

PATIENT NAME : MATHEW JOSEPH

REF. DOCTOR : DR.KAMINI MEHTA

KHARGHAR
9870331316

ACCESSION NO : 0040YE002645

PATIENT ID : MATHM16030540

CLIENT PATIENT ID:

ABHA NO :

AGE/SEX : 20 Years Male

DRAWN : 13/05/2025 09:33:02

RECEIVED : 13/05/2025 09:40:23

REPORTED : 13/05/2025 13:54:02

Test Report Status	Preliminary	Results	Biological Reference Interval	Units
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HAEMATOLOGY - CBC**COMPLETE CARE VITAL PRO****BLOOD COUNTS, EDTA WHOLE BLOOD**

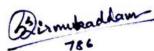
HEMOGLOBIN (HB)	16.1	13.0 - 17.0	g/dL
METHOD : SLS- HEMOGLOBIN DETECTION METHOD			
RED BLOOD CELL (RBC) COUNT	5.41	4.5 - 5.5	mil/ μ L
METHOD : HYDRO DYNAMIC FOCUSING & DC DETECTION METHOD			
WHITE BLOOD CELL (WBC) COUNT	8.66	4.0 - 10.0	thou/ μ L
METHOD : FLOWCYTOMETRY			
PLATELET COUNT	228	150 - 410	thou/ μ L
METHOD : HYDRODYNAMIC FOCUSING BY DC DETECTION			

RBC AND PLATELET INDICES

HEMATOCRIT (PCV)	48.5	40.0 - 50.0	%
METHOD : RBC PULSE HEIGHT DETECTION			
MEAN CORPUSCULAR VOLUME (MCV)	89.6	83.0 - 101.0	fL
METHOD : CALCULATED			
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	29.8	27.0 - 32.0	pg
METHOD : CALCULATED			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC)	33.2	31.5 - 34.5	g/dL
METHOD : CALCULATED			
RED CELL DISTRIBUTION WIDTH (RDW)	12.9	11.6 - 14.0	%
METHOD : CALCULATED			
MEAN PLATELET VOLUME (MPV)	9.2	6.8 - 10.9	fL
METHOD : CALCULATED			

WBC DIFFERENTIAL COUNT

NEUTROPHILS	55	40.0 - 80.0	%
METHOD : FLOW CYTOMETRY & MICROSCOPY			
LYMPHOCYTES	34	20.0 - 40.0	%
METHOD : FLOW CYTOMETRY & MICROSCOPY			
MONOCYTES	7	2.0 - 10.0	%
METHOD : FLOW CYTOMETRY & MICROSCOPY			



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Tel : 9111591115, Fax :
CIN - U74899PB1995PLC045956



Patient Ref. No. 77500012388691

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EOSINOPHILS		4	1 - 6	%
	METHOD : FLOW CYTOMETRY & MICROSCOPY			
BASOPHILS		0	0 - 2	%
	METHOD : FLOW CYTOMETRY & MICROSCOPY			
ABSOLUTE NEUTROPHIL COUNT		4.76	2.0 - 7.0	thou/ μ L
	METHOD : CALCULATED			
ABSOLUTE LYMPHOCYTE COUNT		2.94	1.0 - 3.0	thou/ μ L
	METHOD : CALCULATED			
ABSOLUTE MONOCYTE COUNT		0.61	0.2 - 1.0	thou/ μ L
	METHOD : CALCULATED			
ABSOLUTE EOSINOPHIL COUNT		0.35	0.02 - 0.50	thou/ μ L
	METHOD : CALCULATED			
BAND (STAB) CELLS		00	0.0 - 5.0	%
	METHOD : MICROSCOPIC EXAMINATION			

MORPHOLOGY (MICROSCOPY)

RBC	PREDOMINANTLY NORMOCYTIC NORMOCHROMIC
WBC	NORMAL MORPHOLOGY
PLATELETS	ADEQUATE

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

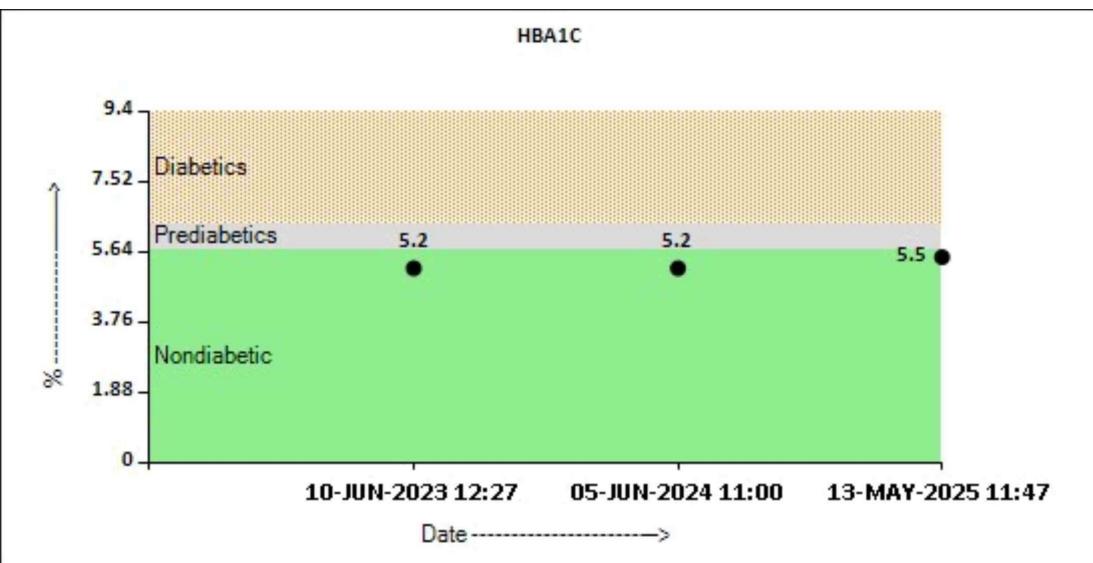
COMPLETE CARE VITAL PRO**HBA1C (GLYCOSYLATED HEMOGLOBIN)**

HBA1C 5.5 Non-diabetic: < 5.7 %
 Pre-diabetics: 5.7 - 6.4
 Diabetics: > or = 6.5
 ADA Target: 7.0
 Action suggested: > 8.0

METHOD : HIGH PERFORMANCE LIQUID CHROMATOGRAPHY (HPLC)

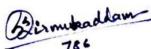
ESTIMATED AVERAGE GLUCOSE(EAG) 111.2 < 116.0 mg/dL

METHOD : CALCULATED PARAMETER

**Interpretation(s)**

HBA1C (GLYCOSYLATED HEMOGLOBIN)-Used For:

- Evaluating the long-term control of blood glucose concentrations in diabetic patients.
 - Diagnosing diabetes.
 - Identifying patients at increased risk for diabetes (prediabetes).
- The ADA recommends measurement of HbA1c (typically 3-4 times per year for type 1 and poorly controlled type 2 diabetic patients, and 2 times per year for well-controlled type 2 diabetic patients) to determine whether a patient's metabolic control has remained continuously within the target range.
1. eAG (Estimated average glucose) converts percentage HbA1c to mg/dL, to compare blood glucose levels.



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2. eAG gives an evaluation of blood glucose levels for the last couple of months.
 3. eAG is calculated as eAG (mg/dl) = 28.7 * HbA1c - 46.7

HbA1c Estimation can get affected due to :

1. Shortened Erythrocyte survival : Any condition that shortens erythrocyte survival or decreases mean erythrocyte age (e.g. recovery from acute blood loss,hemolytic anemia) will falsely lower HbA1c test results.Fructosamine is recommended in these patients which indicates diabetes control over 15 days.
- 2.Vitamin C & E are reported to falsely lower test results,(possibly by inhibiting glycation of hemoglobin).
3. Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia,uremia, hyperbilirubinemia, chronic alcoholism,chronic ingestion of salicylates & opiates addiction are reported to interfere with some assay methods,falsely increasing results.
4. Interference of hemoglobinopathies in HbA1c estimation is seen in

- a) Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.
 b) Heterozygous state detected (D10 is corrected for HbS & HbC trait.)
 c) HbF > 25% on alternate platform (Boronate affinity chromatography) is recommended for testing of HbA1c.Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy



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BIOCHEMISTRY**MICROALBUMIN, URINE**

RESULT PENDING

URINARY PROTEIN CREATININE RATIO

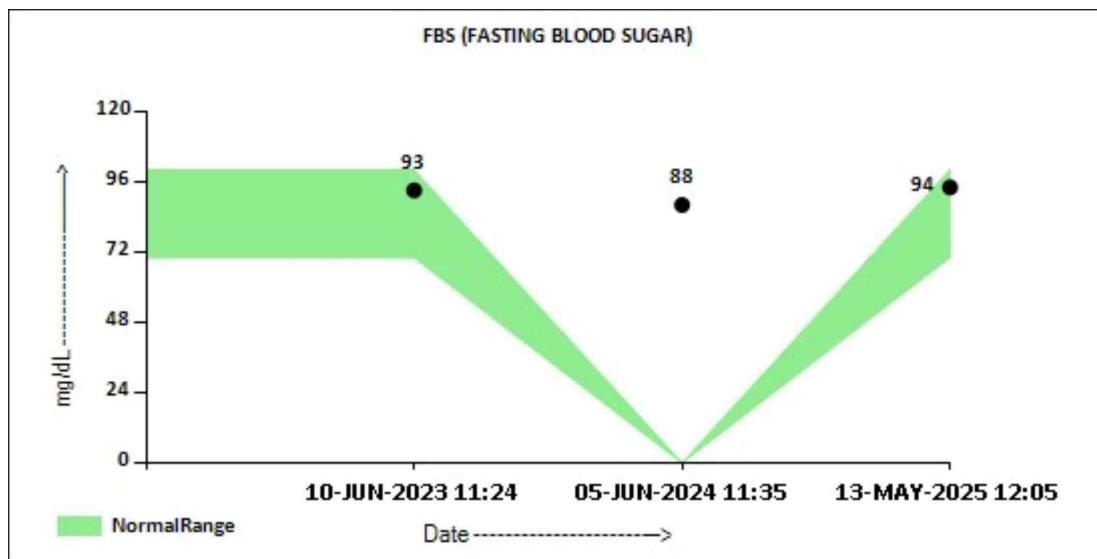
RESULT PENDING

COMPLETE CARE VITAL PRO**GLUCOSE FASTING (BLOOD SUGAR TEST)**

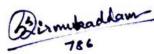
FBS (FASTING BLOOD SUGAR)

94

(Normal <100, Impaired fasting glucose: 100 to 125, Diabetes mellitus: >=126 (on more than 1 occasion) (ADA guidelines 2024))

**LIVER FUNCTION PROFILE (LFT) (12)**

BILIRUBIN, TOTAL	0.41	Upto 1.2	mg/dL
BILIRUBIN, DIRECT	0.20	< or = 0.3	mg/dL
BILIRUBIN, INDIRECT	0.21	0.1 - 1.0	mg/dL
TOTAL PROTEIN	6.9	6.0 - 8.0	g/dL
ALBUMIN	4.5	3.97 - 4.94	g/dL



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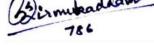
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GLOBULIN	2.4	2.0 - 3.5		g/dL
ALBUMIN/GLOBULIN RATIO	1.9	1.0 - 2.1		RATIO
ASPARTATE AMINOTRANSFERASE(AST/SGOT)	19	< OR = 50		U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)	12	< OR = 50		U/L
ALKALINE PHOSPHATASE	81	40 - 129		U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)	8	0 - 60		U/L
LACTATE DEHYDROGENASE	122 Low	125 - 220		U/L

KIDNEY FUNCTION TEST, SERUM

BLOOD UREA NITROGEN	12	6 - 20	mg/dL
CREATININE	1.16	0.90 - 1.30	mg/dL
BUN/CREAT RATIO	10.34	8.0 - 15.0	
URIC ACID	7.7 High	3.4 - 7.0	mg/dL
TOTAL PROTEIN	6.9	6.0 - 8.0	g/dL
ALBUMIN	4.5	3.97 - 4.94	g/dL
GLOBULIN	2.4	2.0 - 3.5	g/dL
CALCIUM	9.4	8.6 - 10.0	mg/dL
SODIUM, SERUM	136	135 - 145	mmol/L
POTASSIUM, SERUM	4.19	3.5 - 5.3	mmol/L
CHLORIDE, SERUM	102	97 - 110	mmol/L



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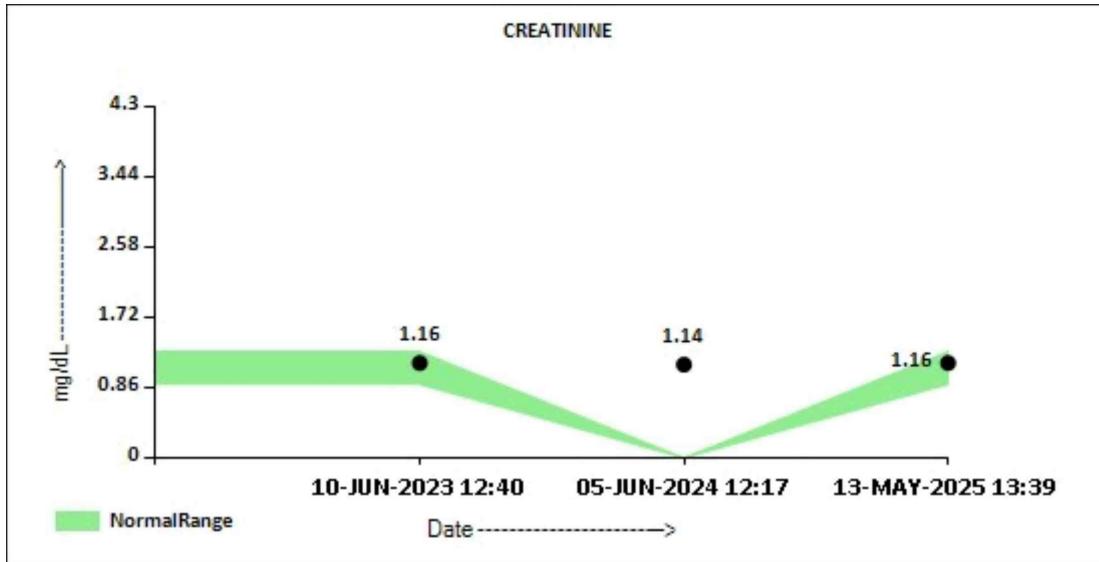
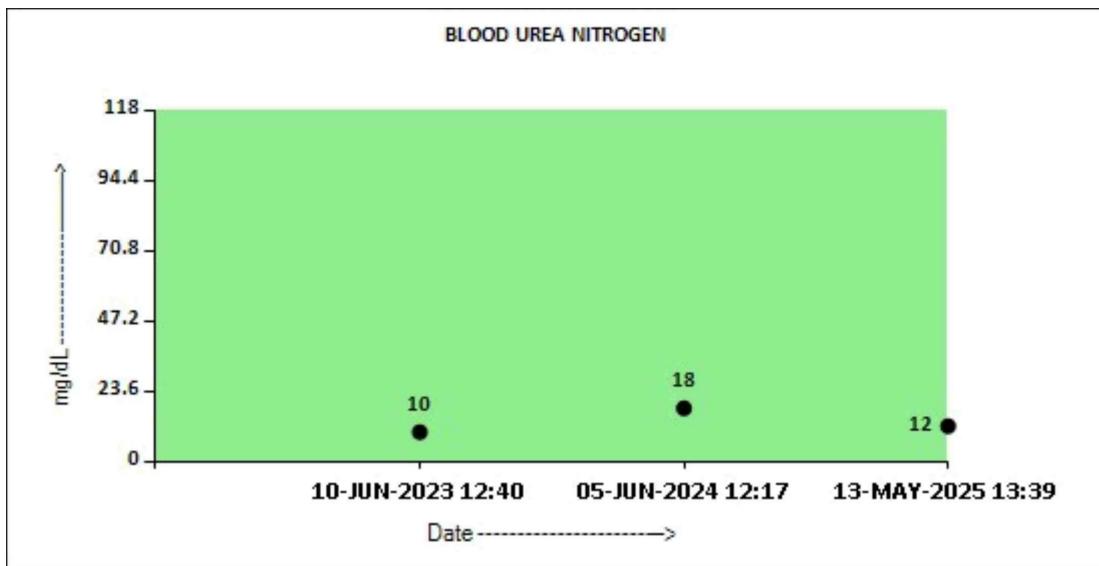
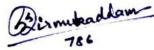
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**IRON, SERUM**

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IRON 63 59 - 158 µg/dL

PHOSPHORUS

PHOSPHORUS 3.7 2.5 - 4.5 mg/dL

Interpretation(s)**GLUCOSE FASTING (BLOOD SUGAR TEST)- TEST DESCRIPTION**

Normally, the glucose concentration in extracellular fluid is closely regulated so that a source of energy is readily available to tissues and so that 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 Glycosuria,Glycaemic index & response to food consumed,Alimentary Hypoglycemia,Increased insulin response & sensitivity etc.

LIVER FUNCTION PROFILE (LFT) (12)-

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.

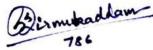
ALP is a protein found in almost all body tissues.Tissues with higher amounts of ALP include the liver,bile ducts and bone.Elevated ALP levels are seen in Biliary obstruction, Osteoblastic bone tumors, osteomalacia, hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, Pagets disease,Rickets,Sarcoidosis 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

IRON, SERUM-Serum iron test is useful for etio- morphological diagnosis of anemias, in hemochromatosis, in hemosiderosis and in acute iron toxicity. Serum iron is recommended to be correlated with Total Iron Binding Capacity (TIBC) for evaluation of iron deficiency.



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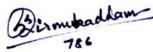
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BIOCHEMISTRY - LIPID**COMPLETE CARE VITAL PRO****LIPID PROFILE WITH CALCULATED LDL**

CHOLESTEROL, TOTAL	132	Desirable : < 200 Borderline : 200 - 239 High : > / = 240	mg/dL
TRIGLYCERIDES	96	Normal: < 150 Borderline high: 150 - 199 High: 200 - 499 Very High: >/= 500	mg/dL
HDL CHOLESTEROL	45	At Risk: < 40 Desirable: > or = 60	mg/dL
CHOLESTEROL LDL	68	Adult levels: Optimal < 100 Near optimal/above optimal: 100-129 Borderline high : 130-159 High : 160-189 Very high : = 190	mg/dL
NON HDL CHOLESTEROL	87	Desirable : < 130 Above Desirable : 130 -159 Borderline High : 160 - 189 High : 190 - 219 Very high : > / = 220	mg/dL
VERY LOW DENSITY LIPOPROTEIN CHOL/HDL RATIO	19.2 2.9 Low	< OR = 30.0 Low Risk : 3.3 - 4.4 Average Risk : 4.5 - 7.0 Moderate Risk : 7.1 - 11.0 High Risk : > 11.0	mg/dL
LDL/HDL RATIO	1.5	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	



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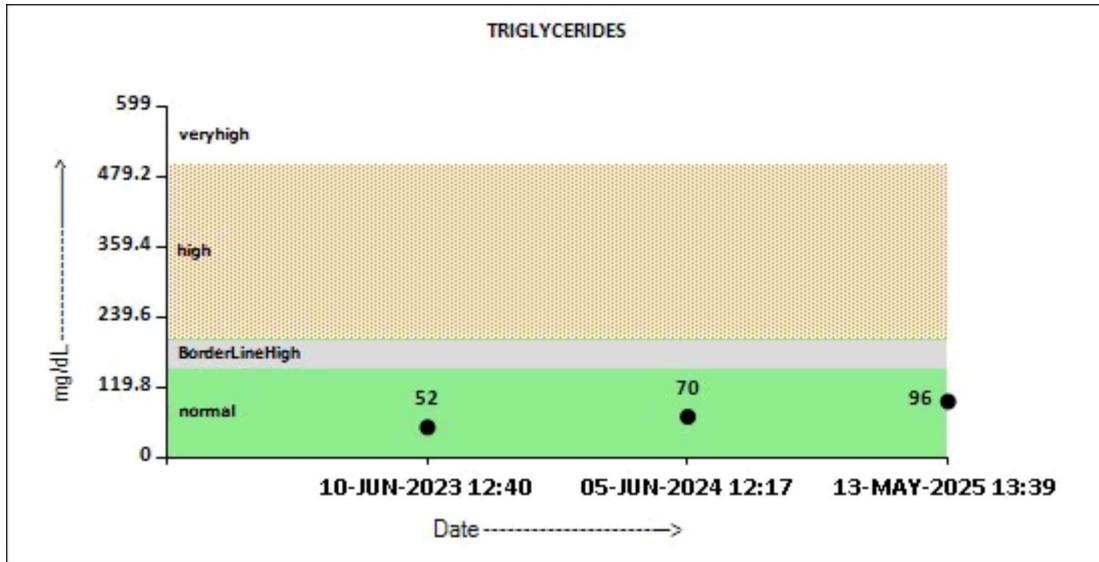
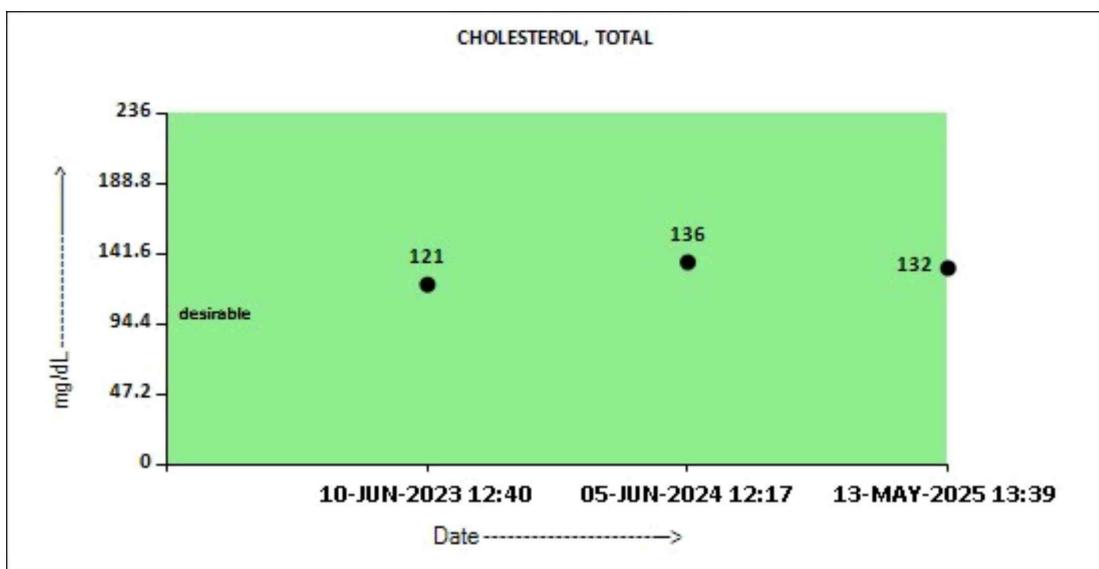
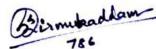
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**PERFORMED AT :****Agilus Diagnostics Ltd**

Bhoomi Tower, 1st Floor, Hall No.1, Plot No.28 Sector 4, Kharghar
Navi Mumbai, 410210
Maharashtra, India
Tel : 9111591115, Fax :
CIN - U74899PB1995PLC045956



Patient Ref. No. 775000012388691

View Details

View Report

PATIENT NAME : MATHEW JOSEPH

REF. DOCTOR : DR.KAMINI MEHTA

KHARGHAR
9870331316

ACCESSION NO : **0040YE002645**
PATIENT ID : MATHM16030540
CLIENT PATIENT ID:
ABHA NO :

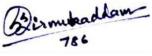
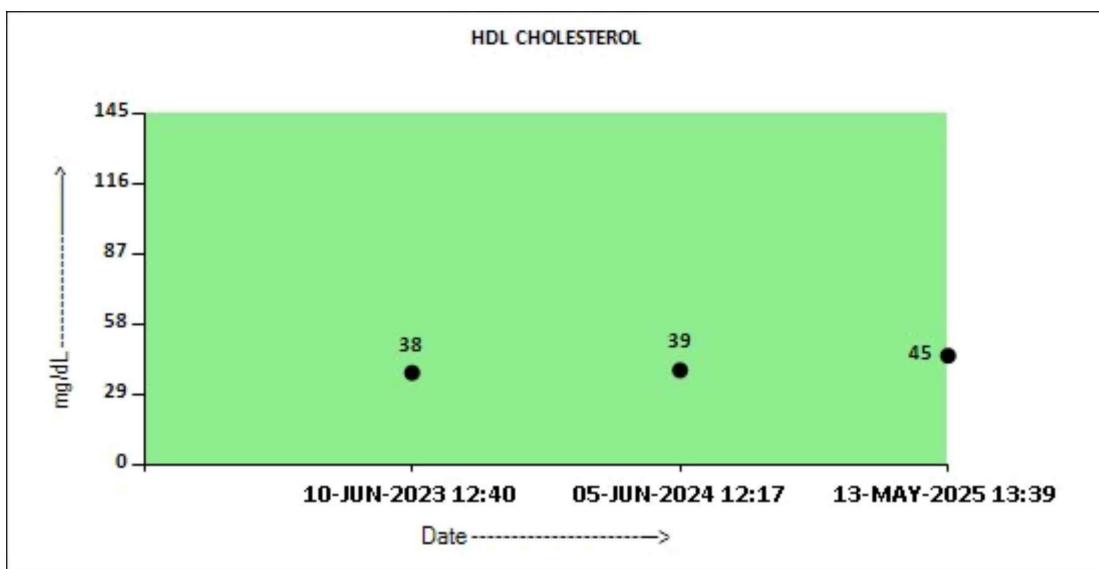
AGE/SEX : 20 Years Male
DRAWN : 13/05/2025 09:33:02
RECEIVED : 13/05/2025 09:40:23
REPORTED : 13/05/2025 13:54:02

Test Report Status **Preliminary**

Results

Biological Reference Interval

Units



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Consultant Pathologist

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NEPHELOMETRY**COMPLETE CARE VITAL PRO****CRP (C-REACTIVE PROTEIN)**

C-REACTIVE PROTEIN	1.4	< 5.0	mg/L
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Interpretation(s)**CRP (C-REACTIVE PROTEIN)-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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CLINICAL PATH - URINALYSIS**COMPLETE CARE VITAL PRO****PHYSICAL EXAMINATION, URINE**

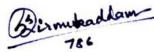
COLOR	PALE YELLOW
APPEARANCE	CLEAR

CHEMICAL EXAMINATION, URINE

PH	5.5	4.5 - 7.5
SPECIFIC GRAVITY	1.015	1.005 - 1.030
PROTEIN	NOT DETECTED	NOT DETECTED
GLUCOSE	NOT DETECTED	NOT DETECTED
KETONES	NOT DETECTED	NOT DETECTED
BLOOD	NOT DETECTED	NEGATIVE
BILIRUBIN	NOT DETECTED	NOT DETECTED
UROBILINOGEN	NORMAL	NORMAL
NITRITE	NOT DETECTED	NOT DETECTED
LEUKOCYTE ESTERASE	NOT DETECTED	NOT DETECTED

MICROSCOPIC EXAMINATION, URINE

RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
PUS CELL (WBCS)	0-1	0-5	/HPF
EPIHELIAL CELLS	0-1	0-5	/HPF
CASTS	NOT DETECTED		
CRYSTALS	NOT DETECTED		
BACTERIA	NOT DETECTED	NOT DETECTED	
YEAST	NOT DETECTED	NOT DETECTED	
REMARKS	URINE ANALYSIS : MICROSCOPIC EXAMINATION IS CARRIED OUT ON CENTRIFUGED URINARY SEDIMENT.		



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Patient Ref. No. 77500012388691

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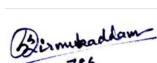
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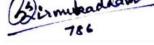
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SPECIALISED CHEMISTRY - HORMONE**COMPLETE CARE VITAL PRO****THYROID PANEL(T3,T4 & TSH)**

T3	111.00	80 - 200	ng/dL
T4	7.67	5.1 - 14.1	µg/dL
TSH (ULTRASENSITIVE)	0.979	0.270 - 4.200	µIU/mL



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SPECIALISED CHEMISTRY - VITAMIN**COMPLETE CARE VITAL PRO****VITAMIN B12(CYANOCOBALAMINE)**

VITAMIN B12 380.0 197 - 771 pg/mL

VITAMIN D TOTAL (25 HYDROXY)

25 - HYDROXYVITAMIN D 13.30 Low Deficiency: < 20.0 ng/mL
Insufficiency: 20.0 - < 30.0
Sufficiency: 30.0 -100.0
Toxicity > 100.0

Interpretation(s)**VITAMIN B12(CYANOCOBALAMINE)-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 vegetarians lead 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 borderline and deficient cases for confirmation.

References-O-Leary F, Samman S. Vitamin B12 in health and disease. Nutrients. 2010 Mar;2(3):299-316.

VITAMIN D TOTAL (25 HYDROXY)-Test description

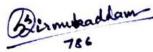
Vitamin D has anti-inflammatory and immune-modulating properties and it works towards the bones, teeth, intestines, immune system, pancreas, muscles and brain. It helps to maintain normal calcium and phosphate levels. Vitamin D is a fat-soluble vitamin. Also called as "Sunshine Vitamin". Two main forms 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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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.

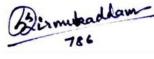
Reference: 1.Wallach Interpretation of diagnostic test, 10th edition.

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.

Agilus Diagnostics Limited
 Fortis Hospital, Sector 62, Phase VIII,
 Mohali 160062


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