GENERAL DIAGNOSTICS
INTERNATIONAL (P) LTD.,

RPT House, Plot No. - 06, Sector - 24,
Turbhe, Navi Mumbai, 400705, India.
Customer Support : +91 98717 15111

MC-2216

General DIAGNOSTICS
Accurate Results • Timely Delivered

Name:	SUDANSHU GAWALE	**Age/Gender:**	23 Years/Male
Referred By:	MEDICAL OFFICER	**Client Name:**	TOP DIAGNOSTICS CENTER, VASIND
Collection Date:	22-08-2024 17:58:00	**Report Release Date:**	25-08-2024 01:54:08

GD Wellness 1.3

No.	Investigation	Observed Value	Unit	Biological Ref. Interval
Complete Haemogram Test				
Erythrocytes				
1	Total RBC	5.71	10^6/µL	4.1-6
2	Hemoglobin	17.4	g/dL	13 -17.5
3	Hematocrit (PCV)	52.7	%	33-57
4	Mean Corpuscular Volume (MCV)	92.2	fL	80-96
5	Mean Corpuscular Hemoglobin (MCH)	30.4	pg	27.5-33.2
6	Mean Corpuscular Hemoglobin Concentration (MCHC)	33.0	g/dL	30.4-34.5
7	Red Cell Distribution Width (RDW-CV)	14.6	%	12-15
8	Red Cell Distribution Width-SD(RDW-SD)	48.6	fl	30-64.5
9	Nucleated Red Blood Cells	0.03	cells/µL	0 - 1.36
10	Nucleated Red Blood Cells Percentage	0.3	%	0-4
Platelets				
11	Platelet Count	332.0	10^3/µL	150-450
12	Mean Platelet Volume (MPV)	8.4	fL	6 - 12
13	Platelet Distribution Width (PDW)	16.6	%	15.5-18.3
14	Plateletcrit (PCT)	0.279	%	0.12-0.37
Leucocytes				
15	Total Leucocytes Count	9.3	10^3/µL	4.4-11
16	Neutrophils	49.2	%	40-77
17	Lymphocyte Percentage	29.5	%	16-44
18	Monocytes Percentage	6.7	%	2.0-10.0
19	**Eosinophils Percentage**	**14.0**	**%**	**0-7**
20	Basophils Percentage	0.6	%	0 - 1
21	Neutrophils-Absolute Count	4.58	10^3/µL	1.8-7.8
22	Lymphocytes-Absolute Count	2.74	10^3/µL	1-4.8
23	Monocytes-Absolute Count	0.62	10^3/µL	0.1-1.0

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Authorized Signatory
Dr Maibam Debala Chanu
MBBS,MD (Pathology)

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No.	Investigation	Observed Value	Unit	Biological Ref. Interval
	Leucocytes			
24	**Eosinophils-Absolute Count**	**1.30**	**10^3/µL**	**0 - 0.45**
25	Basophils-Absolute Count	0.06	10^3/µL	0-0.2
	Peripheral Blood Smear			
26	RBC Morphology	Normocytic Normochromic		
27	WBC Morphology	Eosinophilia		
28	Platelets	Adequate On Smear		

Interpretation

Sample type: EDTA whole blood.

Test Methods:

RBC/WBC/Platelets: Impedance method,

Hemoglobin: Photometric measurement,

Differential count: VCSn Technology,

MCV, MPV: Measured parameter Indices,

Absolute counts: Calculated.

(Processed on Fully Automated 5 parts differential Hematology analyzer).

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No.	Investigation	Observed Value	Unit	Biological Reference Interval
	Liver Function Test			
1	Bilirubin Total Serum, Method: Jendrassik Grof	0.81	mg/ dL	0.2-1.2
2	Bilirubin Direct Serum, Method: Diazotization	0.13	mg/ dL	0.01 - 0.4
3	Bilirubin Indirect Serum, Method: Calculated	0.68	mg/dL	0.01-1.0
4	Aspartate Transaminase (AST/SGOT) Serum, Method: IFCC without P5P	22.9	U/ L	<50
5	Alanine Transaminase (ALT/SGPT) Serum, Method: IFCC without P5P	18.4	U/ L	<50
6	Alkaline Phosphatase Serum, Method: AMP – pNPP Kinetic	88.0	U/L	30 - 130
7	**Total Protein** Serum, Method: Biuret end point	**8.34**	**g/dL**	**6.4 - 8.2**
8	Albumin Serum, Method: Bromocresol Purple (BCP)	4.58	g/dL	3.4 - 5
9	Globulin Serum, Method: Calculated	3.76	g/dL	1.9-3.9
10	A/G ratio Serum, Method: Calculated	1.22	Ratio	1.0 - 2.0
11	Gamma GT Serum, Method: G glutamyl carboxy nitroanilide	21.5	U/L	5 - 85

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No.	Investigation	Observed Value	Unit	Biological Reference Interval
Kidney Profile				
1	BUN (Blood Urea Nitrogen) Serum, Method: Calculated	8.6	mg/dL	3.3 - 18.7
2	Creatinine Serum, Method: Alkaline picrate kinetic	1.1	mg/dL	0.5 - 1.3
3	BUN/Creatinine ratio Serum, Method: Calculated	7.82		4.0 - 21.5
4	Uric Acid Serum, Method: Uricase, UV	6.53	mg/ dL	2.1 - 7.5
5	Calcium Serum, Method: O cresolphthalein complexone	9.6	mg/dL	8.5 - 10.5
6	eGFR (estimated Glomerular Filtration Rate) Serum, Method: Calculated (MDRD formula)	88.01	mL/min/1.73 m²	Normal: > 90 Mild decrease in GFR: 60- 89 Moderate decrease in GFR: 30-59 Severe decrease in GFR: 15-29 Kidney failure: < 15
7	Urea Serum, Method: Urease-GLDH	18.4	mg/dL	7 - 40

Interpretation

A renal function panel could be ordered when a patient has risk factors for kidney dysfunction such as high blood pressure (hypertension), diabetes, cardiovascular disease, obesity, elevated cholesterol, or a family history of kidney disease. A renal function panel may also be ordered when someone has signs and symptoms of kidney disease, though early kidney disease often does not cause any noticeable symptoms. It may be initially detected through routine blood or urine testing. Renal function panel results are not diagnostic but rather indicate that there may be a problem with the kidneys and that further testing is required to make a diagnosis and determine the cause. Results of the panel are usually considered together, rather than separately. Individual test result can be abnormal due to causes other than kidney disease, but taken together with risks and signs and symptoms, they may give an indication of whether kidney disease is present.

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No.	Investigation	Observed Value	Unit	Biological Reference Interval
Lipid Profile				
1	Total Cholesterol Serum, Method: Cholesterol oxidase,esterase,peroxidase	133.4	mg/dL	Desirable: <200; Borderline high = 200-239; High: > 240
2	Triglycerides Serum, Method: Enzymatic, end point GPO-POD	103.1	mg/dL	Desirable: <150 Borderline High: 150 - 199 High: > 200 - 499
3	HDL-Cholesterol Serum, Method: Enzymatic Immunoinhibition	35.8	mg/dL	30 - 60
4	LDL- Cholesterol Serum, Method: Calculated	76.98	mg/dL	Optimal: <100; Near Optimal: 100-129; Borderline High: 130-159; High: 160-189; Very high: >190
5	Cholesterol/HDL ratio Serum, Method: Calculated	3.73		Optimal: <3.5 Near Optimal: 3.5 - 5.0 High >5.0
6	VLDL Cholesterol Serum, Method: Calculated	20.62	mg/dL	6 - 40
7	Non HDL Cholesterol Serum, Method: Calculated	97.60	mg/dl	Desirable: <130 Borderline high: 130-159 High : 160-189 Very High :>190
8	LDL /HDL ratio Serum, Method: Calculated	2.15		Optimal: <2.5 Near Optimal: 2.5-3.5 High >3.5

Interpretation

1.Triglycerides: When triglycerides are very high greater than 1000 mg/dL, there is a risk of developing pancreatitis in children and adults. Triglycerides change dramatically in response to meals, increasing as much as 5 to 10 times higher than fasting levels just a few hours after eating. Even fasting levels vary considerably day to day. Therefore, modest changes in fasting triglycerides measured on different days are not considered to be abnormal.

2. HDL-Cholesterol: HDL- C is considered to be beneficial, the so-called "good" cholesterol, because it removes excess cholesterol from tissues and carries it to the liver for disposal. If HDL-C is less than 40 mg/dL for men and less than 50 mg/dL for women, there is an increased risk of heart disease that is independent of other risk factors, including the LDL-C level. The NCEP guidelines suggest that an HDL cholesterol value greater than 60 mg/dL is protective and should be treated as a negative risk factor.

3. LDL-Cholesterol: Desired goals for LDL-C levels change based on individual risk factors. For young adults, less than 120 mg/dL is acceptable. Values between 120-159 mg/dL are considered Borderline high. Values greater than 160 mg/dL are considered high. Low levels of LDL cholesterol may be seen in people with an inherited lipoprotein deficiency and in people with hyperthyroidism, infection, inflammation, or cirrhosis.

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GD Wellness 1.3

No.	Investigation	Observed Value	Unit	Biological Reference Interval
Thyroid Profile - Total T3,Total T4,TSH (TFT)				
1	Total T3 Serum, Method: CLIA	105.24	ng/dL	60 - 200
2	Total T4 Serum, Method: CLIA	13.45	µg/dL	4.5 - 14.5
3	TSH (Thyroid Stimulating Hormone) Serum, Method: CLIA	1.568	µIU/ml	0.35 - 5.5

Interpretation

1. Triodothyronine (T3) is produced by the thyroid gland and along with thyroxine (T4) help control the rate at which the body uses energy.Elevated T3 denote hyperthyroidism while low levels indicate hypothyroidism.

2.The most common causes of thyroid dysfunction are related to autoimmune disorders. Graves disease causes hyperthyroidism, but it can also be caused by thyroiditis, thyroid cancer, and excessive production of TSH. Total T3 is used to assess thyroid function.

3. Elevated T4 levels may indicate hyperthyroidism. They may also indicate other thyroid problems, such as thyroiditis or toxic multinodular goiter. Abnormally low levels of T4 may indicate: dietary issues, such as fasting, malnutrition, or an iodine deficiency, medications that affect protein levels, hypothyroidism, illness.

4. Thyroid-stimulating hormone (TSH) stimulates the production and release of T4 (primarily) and T3. They help control the rate at which the body uses energy and are regulated by a feedback system. Most of the T4 circulates in the blood bound to protein, while a small percentage is free (not bound).

5. Lab has estimated Total T4 reference intervals that are specific for India, using the indirect sampling technique following CLSI EP28-A3c document: Defining Establishing, and Verifying Reference Intervals in the Clinical Laboratory: Approved Guideline-Third Edition.

5. Thyroid hormone status during pregnancy:

Pregnancy stage	TSH (µIU/ml)	T3 (ng/dl)	T4 (µg/dL)
First trimester	0.05-3.70	71-175	6.5-10.1
Second trimester	0.31-4.35	91-195	7.5-10.3
Third trimester	0.41-5.18	104-182	6.3-9.7

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No.	Investigation	Observed Value	Unit	Biological Reference Interval
1	**Vitamin B12** Serum, Method: CLIA	**116.0**	**pg/ml**	**120 - 807**

Interpretation

Low B12 level in a person with signs and symptoms indicates that the person has a deficiency but does not necessarily reflect the severity of the anemia or associated neuropathy. Vitamin B12 levels are decreased in megaloblastic anaemia, partial/total gastrectomy, pernicious anaemia, peripheral neuropathy, chronic alcoholism, senile dementia, and treated epilepsy. Associated increased in homocysteine levels and Vitamin B12 has better predictivity for cardiovascular disease and deep vein thrombosis. Holo-Transcobalamin II levels and methylmalonic acid levels are more accurate markers of active Vitamin B12 component. Additional tests are usually done to investigate the underlying cause of the deficiency.

In method comparison study done at our centre, we found acceptable correlation and these results showed that there was no statistically significant between our methods and other Lab procedures (like, CLIA, CMIA, ELISA, IFA etc). The harmonization between total vitamin B12 assays is variable and individual results can differ significantly between assays. Though cut-off value of 200 pg/mL was used commonly, however, since there is not a reference method for measuring vitamin B12, this cut-off value may not be suitable to use in the evaluation of cobalamin deficiency diagnosis. Until the harmonization study between measurement methods is concluded, it is always suggested by NABL that laboratories should use their own reference values or reference values for Lab assay methods instead of cut-off value of 200 pg/mL.

2	Testosterone Serum, Method: CLIA	569.72	ng/dL	241 – 827

Interpretation

Testosterone is the main sex hormone (androgen) in men. It is responsible for male physical characteristics. It is present in large amounts in males during puberty and in adult males to regulate the sex drive and maintain muscle mass. In women, testosterone is converted to estradiol, the main sex hormone in females. Testosterone levels are diurnal, peaking in the early morning hours (about 4:00 to 8:00 am), with the lowest levels in the evening (about 4:00 to 8:00 pm). Levels also increase after exercise and also decrease with age. Testosterone test may be used to help evaluate conditions such as delayed or precocious (early) puberty in boys, decreased sex drive in men and women, erectile dysfunction in men, infertility in men and women, testicular tumors in men, hypothalamus or pituitary disorders, hirsutism and virilization in girls and women.

25 - OH Vitamin D

3	25 - OH Vitamin D Serum, Method: CLIA	26.53	ng/mL	Deficiency: <20 Insufficiency: 20 - 30 Sufficiency: 30 - 100 Toxicity: > 100

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Interpretation

1. The 25-hydroxyvitamin D is the major form found in the blood and is the relatively inactive precursor to the active hormone, 1,25-dihydroxyvitamin D. Because of its long half-life and higher concentration, 25-hydroxyvitamin D is commonly measured to assess and monitor vitamin D status in individuals. A low blood level of 25-hydroxyvitamin D may mean that a person is not getting enough exposure to sunlight or enough dietary vitamin D to meet his or her body's demand or that there is a problem with its absorption from the intestines.

2. Vitamin D is a fat soluble vitamin and exists in two main forms as cholecalciferol (vitamin D3) which is synthesized in skin from 7-dehydrocholesterol in response to sunlight exposure & Ergocalciferol(vitamin D2) present mainly in dietary sources.Both cholecalciferol & Ergocalciferol are converted to 25(OH)vitamin D in liver. 3. Testing for 25(OH) vitamin D is recommended as it is the best indicator of vitamin D nutritional status.

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No.	Investigation	Observed Value	Unit	Biological Reference Interval
Iron Studies (Iron,TIBC, Transferrin saturation)				
1	Iron Serum, Method: Ferene	141.88	µg/dL	65 - 175
2	TIBC Serum, Method: Calculated	349.51	µg/dL	250-450
3	Transferrin saturation Serum, Method: Calculated	40.59	%	20 - 50

Interpretation

1. Serum iron measures the level of iron in the liquid portion of the blood. Low iron levels may seen in anemia (microcytic and hypochromic) . High levels of serum iron in hereditary hemochromatosis, multiple blood transfusions, and a few other conditions.

2. TIBC (Total iron-binding capacity) measures all the proteins in blood available to bind with iron, including transferrin.TIBC test is a good indirect measurement of transferrin. The body produces transferrin in relationship to the need for iron. When iron stores are low, transferrin levels increase and vice versa. Since transferrin is the primary iron-binding protein, the TIBC test is a good indirect measurement of transferrin availability.

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No.	Investigation	Observed Value	Unit	Biological Reference Interval
HbA1c (Whole Blood)				
1	HBA1c-Glycated Haemoglobin EDTA Whole Blood, Method: HPLC	4.8	%	Non-diabetic: 4-6 Excellent Control: 6-7 Fair to good control: 7-8 Unsatisfactory control: 8-10 Poor Control: >10
2	Estimated Average Glucose (eAG) EDTA Whole Blood, Method: Calculated	91.06	mg/dL	90-120 mg/dL : Good control 121-150 mg/dL : Fair control 151-180 mg/dL : Unsatisfactory control >180 mg/dL : Poor control

Interpretation

1.The term HbA1c refers to Glycated Haemoglobin. Measuring HbA1c gives an overall picture of what the average blood sugar levels have been over a period of weeks/month. Higher the HbA1c, the greater the risk of developing diabetes-related complications.

2.HbA1c has been endorsed by clinical groups and ADA (American Diabetes Assocation) guidelines 2012, for the diagnosis of diabetes using a cut-off point of 6.5%. ADA defined biological reference range for HbA1c is between 4-6%. Patients with HBA1c value between 6.0-6.5% are considered at risk for developing diabetes in the future. Trends in HbA1c area a better indicator of glucose control than standalone test.

3.To estimate the eAG from the HbA1c value, the following equation is used: eAG(mg/dl) =28.7*A1c-46.7.

4.Diabetic must aspire to keep values under 7% to avoid the various complications resulting from diabetes.

5.Certain conditions can give rise to a spuriously low HbA1C values. Such conditions include Hemolytic anemias, certain hemoglobinopathies (Hb SS, HbSC, Hb CC, unknown variant), recent blood transfusion,acute blood loss, hypertriglyceridemia, drugs (eg dapsone, ribavirin, trimethoprim-sulfamethoxazole, hydroxyurea, vitamin C/E), chronic liver disease.

6.Certain conditions can give rise to a spuriously high HbA1C values. Such conditions include Iron deficiency, vitamin B12 deficiency, alcoholism, uremia, hyperbilirubinemia, drugs (chronic ingestion of salicylates in high doses and opiate addiction).

Note:The reportable range for HbA1C HPLC analyser is 3.8 % to 18.5 %, eAG calculation not possible above or below this range. In such scenario, observed HbA1c results may not be truly representative of the glycemic control and need to be cross checked by other methods of testing like fructosamine test.

End Of Report

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QUALITY POLICY

GENERAL DIAGNOSTICS INTERNATIONAL (P) Ltd. maintains the highest standards of quality control in all aspects of laboratory work. The purpose of our laboratory's Quality Management System is to ensure that:

- Principles of all accreditations, including that of NABL - ISO1518:2012 (National Accreditation Board of Laboratories) are adhered for each test in the scope of the accreditation, and beyond.
- Test methods, processes and control mechanisms are timely updated and fully validated to ensure the accuracy and reliability of our test results.

The objectives of our Quality Control system are:

- Use Bar-Coded operations to enable full traceability throughout the sample flow process and to ensure sample handling procedures and environmental conditions are managed well and there is no or minimal affect on the results.
- Continually improve the practices of our clients, franchise partners, associate doctors, clinics and hospitals and monitor their training needs. Be proactive in identifying gaps in the processes being followed. Guide them to ensure that the patients are served in the best possible way.
- Report the results with accuracy and clarity in a timely manner. Do a root cause analysis whenever there is a deviation against protocols and find solutions to the identified causes.
- Ensure a continual enhancement, implementation and maintenance of the quality system and seek improvement in the effectiveness of the quality system from experts at regular intervals.
- Meet and exceed expectations with respect to turn-around time, sample collection hygiene & reliability of service.
- Ensure that each test is performed by qualified and trained staff. Provide opportunities to the staff so that they can increase their knowledge and use the same for self and organizational betterment.
- Ensure that the equipment used are best in class, properly maintained and calibrated and where possible, measurements are traceable to recognized standards. Also explore methods which may lead to improvement in equipment performance and methodologies used for conducting tests.
- Enable technology upgrades to achieve higher accuracy and reduced complexities.
- Use internal audits and other checks to ensure the quality system complies with requirements; ensure problems are investigated promptly, root cause(s) established and effective action taken to prevent a recurrence.
- Have a smooth communication mechanism to ensure information is made available as rapidly as possible to those who need it, both internal and external to the organization.
- Monitor, help and support our franchise and service partners to be sensitive on all aspects of service delivery and to ensure quality standards are followed with no exceptions.

CONDITIONS of REPORTING

01. It is presumed that the specimen accompanying the TRF (Test Requisition Form where the details of patient are recorded) is of the same patient whose details are there in the TRF.
02. A test requested might not be performed due to the following reasons(s):
    - 2.1 Insufficient quantity of specimen required to conduct the test.
    - 2.2 Poor quality of the Specimen not meeting the quality criteria (hemolysis of sample/clotted.)
    - 2.3 Incorrect specimen type as required to conduct a test.
03. Test(s) may be patly or fully cancelled due to incorrect test code, incorrect name of the test or incorrect type of specimen. A communication shall be made and it is expected that a fresh specimen will be sent to laboratory for analysis of same parameter(s).
04. The results of laboratory investigation are dependent on the quality of the specimen as well as the assay procedures/technologies used. All samples collected for tests are required to be prepared, stored, labeled and brought to processing laboratory as per the prescribed guidelines of GENERAL DIAGNOSTICS.
05. GENERAL DIAGNOSTICS laboratory cannot be held liable for incorrect results of a sample which deviated from the guidelines issued.
06. There can be several factors like sample's unintended exposure to heat or travel through rough terrain which affect the quality of test results. Therefore a 2% chance of error/ deviation in results is a possibility.
07. For certain category of tests, the report may carry a "PRELIMINARY" status implying that the results are yet to be reported for one (or more) tests. For example, in the case with certain microbiology tests, a "FINAL" culture, identification or drug susceptibility result might be pending. In such case, the status "RESULT PENDING" will be mentioned on report. The same shall be replaced by the test results whenever it is ready.
08. If the collection date or any other details was not stated in the Test Requisition Form, the same will not be printed on the report. In cases where the missing information is mandatory for report generation or meeting accreditation guidelines, the sample shall not be processed at all.
09. Tests parameters excluded from the "scope" of NABL accreditation shall be marked by asterisks.
10. In case you are not the intended recipient of the report, please immediately inform the same to the issuing entity. Any use, disclosure, copy or distribution of any contents of such report, is unlawful and is strictly prohibited.
11. Some test may be referred to other laboratories to provide a wider test menu to the patients. The details of the laboratory where the sample was referred to, can be obtained from Customer Care department.
12. Claims of comparing results against that from a different laboratory shall be looked into only if it was the same sample which was split and sent in same conditions to all laboratories and processed on the same technology.

इस श्रिष्टि का मूल आधार है "बेटी"
माता पिता ही नहीं, देश का सम्मान है "बेटी"

बेटी बचाओ बेटी पढ़ाओ

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