Ms. LALITA DEVI

80875707

57 Years/Female

Client :MediTest.in
FF-229, MSX Mall, Site 4, Greater Noida

7840899000 | care@meditest.in
Referred By : Dr. SELF

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Status **: Final**

DEPARTMENT OF HAEMATOLOGY

Meditest Full Body Checkup Panel 3

Test Name	Value	Unit	Bio Ref.Interval
Complete Blood Count (CBC) Extended			
Haemoglobin (Hb) Method: Electrical Impedance	12.9	g/dL	12.0-16.0
TLC (Total Leucocyte Count) Method: Electrical Impedance	6900	/cumm	4000-11000
RBC Count.	4.51	10^6/uL	4.2-5.4
Packed Cell Volume Method: Electrical Impedance	40.1	%	36-46
MCV Method: Calculated	89.0	fL	80-100
MCH Method: Calculated	28.6	pg	26-34
MCHC Method: Calculated	32.1	g/dL	31-37
Platelet Count . Method: Electrical Impedance	3.40	lakh/cumm	1.5-4.0
Differential Leucocyte Count			
Neutrophil Method: Microscopy	52	%	40-80
Lymphocyte Method: Microscopy	35	%	24-44
Eosinophils Method: Microscopy	**8**	%	01-06
Monocytes Method: Microscopy	5	%	3-6
Basophils Method: Microscopy	0.00	%	0-1
Absolute Neutrophil Count	3.6	x 10^3 /uL	2.0-7.0
Absolute Lymphocyte Count	2.42	x 10^3/uL	1.5-4.0
Absolute Eosinophil Count	**0.55**	x 10^3 cells/uL	0.02-0.50
Absolute Monocyte Count	0.4	x 10^3/uL	0.2-1.0
Absolute Basophil Count	0.00	x 10^3 cells/uL	0.00-0.00
Band Forms Method: Microscopy	0	%	
Metamyelocytes Method: Microscopy	0	%	
Myelocytes Method: Microscopy	0.00	%	
RDW-SD	41.2	fl	39.0-46.0

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Meditest Full Body Checkup Panel 3

Test Name	Value	Unit	Bio Ref.Interval
Method: Electrical Impedance			
RDW-CV	12.7	%	11.5-14.5
Method: Dc Detection Method (Calculated)			
MPV	10.7	fL	9.4-12.3
Method: Calculated			
PCT	**0.29**	%	0.10-0.28
Method: Calculated			
PDW	13.6	fL	9.0-17.0
Method: Calculated			
Menzter Index	19.73	Ratio	
Method: Calculated			

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Test Name	Value	Unit	Bio Ref.Interval
Erythrocyte Sedimentation Rate (ESR)	**35**	mm/h	0-20

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DEPARTMENT OF BIOCHEMISTRY

Meditest Full Body Checkup Panel 3

Test Name	Value	Unit	Bio Ref.Interval
HbA1c (Glycated Haemoglobin)	**7.2**	%	4.5-6.0

REMARKS

In vitro quantitative determination of **HbA1c** in whole blood is utilized in long term monitoring of glycemia.The **HbA1c** level correlates with the mean glucose concentration prevailing in the course of the patient's recent history (approx - 6-8 weeks) and therefore provides much more reliable information for glycemia monitoring than do determinations of blood glucose or urinary glucose. It is recommended that the determination of **HbA1c** be performed at intervals of 4-6 weeks during Diabetes Mellitus therapy. Results of **HbA1c** should be assessed in conjunction with the patient's medical history, clinical examinations and other findings.

Mean Plasma Glucose	159.94	mg/dl

Mean Plasma Glucose is based on estimated Average Glucose (eAG) value calculated according to National Glycohemoglobin Standardization Program (NGSP) criteria.

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DEPARTMENT OF BIOCHEMISTRY

Meditest Full Body Checkup Panel 3

Test Name	Value	Unit	Bio Ref.Interval
Blood Glucose Fasting	102.0	mg/dL	70.0 - 110.0

Interpretation (In accordance with the American diabetes association guidelines):

- A fasting plasma glucose level below 100 mg/dL is considered normal.
- A fasting plasma glucose level between 100-126 mg/dL is considered as glucose intolerant or pre diabetic. A fasting and post-prandial blood sugar test (after consumption of 75 gm of glucose) is recommended for all such patients.
- A fasting plasma glucose level of above 126 mg/dL is highly suggestive of a diabetic state. A repeat fasting test is strongly recommended for all such patients. A fasting plasma glucose level in excess of 126 mg/dL on both the occasions is confirmatory of a diabetic state.

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Meditest Full Body Checkup Panel 3

Test Name	Value	Unit	Bio Ref.Interval
Liver Function Test (LFT) - 2			
Bilirubin, Total Method: Diazo	0.50	mg/dL	0.30-1.20
Bilirubin, Direct Method: Diazo	**0.30**	mg/dL	0.00-0.20
Bilirubin, Indirect	0.20	mg/dL	0.10-1.00
SGOT (AST), Serum Method: IFCC without pyridoxal phosphate	26.00	IU/L	0.00-31.00
SGPT (ALT), Serum Method: IFCC without pyridoxal phosphate	**47.00**	IU/L	0.00-32.00
Alkaline Phosphatase (ALP), Serum Method: PNP AMP Kinetic	56.0	U/L	42.0-98.0
Protein, Total Method: Biuret	7.50	g/dL	6.0-8.0
Albumin	4.1	g/dL	3.5-5.2
Globulin	3.40	g/dL	2.00-3.50
A/G Ratio	1.21		
Gamma Glutamyl Transferase (GGT) Method: L-Gamma-glutamyl-3-carboxy-4-nitroanilide Substrat	**85**	U/L	12-64
ALT/AST Ratio	1.81	Ratio	

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Meditest Full Body Checkup Panel 3

Test Name	Value	Unit	Bio Ref.Interval
Lipid Profile - 1			
Total Cholesterol Method: CHOD-PAP	154.0	mg/dL	<200.0
Triglyceride Method: GPO (Trinders)	133.0	mg/dL	35.0-135.0
HDL Cholesterol Method: Direct (PVS/PEGME precipitation & Trinder reaction)	36.0	mg/dL	35.3-79.5
VLDL Cholesterol Method: Calculated	**26.6**	mg/dL	4.7-21.1
LDL Cholesterol Method: Calculated	91.4	mg/dL	0-100
Non-HDL Cholesterol Method: Calculated	118	mg/dL	<130
LDL / HDL Cholesterol Ratio	2.54	Ratio	0.00-3.55
Total / HDL Cholesterol Ratio	4.28	Ratio	0.00-4.97

Comment - Lipid profile checks cholesterol levels, comprising of parameters total cholesterol, LDL cholesterol, HDL cholesterol and triglycerides. The results of the lipid profile as per the AHA guidelines mentioned below.

Guidelines from The American Heart Association (AHA)

Total Cholesterol (mg/dL)		**HDL Cholesterol (mg/dL)**	
<200	Best	<40 (men); <50 (women)	Poor
200-239	Borderline high	50-59	Better
>=240	High	>=60	Best

Triglyceride (mg/dL)		**LDL Cholesterol (mg/dL)**		**Non-HDL (mg/dL)**	
<150	Best	<70	Best for people with heart disease	<130	Best
150-199	Borderline high	<100	Best for people at risk of heart disease.	130-159	Near Ideal
200-499	High	100-129	Near ideal	160-189	Borderline high
>=500	Very high	130-159	Borderline high	190-219	High
		160-189	High	>=220	Very high
		>=190	Very high		

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Meditest Full Body Checkup Panel 3

Test Name	Value	Unit	Bio Ref.Interval
Kidney Function Test (KFT/RFT) - 2			
Urea, Blood Method: Urease-GLDH	27.82	mg/dL	13.00-43.00
Blood Urea Nitrogen (BUN) Method: Spectro-photometry	13.00	mg/dL	7.00-18.00
Creatinine Method: Spectrophotometry	0.79	mg/dL	0.6-1.10
Uric Acid, Serum Method: Uricase	5.30	mg/dL	2.50-6.80
Sodium, Serum Method: Ion Selective Electrode	142.0	mmol/L	136.0-149.0
Potassium, Serum Method: Ion Selective Electrode	5.40	mmol/L	3.50-5.50
Chloride Method: Ion Selective Electrode	102.0	mmol/L	98.0-109.0
Calcium, Serum Method: Aresenazo	**8.20**	mg/dL	8.40-10.40
Phosphorous Method: Ammonium molybdate UV	4.30	mg/dL	2.50-5.00
BUN / Creatinine Ratio	16.46		
Urea / Creatinine Ratio	35.22		
Iron Study-1			
Iron, Serum Method: Colorimetric	85.30	ug/dL	50.00-170.00
UIBC	**376.02**	ug/dL	110.0-370.0
Total Iron Binding capacity Method: Spectro-photometry	**461**	ug/dL	250-400
Transferrin Saturation	18.49	%	14-50%

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DEPARTMENT OF IMMUNOASSAY

Meditest Full Body Checkup Panel 3

Test Name	Value	Unit	Bio Ref.Interval
Vitamin B12 Level	206.0	pg/mL	187-883

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Meditest Full Body Checkup Panel 3

Test Name	Value	Unit	Bio Ref.Interval
Vitamin D, 25 Hydroxy	**17.4**	ng/mL	20-100

Comments

The test is useful for diagnosis of vitamin D deficiency, hypervitaminosis D, differential diagnosis of causes of rickets and osteomalacia and monitoring vitamin D replacement therapy. Vitamin D is a generic designation for a group of fat-soluble, structurally similar sterols, which act as hormones. Vitamin D compounds in the body are exogenously derived by dietary means; from plants as 25-hydroxyvitamin D2 (ergocalciferol or calciferol) or from animal products as 25-hydroxyvitamin D3 (cholecalciferol or calcidiol). Vitamin D may also be endogenously derived by conversion of 7-dihydrocholesterol to 25-hydroxyvitamin D3 in the skin upon ultraviolet exposure.

Reference Values

- <10 ng/mL (severe deficiency)
- 10-19 ng/mL (mild to moderate deficiency)
- 20-50 ng/mL (optimum levels)
- 51-80 ng/mL (increased risk of hypercalciuria)
- >80 ng/mL (toxicity possible)

Interpretation

25-OH-VitD levels below 25 ng/mL are associated with an increased risk of secondary hyperparathyroidism, reduced bone mineral density, and fractures, particularly in the elderly. Intervention studies support this clinical cutoff, showing a reduction of fracture risk with 25-OH-VitD replacement.

Levels <10 ng/mL may be associated with more severe abnormalities and can lead to inadequate mineralization of newly formed osteoid, resulting in rickets in children and osteomalacia in adults. In these individuals, serum calcium levels may be marginally low, and parathyroid hormone (PTH) and serum alkaline phosphatase are usually elevated. Definitive diagnosis rests on the typical radiographic findings or bone biopsy/histomorphometry.

In patients where testing is not completely consistent with the suspected diagnosis, in particular, if serum 25-OH-VitD levels are >10 ng/mL, an alternative cause for impaired mineralization should be considered. Possible differential diagnosis includes: partly treated vitamin D deficiency, extremely poor calcium intake, vitamin D resistant rickets, renal failure, renal tubular mineral loss with or without renal tubular acidosis, hypophosphatemic disorders (eg, X-linked or autosomal dominant hypophosphatemic rickets), congenital hypoparathyroidism, activating calcium sensing receptor mutations, and osteopetrosis. Measurement of serum urea, creatinine, magnesium, and 1,25-dihydroxyvitamin D (DHVD) is recommended as a minimal additional workup for these patients.

Patients who present with hypercalcemia, hyperphosphatemia, and low PTH may suffer either from ectopic, unregulated conversion of 25-OH-VitD to 1,25-OH-VitD, as can occur in granulomatous diseases, particular sarcoid, or from nutritionally-induced hypervitaminosis D. Serum 1,25-OH-VitD levels will be high in both groups, but only patients with hypervitaminosis D will have serum 25-OH-VitD concentrations of greater than 80 ng/mL, typically greater than 150 ng/mL.

Cautions

Long term use of anticonvulsant medications may result in vitamin D deficiency that could lead to bone disease; the anticonvulsants most implicated are phenytoin, phenobarbital, carbamazepine, and valproic acid. Newer antiseizure medications have not been studied or are not thought to contribute to vitamin D deficiency.

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Meditest Full Body Checkup Panel 3

Test Name	Value	Unit	Bio Ref.Interval
Thyroid Profile Total			
Triiodothyronine, Total (T3) Method: Chemiluminescence Immunoassay (CLIA)	99	ng/dL	58.6-156.2
Thyroxine, Total (T4) Method: Chemiluminescence Immunoassay (CLIA)	6.39	ug/dL	4.8-10.4
TSH Ultra Sensitive	**5.08**	uIU/ml	0.55-4.78

Comment

T_3 or 3 5 3 triiodothyronine is a hormone synthesized and secreted from the thyroid gland, and formed by peripheral deiodination of thyroxine (T4). The determination of T3 levels in serum is essential in assessing thyroid functions. T3 is secreted by thyroid glands and circulates in the blood stream; mostly (99.7%) bound to the plasma protein, thyroxin binding globulin (TBG) and prealbumin (TBPA) and albumin. The remaining (0.3%) is free, unbound and its metabolic potency is much greater. T3 hormone regulates cell metabolism and body growth and its level is a good indicator of thyroid disease state and body metabolism. Further the concentrations of the carrier protein are altered in many conditions such as pregnancy in normal thyroid function, as the concentrations of the carrier proteins alters, the total T3 level changes so that free T3 concentration remains constant. Thus, measurements of the free T3 concentrations correlate excellently with clinical status than total T3 levels.

T_4 or Thyroxine or 3,5,3,5-tetraiodothyronine is a hormone synthesized and secreted by the thyroid gland and plays an important role in regulating metabolism. In the peripheral tissues it act as a prohormone which is further metabolized to another most active thyroid hormone, tri-iodothyronine (T3) and other inactive metabolites such as reverse T3.

TSH or Thyroid-stimulating hormone is a hormone synthesized and secreted by Pituitary gland. TSH is glycoprotein with two non-covalently bound alpha and beta subunits. The beta subunit of TSH is unique, which results in the specific biochemical and immunological properties of this hormone. The ability to quantitate circulating levels of TSH is important in evaluating thyroid function. It is especially useful in the differential diagnosis of primary (thyroid) from secondary (pituitary) and tertiary (hypothalamus) hypothyroidism. In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hypothyroidism, TSH levels are low. The measurement of serum TSH has proven to be one of the most sensitive methods for the detection of primary hypothyroidism. In primary hypothyroidism the production of thyroid hormones is impaired and the TSH levels are observed to be higher. However in secondary and tertiary hypothyroidism the TSH levels are low because of pituitary of hypothalamic lesions. In hyperthyroidism the circulating levels of TSH is usually subnormal. In some instance however this condition may result from hyperstimulation of thyroid.

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DEPARTMENT OF CLINICAL PATHOLOGY

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Meditest Full Body Checkup Panel 3

Test Name	Value	Unit	Bio Ref.Interval
Urine Routine and Microscopy			
Physical Examination			
Volume	22.00	mL	
Colour	Pale Yellow		
Appearance	Clear		
pH Method: Double Indicators Test	5.35		
Specific Gravity Method: Refractometric	1.030		1.003-1.030
Chemical Examination			
Urine Protein Method: Protein Indicator	Negative		Negative
Urine Sugar Method: Oxidation Reaction	Negative		Negative
Ketones Method: Sodium nitroprusside	Negative		Negative
Nitrite Method: Diazotisation Reaction	Negative		Negative
Blood Method: Peroxidase Reaction	Negative		Negative
Urobilinogen Method: Modified Ehrlich Reaction	Negative		Negative
Urine Bilirubin Method: Diazotisation	Negative		Negative
Microscopic Examination			
R.B.C. Method: Microscopy	Nil	/HPF	NIL
Pus Cells Method: Microscopy	2-4	/HPF	2-3
Epithelial Cells Method: Microscopy	3-5	/HPF	2-3
Casts Method: Microscopy	Nil	/LPF	Nil
Crystals Method: Microscopy	Nil		Nil
Bacteria Method: Microscopy	Nil		Nil
Others	NIL		

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Consultant Microbiologist