ALISHA BAHETI
E-801 Amar Renaissance
Sopan Baug Pune

REPORT

Tel No: 919764521111
PID: 112589

Age:29.20 Years Sex:FEMALE

Reference:Dr.--

SID: 120156092

Collection Date:
18-12-2020 12:26 PM
Registration Date:
18-12-2020 12:26 pm
Report Date:
18-12-2020 04:02 PM

Test Description	Observed Value	Biological Reference Interval
TEST NAME		
Glycated Hemoglobin (HbA1C), by HPLC	**4.90**	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)

MC-3143

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Test Description	Observed Value	Biological Reference Interval
Hormones :		
T3 (Total), serum by CMIA	**1.06**	0.64 to 1.52 ng/ml
T4 (Total), serum by CMIA	**8.63**	4.87 to 11.72 µg/dL
TSH(Ultrasensitive), serum by CMIA	**2.86**	For non pregnant female : 0.40 - 4.00 µIU/mL For pregnant female : 1st trimester : 0.1 - 2.5 µIU/mL 2nd trimester : 0.2 - 3.0 µIU/mL 3rd trimester : 0.3 - 3.0 µIU/mL Ref : American Thyroid Association guidelines 2017
FSH - Follicle Stimulating Hormone, Serum by CMIA (11 Days Of Cycle)	**4.77**	Females : Follicular phase : 1.40 - 9.90 mIU/mL Midcycle : 0.20 - 17.20 mIU/mL Luteal phase : 1.10 - 9.20 mIU/mL Menopause : 19.30 - 100.60 mIU/mL
LH-Leutinising Hormone Specific, serum by CMIA	**9.02**	Female : Follicular phase : 1.90 - 14.60 mIU/mL Midcycle : 12.20 - 118.00 mIU/mL Luteal phase : 0.70 - 12.90 mIU/mL Menopause : 5.30 - 65.40 mIU/mL

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Test Description	Observed Value	Biological Reference Interval
TEST NAME		
Vitamin B12, serum by CMIA	**258.0**	187 - 883 pg/mL

Interpretation :

1. Vitamin B12 (cobalamin) is necessary for hematopoiesis and normal neuronal function.

2. Vitamin B12 is decreased in

Decreased Serum B12
Pregnancy
Contraceptive hormones
Malabsorption
Ethanol ingestion
Smoking
Strict vegan diet
Pernicious anemia

3. Serum methylmalonic acid and homocysteine levels are also elevated in vitamin B12 deficiency states. Active B12 (Holotranscobalamin) is low in Vitamin B12 deficiency.

4. Please correlate in case of patients taking vitamin B12 supplementation.

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Test Description	Observed Value	Biological Reference Interval
Prolactin (HPRL) Total , serum by CMIA	**13.28**	Female : 5.18 - 26.53 ng/mL

Interpretation :

MALE:

Hyperprolactinaemia in males may be associated with decreased libido, impotence, infertility, gynaecomastia.

FEMALE:

Prolactin secretion from pituitary shows significant diurnal, episodic and cyclical variations.

Following is a suggested approach to hyperprolactinaemia in females -

5.18 to 26.53 ng/mL : Normal

26.53 to 50 ng/mL : Mild prolactin excess
Often seen with physiological conditions like physical/emotional stress, exercise, pregnancy, lactation etc. This may not be associated with clinical hyperprolactinaemia & needs review after a month.

51 to 75 ng/mL : Moderate prolactin excess
Often associated with clinical hyperprolactinaemia(short luteal phase,oligomennorrhea), hypothyroidism (often subclinical) Macroprolactinaemia to be ruled out.

Above 100 ng/mL : Marked prolactin excess
Associated with clinical hyperprolactinaemia-hypogonadism, amenorrhea, galactorrhea, hypothyroidism(often subclinical) Macroprolactinaemia to be ruled out.

Above 200 ng/mL : Marked prolcatin excess
Required further workup High levels may be repeated with tripcoled sample.

References:

1. Diagnosis & Treatment of hyperprolactinaemia. The endocrine society clinical practice guideline, 2011
2. Diagnosis & Management of hyperprolactinaemia. Canadian Medical Association CMAJ Sep 16 2003; 169(6)

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Test Description	Observed Value	Biological Reference Interval
TEST NAME		
25 - OH Vitamin D, serum by CMIA	**17.40**	Severe deficiency : < 10 ng/mL Mild to moderate deficiency : 10 to 19 ng/mL Optimum levels : 20 to 50 ng/mL Increased risk of hypercalciuria: 51 to 80 ng/mL Toxicity possible : > 80 ng/mL Ref. : Mayo Medical Laboratories These reference ranges represent clinical decision values, based on the 2011 Institute of Medicine report

Interpretation :
Vitamin D is vital for strong bones. It also has important, emerging roles in immune function and cancer prevention.

Vitamin D compounds in the body are exogenously derived by dietary means; from plants as 25-hydroxyvitamin D2 (ergocalciferol or calciferol) or from animal products as 25-hydroxyvitamin D3 (cholecalciferol or calcidiol).

Vitamin D may also be endogenously derived by conversion of 7-dihydrocholesterol to 25-hydroxyvitamin D3 in the skin upon ultraviolet exposure.

The total 25-hydroxyvitamin D (25-OH-VitD) level (the sum of 25-OH-vitamin D2 and 25-OH-vitamin D3) is the appropriate indicator of vitamin D body stores.

Patients with renal failure can have very high 25-OH-VitD levels without any signs of toxicity, as renal conversion to the active hormone 1,25-OH-VitD is impaired or absent.

Kindly corelate clinically, with supplementation history & repeat with fresh sample if necessary.

End of Report

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