Dr Lal PathLabs

Lab: No.1, L.S.C., Pocket-B, Sec.-7, Nelson Mandela Marg, Vasant Kunj, New Delhi-110070, Tel: 011-26134810/25
Regd. Office/National Reference Lab: Dr. Lal PathLabs Ltd., Block E, Sector-18, Rohini, New Delhi - 110085
Tel: +91-11-30244-100, 3988-5050, Fax: +91-11-2788-2134, E-mail: lalpathlabs@lalpathlabs.com
Web: www.lalpathlabs.com, CIN No.: L74899DL1995PLC065388

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MC-2011

Name	: **Mr. RACHIT GUPTA**			**Collected**	: **13/1/2020 9:04:00AM**
Lab No.	: **150667094**	**Age: 35 Years**	**Gender: Male**	**Received**	: **13/1/2020 9:17:23AM**
				Reported	: **13/1/2020 1:45:05PM**
A/c Status	: **P**	**Ref By : SELF**		**Report Status**	: **Final**

Test Name	Results	Units	Bio. Ref. Interval
LIVER & KIDNEY PANEL, SERUM (Spectrophotometry, Indirect ISE)			
Bilirubin Total	0.62	mg/dL	0.30 - 1.20
Bilirubin Direct	0.10	mg/dL	<0.20
Bilirubin Indirect	0.52	mg/dL	<1.10
AST (SGOT)	25	U/L	<50
ALT (SGPT)	43	U/L	<50
GGTP	39	U/L	<55
Alkaline Phosphatase (ALP)	**<30**	U/L	30 - 120
Total Protein	7.66	g/dL	6.40 - 8.30
Albumin	4.27	g/dL	3.50 - 5.20
A : G Ratio	1.26		0.90 - 2.00
Urea	35.30	mg/dL	17.00 - 43.00
Creatinine	0.97	mg/dL	0.67 - 1.17

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Test Name	Results	Units	Bio. Ref. Interval
Uric Acid	**7.40**	mg/dL	3.50 - 7.20
Calcium, Total	9.84	mg/dL	8.80 - 10.60
Phosphorus	**4.48**	mg/dL	2.40 - 4.40
Sodium	137.10	mEq/L	136.00 - 146.00
Potassium	3.96	mEq/L	3.50 - 5.10
Chloride	101.40	mEq/L	101.00 - 109.00

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Test Name	Results	Units	Bio. Ref. Interval
COMPLETE BLOOD COUNT;CBC (Electrical Impedence,Flow cytometry & SLS)			
Hemoglobin	15.10	g/dL	13.00 - 17.00
Packed Cell Volume (PCV)	45.30	%	40.00 - 50.00
RBC Count	5.36	mill/mm3	4.50 - 5.50
MCV	84.50	fL	80.00 - 100.00
MCH	28.20	pg	27.00 - 32.00
MCHC	33.30	g/dL	32.00 - 35.00
Red Cell Distribution Width (RDW)	13.10	%	11.50 - 14.50
Total Leukocyte Count (TLC)	7.94	thou/mm3	4.00 - 10.00
Differential Leucocyte Count (DLC)			
Segmented Neutrophils	58.20	%	40.00 - 80.00
Lymphocytes	33.10	%	20.00 - 40.00
Monocytes	6.80	%	2.00 - 10.00
Eosinophils	1.80	%	1.00 - 6.00
Basophils	0.10	%	<2.00
Absolute Leucocyte Count			
Neutrophils	4.62	thou/mm3	2.00 - 7.00
Lymphocytes	2.63	thou/mm3	1.00 - 3.00
Monocytes	0.54	thou/mm3	0.20 - 1.00
Eosinophils	0.14	thou/mm3	0.02 - 0.50
Basophils	0.01	thou/mm3	0.01 - 0.10
Platelet Count	294.0	thou/mm3	150.00 - 450.00

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Test Name	Results	Units	Bio. Ref. Interval
Mean Platelet Volume (MPV)	9.70	fL	6.50 - 12.00

Note

1. As per the recommendation of International council for Standardization in Hematology, the differential leucocyte counts are additionally being reported as absolute numbers of each cell in per unit volume of blood

2. Test conducted on EDTA whole blood

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Test Name	Results	Units	Bio. Ref. Interval
HbA1c (GLYCOSYLATED HEMOGLOBIN), BLOOD (HPLC)			
HbA1c	5.6	%	
Estimated average glucose (eAG)	114	mg/dL	

Interpretation

As per American Diabetes Association (ADA)	
Reference Group	HbA1c in %
Non diabetic adults >=18 years	4.0 - 5.6
At risk (Prediabetes)	5.7 - 6.4
Diagnosing Diabetes	>= 6.5
Therapeutic goals for glycemic control	. Goal of therapy: < 7.0 . Action suggested: > 8.0

Note

1. Since HbA1c reflects long term fluctuations in the blood glucose concentration, a diabetic patient who is recently under good control may still have a high concentration of HbA1c. Converse is true for a diabetic previously under good control but now poorly controlled
2. Target goals of < 7.0 % may be beneficial in patients with short duration of diabetes, long life expectancy and no significant cardiovascular disease. In patients with significant complications of diabetes, limited life expectancy or extensive co-morbid conditions, targeting a goal of < 7.0 % may not be appropriate
3. Any condition that shortens erythrocyte survival such as sickle cell disease, pregnancy (second and third trimesters), hemodialysis, recent blood loss or transfusion, or erythropoietin will falsely lower HbA1c results regardless of the assay method
4. In patients with HbA1c level between 7-8%, Glycemark (1,5 Anhydroglucitol) test may be done to identify those with more frequent and extreme hyperglycemic excursions

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Test Name	Results	Units	Bio. Ref. Interval

Comments

HbA1c provides an index of average blood glucose levels over the past 8 - 12 weeks and is a much better indicator of long term glycemic control as compared to blood and urinary glucose determinations. This single test can be used both for diagnosing & monitoring diabetes. ADA recommends measurement of HbA1c 3-4 times per year in Type 1 diabetes and poorly controlled Type 2 diabetes patients. In well controlled Type 2 diabetes patients, the test can be performed twice a year.

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Test Name	Results	Units	Bio. Ref. Interval
THYROID PROFILE,TOTAL, SERUM (Chemiluminescent Immunoassay)			
T3, Total	0.98	ng/mL	0.60 - 1.81
T4, Total	8.10	ug/dL	5.01 - 12.45
TSH	1.37	uIU/mL	0.35 - 5.50

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. Recommended test for T3 and T4 is unbound fraction or free levels as it is metabolically active.
3. Physiological rise in Total T3 / T4 levels is seen in pregnancy and in patients on steroid therapy.

Clinical Use

- Primary Hypothyroidism
- Hyperthyroidism
- Hypothalamic - Pituitary hypothyroidism
- Inappropriate TSH secretion
- Nonthyroidal illness
- Autoimmune thyroid disease
- Pregnancy associated thyroid disorders
- Thyroid dysfunction in infancy and early childhood

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Test Name	Results	Units	Bio. Ref. Interval
LIPID PROFILE, SCREEN (Spectrophotometry)			
Cholesterol, Total	**208.00**	mg/dL	<200.00
Triglycerides	**181.00**	mg/dL	<150.00
HDL Cholesterol	**28.10**	mg/dL	>40.00
LDL Cholesterol, Calculated	**143.70**	mg/dL	<100.00
VLDL Cholesterol,Calculated	**36.20**	mg/dL	<30.00
Non-HDL Cholesterol	**180**	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
4. NLA-2014 identifies Non HDL Cholesterol(an indicator of all atherogeniclipoproteins such as LDL ,

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Test Name	Results	Units	Bio. Ref. Interval

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

VITAMIN B12; CYANOCOBALAMIN, SERUM (CLIA)	466.00	pg/mL	211.00 - 911.00

Notes

1. Interpretation of the result should be considered in relation to clinical circumstances.
2. It is recommended to consider supplementary testing with plasma Methylmalonic acid (MMA) or plasma homocysteine levels to determine biochemical cobalamin deficiency in presence of clinical suspicion of deficiency but indeterminate levels. Homocysteine levels are more sensitive but MMA is more specific
3. The concentration of Vitamin B12 obtained with different assay methods cannot be used interchangeably due to differences in assay methods and reagent specificity

Comments

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Vitamin B12 performs many important functions in the body, but the most significant function is to act as co-enzyme for reducing ribonucleotides to deoxyribonucleotides, a step in the formation of genes. Inadequate dietary intake is not the commonest cause for cobalamine deficiency. The most common cause is malabsorption either due to atrophy of gastric mucosa or diseases of terminal ileum. Cobalamine deficiency leads to Megaloblastic anemia and demyelination of large nerve fibres of spinal cord. Normal body stores are sufficient to last for 3-6 years. Sources of Vitamin B12 are liver, shellfish, fish, meat, eggs, milk, cheese & yogurt.

Decreased Levels

- **Lack of Intrinsic factor:** Total or partial gastrectomy, Atrophic gastritis, Intrinsic factor antibodies
- **Malabsorption**: Regional ileitis, resected bowel, Tropical Sprue, Celiac disease, pancreatic insufficiency, bacterial overgrowth & achlorhydria
- **Loss of ingested vitamin B12:** fish tapeworm
- **Dietary deficiency:** Vegetarians
- **Congenital disorders:** Orotic aciduria & transcobalamine deficiency
- **Increased demand**: Pregnancy specially last trimester

Increased Levels

Chronic renal failure, Congestive heart failure, Acute & Chronic Myeloid Leukemia, Polycythemia vera, Carcinomas with liver metastasis, Liver disease, Drug induced cholestasis & Protein malnutrition

VITAMIN D, 25 - HYDROXY, SERUM (CLIA)	61.54	nmol/L

Interpretation

LEVEL	REFERENCE RANGE IN nmol/L	COMMENTS
Deficient	< 50	High risk for developing bone disease
Insufficient	50-74	Vitamin D concentration which normalizes Parathyroid hormone concentration
Sufficient	75-250	Optimal concentration for maximal health benefit

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Test Name	Results	Units	Bio. Ref. Interval
Potential intoxication	>250	High risk for toxic effects	

Note

- The assay measures both D2 (Ergocalciferol) and D3 (Cholecalciferol) metabolites of vitamin D.
- 25 (OH)D is influenced by sunlight, latitude, skin pigmentation, sunscreen use and hepatic function.
- Optimal calcium absorption requires vitamin D 25 (OH) levels exceeding 75 nmol/L.
- It shows seasonal variation, with values being 40-50% lower in winter than in summer.
- Levels vary with age and are increased in pregnancy.
- A new test Vitamin D, Ultrasensitive by LC-MS/MS is also available

Comments

Vitamin D promotes absorption of calcium and phosphorus and mineralization of bones and teeth. Deficiency in children causes Rickets and in adults leads to Osteomalacia. It can also lead to Hypocalcemia and Tetany. Vitamin D status is best determined by measurement of 25 hydroxy vitamin D, as it is the major circulating form and has longer half life (2-3 weeks) than 1,25 Dihydroxy vitamin D (5-8 hrs).

Decreased Levels

- Inadequate exposure to sunlight
- Dietary deficiency
- Vitamin D malabsorption
- Severe Hepatocellular disease
- Drugs like Anticonvulsants
- Nephrotic syndrome

Increased levels

Vitamin D intoxication

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Dr Neha Tyagi
MD Pathology
Chief of Laboratory
Dr Lal PathLabs Ltd

Dr Bhavika Rishi
MD, Pathology
Consultant Pathologist
Dr Lal PathLabs Ltd

Dr Rachna Malik
MD, Pathology
Consultant Pathologist
Dr Lal PathLabs Ltd

----------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.