref. Interval	Method
COMPLETE BLOOD COUNT (CBC) , *WHOLE BLOOD EDTA*				
HAEMOGLOBIN	14	g/dL	13-17	Spectrophotometer
PCV	40.90	%	40-50	Electronic pulse & Calculation
RBC COUNT	4.99	Million/cu.mm	4.5-5.5	Electrical Impedence
MCV	**82.1**	fL	83-101	Calculated
MCH	28.2	pg	27-32	Calculated
MCHC	34.3	g/dL	31.5-34.5	Calculated
R.D.W	**14.7**	%	11.6-14	Calculated
TOTAL LEUCOCYTE COUNT (TLC)	6,090	cells/cu.mm	4000-10000	Electrical Impedance
DIFFERENTIAL LEUCOCYTIC COUNT (DLC)				
NEUTROPHILS	59.5	%	40-80	Electrical Impedance
LYMPHOCYTES	33.1	%	20-40	Electrical Impedance
EOSINOPHILS	1.1	%	1-6	Electrical Impedance
MONOCYTES	5.8	%	2-10	Electrical Impedance
BASOPHILS	0.5	%	<1-2	Electrical Impedance
CORRECTED TLC	6,090	Cells/cu.mm		Calculated
ABSOLUTE LEUCOCYTE COUNT				
NEUTROPHILS	3623.55	Cells/cu.mm	2000-7000	Calculated
LYMPHOCYTES	2015.79	Cells/cu.mm	1000-3000	Calculated
EOSINOPHILS	66.99	Cells/cu.mm	20-500	Calculated
MONOCYTES	353.22	Cells/cu.mm	200-1000	Calculated
BASOPHILS	30.45	Cells/cu.mm	0-100	Calculated
Neutrophil lymphocyte ratio (NLR)	1.8		0.78- 3.53	Calculated
PLATELET COUNT	303000	cells/cu.mm	150000-410000	Electrical impedence

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SIN No:HA07719283

Patient Name	: Mr.RAGHAVENDRA	Collected	: 23/Sep/2024 08:18PM
Age/Gender	: 30 Y 0 M 0 D /M	Received	: 24/Sep/2024 11:24AM
UHID/MR No	: DSDU.0000002492	Reported	: 24/Sep/2024 03:39PM
Visit ID	: DSDUOPV5555	Status	: Final Report
Ref Doctor	: ANJANADRI DIAGNOSTICS KARATAGI	Client Name	: PCC SINDHANUR
IP/OP NO	:	Center location	: Sindhanur,Sindhanur

DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	Unit	Bio. Ref. Interval	Method
HBA1C (GLYCATED HEMOGLOBIN) , *WHOLE BLOOD EDTA*				
HBA1C, GLYCATED HEMOGLOBIN	**6.0**	%		HPLC
ESTIMATED AVERAGE GLUCOSE (eAG)	126	mg/dL		Calculated

Comment:

Reference Range as per American Diabetes Association (ADA) 2023 Guidelines:

REFERENCE GROUP	HBA1C %
NON DIABETIC	<5.7
PREDIABETES	5.7 – 6.4
DIABETES	≥ 6.5
DIABETICS	
EXCELLENT CONTROL	6 – 7
FAIR TO GOOD CONTROL	7 – 8
UNSATISFACTORY CONTROL	8 – 10
POOR CONTROL	>10

Note: Dietary preparation or fasting is not required.

1. HbA1C is recommended by American Diabetes Association for Diagnosing Diabetes and monitoring Glycemic Control by American Diabetes Association guidelines 2023.
2. Trends in HbA1C values is a better indicator of Glycemic control than a single test.
3. Low HbA1C in Non-Diabetic patients are associated with Anemia (Iron Deficiency/Hemolytic), Liver Disorders, Chronic Kidney Disease. Clinical Correlation is advised in interpretation of low Values.
4. Falsely low HbA1c (below 4%) may be observed in patients with clinical conditions that shorten erythrocyte life span or decrease mean erythrocyte age. HbA1c may not accurately reflect glycemic control when clinical conditions that affect erythrocyte survival are present.
5. In cases of Interference of Hemoglobin variants in HbA1C, alternative methods (Fructosamine) estimation is recommended for Glycemic Control
   A: HbF >25%
   B: Homozygous Hemoglobinopathy.
   (Hb Electrophoresis is recommended method for detection of Hemoglobinopathy)

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SIN No:BI21899316

This test has been performed at Apollo Health & Lifestyle Ltd, RRL BANGALORE Laboratory

Patient Name	: Mr.RAGHAVENDRA	Collected	: 23/Sep/2024 08:18PM
Age/Gender	: 30 Y 0 M 0 D /M	Received	: 24/Sep/2024 11:26AM
UHID/MR No	: DSDU.0000002492	Reported	: 24/Sep/2024 04:35PM
Visit ID	: DSDUOPV5555	Status	: Final Report
Ref Doctor	: ANJANADRI DIAGNOSTICS KARATAGI	Client Name	: PCC SINDHANUR
IP/OP NO	:	Center location	: Sindhanur,Sindhanur

DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	Unit	Bio. Ref. Interval	Method
LIPID PROFILE , *SERUM*				
TOTAL CHOLESTEROL	179	mg/dL	<200	CHO-POD
TRIGLYCERIDES	**555**	mg/dL	<150	GPO-POD
HDL CHOLESTEROL	**29**	mg/dL	40-60	Enzymatic Immunoinhibition
NON-HDL CHOLESTEROL	**150**	mg/dL	<130	Calculated
VLDL CHOLESTEROL	**111**	mg/dL	<30	Calculated
CHOL / HDL RATIO	**6.17**		0-4.97	Calculated
ATHEROGENIC INDEX (AIP)	**0.92**		<0.11	Calculated

Comment:

Reference Interval as per National Cholesterol Education Program (NCEP) Adult Treatment Panel III Report.

	Desirable	Borderline High	High	Very High
TOTAL CHOLESTEROL	< 200	200 - 239	≥ 240	
TRIGLYCERIDES	<150	150 - 199	200 - 499	≥ 500
LDL	Optimal < 100 Near Optimal 100-129	130 - 159	160 - 189	≥ 190
HDL	≥ 60			
NON-HDL CHOLESTEROL	Optimal <130; Above Optimal 130-159	160-189	190-219	>220

Measurements in the same patient can show physiological and analytical variations.

NCEP ATP III identifies non-HDL cholesterol as a secondary target of therapy in persons with high triglycerides.

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MC-6146

Patient Name	: Mr.RAGHAVENDRA	Collected	: 24/Sep/2024 12:07PM
Age/Gender	: 30 Y 0 M 0 D /M	Received	: 24/Sep/2024 12:07PM
UHID/MR No	: DSDU.0000002492	Reported	: 24/Sep/2024 04:14PM
Visit ID	: DSDUOPV5555	Status	: Final Report
Ref Doctor	: ANJANADRI DIAGNOSTICS KARATAGI	Client Name	: PCC SINDHANUR
IP/OP NO	:	Center location	: Sindhanur,Sindhanur

DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	Unit	Bio. Ref. Interval	Method
LDL CHOLESTEROL - (DIRECT LDL)	99.00	mg/dL	<100	Enzymatic Selective Protection

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Patient Name	: Mr.RAGHAVENDRA	Collected	: 23/Sep/2024 08:18PM
Age/Gender	: 30 Y 0 M 0 D /M	Received	: 24/Sep/2024 11:26AM
UHID/MR No	: DSDU.0000002492	Reported	: 24/Sep/2024 12:08PM
Visit ID	: DSDUOPV5555	Status	: Final Report
Ref Doctor	: ANJANADRI DIAGNOSTICS KARATAGI	Client Name	: PCC SINDHANUR
IP/OP NO	:	Center location	: Sindhanur,Sindhanur

DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	Unit	Bio. Ref. Interval	Method
LIVER FUNCTION TEST (LFT) , *SERUM*				
BILIRUBIN, TOTAL	0.39	mg/dL	0.3–1.2	DPD
BILIRUBIN CONJUGATED (DIRECT)	0.06	mg/dL	<0.2	DPD
BILIRUBIN (INDIRECT)	0.33	mg/dL	0.0-1.1	Dual Wavelength
ALANINE AMINOTRANSFERASE (ALT/SGPT)	34	U/L	<50	IFCC
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	29.0	U/L	<50	IFCC
AST (SGOT) / ALT (SGPT) RATIO (DE RITIS)	0.8		<1.15	Calculated
ALKALINE PHOSPHATASE	99.00	U/L	30-120	IFCC
PROTEIN, TOTAL	7.14	g/dL	6.6-8.3	Biuret
ALBUMIN	4.36	g/dL	3.5-5.2	BROMO CRESOL GREEN
GLOBULIN	2.78	g/dL	2.0-3.5	Calculated
A/G RATIO	1.57		0.9-2.0	Calculated

Comment:

LFT results reflect different aspects of the health of the liver, i.e., hepatocyte integrity (AST & ALT), synthesis and secretion of bile (Bilirubin, ALP), cholestasis (ALP, GGT), protein synthesis (Albumin) Common patterns seen:

1. Hepatocellular Injury:

*AST – Elevated levels can be seen. However, it is not specific to liver and can be raised in cardiac and skeletal injuries. *ALT – Elevated levels indicate hepatocellular damage. It is considered to be most specific lab test for hepatocellular injury. Values also correlate well with increasing BMI. Disproportionate increase in AST, ALT compared with ALP. AST: ALT (ratio) – In case of hepatocellular injury AST: ALT > 1In Alcoholic Liver Disease AST: ALT usually >2. This ratio is also seen to be increased in NAFLD, Wilsons's diseases, Cirrhosis, but the increase is usually not >2.

2. Cholestatic Pattern:

*ALP – Disproportionate increase in ALP compared with AST, ALT. ALP elevation also seen in pregnancy, impacted by age and sex. *Bilirubin elevated- predominantly direct , To establish the hepatic origin correlation with elevated GGT helps.

3. Synthetic function impairment:

*Albumin- Liver disease reduces albumin levels, Correlation with PT (Prothrombin Time) helps.

4. Associated tests for assessment of liver fibrosis - Fibrosis-4 and APRI Index.

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DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	Unit	Bio. Ref. Interval	Method
RENAL PROFILE/KIDNEY FUNCTION TEST (RFT/KFT) , *SERUM*				
CREATININE	0.91	mg/dL	0.84 - 1.25	Modified Jaffe, Kinetic
UREA	18.70	mg/dL	17-43	GLDH, Kinetic Assay
BLOOD UREA NITROGEN	8.7	mg/dL	8.0 - 23.0	Calculated
URIC ACID	5.34	mg/dL	3.5–7.2	Uricase PAP
CALCIUM	9.00	mg/dL	8.8-10.6	Arsenazo III
PHOSPHORUS, INORGANIC	2.96	mg/dL	2.5-4.5	Phosphomolybdate Complex
SODIUM	136	mmol/L	136–146	ISE (Indirect)
POTASSIUM	4.9	mmol/L	3.5–5.1	ISE (Indirect)
CHLORIDE	104	mmol/L	101–109	ISE (Indirect)
PROTEIN, TOTAL	7.14	g/dL	6.6-8.3	Biuret
ALBUMIN	4.36	g/dL	3.5-5.2	BROMO CRESOL GREEN
GLOBULIN	2.78	g/dL	2.0-3.5	Calculated
A/G RATIO	1.57		0.9-2.0	Calculated

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Visit ID	: DSDUOPV5555	Status	: Final Report
Ref Doctor	: ANJANADRI DIAGNOSTICS KARATAGI	Client Name	: PCC SINDHANUR
IP/OP NO	:	Center location	: Sindhanur,Sindhanur

DEPARTMENT OF IMMUNOLOGY

Test Name	Result	Unit	Bio. Ref. Interval	Method
THYROID PROFILE TOTAL (T3, T4, TSH) , *SERUM*				
TRI-IODOTHYRONINE (T3, TOTAL)	1	ng/mL	0.7-2.04	CLIA
THYROXINE (T4, TOTAL)	10.4	µg/dL	5.48-14.28	CLIA
THYROID STIMULATING HORMONE (TSH)	3.512	µIU/mL	0.34-5.60	CLIA

Comment:

For pregnant females	Bio Ref Range for TSH in uIU/ml (As per American Thyroid Association)
First trimester	0.1 - 2.5
Second trimester	0.2 – 3.0
Third trimester	0.3 – 3.0

1. TSH is a glycoprotein hormone secreted by the anterior pituitary. TSH activates production of T3 (Triiodothyronine) and its prohormone T4 (Thyroxine). Increased blood level of T3 and T4 inhibit production of TSH.

2. TSH is elevated in primary hypothyroidism and will be low in primary hyperthyroidism. Elevated or low TSH in the context of normal free thyroxine is often referred to as sub-clinical hypo- or hyperthyroidism respectively.

3. Both T4 & T3 provides limited clinical information as both are highly bound to proteins in circulation and reflects mostly inactive hormone. Only a very small fraction of circulating hormone is free and biologically active.

4. Significant variations in TSH can occur with circadian rhythm, hormonal status, stress, sleep deprivation, medication & circulating antibodies.

TSH	T3	T4	FT4	Conditions
High	Low	Low	Low	Primary Hypothyroidism, Post Thyroidectomy, Chronic Autoimmune Thyroiditis
High	N	N	N	Subclinical Hypothyroidism, Autoimmune Thyroiditis, Insufficient Hormone Replacement Therapy.
N/Low	Low	Low	Low	Secondary and Tertiary Hypothyroidism
Low	High	High	High	Primary Hyperthyroidism, Goitre, Thyroiditis, Drug effects, Early Pregnancy
Low	N	N	N	Subclinical Hyperthyroidism
Low	Low	Low	Low	Central Hypothyroidism, Treatment with Hyperthyroidism
Low	N	High	High	Thyroiditis, Interfering Antibodies
N/Low	High	N	N	T3 Thyrotoxicosis, Non thyroidal causes
High	High	High	High	Pituitary Adenoma; TSHoma/Thyrotropinoma

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SIN No:IM08318033
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IP/OP NO	:	Center location	: Sindhanur,Sindhanur

DEPARTMENT OF IMMUNOLOGY

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Age/Gender	: 30 Y 0 M 0 D /M	Received	: 24/Sep/2024 11:24AM
UHID/MR No	: DSDU.0000002492	Reported	: 24/Sep/2024 01:28PM
Visit ID	: DSDUOPV5555	Status	: Final Report
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IP/OP NO	:	Center location	: Sindhanur,Sindhanur

DEPARTMENT OF IMMUNOLOGY

Test Name	Result	Unit	Bio. Ref. Interval	Method
VITAMIN D (25 - OH VITAMIN D) , *SERUM*	**12.1**	ng/mL	30 -100	CLIA

Comment:

BIOLOGICAL REFERENCE RANGES

VITAMIN D STATUS	VITAMIN D 25 HYDROXY (ng/mL)
DEFICIENCY	<10
INSUFFICIENCY	10 – 30
SUFFICIENCY	30 – 100
TOXICITY	>100

The biological function of Vitamin D is to maintain normal levels of calcium and phosphorus absorption. 25-Hydroxy vitamin D is the storage form of vitamin D. Vitamin D assists in maintaining bone health by facilitating calcium absorption. Vitamin D deficiency can also cause osteomalacia, which frequently affects elderly patients.

Vitamin D Total levels are composed of two components namely 25-Hydroxy Vitamin D2 and 25-Hydroxy Vitamin D3 both of which are converted into active forms. Vitamin D2 level corresponds with the exogenous dietary intake of Vitamin D rich foods as well as supplements. Vitamin D3 level corresponds with endogenous production as well as exogenous diet and supplements. Vitamin D from sunshine on the skin or from dietary intake is converted predominantly by the liver into 25-hydroxy vitamin D, which has a long half-life and is stored in the adipose tissue. The metabolically active form of vitamin D, 1,25-di-hydroxy vitamin D, which has a short life, is then synthesized in the kidney as needed from circulating 25-hydroxy vitamin D. The reference interval of greater than 30 ng/mL is a target value established by the Endocrine Society.

Decreased Levels:

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

Increased levels:

Vitamin D intoxication.

Test Name	Result	Unit	Bio. Ref. Interval	Method

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MC-6146

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DEPARTMENT OF IMMUNOLOGY

VITAMIN B12 , *SERUM*	**163**	pg/mL	190-900	CLIA

Comment:

Vitamin B12 deficiency frequently causes macrocytic anemia, glossitis, peripheral neuropathy, weakness, hyperreflexia, ataxia, loss of proprioception, poor coordination, and affective behavioral changes. A significant increase in RBC MCV may be an important indicator of vitamin B12 deficiency.

Patients taking vitamin B12 supplementation may have misleading results. A normal serum concentration of B12 does not rule out tissue deficiency of vitamin B12 . The most sensitive test for B12 deficiency at the cellular level is the assay for MMA. If clinical symptoms suggest deficiency, measurement of MMA and homocysteine should be considered, even if serum B12 concentrations are normal.

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

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TERMS AND CONDITIONS GOVERNING THIS REPORT

The reported results are for information and interpretation of the referring doctor or such other medical professionals, who understand reporting units, reference ranges and limitations of technologies.
Laboratories not be responsible for any interpretation whatsoever.
It is presumed that the tests performed are, on the specimen / sample being to the patient named or identified and the verifications of the particulars have been cleared out by the patient or his / her representative at the point of generation of said specimen.
The reported results are restricted to the given specimen only. Results may vary from lab to lab and from time to time for the same parameter for the same patient.
Assays are performed in accordance with standard procedures, The reported results are dependent on individual assay methods / equipment used and quality of specimen received.
This report is not valid for medico legal purposes.

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