L23 - MR. AKSHAY KUMAR SHARMA - FPSC
BANIPARK

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Name	: **Mrs. KALA LOYALKA**			**Collected**	: **22/11/2020 10:43:00AM**
				Received	: **22/11/2020 11:01:44AM**
Lab No.	: **295989685**	**Age: 81 Years**	**Gender: Female**	**Reported**	: **25/11/2020 10:23:11AM**
A/c Status	: **P**	**Ref By : Dr. PUSHPENDRA GARG**		**Report Status**	: **Final**

Swasthfit Total - Iron Check

Test Name	Results	Units	Bio. Ref. Interval
IRON STUDIES MONITORING PANEL			
Iron	**37.00**	µg/dL	50.00 - 170.00
Total Iron Binding Capacity (TIBC)	356.00	µg/dL	250.00 - 425.00
Transferrin Saturation	**10.39**	%	15.00 - 50.00
Ferritin	64.60	ng/mL	10.00 - 291.00

Comment

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 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.

Ferritin appears to be in equilibrium with tissue ferritin and is a good indicator of storage iron in normal subjects and in most disorders. In patients with some hepatocellular diseases, malignancies and inflammatory diseases, serum ferritin is a disproportionately high estimate of storage iron because serum ferritin is an acute phase reactant. In such disorders iron deficiency anemia may exist with a normal serum ferritin concentration. In the presence of inflammation, persons with low serum ferritin are likely to respond to iron therapy.

THYROID PROFILE,TOTAL, SERUM (CLIA)			
T3, Total	1.37	ng/mL	0.40 - 1.81
T4, Total	11.30	µg/dL	5.01 - 12.45
TSH	2.99	µIU/mL	0.35 - 5.50

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Test Name	Results	Units	Bio. Ref. Interval

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

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Test Name	Results	Units	Bio. Ref. Interval
LIVER & KIDNEY PANEL, SERUM			
Bilirubin Total (DPD)	0.58	mg/dL	0.20 - 1.10
Bilirubin Direct (DPD)	0.14	mg/dL	<0.20
Bilirubin Indirect (Calculated)	0.44	mg/dL	<1.10
AST (SGOT) (IFCC without P5P)	24	U/L	<35
ALT (SGPT) (IFCC without P5P)	15	U/L	<35
GGTP (IFCC)	33	U/L	<38
Alkaline Phosphatase (ALP) (IFCC-AMP)	**130**	U/L	30 - 120
Total Protein (Biuret)	7.09	g/dL	6.40 - 8.10
Albumin (BCG)	3.92	g/dL	3.20 - 4.60
A : G Ratio (Calculated)	1.24		0.90 - 2.00
Urea (Urease UV)	17.67	mg/dL	17.00 - 43.00
Creatinine (Modified Jaffe,Kinetic)	0.62	mg/dL	0.51 - 0.95

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Test Name	Results	Units	Bio. Ref. Interval
Uric Acid (Uricase)	2.69	mg/dL	2.60 - 6.00
Calcium, Total (Arsenazo III)	8.96	mg/dL	8.80 - 10.20
Phosphorus (Molybdate UV)	3.37	mg/dL	2.80 - 4.00
Sodium (Indirect ISE)	**134.00**	mEq/L	136.00 - 146.00
Potassium (Indirect ISE)	4.10	mEq/L	3.50 - 5.10
Chloride (Indirect ISE)	**92.00**	mEq/L	101.00 - 109.00

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Test Name	Results	Units	Bio. Ref. Interval
COMPLETE BLOOD COUNT;CBC (Electrical Impedence,Manual)			
Hemoglobin	**15.90**	g/dL	11.50 - 15.00
Packed Cell Volume (PCV)	**47.60**	%	36.00 - 46.00
RBC Count	**5.27**	mill/mm3	3.80 - 4.80
MCV	90.00	fL	80.00 - 100.00
MCH	30.10	pg	27.00 - 32.00
MCHC	33.40	g/dL	32.00 - 35.00
Red Cell Distribution Width (RDW)	13.10	%	11.50 - 14.50
Total Leukocyte Count (TLC)	9.00	thou/mm3	4.00 - 10.00
Differential Leucocyte Count (DLC)			
Segmented Neutrophils	68.30	%	40.00 - 80.00
Lymphocytes	25.80	%	20.00 - 40.00
Monocytes	4.60	%	2.00 - 10.00
Eosinophils	**0.60**	%	1.00 - 6.00
Basophils	0.70	%	<2.00
Absolute Leucocyte Count			
Neutrophils	6.15	thou/mm3	2.00 - 7.00
Lymphocytes	2.32	thou/mm3	1.00 - 3.00
Monocytes	0.41	thou/mm3	0.20 - 1.00
Eosinophils	0.05	thou/mm3	0.02 - 0.50
Basophils	0.06	thou/mm3	0.01 - 0.10
Platelet Count	254.0	thou/mm3	150.00 - 450.00

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Test Name	Results	Units	Bio. Ref. Interval
Mean Platelet Volume (MPV)	8.40	fL	6.50 - 12.00

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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Test Name	Results	Units	Bio. Ref. Interval
HbA1c (GLYCOSYLATED HEMOGLOBIN), BLOOD (HPLC)			
HbA1c	**6.1**	%	
Estimated average glucose (eAG)	128	mg/dL	

Interpretation

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

Note

1. Since HbA1c reflects long term fluctuations in the blood glucose concentration, a diabetic patient who is recently under good control may still have a high concentration of HbA1c. Converse is true for a diabetic previously under good control but now poorly controlled
2. Target goals of < 7.0 % may be beneficial in patients with short duration of diabetes, long life expectancy and no significant cardiovascular disease. In patients with significant complications of diabetes, limited life expectancy or extensive co-morbid conditions, targeting a goal of < 7.0 % may not be appropriate
3. Presence of Hemoglobin variants and/or conditions that affect red cell turnover must be considered, particularly when the A1C result does not correlate with the patient's blood glucose levels
4. In patients with HbA1c level between 7-8%, Glycemark (1,5 Anhydroglucitol) test may be done to identify those with more frequent and extreme hyperglycemic excursions

Comments

HbA1C reflects average glycemia over approximately 3 months, the test is the major tool for assessing glycemic control and has strong predictive value for diabetes complications. Thus, HbA1C testing should be performed routinely in all patients with diabetes - at initial assessment and as part of continuing care.

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Test Name	Results	Units	Bio. Ref. Interval

Measurement approximately every 3 months determines whether patients' glycemic targets have been reached and maintained. The frequency of A1C testing should depend on the clinical situation, the treatment regimen, and the clinician's judgement.

ADA Recommendations for HbA1c testing

1. Perform the A1C test at least two times a year in patients who are meeting treatment goals (and who have stable glycemic control)
2. Perform the A1C test quarterly in patients whose therapy has changed or who are not meeting glycemic goals

Factors that Interfere with HbA1c Measurement: 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

Factors that affect interpretation of HbA1c Results: 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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Test Name	Results	Units	Bio. Ref. Interval
RETICULOCYTE COUNT, WHOLE BLOOD (Manual)	0.90	%	0.50 - 2.50
GLUCOSE, FASTING (F), PLASMA (Hexokinase)	**116.00**	mg/dL	70.00 - 100.00
FOLATE (FOLIC ACID), SERUM @ (CLIA)	**>24.00**	ng/mL	>5.38

Interpretation

RESULT IN ng/mL	REMARKS
<3.37	Deficient
3.38-5.38	Indeterminate
>5.38	Normal

Note

1. Drugs like Methotrexate & Leucovorin interfere with folate measurement
2. To differentiate vitamin B12 & folate deficiency, measurement of Methyl malonic acid in urine & serum Homocysteine level is suggested
3. Risk of toxicity from folic acid is low as it is a water soluble vitamin regularly excreted in urine

Comments

Folate plays an important role in the synthesis of purine & pyrimidines in the body and is important for the maturation of erythrocytes. It is widely available from plants and to a lesser extent organ meats, but more than half the folate content of food is lost during cooking. Folate deficiency is commonly prevalent in alcoholic liver disease, pregnancy and the elderly. It may result from poor intestinal absorption, nutrition deficiency, excessive demand as in pregnancy or in malignancy and in response to certain drugs like Methotrexate & anticonvulsants.

Decreased Levels

Megaloblastic anemia, Infantile hyperthyroidism, Alcoholism, Malnutrition, Scurvy, Liver disease, B12 deficiency, dietary amino acid excess, adult Celiac disease, Tropical Sprue, Crohn's disease, Hemolytic anemias, Carcinomas, Myelofibrosis, vitamin B6 deficiency, pregnancy, Whipple's disease, extensive intestinal resection and severe exfoliative dermatitis

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Test Name	Results	Units	Bio. Ref. Interval
VITAMIN B12; CYANOCOBALAMIN, SERUM (CLIA)	769.00	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 interchangeably due to differences in assay methods and reagent specificity

VITAMIN D, 25 - HYDROXY, SERUM (Chemiluminescence)	58.58	nmol/L

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.

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Test Name	Results	Units	Bio. Ref. Interval

- 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 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 Name	Results	Units	Bio. Ref. Interval
LIPID SCREEN, SERUM			
Cholesterol, Total (CHO-POD)	150.00	mg/dL	<200.00
Triglycerides (GPO-POD)	92.00	mg/dL	<150.00
HDL Cholesterol (Enzymatic Immunoinhibition)	**48.00**	mg/dL	>50.00
LDL Cholesterol, Calculated	83.60	mg/dL	<100.00
VLDL Cholesterol,Calculated	18.40	mg/dL	<30.00
Non-HDL Cholesterol (Calculated)	102	mg/dL	<130

Interpretation

REMARKS	TOTAL CHOLESTEROL in mg/dL	TRIGLYCERIDE in mg/dL	LDL CHOLESTEROL in mg/dL	NON HDL CHOLESTEROL in mg/dL
Optimal	<200	<150	<100	<130
Above Optimal	-	-	100-129	130 - 159
Borderline High	200-239	150-199	130-159	160 - 189
High	>=240	200-499	160-189	190 - 219
Very High	-	>=500	>=190	>=220

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. NLA-2014 recommends a complete lipoprotein profile as the initial test for evaluating cholesterol.

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Test Name	Results	Units	Bio. Ref. Interval

3. 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
4. NLA-2014 identifies Non HDL Cholesterol(an indicator of all atherogeniclipoproteins such as LDL , VLDL, IDL, Lpa, Chylomicron remnants)along with LDL-cholesterol as co- primary target for cholesterol lowering therapy. Note that major risk factors can modify treatment goals for LDL &Non HDL.
5. Apolipoprotein B is an optional, secondary lipid target for treatment once LDL & Non HDL goals have been achieved
6. 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 2016

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)
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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Test Name	Results	Units	Bio. Ref. Interval
INTERLEUKIN-6 (IL-6) MINI PANEL (ECLIA, Immunoturbidimetry)			
(IL-6) *	**5.00**	pg/mL	<4.4
D-Dimer , Quantitative @	**0.71**	mg/L FEU	<0.50

Note

1. Patient samples may contain heterophilic antibodies or mouse monoclonal antibodies that could react in immunoassays to give a falsely elevated or depressed result.
2. Results should always be interpreted in conjunction with the patient's medical history, clinical presentation and other findings.
3. Patients receiving Biotin therapy in high doses (>5mg/day) should not be tested for at least 8 hours after the last dose.
4. Test conducted in Plasma.

Comment

Symptoms of SARS-CoV-2 (COVID-19) vary from mild fever to ARDS complicating diagnosis, prognosis, and monitoring. Hence it is vital to ascertain a patient's condition in a timely manner. Biomarkers are quantitative measurements used clinically for many conditions reflecting pathological development. When assessing a patient with COVID-19 infection, biomarkers can be useful to clinicians in starting treatment and close monitoring.

C-REACTIVE PROTEIN; CRP, SERUM * (Immunoturbidimetry)	**19.29**	mg/L	<5.00

Comments

CRP is an acute phase reactant which is used in inflammatory disorders for monitoring course and effect of therapy. It is most useful as an indicator of activity in Rheumatoid arthritis, Rheumatic fever, tissue injury or necrosis and infections. As compared to ESR, CRP shows an earlier rise in inflammatory disorders which begins in 4-6 hrs, the intensity of the rise being higher than ESR and the recovery being earlier than ESR. Unlike ESR, CRP levels are not influenced by hematologic conditions like Anemia, Polycythemia etc.

LDH;LACTATE DEHYDROGENASE, SERUM @ (IFCC)	236.00	U/L	<247.00

Comments

Lactate dehydrogenase (LDH) is a nonspecific enzyme found in most organs. Highest concentrations are found in liver, heart, kidney and blood cells. LDH measurements are used in the diagnosis and treatments of

* Not in NABL scope

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Dr. Vandana Lal
M.D (PATH), IFCAP
Chief of Pathology
SHIROMANI AWARD WINNER

Name	: Mrs. KALA LOYALKA			**Collected**	: 22/11/2020 10:43:00AM
				Received	: 22/11/2020 11:01:44AM
Lab No.	: 295989685	**Age:** 81 Years	**Gender:** Female	**Reported**	: 25/11/2020 10:23:11AM
A/c Status	: P	**Ref By :** Dr. PUSHPENDRA GARG		**Report Status**	: Final

Test Name	Results	Units	Bio. Ref. Interval

liver diseases like Acute viral hepatitis, Cirrhosis & Metastatic carcinoma; Cardiac diseases like Myocardial infarction; Tumors of lungs / kidneys & Hematologic disorders like Megaloblastic anemia & Hemolytic anemia.

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Test Name	Results	Units	Bio. Ref. Interval
URINE EXAMINATION, ROUTINE; URINE, R/E (Dipstick, Microscopy)			
Physical			
Colour	Pale Yellow		Pale yellow
Specific Gravity	1.010		1.001 - 1.030
pH	6.5		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	0-1 WBC/HPF		0-5 WBC / hpf
Epithelial Cells	2-3 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

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(#) Sample drawn from outside source.

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Test Name	Results	Units	Bio. Ref. Interval
CULTURE, URINE @ (Conventional culture, Automated Identification & Sensitivity) Type of Specimen :			

Result :- No Aerobic pyogenic organism grown

Dr Anil Arora
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HOD Hematology & Immunohematology
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Dr Anjana Mittal
MD, Pathology
Consultant Pathologist
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Dr Himangshu Mazumdar
MD, Biochemistry
Senior Consultant - Clinical Chemistry & Biochemical Genetics
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Dr Jasmine Kohli
MD, Pathology
Chief of Laboratory
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Dr.Kamal Modi
MD, Biochemistry
Consultant Biochemist
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Dr Ritu Nayar
MD, Microbiology
Deputy HOD - Microbiology & Serology
NRL - Dr Lal PathLabs Ltd

Dr Nimmi Kansal
MD, Biochemistry
National Head - Clinical Chemistry & Biochemical Genetics
NRL - Dr Lal PathLabs Ltd

Dr Shalabh Malik
MD, Microbiology
National Head - Microbiology & Serology
NRL - Dr Lal PathLabs Ltd

Dr Sunanda
MD, Pathology
Consultant
NRL - Dr Lal PathLabs Ltd

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

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