DIAGNOSTIC REPORT

agilus diagnostics

PATIENT NAME : SANATAN SAHOO **REF. DOCTOR :** SELF

CODE/NAME & ADDRESS : C000139306 MED ACTIVE PLOT NO. GM-15, NEAR BSNL CHOWK, PHASE II,CHHEND COLONY ROURKELA 769015 7061912526	ACCESSION NO : **0340XF000040** PATIENT ID : SANAM140419650 CLIENT PATIENT ID: ABHA NO :	AGE/SEX :60 Years Male DRAWN :02/06/2024 12:29:55 RECEIVED : 02/06/2024 17:53:17 REPORTED :02/06/2024 20:51:28

Test Report Status **Final**	Results	Biological Reference Interval	Units

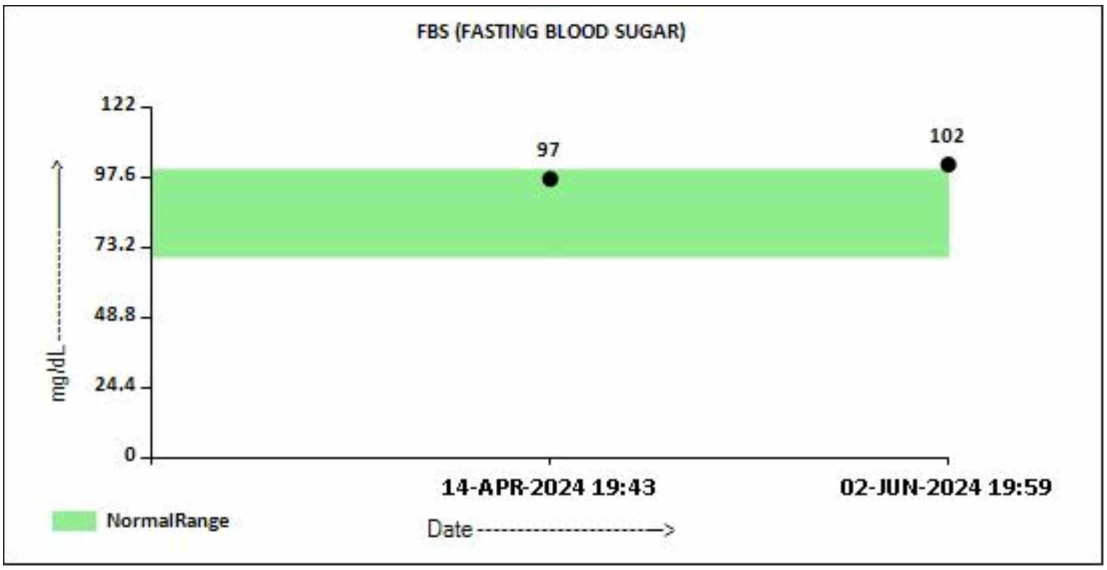
BIOCHEMISTRY

AGILUS SCREEN 1

GLUCOSE FASTING,FLUORIDE PLASMA

FBS (FASTING BLOOD SUGAR)	**102 High**	(Normal <100,Impaired fasting glucose:100 to 125,Diabetes mellitus:>=126(on more than 1 occasion)(ADA guidelines 2024)	mg/dL

METHOD : GOD-POD METHOD



LIVER FUNCTION PROFILE, SERUM

BILIRUBIN, TOTAL	0.30	0.3 - 1.2	mg/dL
METHOD : DIAZO METHOD			
BILIRUBIN, DIRECT	0.17	0.00 - 0.40	mg/dL
METHOD : DIAZO METHOD			
BILIRUBIN, INDIRECT	0.13	0.1 - 1.0	mg/dL
METHOD : CALCULATED PARAMETER			
TOTAL PROTEIN	7.9	6.4 - 8.3	g/dL
ALBUMIN	4.3	3.2 - 4.6	g/dL

Dr. Yespal Sharma
Consultant Pathologist

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Deheripalli, P.O. - Budhiraja,
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Odisha, India

ULR No.775000007839100-0340

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CODE/NAME & ADDRESS : C000139306
MED ACTIVE
PLOT NO. GM-15, NEAR BSNL CHOWK, PHASE II,CHHEND COLONY
ROURKELA 769015
7061912526

ACCESSION NO : **0340XF000040**
PATIENT ID : SANAM140419650
CLIENT PATIENT ID:
ABHA NO :

AGE/SEX :60 Years Male
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GLOBULIN	**3.6 High**	2.3 - 3.5	g/dL
ALBUMIN/GLOBULIN RATIO	1.2	1.0 - 2.1	RATIO
ASPARTATE AMINOTRANSFERASE(AST/SGOT)	20	0.0 - 35.0	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)	25	0.0 - 45.0	U/L
ALKALINE PHOSPHATASE	**55 Low**	56 - 119	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)	33	0.0 - 55.0	U/L
LACTATE DEHYDROGENASE	321	225 - 450	U/L
KIDNEY FUNCTION TEST, SERUM			
BLOOD UREA NITROGEN	12	8.0 - 26.0	mg/dL
METHOD : UREASE -GLDH			
CREATININE	0.95	0.7 - 1.3	mg/dL
METHOD : JAFFE KINETIC METHOD			
BUN/CREAT RATIO	12.63	5.0 - 15.0	
METHOD : CALCULATED PARAMETER			
URIC ACID	4.7	3.5 - 7.2	mg/dL
METHOD : URICASE			
TOTAL PROTEIN	7.9	6.4 - 8.3	g/dL
METHOD : BIURET			
ALBUMIN	4.3	3.2 - 4.6	g/dL
METHOD : BCG			
GLOBULIN	**3.6 High**	2.3 - 3.5	g/dL
CALCIUM	9.8	8.6 - 10.2	mg/dL
METHOD : ARSENAZO III			
SODIUM, SERUM	141.6	136.0 - 146.0	mmol/L
METHOD : ISE INDIRECT			
POTASSIUM, SERUM	3.62	3.50 - 5.10	mmol/L
METHOD : ISE INDIRECT			
CHLORIDE, SERUM	103.0	98.0 - 106.0	mmol/L
METHOD : ISE INDIRECT			
LIPID PROFILE WITH CALCULATED LDL, SERUM			
CHOLESTEROL, TOTAL	124	< 200 Desirable 200 - 239 Borderline > or = 240 High	mg/dL
METHOD : CHOD-POD			

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TRIGLYCERIDES	97	< 161 Normal 161 - 199 High 200 - 499 Hypertriglyceridemia > or = 500 Very High	mg/dL
METHOD : GPO - POD METHOD			
HDL CHOLESTEROL	**35 Low**	35.3 - 79.5	mg/dL
METHOD : DIRECT			
CHOLESTEROL LDL	70	< 100 Optimal 100 - 129 Near or above optimal 130 - 159 Borderline High 160 - 189 High >/= 190 Very High	mg/dL
NON HDL CHOLESTEROL	89	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
VERY LOW DENSITY LIPOPROTEIN	19.4	< 30.0	mg/dL
CHOL/HDL RATIO	3.5	3.30 - 4.40	
LDL/HDL RATIO	2	0.50 - 3.00	

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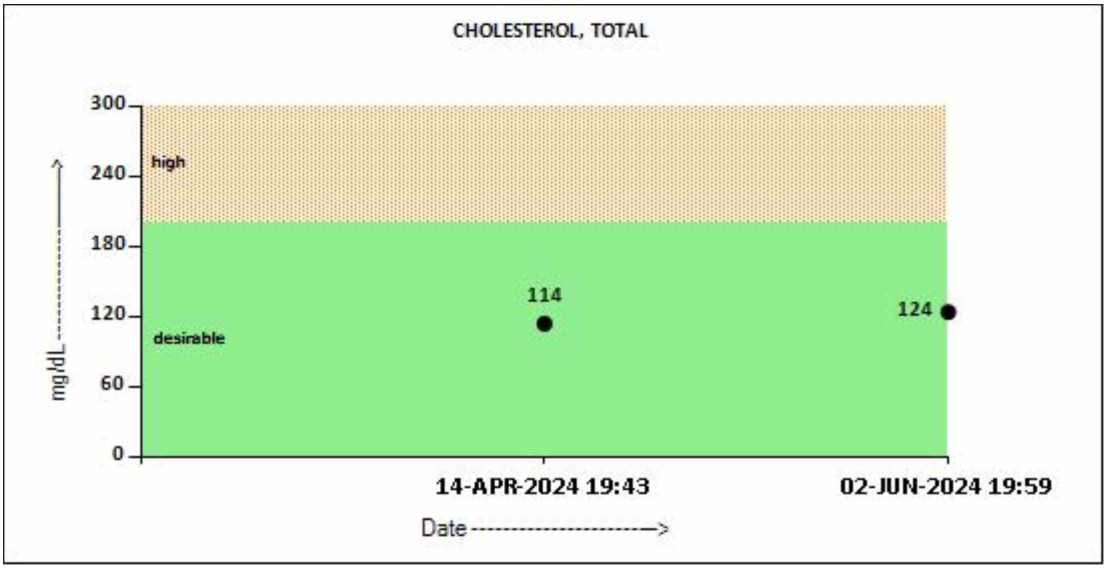

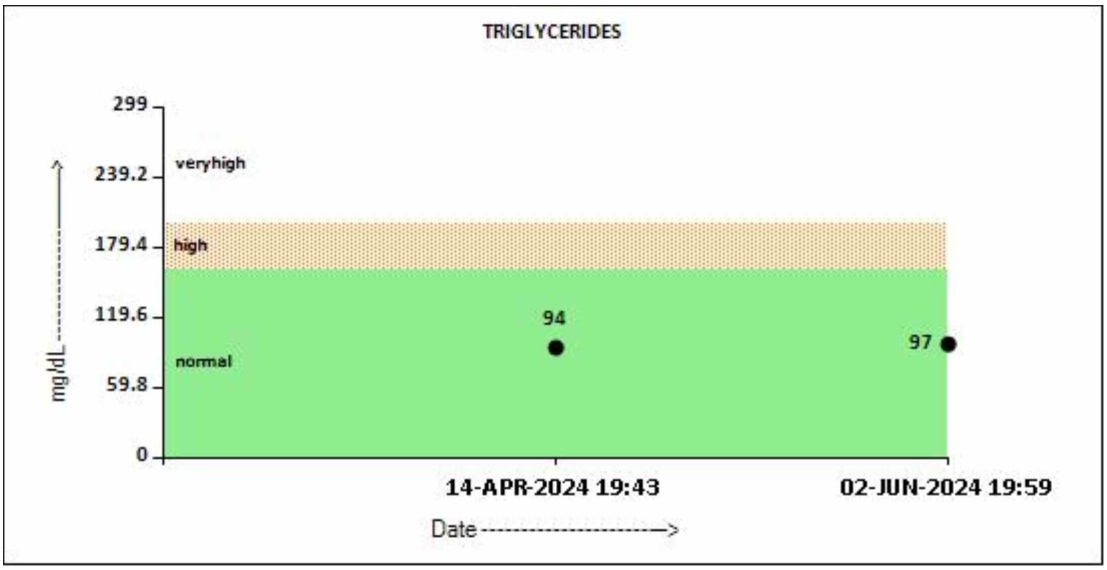

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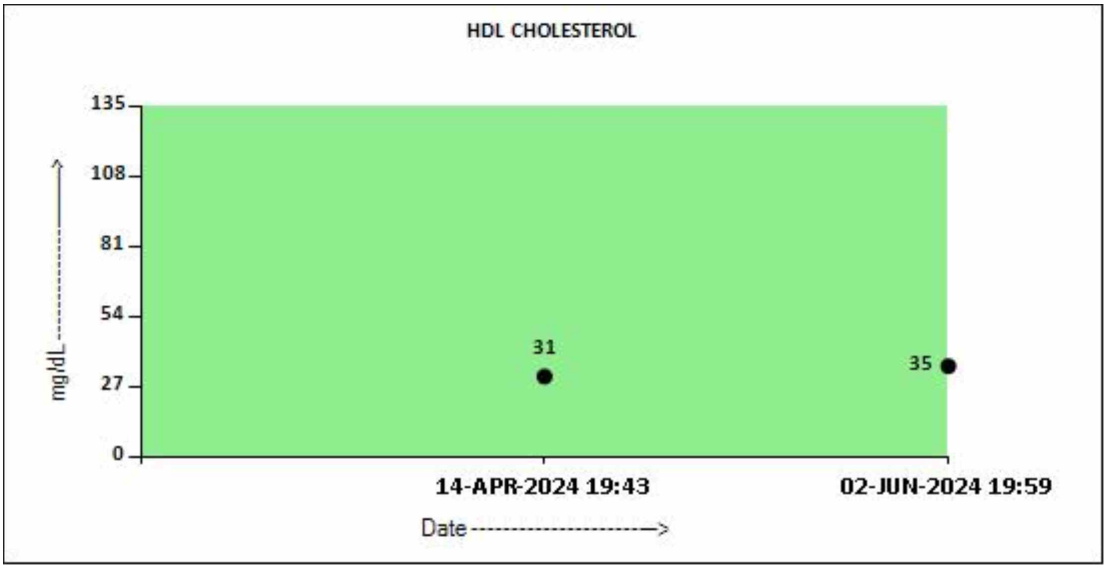

Interpretation(s)

Serum lipid profile is measured for cardiovascular risk prediction. Lipid Association of India recommends LDL-C as primary target and Non HDL-C as co-primary treatment target.

Risk Stratification for ASCVD (Atherosclerotic cardiovascular disease) by Lipid Association of India

Risk Category	
Extreme risk group	A.CAD with > 1 feature of high risk group
	B. CAD with > 1 feature of Very high risk group or recurrent ACS (within 1 year) despite LDL-C < or = 50 mg/dl or polyvascular disease
Very High Risk	1. Established ASCVD 2. Diabetes with 2 major risk factors or evidence of end organ damage 3. Familial Homozygous Hypercholesterolemia
High Risk	1. Three major ASCVD risk factors. 2. Diabetes with 1 major risk factor or no evidence of end organ damage. 3. CKD stage 3B or 4. 4. LDL >190 mg/dl 5. Extreme of a single risk factor. 6. Coronary Artery Calcium - CAC >300 AU. 7. Lipoprotein a >/= 50mg/dl 8. Non stenotic carotid plaque
Moderate Risk	2 major ASCVD risk factors
Low Risk	0-1 major ASCVD risk factors

Major ASCVD (Atherosclerotic cardiovascular disease) Risk Factors	
1. Age > or = 45 years in males and > or = 55 years in females	3. Current Cigarette smoking or tobacco use
2. Family history of premature ASCVD	4. High blood pressure
5. Low HDL	

Newer treatment goals and statin initiation thresholds based on the risk categories proposed by LAI in 2020.

Risk Group	**Treatment Goals**	**Consider Drug Therapy**

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	LDL-C (mg/dl)	Non-HDL (mg/dl)	LDL-C (mg/dl)	Non-HDL (mg/dl)
Extreme Risk Group Category A	<50 (Optional goal < OR = 30)	< 80 (Optional goal <OR = 60)	>OR = 50	>OR = 80
Extreme Risk Group Category B	<OR = 30	<OR = 60	> 30	>60
Very High Risk	<50	<80	>OR= 50	>OR= 80
High Risk	<70	<100	>OR= 70	>OR= 100
Moderate Risk	<100	<130	>OR= 100	>OR= 130
Low Risk	<100	<130	>OR= 130*	>OR= 160

*After an adequate non-pharmacological intervention for at least 3 months.

References: Management of Dyslipidaemia for the Prevention of Stroke: Clinical Practice Recommendations from the Lipid Association of India. Current Vascular Pharmacology, 2022, 20, 134-155.

Interpretation(s)

GLUCOSE FASTING,FLUORIDE PLASMA-**TEST DESCRIPTION**

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

LIVER FUNCTION PROFILE, SERUM-

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

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CLINICAL PATH - URINALYSIS

AGILUS SCREEN 1

PHYSICAL EXAMINATION, URINE

COLOR	PALE YELLOW		
APPEARANCE	CLEAR		

CHEMICAL EXAMINATION, URINE

PH	6.0	4.7 - 7.5	
SPECIFIC GRAVITY	1.030	1.003 - 1.035	
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 (WBC'S)	2-3	0-5	/HPF
EPITHELIAL CELLS	1-2	0-5	/HPF
CASTS	NOT DETECTED		
CRYSTALS	NOT DETECTED		
BACTERIA	NOT DETECTED	NOT DETECTED	
YEAST	NOT DETECTED	NOT DETECTED	

Interpretation(s)

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The following table describes the probable conditions, in which the analytes are present in urine

Presence of	**Conditions**
Proteins	Inflammation or immune illnesses
Pus (White Blood Cells)	Urinary tract infection, urinary tract or kidney stone, tumors or any kind of kidney impairment
Glucose	Diabetes or kidney disease
Ketones	Diabetic ketoacidosis (DKA), starvation or thirst
Urobilinogen	Liver disease such as hepatitis or cirrhosis
Blood	Renal or genital disorders/trauma
Bilirubin	Liver disease
Erythrocytes	Urological diseases (e.g. kidney and bladder cancer, urolithiasis), urinary tract infection and glomerular diseases
Leukocytes	Urinary tract infection, glomerulonephritis, interstitial nephritis either acute or chronic, polycystic kidney disease, urolithiasis, contamination by genital secretions
Epithelial cells	Urolithiasis, bladder carcinoma or hydronephrosis, ureteric stents or bladder catheters for prolonged periods of time
Granular Casts	Low intratubular pH, high urine osmolality and sodium concentration, interaction with Bence-Jones protein
Hyaline casts	Physical stress, fever, dehydration, acute congestive heart failure, renal diseases
Calcium oxalate	Metabolic stone disease, primary or secondary hyperoxaluria, intravenous infusion of large doses of vitamin C, the use of vasodilator naftidrofuryl oxalate or the gastrointestinal lipase inhibitor orlistat, ingestion of ethylene glycol or of star fruit (Averrhoa carambola) or its juice
Uric acid	arthritis
Bacteria	Urinary infectionwhen present in significant numbers & with pus cells.
Trichomonas vaginalis	Vaginitis, cervicitis or salpingitis

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SPECIALISED CHEMISTRY - HORMONE

AGILUS SCREEN 1

THYROID PANEL, SERUM

T3	158.00	69.0-215.0 Pregnant women: First trimester: 120-339 Bitmap Second trimester: 136-318 Third trimester: 122-260	ng/dL
T4	6.96	5.2 - 12.7	µg/dL
TSH (ULTRASENSITIVE)	**8.720 High**	0.3-4.5 Bitmap Pregnant women: First trimester: 0.25-4.33 Bitmap Bitmap Bitmap Second trimester: 0.43-6.61 Third trimester: 0.38-6.22	IU/mL

Interpretation(s)

Triiodothyronine T3 , **Thyroxine T4,** and **Thyroid Stimulating Hormone TSH** are thyroid hormones which affect almost every physiological process in the body, including growth, development, metabolism, body temperature, and heart rate.
Production of T3 and its prohormone thyroxine (T4) is activated by thyroid-stimulating hormone (TSH), which is released from the pituitary gland. Elevated concentrations of T3, and T4 in the blood inhibit the production of TSH.
Excessive secretion of thyroxine in the body is hyperthyroidism, and deficient secretion is called hypothyroidism.
In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hyperthyroidism, TSH levels are low.
Below mentioned are the guidelines for Pregnancy related reference ranges for Total T4, TSH & Total T3.Measurement of the serum TT3 level is a more sensitive test for the diagnosis of hyperthyroidism, and measurement of TT4 is more useful in the diagnosis of hypothyroidism.Most of the thyroid hormone in blood is bound to transport proteins. Only a very small fraction of the circulating hormone is free and biologically active. It is advisable to detect Free T3, FreeT4 along with TSH, instead of testing for albumin bound Total T3, Total T4.

Sr. No.	TSH	Total T4	FT4	Total T3	Possible Conditions
1	High	Low	Low	Low	(1) Primary Hypothyroidism (2) Chronic autoimmune Thyroiditis (3) Post Thyroidectomy (4) Post Radio-Iodine treatment

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2	High	Normal	Normal	Normal	(1)Subclinical Hypothyroidism (2) Patient with insufficient thyroid hormone replacement therapy (3) In cases of Autoimmune/Hashimoto thyroiditis (4). Isolated increase in TSH levels can be due to Subclinical inflammation, drugs like amphetamines, Iodine containing drug and dopamine antagonist e.g. domperidone and other physiological reasons.
3	Normal/Low	Low	Low	Low	(1) Secondary and Tertiary Hypothyroidism
4	Low	High	High	High	(1) Primary Hyperthyroidism (Graves Disease) (2) Multinodular Goitre (3)Toxic Nodular Goitre (4) Thyroiditis (5) Over treatment of thyroid hormone (6) Drug effect e.g. Glucocorticoids, dopamine, T4 replacement therapy (7) First trimester of Pregnancy
5	Low	Normal	Normal	Normal	(1) Subclinical Hyperthyroidism
6	High	High	High	High	(1) TSH secreting pituitary adenoma (2) TRH secreting tumor
7	Low	Low	Low	Low	(1) Central Hypothyroidism (2) Euthyroid sick syndrome (3) Recent treatment for Hyperthyroidism
8	Normal/Low	Normal	Normal	High	(1) T3 thyrotoxicosis (2) Non-Thyroidal illness
9	Low	High	High	Normal	(1) T4 Ingestion (2) Thyroiditis (3) Interfering Anti TPO antibodies

REF: 1. TIETZ Fundamentals of Clinical chemistry 2.Guidlines of the American Thyroid association duriing pregnancy and Postpartum, 2011.

NOTE: It is advisable to detect Free T3,FreeT4 along with TSH, instead of testing for albumin bound Total T3, Total T4.TSH is not affected by variation in thyroid - binding protein. TSH has a diurnal rhythm, with peaks at 2:00 - 4:00 a.m. And troughs at 5:00 - 6:00 p.m. With ultradian variations.

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DIAGNOSTIC REPORT

PATIENT NAME : SANATAN SAHOO		**REF. DOCTOR :** SELF
CODE/NAME & ADDRESS : C000139306 MED ACTIVE PLOT NO. GM-15, NEAR BSNL CHOWK, PHASE II,CHHEND COLONY ROURKELA 769015 7061912526	ACCESSION NO : **0340XF000040** PATIENT ID : SANAM140419650 CLIENT PATIENT ID: ABHA NO :	AGE/SEX :60 Years Male DRAWN :02/06/2024 12:29:55 RECEIVED :02/06/2024 17:53:17 REPORTED :02/06/2024 20:51:28

Test Report Status **Final**	Results	Biological Reference Interval	Units

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.

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

Dr. Yespal Sharma
Consultant Pathologist

View Details View Report

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