JINENDRA MUNOT
294, Sindh Housing Society Aundh

REPORT

Tel No: 919370707001
PID: 112395 Ref: --

Age:68.00 Years Sex:MALE

Reference:Dr.--

SID: 120062357
Collection Date:
17-08-2020 10:03 AM
Sample Date:
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Report Date:
17-08-2020 04:02 PM

Test Description	Observed Value	Biological Reference Interval
Lipid Profile Mini :		
Cholesterol (Total), serum by Enzymatic method	**165**	Desirable : < 200 mg/dL Borderline high : 200 - 239 mg/dL High : >/= 240 mg/dL
Triglycerides, serum by Enzymatic method	**181**	Normal : < 150 mg/dL Borderline high : 150-199 mg/dL High : 200-499 mg/dL Very high : >/= 500 mg/dL
HDL Cholesterol, serum by Enzymatic method	**35**	Men : > 40 mg/dL Women : > 50 mg/dL
VLDL Cholestrol, serum by calculation	**36**	< 30 mg/dL
LDL Cholesterol, serum by calculation	**94**	Optimal : <100 mg/dL Near optimal/above optimal : 100-129 mg/dL Borderline high : 130-159 mg/dL High : 160-189 mg/dL Very high : >/= 190 mg/dL
Cholesterol(Total)/HDL Cholesterol Ratio	**4.71**	Males : Acceptable ratio </= 5.00 Females : Acceptable ratio </= 4.50
LDL Cholesterol/HDL Cholesterol Ratio	**2.68**	Males : Acceptable ratio </= 3.60 Females : Acceptable ratio </= 3.20

Reference : ATP III, NCEP Guidelines and National Lipid Association (NLA) 2014 Recommendations

As per most international and national guidelines including Lipid Association of India 2016 :

1. Lipoprotein and lipid levels should be considered in conjunction with other atherosclerotic cardiovascular disease (ASCVD) risk determinants to assess treatment goals and strategies.
2. Non-fasting lipid levels can be used in screening and in general risk estimation.

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Test Description	Observed	Biological Reference Interval
Liver Function Test :		
Bilirubin-Total, serum by Diazo method	**0.79**	0.10 - 1.20 mg/dL Neonates : Upto 15.0 mg/dL
Bilirubin-Conjugated, serum by Diazo method	**0.28**	Upto 0.5 mg/dL
Bilirubin-Unconjugated, serum by calculation	**0.51**	0.1 to 1.0 mg/dL
SGOT (AST), serum by Enzymatic method	**16**	15 - 37 U/Lt
SGPT (ALT), serum by Enzymatic Method	**21**	16 to 63 U/Lt
Alkaline Phosphatase,serum by pNPP-kinetic	**68**	Adult Male : 46 - 116 U/Lt
Protein (total), serum by Biuret method	**7.09**	6.4 to 8.2 g/dL
Albumin, serum by Bromocresol purple method	**4.45**	3.4 to 5.0 g/dL
Globulin, serum by calculation	**2.64**	2.3 - 3.5 g/dL

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Test Description	Observed Value	Biological Reference Interval
TEST NAME		
Glycated Hemoglobin (HbA1C), by HPLC	**8.50**	4.0 to 5.6 %

Interpretation :
HbA1C level reflects the mean glucose concentration over previous 8-12 weeks and provides better indication of long term glycemic control.

For diagnosis of Diabetes Mellitus (>/= 18 yrs of age) :
5.7 % - 6.4 % : Increased risk for developing diabetes.
>/= 6.5 % : Diabetes

Therapeutic goals for glycemic control :
Adults : < 7%
Toddlers and Preschoolers : < 8.5% (but > 7.5 %)
School age (6-12 yrs) : < 8%
Adolescents and young adults (13 - 19 yrs) : < 7.5 %

Levels of HbA1C may be low as result of shortened RBC life span in case of hemolytic anemia.
Increased HbA1C values may be found in patients with polycythemia or post splenectomy patients.
Patients with Homozygous forms of rare variant Hb(CC,SS,EE,SC) HbA1c can not be quantitated as there is no HbA. In such circumstances glycemic control can be monitored using plasma glucose levels or serum Fructosamine.

The A1c target should be individualized based on numerous factors, such as age, life expectancy, comorbid conditions, duration of diabetes, risk of hypoglycemia or adverse consequences from hypoglycemia, patient motivation and adherence.

Ref : ADA (Standards of Medical Care in Diabetes - 2017)

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Test Description	Observed Value	Biological Reference Interval
CRP(hs) by Nephelometry	**6.74**	See clinical information below

Clinical Information :

1. C-reactive protein (CRP) is a biomarker of inflammation. Plasma CRP concentrations increase rapidly and dramatically (100-fold or more) in response to tissue injury or inflammation.

2. High-sensitivity CRP (hs-CRP) is more precise than standard CRP when measuring baseline (i.e. normal) concentrations and enables a measure of chronic inflammation. It is recommended for cardiovascular risk assessment. Atherosclerosis is an inflammatory disease and hs-CRP has been endorsed by multiple guidelines as a biomarker of atherosclerotic cardiovascular disease risk.

Low cardiovascular risk : < 2.0 mg/L
High cardiovascular risk : >/= 2.0 mg/L
Acute inflammation : > 10.0 mg/L

3. A single test for high-sensitivity CRP (hs-CRP) may not reflect an individual patient's basal hs-CRP Repeat measurement may be required to firmly establish an individual's basal hs-CRP concentration. The lowest of the measurements should be used as the predictive value.

Reference : Mayo Medical Laboratories, 2018 Interpretive Handbook.

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Test Description	Observed Value	Biological Reference Interval
Plasma Glucose :		
Plasma glucose fasting, by Hexokinase method	**147**	< 100 mg/dL 100 to 125 mg/dL : Impaired fasting glucose tolerance / Prediabetes >/= 126 mg/dL : Suggestive of diabetes mellitus (On more than one occasion) American Diabetes Association Guidelines 2019

Clinical Chemistry

Urea, serum by GLDH-urease	**29**	17 to 49 mg/dL
BUN-Blood Urea Nitrogen,serum by calculation	**13.55**	8 to 23 mg/dL
Creatinine, serum by Jaffe w/o deproteinization	**1.06**	0.6 to 1.2 mg/dL
Uric Acid, serum by Uricase method	**5.90**	Male : 3.50 to 7.20 mg/dL

** Uric acid is useful for 1. Diagnosis and follow up of renal failure. 2. Monitoring patients receiving cytotoxic drugs and a variety of other disorders, including gout, leukemia, psoriasis, starvation and other wasting conditions . * Increased uric acid is seen in following conditions : 1. Increased purine synthesis 2. Inherited metabolic disorders 3. Excess dietary purine intake 4. Increased nucleic acid turnover 5. Malignancy, cytotoxic drugs 6. Decreased urinary excretion (due to CRF) 7. Increased renal reabsorption . * Uric acid is decreased in : 1. Hepatocellular disease with reduced purine synthesis 2. Defective renal reabsorption 3. Overtreatment of uricemia (allopurinol or cancer therpies like 6-mercaptopurine, etc).*

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Test Description	Observed Value	Biological Reference Interval

Clinical Chemistry :

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"Laboratory is accredited as per ISO 15189:2012, Certificate Number MC-3143. Scope available on request / @ ww

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MD (Pathology)

Dr. Vinanti Golwilkar
MD (Pathology)

Test Description	Observed value	Biological Reference Interval
HOMA Index Insulin Resistance Test		
Plasma glucose fasting, by Hexokinase method	**147**	< 100 mg/dL 100 to 125 mg/dL : Impaired fasting glucose tolerance / Prediabetes >/= 126 mg/dL : Suggestive of diabetes mellitus (On more than one occasion) American Diabetes Association Guidelines 2019
Insulin Fasting, Serum by CMIA	**3.60**	Fasting : 2.5 to 25 µU/mL Peak upto 150 µU/mL
HOMA IR Index	**1.31**	> 2.5 indicates insulin resistance

Interpretation

1. As, the direct measurement of the insulin effect on the blood sugar concentration is not possible other indices are used for determining an insulin resistance.
2. One of the most common indices is the HOMA index (Homeostasis Model Assessment), which is calculated according to the following formula:
   HOMA index = fasting insulin (µU/ml) X fasting blood sugar (mg/dl) /405
3. Indications :
   * Adiposis (BMI > 28 kg/m²)
   * Suspected insulin resistance (metabolic syndrome, diabetes mellitus type 2)
   * Suspected polycystic ovary syndrome (PCO-S)
   * Cycle disturbances (e. g. amenorrhea)
   * Infertility
4. Reference ranges :
   > 2.0 indication for insulin resistance
   > 2.5 insulin resistance probable
   > 5.0 average value in patients with diabetes mellitus type 2

Reference : https://www.bioscientia.de/en/files/2011/10/Marker

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Test Description	Observed Value	Reference range & Units
TEST NAME		
Homocysteine,plasma by CMIA	**17.70**	Male : 5.08 to 15.39 µmol/Lt

Homocysteine concentration is an indicator of acquired folate or cobalamin deficiency, and is a contributing factor in the pathogenesis of neural tube defects. Currently, the use of homocysteine for assessment of cardiovascular risk is uncertain and controversial. Based on several meta-analyses, at present, homocysteine may be regarded as a weak risk factor for coronary heart disease, and there is a lack of direct causal relationship between hyperhomocysteinemia and cardiovascular disease. It is most likely an indicator of poor lifestyle and diet. Homocysteine concentrations >13 mcmol/L are considered abnormal in patients evaluated for suspected nutritional deficiencies (B12, folate) and inborn errors of metabolism. Homocysteine concentrations < or =10 mcmol/L are desirable when utilized for cardiovascular risk.

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Urine Routine Examination	Result	Biological Reference Interval
(Sample : Urine, Automated / Semiautomated)		
Physical		
Quantity Examined	**5.0**	ml
Method : Visual		
Appearance	**Clear**	-
Method : Visual / Automated		
Colour	**Pale yellow**	-
Method : Visual / Automated		
Chemical (Dipstick)		
pH	**6.5**	4.6 - 8.0
Method : Indicator Principle		
Protein	**Absent**	Absent
Method : Sulphosalycylic Acid/ pH Indicator		
Glucose	**Absent**	Absent
Method : GOD-POD / Benedict's		
Acetone	**Absent**	Absent
Method : Sodium Nitroprusside reaction		
Bile Pigments	**Absent**	Absent
Method : Diazo Reaction / Fouchet's test		
Urobilinogen	**Not significant**	Not Significant
Method : Modified Ehrlich / Watson Schwartz		
Microscopy / Flow cytometry		
R.B.Cs	**Absent**	0 - 2 per hpf
Pus cells	**1-2**	0 - 5 per hpf
Epithelial cells	**Occasional**	0 - 5 per hpf
Casts	**Not detected**	-
Crystals	**Not detected**	-
-	**#*-**	

End of Report

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