Name	: **Mr. YOGESH WARDUTT**		
Lab No.	: **175078604**	**Age**	: **83 Years**
Ref By	: **ajay yadav**	**Gender**	: **Male**
Collected	: **28/12/2023 8:27:00AM**	**Reported**	: **28/12/2023 8:14:15PM**
A/c Status	: **P**	**Report Status**	: **Final**
Collected at	: **FOFO NAZAFGARH** **Plot No- 1, Tura Mandi Chowk Najafgarh** **NEW DELHI**	**Processed at**	: **DWARKA -2** **Plot No. 60, Sector 12 B, Dwarka-New Delhi-110075**

Test Report

SwasthFit Super 2

Test Name	Results	Units	Bio. Ref. Interval
LIVER & KIDNEY PANEL, SERUM (Spectrophotometry, Indirect ISE)			
Creatinine	0.90	mg/dL	0.67 - 1.17
GFR Estimated	85	mL/min/1.73m2	>59
GFR Category	G2		
Urea	32.40	mg/dL	17.00 - 43.00
Urea Nitrogen Blood	15.13	mg/dL	8.00 - 23.00
BUN/Creatinine Ratio	17		
Uric Acid	4.00	mg/dL	3.50 - 7.20
AST (SGOT)	20.3	U/L	<50
ALT (SGPT)	14.8	U/L	<50
GGTP	9.7	U/L	<55
Alkaline Phosphatase (ALP)	55.20	U/L	30 - 120
Bilirubin Total	0.49	mg/dL	0.20 - 1.10
Bilirubin Direct	0.06	mg/dL	<0.20
Bilirubin Indirect	0.43	mg/dL	<1.10
Total Protein	7.90	g/dL	6.40 - 8.10
Albumin	4.53	g/dL	3.20 - 4.60
A : G Ratio	1.34		0.90 - 2.00
Globulin(Calculated)	3.37	gm/dL	2.0 - 3.5
Calcium, Total	10.18	mg/dL	8.80 - 10.20

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Test Report

Test Name	Results	Units	Bio. Ref. Interval
Phosphorus	**3.86**	mg/dL	2.30 - 3.70
Sodium	**135.00**	mEq/L	136.00 - 146.00
Potassium	**5.20**	mEq/L	3.50 - 5.10
Chloride	**99.80**	mEq/L	101.00 - 109.00

Advise: CKD Risk Map (Z1014)

Note

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

LIPID SCREEN, SERUM
(CHO-POD)

Cholesterol, Total	159.30	mg/dL	<200.00
Triglycerides	90.10	mg/dL	<150.00
HDL Cholesterol	75.10	mg/dL	>40.00
LDL Cholesterol, Calculated	66.18	mg/dL	<100.00
VLDL Cholesterol,Calculated	18.02	mg/dL	<30.00
Non-HDL Cholesterol	84	mg/dL	<130

Note

1. Measurements in the same patient can show physiological & analytical variations. Three serial samples 1 week apart are recommended for Total Cholesterol, Triglycerides, HDL& LDL Cholesterol.
2. Friedewald equation to calculate LDL cholesterol is most accurate when Triglyceride level is < 400 mg/dL. Measurement of Direct LDL cholesterol is recommended when Triglyceride level is > 400 mg/dL

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Test Report

Test Name	Results	Units	Bio. Ref. Interval

3. Lipid Association of India (LAI) recommends screening of all adults above the age of 20 years for Atherosclerotic Cardiovascular Disease (ASCVD) risk factors especially lipid profile. This should be done earlier if there is family history of premature heart disease, dyslipidemia, obesity or other risk factors
4. Indians tend to have higher triglyceride levels & Lower HDL cholesterol combined with small dense LDL particles, a pattern known as atherogenic dyslipidemia
5. Non HDL Cholesterol comprises the cholesterol carried by all atherogenic particles, including LDL, IDL, VLDL & VLDL remnants, Chylomicron remnants & Lp(a)
6. LAI recommends LDL cholesterol as primary target and Non HDL cholesterol as co-primary treatment target
7. Apolipoprotein B is an, secondary lipid target for treatment once LDL & Non HDL goals have been achieved
8. Additional testing for Apolipoprotein B, hsCRP, Lp(a) & LP-PLA2 should be considered among patients with moderate risk for ASCVD for risk refinement

Treatment Goals as per Lipid Association of India 2020

RISK CATEGORY	TREATMENT GOAL		CONSIDER THERAPY	
	LDL CHOLESTEROL (LDL-C)(mg/dL)	NON HDL CHLOESTEROL (NON HDL-C) (mg/dL)	LDL CHOLESTEROL (LDL-C)(mg/dL)	NON HDL CHLOESTEROL (NON HDL-C) (mg/dL)
Extreme Risk Group Category A	<50 (Optional goal ≤30)	<80 (Optional goal ≤60)	≥50	≥80
Extreme Risk Group Category A	≤30	≤60	>30	>60
Very High	<50	<80	≥50	≥80
High	<70	<100	≥70	≥100
Moderate	<100	<130	≥100	≥130
Low	<100	<130	≥130*	≥160*

*In low risk patient, consider therapy after an initial non-pharmacological intervention for at least 3 months

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Test Report

Test Name	Results	Units	Bio. Ref. Interval
COMPLETE BLOOD COUNT;CBC (Photometry,Electrical Impedance, Optical/Impedance & Calculated)			
Hemoglobin	**12.52**	g/dL	13.00 - 17.00
Packed Cell Volume (PCV)	**38.90**	%	40.00 - 50.00
RBC Count	4.69	mill/mm3	4.50 - 5.50
MCV	83.00	fL	83.00 - 101.00
MCH	**26.70**	pg	27.00 - 32.00
MCHC	32.20	g/dL	31.50 - 34.50
Red Cell Distribution Width (RDW)	**16.10**	%	11.60 - 14.00
Total Leukocyte Count (TLC)	6.53	thou/mm3	4.00 - 10.00
Differential Leucocyte Count (DLC)			
Segmented Neutrophils	60.93	%	40.00 - 80.00
Lymphocytes	30.44	%	20.00 - 40.00
Monocytes	6.69	%	2.00 - 10.00
Eosinophils	1.44	%	1.00 - 6.00
Basophils	0.50	%	<2.00
Absolute Leucocyte Count			
Neutrophils	3.98	thou/mm3	2.00 - 7.00
Lymphocytes	1.99	thou/mm3	1.00 - 3.00
Monocytes	0.44	thou/mm3	0.20 - 1.00
Eosinophils	0.09	thou/mm3	0.02 - 0.50
Basophils	0.03	thou/mm3	0.02 - 0.10
Platelet Count	252	thou/mm3	150.00 - 410.00
Mean Platelet Volume	9.5	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

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Test Report

Test Name	Results	Units	Bio. Ref. Interval

blood

2. Test conducted on EDTA whole blood

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	Plot No- 1, Tura Mandi Chowk Najafgarh			**Delhi-110075**	
	NEW DELHI				

Test Report

Test Name	Results	Units	Bio. Ref. Interval
HbA1c (GLYCOSYLATED HEMOGLOBIN), BLOOD (HPLC, NGSP Certified)			
HbA1c	**9.5**	%	4 - 5.6
Estimated average glucose (eAG)	226	mg/dL	

Interpretation

HbA1c result is suggestive of Diabetes/ Higher than glycemic goal in a known Diabetic patient.

Please note, Glycemic goal should be individualized based on duration of diabetes, age/life expectancy, comorbid conditions, known CVD or advanced microvascular complications, hypoglycaemia unawareness, and individual patient considerations

Result Rechecked,
Please Correlate Clinically.

Interpretation as per American Diabetes Association (ADA) Guidelines

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

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

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

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Test Report

Test Name	Results	Units	Bio. Ref. Interval
GLUCOSE, FASTING (F), PLASMA (Hexokinase)	98.40	mg/dL	70.00 - 100.00

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Test Report

Test Name	Results	Units	Bio. Ref. Interval
THYROID PROFILE,TOTAL, SERUM (ECLIA)			
T3, Total	1.04	ng/mL	0.80 - 2.00
T4, Total	8.21	µg/dL	5.10 - 14.10
TSH	3.20	µIU/mL	0.27 - 4.20

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 Report

Test Name	Results	Units	Bio. Ref. Interval
ERYTHROCYTE SEDIMENTATION RATE (ESR) (Capillary photometry)	5	mm/hr	0.00 - 20.00

Note

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

GLUCOSE, POST PRANDIAL (PP), 2 HOURS, PLASMA (Hexokinase)	138.80	mg/dL	70.00 - 140.00

Note

1. The diagnosis of Diabetes requires a fasting plasma glucose of > or = 126 mg/dL and/or a random / 2 hr post glucose value of > or = 200 mg/dL on at least 2 occasions

2. Very low glucose levels cause severe CNS dysfunction

3. Very high glucose levels (>450 mg/dL in adults) may result in Diabetic Ketoacidosis & is considered critical

Interpretation

Status	Fasting plasma glucose in mg/dL	PP plasma glucose in mg/dL
Normal	70-100	70-140
Impaired fasting glucose	101-125	70-140
Impaired glucose tolerance	70-100	141-199
Pre-Diabetes	101-125	141-199
Diabetes mellitus	>126	>200

CARDIO C-REACTIVE PROTEIN (hsCRP), SERUM (Immunoturbidimetry)	0.31	mg/L	<1.00

Interpretation

CARDIO CRP IN mg/L	CARDIOVASCULAR RISK
<1	Low
1-3	Average

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	NEW DELHI				

Test Report

Test Name	Results	Units	Bio. Ref. Interval
3-10	High		
>10	Persistent elevation may represent Non cardiovascular inflammation		

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

Comments

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

DMC NO 69098

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

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MC-2011

Test Report

Test Name	Results	Units	Bio. Ref. Interval
MICROALBUMIN/ALBUMIN, 1ST MORNING/ RANDOM URINE (Immunoturbidimetry, Compensated Jaffe's reaction, IDMS traceable)			
Microalbumin	<5.00	mg/L	<30
Creatinine	**16.55**	mg/dL	22.00 - 328.00
Microalbumin : Creatinine Ratio	<30.00	mg/g creatinine	<30.00
ACR Category	A1 (Normal to mildly increased)		

Note

1. Due to high biological variability and non-renal influences, ACR>30 mg/g creatinine in a random urine sample should be confirmed with a subsequent early morning urine sample or 24 hours urine sample.
2. The diagnosis of albuminuria requires the demonstration of increased albumin loss (either increased albumin creatinine ratio or albumin loss in 24 hrs urine sample) in at least two out of three urine specimens collected in the absence of infection or acute metabolic crisis.
3. The term Microalbuminuria is misleading as it implies a small version of albumin molecule rather than an excretion rate of albumin greater than normal but less than that detected by routine method. It is recommended to use term Albuminuria or Albumin Creatinine ratio (ACR) instead of Microalbuminuria.

Comments

Albumin creatinine ratio (ACR) in urine is a sensitive and specific measure of kidney damage. Urinalysis for albuminuria has been accepted as a useful way of identifying patients at risk of progressive Chronic Kidney Disease (CKD). Increased urinary albumin excretion is highly predictive of Diabetic Nephropathy, End-stage renal disease, Cardiovascular mortality, and total mortality in patients with Diabetes Mellitus.

Non-Renal causes of increased ACR

Menstrual contamination, Uncontrolled Hypertension, Urinary Tract Infection, Heart failure, Strenuous exercise and other transitory illnesses.

Usage

- Marker for classification of CKD & its progression
- To screen Diabetic Nephropathy

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MC-2011

Test Report

Test Name	Results	Units	Bio. Ref. Interval

DMC-38596

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

DMC-5243

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

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

IMPORTANT INSTRUCTIONS

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

(#) Sample drawn from outside source.

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

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