GENERAL DIAGNOSTICS
PreventiNe Life Care (P) Ltd.
Plot-6, Sector - 24, Navi Mumbai
Maharashtra, India. Pin - 400705
Tel: +91-22-40450000

0000002721854

Name:	MR SUJIT JAIN	**Age/Gender:**	45 Year(s) 0 Months(s) 0 Day(s)/Male
Referred By:		**Client Name:**	
Collection Date:	11-06-2021 09:53:00	**Report Release Date:**	11-06-2021 20:41:23

Sr.No	Investigation	Observed Value	Reference Range	Unit
Complete Haemogram Test				
Erythrocytes				
1	Total RBC	4.99	4.1-6	10^6/µL
2	Hemoglobin	14.4	13 -17.5	g/dL
3	Hematocrit (PCV)	44.5	33-57	%
4	Mean Corpuscular Volume (MCV)	89.2	80-96	fL
5	Mean Corpuscular Hemoglobin (MCH)	28.9	27.5-33.2	pg
6	Mean Corpuscular Hemoglobin Concentration (MCHC)	32.4	30.4-34.5	g/dL
7	Red Cell Distribution Width (RDW-CV)	13.4	12-15	%
8	Red Cell Distribution Width-SD(RDW-SD)	42.0	30-64.5	fl
9	Nucleated Red Blood Cells	0.02	0 - 1.36	cells/µL
10	Nucleated Red Blood Cells Percentage	0.4	0-4	%
Platelets				
11	Platelet Count	219.0	150-450	10^3/µL
12	Mean Platelet Volume (MPV)	9.2	6 - 12	fL
13	Platelet Distribution Width (PDW)	17.6	15.5-18.3	%
14	Plateletcrit (PCT)	0.202	0.12-0.37	%
Leucocytes				
15	Total Leucocytes Count	5.6	4.4-11	10^3/µL
16	Neutrophils	40.6	40-77	%
17	Lymphocyte Percentage	42.2	16-44	%
18	Monocytes Percentage	9.4	2.0-10.0	%
19	Eosinophils Percentage	6.9	0-7	%
20	Basophils Percentage	0.9	0 - 1	%
21	Neutrophils-Absolute Count	2.27	1.8-7.8	10^3/µL
22	Lymphocytes-Absolute Count	2.36	1-4.8	10^3/µL
23	Monocytes-Absolute Count	0.53	0.1-1.0	10^3/µL
24	Eosinophils-Absolute Count	0.39	0-0.45	10^3/µL
25	Basophils-Absolute Count	0.05	0-0.2	10^3/µL

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Authorized Signatory
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Authorized Signatory
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Peripheral Blood Smear				
26	RBC Morphology	Normocytic Normochromic		
27	WBC Morphology	Within Normal Range		
28	Platelets	Adequate On Smear		

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Urine Complete				
Physical Examination				
1	Specific Gravity	1.010	1.000 - 1.035	
2	pH-value	6.0	5 - 8	
3	Color	Pale Yellow		
4	Clarity	Slightly Hazy		
Bio-Chemical Examination				
5	Leukocytes	Negative	Negative	
6	Nitrite	Negative	Negative	
7	Protein	Negative	Negative	
8	Urine Glucose	Negative	Negative	
9	Ketones	Negative	Negative	
10	Urobilinogen	Negative	Normal	
11	Bilirubin	Negative	Negative	
12	Blood	Negative	Negative	
Microscopic Examination				
13	Erythrocytes	0-1	< 4	Cells/hpf
14	Epithelial Cells	0-1		Cells/hpf
15	Casts	Absent	Absent	
16	Crystals	Absent	Absent	
17	Pus Cells	0-1	< 5	Cells/hpf
18	Others	Absent		

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Liver Function Test				
1	Bilirubin Total Serum, Method: Jendrassik Grof	0.59	0.2-1.2	mg/ dL
2	Bilirubin Direct Serum, Method: Diazotization	0.11	0.01 - 0.4	mg/ dL
3	Bilirubin Indirect Serum, Method: Calculated	0.48	0.01-1.0	mg/dL
4	Aspartate Transaminase (AST/SGOT) Serum, Method: UV Kinetic with P5P	30.1	<50	U/ L
5	Alanine Transaminase (ALT/SGPT) Serum, Method: UV Kinetic with P5P	30.6	<50	U/ L
6	Alkaline Phosphatase Serum, Method: AMP – pNPP Kinetic	69.0	30 - 130	U/L
7	Total Protein Serum, Method: Biuret end point	7.12	6.4 - 8.2	g/dL
8	Albumin Serum, Method: Bromocresol Purple (BCP)	4.35	3.4 - 5	g/dL
9	Globulin Serum, Method: Calculated	2.77	1.9-3.9	g/dL
10	A/G ratio Serum, Method: Calculated	1.57	1.0 - 2.0	
11	Gamma GT Serum, Method: G glutamyl carboxy nitroanilide	39.3	5 - 85	U/L

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Serum Electrolyte Profile				
1	Sodium Serum, Method: Indirect ISE	141.76	136 - 145	mmol/L
2	Potassium Serum, Method: Indirect ISE	4.95	3.5 - 5.1	mmol/L
3	Chloride Serum, Method: Indirect ISE	106.92	98 - 107	mmol/L

Interpretation

The electrolyte panel is used to identify an electrolyte, fluid, or pH imbalance (acidosis or alkalosis). It is frequently ordered as part of a routine physical. Electrolyte measurements may be used to help investigate conditions that cause electrolyte imbalances such as dehydration, kidney disease, lung diseases, or heart conditions. Repeat testing may then also be used to monitor treatment of the condition causing the imbalance.

High or low electrolyte levels can be affected by some hormones such as aldosterone, a hormone that conserves sodium and promotes the elimination of potassium, and natriuretic peptides, which increase elimination of sodium by the kidneys. With respect to the amount of water in a person's body, people whose kidneys are not functioning properly, may retain excess fluid. This results in a dilution effect on sodium and chloride so that they fall below normal concentrations. On the other hand, people who experience severe fluid loss may show an increase in potassium, sodium, and chloride concentrations. Some conditions such as heart disease and diabetes may also affect the fluid and electrolytes balance in the body and cause abnormal levels of electrolytes. Hemolysed samples may show false high serum potassium.

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Sr.No	Investigation	Observed Value	Reference Range	Unit
1	Amylase Serum, Method: CNP-triose CNPG3	65.0	25 - 115	U/ L

Interpretation

Amylase is the pancreatic and salivary gland enzyme responsible for digesting carbohydrates. The level will increase 2 to 12 hours after the beginning of symptoms of acute pancreatitis and peaks at 12 to 72 hours afterward. It may rise 5 to 10 times the normal level and will usually return to normal within a week. Pancreatitis is likely if the level reaches 3 times above the upper limit of normal. Amylase also may be monitored in people with chronic pancreatitis; it will often be moderately elevated until the cells that produce it are destroyed (as a result of the pancreatitis), at which point blood levels of amylase may be decreased. It should be noted that amylase is an enzyme that has different forms called isoenzymes: P-amylase refers to the form made by the pancreas and S-amylase refers to the form made by the salivary glands. Normally, a total amylase test is requested. Sometimes, the isoenzyme tests are requested individually to distinguish pancreatic and non-pancreatic causes of increased amylase.

2	Lipase Serum, Method: Enzymatic hydrolysis	36.2	<67	U / L

Interpretation

Lipase is the pancreatic enzyme that, along with bile from the liver, digests fats. It is another test commonly used to diangose pancreatitis. Its level increases in the blood within 4 to 8 hours of the beginning of an acute attack and peaks at 24 hours afterward. Lipase is both more sensitive and more specific than amylase for the diagnosis of acute pancreatitis. However, there are other sources of lipase in the digestive tract. In some assays that detect non-pancreatic lipase, milder elevations may occur as a result of non-pancreatic disorders. In people with pancreatitis, lipase may rise to several times its normal level and remain elevated longer than amylase. Like with the amylase test, pancreatitis is diagnosed if the lipase level reaches 3 times above the upper limit of normal. As cells are destroyed with chronic pancreatitis and as lipase production drops to less than 10% of the normal level, steatorrhea (fatty, foul-smelling stools) will form. As chronic pancreatitis progresses, amylase and lipase may be normal or decreased, even during acute attacks.

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Sr.No	Investigation	Observed Value	Reference Range	Unit
Lipid Profile				
1	Total Cholesterol Serum, Method: Photometry	193.2	Desirable: <200; Borderline high = 200-239; High: > 240	mg/dl
2	**Triglycerides** Serum, Method: Enzymatic, end point coupled assay	**221.9**	**Desirable: <150** **Borderline High: 150 - 199** **High: > 200 - 499**	**mg/dl**
3	HDL-Cholesterol Serum, Method: Photometry	43.9	30 - 60	mg/dL
4	LDL- Cholesterol Serum, Method: Photometry	127.11	Optimal: <100; Near Optimal: 100-129; Borderline High: 130-159; High: 160-189; Very high: >190	mg/dl
5	Cholesterol/HDL ratio Serum, Method: Calculated	4.40	Optimal: <3.5 Near Optimal: 3.5 - 5.0 High >5.0	
6	**VLDL Cholesterol** Serum, Method: Calculated	**44.38**	**6 - 40**	**mg/dL**
7	Non HDL Cholesterol Serum, Method: Calculated	149.30	Desirable: <130 Borderline high: 130-159 High : 160-189 Very High :>190	mg/dl
8	LDL /HDL ratio Serum, Method: Calculated	2.90	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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Sr.No	Investigation	Observed Value	Reference Range	Unit
Thyroid Profile - Total T3,Total T4,TSH (TFT)				
1	Total T3 Serum, Method: CLIA	77.80	60 - 200	ng/dL
2	Total T4 Serum, Method: CLIA	6.47	4.5 - 14.5	µg/dL
3	**TSH (Thyroid Stimulating Hormone)** Serum, Method: CLIA	**5.884**	**0.35 - 5.5**	**µIU/ml**

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:

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Specific Cardiac Profile				
1	hs-CRP (high-sensitivity C-reactive protein) Serum, Method: Nephelometry	0.116	Below 3.0	mg/dL
2	Lipoprotein (a) Serum, Method: Nephelometry	10.3	5.6 - 33.8	mg/dL
3	Apolipoprotein (A1) Serum, Method: Nephelometry	132.0	90 - 170	mg/dL
4	Apolipoprotein (B) Serum, Method: Nephelometry	142.0	56 - 162	mg/dL
5	Homocysteine Serum, Method: Photometry	13.1	3.7 - 30	umol/L
6	Apo B: Apo A1 ratio Serum, Method: Calculated	1.08	0.35 - 1.1	

Interpretation

Cardiovascular disease is the leading cause of death. Many of these events occur in individuals who have no prior symptoms. Standard risk factors, including age, smoking status, hypertension, diabetes, cholesterol, and HDL cholesterol, predict only about 65% of individuals who will go on to have a cardiovascular event. Therefore, identification of patients with residual risk is important to target lifestyle and pharmaceutical intervention to those at higher risk of future events.

Many additional risk markers have been identified for cardiovascular disease but few have emerged as independent risk markers. Two of these additional risk markers, high-sensitivity C-reactive protein (hsCRP) and lipoprotein (a) (Lp[a]), are clearly shown to be independently associated with increased risk of future cardiovascular events.

Several recent guidelines have suggested that clinicians utilize hsCRP and Lp(a) in selected persons to augment risk classification, guide intensity of risk-reduction therapy and modulate clinical judgment when making therapeutic decisions. Prospective studies assessing these risk factors individually have determined them to be independently associated with increased risk for the development of ischemic events.

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GD Wellness Kidney Profile				
1	BUN (Blood Urea Nitrogen) Serum, Method: Calculated	13.27	3.3 - 18.7	mg/dL
2	**Creatinine** Serum, Method: Alkaline picrate kinetic	**1.4**	**0.5 - 1.3**	**mg/dL**
3	BUN/Creatinine ratio Serum, Method: Calculated	9.48	4.0 - 21.5	
4	Urea Serum, Method: Urease-GLDH	28.40	7 - 40	mg/dL
5	**Uric Acid** Serum, Method: Uricase, UV	**8.1**	**2.1 - 7.5**	**mg/ dL**
6	Calcium Serum, Method: O cresolphthalein complexone	10.4	8.5 - 10.5	mg/dL
7	**eGFR (estimated Glomerular Filtration Rate)** Serum, Method: Calculated	**58.14**	**Normal: > 90** **Mild decrease in GFR: 60- 89** **Moderate decrease in GFR: 30-59** **Severe decrease in GFR: 15-29** **Kidney failure: < 15**	**mL/min/1.73 m²**

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.

8	Vitamin B12 Serum, Method: CLIA	135.0	75 - 807	pg/ml

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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.

Sr.No	Investigation	Observed Value	Reference Range	Unit
9	PSA -Total Serum, Method: CLIA	1.46	0 - 4	ng/ml

Interpretation

Prostate cancer is leading cancer in older men. Therefore, early detection is important and Prostate specific antigen (PSA) is widely used for this purpose. It is considered as one of the most promising tumor marker available. The absolute value of serum PSA is useful for determining the extent of prostate cancer and assessing the response to therapy. Its use as a screening method to detect prostate cancer is limited as it is prostate tissue specific and not a prostate cancer specific marker.

PSA exists in three forms–

1) PSA enveloped by protease inhibitor Alpha-2-macroglobulin- This form lacks immunoreactivity.

2) PSA enveloped by protease inhibitor Alpha-1-antichymotrypsin (ACT)

3) PSA not complexed to any protease inhibitor- This is called ‘Free PSA’

The ACT bound PSA & Free PSA are collectively called ‘Total PSA’

Free PSA alone has not been shown to be effective in patient management. Both Total and Free PSA concentrations should be determined on the same serum specimen to calculate the percentage of Free PSA.

10	25 - OH Vitamin D Serum, Method: CLIA	28.54	Deficiency: <20 Insufficiency: 20 - 30 Sufficiency: 30 - 100 Toxicity: > 100	ng/mL

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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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CRM No :2721854
Sample Recd. Time: 11-06-2021 09:59
Report Time: 11-06-2021 20:41
Patient Name: MR SUJIT JAIN
Patient ID: 2721854

Authorized Signatory
Dr. Dina Abhani
DCP, DNB (Pathology)

Authorized Signatory
Dr. Mahesh Hampe
MD (Biochemistry)

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GENERAL DIAGNOSTICS
PreventiNe Life Care (P) Ltd.
Plot-6, Sector - 24, Navi Mumbai
Maharashtra, India. Pin - 400705
Tel: +91-22-40450000

0000002721854

Name:	MR SUJIT JAIN	**Age/Gender:**	45 Year(s) 0 Months(s) 0 Day(s)/Male
Referred By:		**Client Name:**	
Collection Date:	11-06-2021 09:53:00	**Report Release Date:**	11-06-2021 20:41:23

Sr.No	Investigation	Observed Value	Reference Range	Unit
Iron Studies (Iron,TIBC, Transferrin saturation)				
1	Iron Serum, Method: Ferene	134.96	65 - 175	µg/dL
2	TIBC Serum, Method: Ferene	331.97	250-450	µg/dL
3	Transferrin saturation Serum, Method: Calculated	40.65	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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Sr.No	Investigation	Observed Value	Reference Range	Unit
HbA1c (Whole Blood)				
1	HBA1c-Glycated Haemoglobin EDTA Whole Blood, Method: HPLC	5.1	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	99.67	90-120 mg/dL : Good control 121-150 mg/dL : Fair control 151-180 mg/dL : Unsatisfactory control >180 mg/dL : Poor control	mg/dL

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.

End Of Report

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