L55 - SRI VINAYAKA CLINICAL LABORATORY
Hospet H.O, SU SHILPI DIAGNOSTIC LABORAT
AGALI COMPLEX, NEAR KSRTC BUS STAND,
HOS

Name	: **Mr. JYOTHIRMAY R BALDOTA**			**Collected**	: **27/4/2021 10:08:00PM**
Lab No.	: **305137424**	**Age: 18 Years**	**Gender: Male**	**Received**	: **27/4/2021 10:44:05PM**
				Reported	: **30/4/2021 10:44:09AM**
A/c Status	: **P**	**Ref By : Dr. AMOGH**		**Report Status**	: **Final**

Test Name	Results	Units	Bio. Ref. Interval
SwasthFit Super 4			
COMPLETE BLOOD COUNT;CBC (Flow Cytometery, SLS)			
Hemoglobin	13.60	g/dL	13.00 - 17.00
Packed Cell Volume (PCV)	47.40	%	40.00 - 50.00
RBC Count	5.09	mill/mm3	4.50 - 5.50
MCV	93.10	fL	83.00 - 101.00
MCH	**26.70**	pg	27.00 - 32.00
MCHC	**28.70**	g/dL	31.50 - 34.50
Red Cell Distribution Width (RDW)	**15.90**	%	11.60 - 14.00
Total Leukocyte Count (TLC)	9.81	thou/mm3	4.00 - 10.00
Differential Leucocyte Count (DLC)			
Segmented Neutrophils	57.70	%	40.00 - 80.00
Lymphocytes	37.10	%	20.00 - 40.00
Monocytes	2.00	%	2.00 - 10.00
Eosinophils	1.70	%	1.00 - 6.00
Basophils	1.50	%	<2.00
Absolute Leucocyte Count			
Neutrophils	5.66	thou/mm3	2.00 - 7.00
Lymphocytes	**3.64**	thou/mm3	1.00 - 3.00
Monocytes	0.20	thou/mm3	0.20 - 1.00
Eosinophils	0.17	thou/mm3	0.02 - 0.50
Basophils	**0.15**	thou/mm3	0.02 - 0.10

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Test Name	Results	Units	Bio. Ref. Interval
Platelet Count	308.0	thou/mm3	150.00 - 410.00
Mean Platelet Volume	**12.6**	fL	6.5 - 12.0

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
LIVER & KIDNEY PANEL, SERUM (Spectrophotometry, Indirect ISE)			
Bilirubin Total	0.75	mg/dL	<1.00
Bilirubin Direct	0.14	mg/dL	0.00 - 0.30
Bilirubin Indirect	0.61	mg/dL	<1.10
AST (SGOT)	35	U/L	<50
ALT (SGPT)	27	U/L	<50
GGTP	33	U/L	2 - 42
Alkaline Phosphatase (ALP)	124	U/L	52 - 171
Total Protein	7.00	g/dL	6.00 - 8.00
Albumin	4.10	g/dL	3.50 - 5.20
A : G Ratio	1.41		0.90 - 2.00
Urea	28.00	mg/dL	19.2 - 44.9
Creatinine	0.74	mg/dL	0.50 - 1.00

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Test Name	Results	Units	Bio. Ref. Interval
Uric Acid	6.00	mg/dL	3.50 - 7.20
Calcium, Total	9.50	mg/dL	8.40 - 10.20
Phosphorus	**6.60**	mg/dL	2.40 - 4.40
Sodium	137.70	mEq/L	136.00 - 146.00
Potassium	**5.25**	mEq/L	3.50 - 5.10
Chloride	106.00	mEq/L	101.00 - 109.00

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Test Name	Results	Units	Bio. Ref. Interval
HbA1c (GLYCOSYLATED HEMOGLOBIN), BLOOD (HPLC)			
HbA1c	5.6	%	4.00 - 5.60
Estimated average glucose (eAG)	114	mg/dL	

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

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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Test Name	Results	Units	Bio. Ref. Interval
GLUCOSE, FASTING (F), PLASMA (Hexokinase)	91.00	mg/dL	70.00 - 100.00
VITAMIN B12; CYANOCOBALAMIN, SERUM (CLIA)	192.00	pg/mL	180.00 - 914.00

Interpretation : Normal

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 (CLIA)	57.72	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

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Test Name	Results	Units	Bio. Ref. Interval

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 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
THYROID PROFILE,TOTAL, SERUM (CLIA)			
T3, Total	1.63	ng/mL	0.8 - 2.1
T4, Total	**12.04**	µg/dL	5.25 - 9.39
TSH	4.73	µIU/mL	0.70 - 6.40

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
LIPID SCREEN, SERUM (Spectrophotometry)			
Cholesterol, Total	189.00	mg/dL	<200.00
Triglycerides	72.00	mg/dL	<150.00
HDL Cholesterol	46.00	mg/dL	>40.00
LDL Cholesterol, Calculated	**128.60**	mg/dL	<100.00
VLDL Cholesterol,Calculated	14.40	mg/dL	<30.00
Non-HDL Cholesterol	**143**	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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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
CK; CREATINE KINASE, SERUM * (Kinetic)	**696**	U/L	40.00 - 200.00

Comments

CPK is an enzyme found primarily in skeletal and cardiac muscle. It is elevated in diseases like Muscular dystrophy,Myopathies,Polymyositis,Muscle traumaMyocardial infarction,Cardiac catheterization,Electrical cardioversion, Hypothyroidism,Stroke and also following intramuscular injections.Drugs, infections and diseases leading to injury or inflammation of muscles releases CPK into the circulation.Normal levels are seen in Neurogenic muscle diseases like Multiple Sclerosis,Myasthenia gravis and Parkinsonism. Isoenzyme studies are advised in patients with elevated levels.

ERYTHROCYTE SEDIMENTATION RATE (ESR) (Capillary photometry)	9	mm/hr	0 - 15

Note

1. C-Reactive Protein (CRP) is the recommended test in acute inflammatory conditions.
2. Test conducted on EDTA whole blood at 37°C.

APOLIPOPROTEINS A1 & B, SERUM @ (Immunoturbidimetry)			
Apolipoprotein (Apo A1)	**101**	mg/dL	105.00 - 175.00
Apolipoprotein (Apo B)	90	mg/dL	60.00 - 140.00
Apo B / Apo A1 Ratio	0.89		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 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.

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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

C-REACTIVE PROTEIN; CRP, SERUM (Immunoturbidimetry)	**6.90**	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.

HOMOCYSTEINE, QUANTITATIVE, SERUM (CMIA)	12.58	umol/L	5.46 - 16.20

Comments

Homocysteine is a sulphur containing amino acid. There is an association between elevated levels of circulating homocysteine and various vascular and cardiovascular disorders. Clinically the measurement of homocysteine is considered important to diagnose homocystinuria, to identify individuals with or at risk of developing cobalamin or folate deficiency & to assess risk factor for Cardiovascular Disease (CVD) for which the recommendations are:

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- Specially useful in young CVD patients (< 40 yrs)
- In known cases of CVD, high homocysteine levels should be used as a prognostic marker for CVD events and mortality
- CVD patients with homocysteine levels > 15 umol/L belong to a high risk group
- Increased homocysteine levels with low vitamin concentrations should be handled as a potential vitamin deficiency case.

PROLACTIN, SERUM (CLIA)	**27.85**	ng/mL	2.30 - 16.41

Note: 1. Since prolactin is secreted in a pulsatile manner and is also influenced by a variety of physiologic stimuli, it is recommended to test 3 specimens at 20-30 minute intervals after pooling.
2. Major circulating form of Prolactin is a nonglycosylated monomer, but several forms of Prolactin linked with immunoglobulin occur which can give falsely high Prolactin results.
3. Macroprolactin assay is recommended if prolactin levels are elevated, but signs and symptoms of hyperprolactinemia are absent or pituitary imaging studies are normal

Clinical Use

- Diagnosis & management of pituitary adenomas
- Differential diagnosis of male & female hypogonadism

Increased Levels

- **Physiologic:** Sleep, stress, postprandially, pain, coitus
- **Systemic disorders:** Chest wall or thoracic spinal cord lesions, Primary / Secondary hypothyroidism, Adrenal insufficiency, Chronic renal failure, Cirrhosis
- **Medications:**
  - **Psychiatric medications** like Phenothiazine, Haloperidol, Risperidone, Domperidone, Fluoexetine, Amitriptylene, MAO inhibitors etc.,
  - **Antihypertensives:** Alphamethyldopa, Reserpine, Verapamil
  - **Opiates:** Heroin, Methadone, Morphine, Apomorphine
  - **Cimetidine / Ranitidine**
- **Prolactin secreting pituitary tumors:** Prolactinoma, Acromegaly
- **Miscellaneous**: Epileptic seizures, Ectopic secretion of prolactin by non-pituitary tumors, pressure / transaction of pituitary stalk, macroprolactinemia

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Test Name	Results	Units	Bio. Ref. Interval

- **Idiopathic**

Decreased levels

- Pituitary deficiency: Pituitary necrosis / infarction
- Bromocriptine administration
- Pseudohypoparathyroidism

THYROID PROFILE, FREE, SERUM (CLIA)			
T3, Free; FT3	4.71	pg/mL	2.60 - 4.80
T4, Free; FT4	1.03	ng/dL	0.61 - 1.03
TSH, Ultrasensitive	4.730	µIU/mL	0.70 - 6.40

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. TSH Values <0.03 µIU/mL need to be clinically correlated due to presence of a rare TSH variant in some individuals

LDH;LACTATE DEHYDROGENASE, SERUM (IFCC)	194.00	U/L	<248.00

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 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
IRON STUDIES MONITORING PANEL (Spectrophotometry, CLIA)			
Iron	**40.40**	µg/dL	65.00 - 175.00
Total Iron Binding Capacity (TIBC)	407.10	µg/dL	250.00 - 425.00
Transferrin Saturation	**9.92**	%	20.00 - 50.00
Ferritin	29.30	ng/mL	23.9 - 336.2

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.

Test Name	Results	Units	Bio. Ref. Interval
CORTISOL SUPPRESSION BY DEXAMETHASONE, OVERNIGHT HIGH DOSE, SERUM @ (CLIA)			
Cortisol Basal	16.49	ug/dL	4.30 - 22.40

Note: 1. Suppressant is 4 mg tablet Dexamethasone administered orally at 11 p.m of previous day
2. Recommended test is Basal followed by Post Dexamethasone suppression

L55 - SRI VINAYAKA CLINICAL LABORATORY
Hospet H.O, SU SHILPI DIAGNOSTIC LABORAT
AGALI COMPLEX, NEAR KSRTC BUS STAND,
HOS

Name	: Mr. JYOTHIRMAY R BALDOTA			**Collected**	: 27/4/2021 10:08:00PM
Lab No.	: 305137424	**Age:** 18 Years	**Gender:** Male	**Received**	: 27/4/2021 10:44:05PM
				Reported	: 30/4/2021 10:44:09AM
A/c Status	: P	**Ref By :** Dr. AMOGH		**Report Status**	: Final

Test Name	Results	Units	Bio. Ref. Interval

L55 - SRI VINAYAKA CLINICAL LABORATORY
Hospet H.O, SU SHILPI DIAGNOSTIC LABORAT
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Name	: **Mr. JYOTHIRMAY R BALDOTA**			**Collected**	: **27/4/2021 10:08:00PM**
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A/c Status	: **P**	**Ref By : Dr. AMOGH**		**Report Status**	: **Final**

Test Name	Results	Units	Bio. Ref. Interval
URINE EXAMINATION, ROUTINE; URINE, R/E (Automated Strip Test, Microscopy)			
Physical			
Colour	Pale Yellow		Pale yellow
Specific Gravity	1.015		1.001 - 1.030
pH	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 Result Rechecked, Please Correlate Clinically.	**Positive**		Negative
Microscopy			
R.B.C.	Negative		0.0 - 2.0 RBC/hpf
Pus Cells	2-3 WBC/HPF		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

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Test Name	Results	Units	Bio. Ref. Interval

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----------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 .*Sample repeats are accepted on request of Referring Physician within 7 days post reporting.*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. *Contact customer care Tel No. +91-11-39885050 for all queries related to test results.
(#) Sample drawn from outside source.