L96 - RAZA BAZAR -CC
RAZA BAZAR SHEIKHPURA SUKH SMRITI
APARTM ENT PS-SHASHTRINAGAR Patna
MO-9835463985

Name	: Mrs. ANITA SINGH			Collected	: 28/2/2022 10:22:00AM
Lab No.	: 323048249	Age: 53 Years	Gender: Female	Received	: 28/2/2022 10:48:05AM
				Reported	: 28/2/2022 2:42:37PM
A/c Status	: P	Ref By : Dr.ABHAY KUMAR		Report Status	: Final

Test Name	Results	Units	Bio. Ref. Interval
SwasthFit Super 1			
LIVER & KIDNEY PANEL, SERUM (Spectrophotometry, Indirect ISE)			
Bilirubin Total	0.44	mg/dL	<1.10
Bilirubin Direct	0.14	mg/dL	<0.20
Bilirubin Indirect	0.30	mg/dL	<1.10
AST (SGOT)	21	U/L	<32
ALT (SGPT)	18	U/L	<33
GGTP	15	U/L	<42.00
Alkaline Phosphatase (ALP)	**100**	U/L	<98
Total Protein	7.41	g/dL	6.40 - 8.30
Albumin	4.49	g/dL	3.97 - 4.94
A : G Ratio	1.54		0.90 - 2.00
Urea	40.60	mg/dL	21.00 - 43.00
Creatinine	0.80	mg/dL	<0.90

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Test Name	Results	Units	Bio. Ref. Interval
Uric Acid	**7.10**	mg/dL	2.4 - 5.7
Calcium, Total	**10.23**	mg/dL	8.6 - 10.0
Phosphorus	**5.29**	mg/dL	2.6 - 4.5
Sodium	137.30	mEq/L	136.00 - 145.00
Potassium	**5.24**	mEq/L	3.5 - 5.1
Chloride	103.00	mEq/L	97 - 107

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Test Name	Results	Units	Bio. Ref. Interval
GLUCOSE, FASTING (F), PLASMA (Hexokinase)	88.90	mg/dL	70.00 - 100.00

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Test Name	Results	Units	Bio. Ref. Interval
THYROID PROFILE,TOTAL, SERUM (ECLIA)			
T3, Total	0.95	ng/mL	0.80 - 2.00
T4, Total	9.05	µg/dL	5.10 - 14.10
TSH	**5.50**	µIU/mL	0.27 - 4.20

Note

1. TSH levels are subject to circadian variation, reaching peak levels between 2 - 4.a.m. and at a minimum between 6-10 pm . The variation is of the order of 50% . hence time of the day has influence on the measured serum TSH concentrations.
2. Alteration in concentration of Thyroid hormone binding protein can profoundly affect Total T3 and/or Total T4 levels especially in pregnancy and in patients on steroid therapy.
3. Unbound fraction (Free,T4 /Free,T3) of thyroid hormone is biologically active form and correlate more closely with clinical status of the patient than total T4/T3 concentration
4. Values <0.03 uIU/mL need to be clinically correlated due to presence of a rare TSH variant in some individuals

Interpretation

PREGNANCY	REFERENCE RANGE FOR TSH IN µIU/mL (As per American Thyroid Association)
1st Trimester	0.100 - 2.500
2nd Trimester	0.200 - 3.000
3rd Trimester	0.300- 3.000

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Test Name	Results	Units	Bio. Ref. Interval
LIPID SCREEN, SERUM (CHO-POD)			
Cholesterol, Total	156.90	mg/dL	<200
Triglycerides	**162.90**	mg/dL	<150.00
HDL Cholesterol	**43.00**	mg/dL	>50
LDL Cholesterol, Calculated	81.32	mg/dL	<100.00
VLDL Cholesterol,Calculated	**32.58**	mg/dL	<30.00
Non-HDL Cholesterol	114	mg/dL	<130

Interpretation

REMARKS	TOTAL CHOLESTEROL in mg/dL	TRIGLYCERIDE in mg/dL	LDL CHOLESTEROL in mg/dL	NON HDL CHOLESTEROL in mg/dL
Optimal	<200	<150	<100	<130
Above Optimal	-	-	100-129	130 - 159
Borderline High	200-239	150-199	130-159	160 - 189
High	>=240	200-499	160-189	190 - 219
Very High	-	>=500	>=190	>=220

Note

1. Measurements in the same patient can show physiological & analytical variations. Three serial samples 1 week apart are recommended for Total Cholesterol, Triglycerides, HDL& LDL Cholesterol.
2. NLA-2014 recommends a complete lipoprotein profile as the initial test for evaluating cholesterol.
3. Friedewald equation to calculate LDL cholesterol is most accurate when Triglyceride level is < 400 mg/dL. Measurement of Direct LDL cholesterol is recommended when Triglyceride level is > 400 mg/dL

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4. NLA-2014 identifies Non HDL Cholesterol(an indicator of all atherogeniclipoproteins such as LDL , VLDL, IDL, Lpa, Chylomicron remnants)along with LDL-cholesterol as co- primary target for cholesterol lowering therapy. Note that major risk factors can modify treatment goals for LDL &Non HDL.
5. Apolipoprotein B is an optional, secondary lipid target for treatment once LDL & Non HDL goals have been achieved
6. Additional testing for Apolipoprotein B, hsCRP,Lp(a) & LP-PLA2 should be considered among patients with moderate risk for ASCVD for risk refinement

Treatment Goals as per Lipid Association of India 2016

RISK CATEGORY	TREATMENT GOAL		CONSIDER THERAPY	
	LDL CHOLESTEROL (LDL-C)(mg/dL)	NON HDL CHLOESTEROL (NON HDL-C) (mg/dL)	LDL CHOLESTEROL (LDL-C)(mg/dL)	NON HDL CHLOESTEROL (NON HDL-C) (mg/dL)
Very High	<50	<80	>=50	>=80
High	<70	<100	>=70	>=100
Moderate	<100	<130	>=100	>=130
Low	<100	<130	>=130*	>=160*

*In low risk patient, consider therapy after an initial non-pharmacological intervention for at least 3 months

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Test Name	Results	Units	Bio. Ref. Interval
URINE EXAMINATION, ROUTINE; URINE, R/E (Automated Strip test, Chemical, Light microscopy)			
Physical			
Colour	Light Yellow		Pale yellow
Specific Gravity	1.005		1.001 - 1.030
pH	5		5.0 - 8.0
Chemical			
Proteins	Negative		Negative
Glucose	Negative		Negative
Ketones	Negative		Negative
Bilirubin	Negative		Negative
Urobilinogen	Negative		Negative
Leucocyte Esterase	Negative		Negative
Nitrite	Negative		Negative
Microscopy			
R.B.C.	Negative		0.0 - 2.0 RBC/hpf
Pus Cells	2-3 WBC/HPF		0-5 WBC / hpf
Epithelial Cells	0-1 Epi Cells/hpf		0.0 - 5.0 Epi cells/hpf
Casts	None seen		None seen/Lpf
Crystals	None seen		None seen
Others	None seen		None seen

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Test Name	Results	Units	Bio. Ref. Interval
GFR (GLOMERULAR FILTRATION RATE, ESTIMATED)			
Creatinine, Serum	0.80		
GFR, Estimated	**84**	mL/min/1.73m2	>90
GFR Category	G2 (Mild decrease in GFR)		

Note

1. eGFR calculated using the 2009 CKD-EPI creatinine equation and GFR Category reported as per KDIGO guideline 2012
2. In patients, with eGFRcreat between 45-59 ml/min/1.73 m2 (G3a) and without any marker of kidney damage, it is recommended to measure eGFR with cystatin C for confirmation of CKD.
3. eGFR category G1 or G2 does not fulfil the criteria for CKD, in the absence of evidence of kidney damage
4. In a suspected case of Acute kidney injury (AKI), measurement of GFR should be done after 48-96 hours of any intervention or procedure.
5. GFR calculated by Serum Creatinine may be less accurate due to certain factors like Race, Muscle mass, Diet and certain Drugs. In such cases, eGFR should be calculated using Serum Cystatin C.

ADVICE: CKD RISK MAP

KDIGO guideline, 2012 recommends Chronic Kidney disease (CKD) should be classified based on cause, GFR category and albuminuria (ACR) category. GFR & ACR category combined together reflect risk of progression and helps clinician to identify individuals who are progressing at more rapid rate than anticipated

Test Name	Results	Units	Bio. Ref. Interval
MICROALBUMIN/ALBUMIN : CREATININE RATIO (ACR), URINE (Immunoturbidimetry, Modified Jaffe Kinetic)			
Microalbumin	0.13	mg/L	
Creatinine	18.00	mg/dL	15.00 - 278.00
Microalbumin:Creatinine Ratio	0.72	mg/g Creat	<30.00
ACR Category	A1 (Normal to mildly increased)		

Note

1. Due to high biological variability and non-renal influences, ACR>30 mg/g creatinine in a random urine sample should be confirmed with a subsequent early morning urine sample or 24 hours urine sample.

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2. The diagnosis of albuminuria requires the demonstration of increased albumin loss (either increased albumin creatinine ratio or albumin loss in 24 hrs urine sample) in at least two out of three urine specimens collected in the absence of infection or acute metabolic crisis.
3. The term Microalbuminuria is misleading as it implies a small version of albumin molecule rather than an excretion rate of albumin greater than normal but less than that detected by routine method. It is recommended to use term Albuminuria or Albumin Creatinine ratio (ACR) instead of Microalbuminuria.

Comments

Albumin creatinine ratio (ACR) in urine is a sensitive and specific measure of kidney damage. Urinalysis for albuminuria has been accepted as a useful way of identifying patients at risk of progressive Chronic Kidney Disease (CKD). Increased urinary albumin excretion is highly predictive of Diabetic Nephropathy, End-stage renal disease, Cardiovascular mortality and total mortality in patients with Diabetes Mellitus.

Non-Renal causes of increased ACR:
Menstrual contamination, Uncontrolled Hypertension, Urinary Tract Infection, Heart failure, Strenuous exercise and other transitory illnesses.

Usage

- Marker for classification of CKD & its progression
- To screen Diabetic Nephropathy

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Test Name	Results	Units	Bio. Ref. Interval
STOOL EXAMINATION, ROUTINE; STOOL, R/E (Manual Method, Light microscopy)			
Colour	Dark Brown		Brown
Form and Consistency	Semi Solid		Semi Solid
Mucus	Absent		Absent
Visible Blood	Absent		Absent
Reaction	Acidic		Alkaline
Charcot-Leyden Crystals	None Seen		None Seen
Pus Cells	1-2	/hpf	0 - 5
RBC	None Seen	/hpf	None Seen
Macrophages	None Seen		None Seen
Trophozoites	None Seen		None Seen
Cysts	None Seen		None Seen
Helminthic Ova	None Seen		None Seen
Larva	None Seen		None Seen
Other Observations	None Seen		None Seen

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Test Name	Results	Units	Bio. Ref. Interval

Dr Manju Sharma
DCP, Pathology
Chief of Laboratory
Dr Lal PathLabs Ltd

Dr.Shalini Sinha
MBBS , DCP
Chief of Lab

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

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.•Sample repeats are accepted on request of Referring Physician within 7 days post reporting.•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.•Contact customer care Tel No. +91-11-39885050 for all queries related to test results.
(#) Sample drawn from outside source.