Name	: **Mr. INAMANAMELLURI VENKATA KARTHEEK**		**Age**	: **33 Years**	
Lab No.	: **472854364**		**Gender**	: **Male**	
Ref By	: **Self**		**Reported**	: **28/1/2025 4:19:51PM**	
Collected	: **28/1/2025 7:50:00AM**		**Report Status**	: **Final**	
A/c Status	: **P**		**Processed at**	: **LPL-HYDERABAD**	
Collected at	: **R L DIAGNOSTICS** **H NO 5-5-35/240/1/B, Vignanapuri Colony, Mythri Nagar, Kukatpally, Hyderabad, Telangana 500072**			**4th Floor, Oyster Oasis Centre, MCH No. 6-3-1112 Greenland's Road Somajiguda, Circle no. 10, Old MCH Circle no. 5,GHMC, Begumpet, Hyderabad -500016**	

MC-6529

Test Report

Test Name	Results	Units	Bio. Ref. Interval
HEMOGRAM (Photometry, Electrical Impedance, Optical/Impedance & Calculated & Capillary Photometry)			
Hemoglobin	**10.36**	g/dL	13.00 - 17.00
Packed Cell Volume (PCV)	**32.50**	%	40.00 - 50.00
RBC Count	**3.52**	mill/mm3	4.50 - 5.50
MCV	92.20	fL	83.00 - 101.00
Mentzer Index	26.2		
MCH	29.40	pg	27.00 - 32.00
MCHC	31.90	g/dL	31.50 - 34.50
Red Cell Distribution Width (RDW)	13.10	%	11.60 - 14.00
Total Leukocyte Count (TLC)	**3.60**	thou/mm3	4.00 - 10.00
Differential Leucocyte Count (DLC)			
Segmented Neutrophils	79.75	%	40.00 - 80.00
Lymphocytes	**13.08**	%	20.00 - 40.00
Monocytes	5.24	%	2.00 - 10.00
Eosinophils	1.49	%	1.00 - 6.00
Basophils	0.44	%	<2.00
Absolute Leucocyte Count			
Neutrophils	2.87	thou/mm3	2.00 - 7.00
Lymphocytes	**0.47**	thou/mm3	1.00 - 3.00
Monocytes	**0.19**	thou/mm3	0.20 - 1.00
Eosinophils	0.05	thou/mm3	0.02 - 0.50

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Test Report

Test Name	Results	Units	Bio. Ref. Interval
Basophils	0.02	thou/mm3	0.02 - 0.10
Platelet Count	235	thou/mm3	150.00 - 410.00
Mean Platelet Volume	8.3	fL	6.5 - 12.0
E.S.R.	**39**	mm/hr	0 - 15

Comment

In anaemic conditions Mentzer index is used to differentiate Iron Deficiency Anaemia from Beta- Thalassemia trait. If Mentzer Index value is >13, there is probability of Iron Deficiency Anaemia. A value <13 indicates likelihood of Beta- Thalassemia trait and Hb HPLC is advised to rule out the Thalassemia trait.

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 Report

Test Name	Results	Units	Bio. Ref. Interval
KIDNEY PANEL; KFT,SERUM			
Creatinine (Compensated Jaffes reaction, IDMS traceable)	**2.90**	mg/dL	0.67 - 1.17
GFR Estimated (CKD EPI Equation 2021)	**28**	mL/min/1.73m2	>59
GFR Category (KDIGO Guideline 2012)	G4		
Urea (Urease UV)	**85.85**	mg/dL	14.9 - 38.5
Urea Nitrogen Blood (Urease UV)	**40.09**	mg/dL	6.00 - 20.00
BUN/Creatinine Ratio (Calculated)	14		
Uric Acid (Uricase)	6.97	mg/dL	3.50 - 7.20
Total Protein (Biuret)	6.50	g/dL	6.40 - 8.30
Albumin (BCG)	3.94	g/dL	3.50 - 5.20
Globulin(Calculated)	2.56	gm/dL	2.0 - 3.5
A : G Ratio (Calculated)	1.54		0.90 - 2.00
Calcium, Total (Arsenazo III)	**8.64**	mg/dL	8.80 - 10.60
Phosphorus (Molybdate UV)	4.14	mg/dL	2.40 - 4.40
Sodium (Indirect ISE)	137.00	mEq/L	136.00 - 146.00
Potassium (Indirect ISE)	4.86	mEq/L	3.50 - 5.10
Chloride (Indirect ISE)	107.00	mEq/L	101.00 - 109.00

Advise

1. CKD Risk Map (Z1014)
2. Cystatin C, serum (B173)

Note

1. Estimated GFR (eGFR) calculated using the 2021 CKD-EPI creatinine equation and GFR Category

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Test Report

Test Name	Results	Units	Bio. Ref. Interval

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

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Test Report

Test Name	Results	Units	Bio. Ref. Interval
LIVER PANEL 1; LFT,SERUM			
AST (SGOT) (IFCC without P5P)	11.1	U/L	<50
ALT (SGPT) (IFCC without P5P)	13.7	U/L	<50
AST:ALT Ratio (Calculated)	0.81		<1.00
GGTP (IFCC)	17.6	U/L	<55
Alkaline Phosphatase (ALP) (IFCC, PNPP-AMP-Buffer)	80.70	U/L	30 - 120
Bilirubin Total (DPD)	0.36	mg/dL	0.30 - 1.20
Bilirubin Direct (DPD)	0.08	mg/dL	<0.2
Bilirubin Indirect (Calculated)	0.28	mg/dL	<1.10
Total Protein (Biuret)	6.50	g/dL	6.40 - 8.30
Albumin (BCG)	3.94	g/dL	3.50 - 5.20
Globulin(Calculated)	2.56	gm/dL	2.0 - 3.5
A : G Ratio (Calculated)	1.54		0.90 - 2.00

Note

1. In an asymptomatic patient, Non alcoholic fatty liver disease (NAFLD) is the most common cause of increased AST, ALT levels. NAFLD is considered as hepatic manifestation of metabolic syndrome.
2. In most type of liver disease, ALT activity is higher than that of AST; exception may be seen in Alcoholic Hepatitis, Hepatic Cirrhosis, and Liver neoplasia. In a patient with Chronic liver disease, AST:ALT ratio>1 is highly suggestive of advanced liver fibrosis.
3. In known cases of Chronic Liver disease due to Viral Hepatitis B & C, Alcoholic liver disease or NAFLD, Enhanced liver fibrosis (ELF) test may be used to evaluate liver fibrosis.
4. In a patient with Chronic Liver disease, AFP and Des-gamma carboxyprothrombin (DCP)/PIVKA II can be used to assess risk for development of Hepatocellular Carcinoma.

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Test Report

Test Name	Results	Units	Bio. Ref. Interval
HbA1c (GLYCOSYLATED HEMOGLOBIN), BLOOD (HPLC, NGSP certified)			
HbA1c	**7.9**	%	4.00 - 5.60
Estimated average glucose (eAG)	180	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

472854364

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Test Report

Test Name	Results	Units	Bio. Ref. Interval
C-REACTIVE PROTEIN; CRP, SERUM (Immunoturbidimetry)	**9.55**	mg/L	<6.00

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Test Report

Test Name	Results	Units	Bio. Ref. Interval
IRON STUDIES, SERUM (Spectrophotometry, TPTZ, NITROSO - PSAP)			
Iron	90.89	µg/dL	59.00 - 158.0
Total Iron Binding Capacity (TIBC)	236.34	µg/dL	228.00 - 428.00
Transferrin Saturation	38.46	%	20.00 - 50.00

Comments

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.

Dr Mattaparti Sridevi
MD Pathology
Chief of Laboratory
Dr Lal PathLabs Ltd

Dr Syeda Iqra Taskeen
MD Pathology
Consultant Pathologist
Dr Lal PathLabs Ltd

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

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Test Report

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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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