LARA SUBHAKANT SAHU E 301 Callifornia Next

Orchid Palace NIBM Road

Pune

Tel No: 919958218333

PID: 1196622

Reference: Dr.--SID: 121060641

121060641

Collection Date: 06-05-2021 12:59 PM Sample Date:

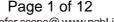
06-05-2021 12:59 pm Report Date:

06-05-2021 05:35 PM

Age:45.80 Years Sex:FEMALE

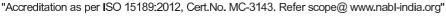
| Complete Blood Count | Result | Biological Reference Interval |
|---|---------|-------------------------------|
| (EDTA Whole Blood) | | |
| Hemoglobin (Hb), EDTA whole blood | 13.30 | 12.3 - 15.3 g/dL |
| Method: Photometry | | |
| Total Leucocytes (WBC) count | 6,900 | 4000-10000/μL |
| Method : Coulter Principle / Microscopy | | |
| Platelet count | 183,000 | 150000 - 450000 /µL |
| Method : Coulter Principle / Microscopy | | |
| Red blood cell (RBC) count | 4.23 | 4.10 - 5.10 x 10^6 /μL |
| Method: Coulter Principle | | |
| PCV (Packed Cell Volume) | 39.70 | 35.9 - 44.6 % |
| Method: Calculated | | |
| MCV (Mean Corpuscular Volume) | 93.90 | 80.0 - 96.0 fL |
| Method: Derived from RBC histogram | | |
| MCH (Mean Corpuscular Hb) | 31.40 | 27.5 - 33.2 pgms |
| Method: Calculated | | |
| MCHC (Mean Corpuscular Hb Conc.) | 33.50 | 33.4 - 35.5 g/dL |
| Method: Calculated | | |
| RDW (RBC distribution width) | 14.10 | 11.6 - 14.6 % |
| Method: Derived from RBC Histogram | | |
| WBC Differential Count | | |
| Method: VCSn / Microscopy / Calculated | | |
| Neutrophils | 69 | 40 - 80 % |
| Absolute Neutrophils | 4,761 | 2000 - 7000 /μL |
| | | |
| Eosinophils | 1 | 1 - 6 % |
| Absolute Eosinophils | 69 | 20 - 500 /μL |
| | | |
| Basophils | 0 | 0 - 2 % |
| Absolute Basophils | 0 | 0 - 100 /µL |
| | | 00 40 04 |
| Lymphocytes | 22 | 20 - 40 % |
| Absolute Lymphocytes | 1,518 | 1000 - 3000 /μL |
| Monocytes | 8 | 2 - 10 % |
| Absolute Monocytes | 552 | 200 - 1000 /μL |
| | #*- | 200 1000/μΕ |
| • | # - | |







Molwilkan



Dr. Awanti Golwilkar

MBBS, MD (Pathology)

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Complete Blood Count Findings

R.B.C. : Normocytic, Normochromic

W.B.C. : No abnormality detected

Platelets : Adequate

Remark : --

-

-

-

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F----

Age:45.80 Years Sex:FEMALE

Test Description Observed Value Biological Reference Interval

<u>Lipid Profile Mini :</u>

Cholesterol (Total), serum by Enzymatic 212 Desirable : < 200 mg/dL

method

Borderline high: 200 - 239 mg/dL

High : >/= 240 mg/dL

Triglycerides, serum by Enzymatic method 84 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 74 Men: > 40 mg/dL

Women: > 50 mg/dL

VLDL Cholestrol, serum by calculation 17 < 30 mg/dL

LDL Cholesterol, serum by calculation 121 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 2.86 Males : Acceptable ratio

Females : Acceptable ratio </= 4.50

LDL Cholesterol/HDL Cholesterol Ratio 1.64 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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Age:45.80 Years Sex:FEMALE

| Test Description | Observed | Biological Reference Interval |
|--|----------|--|
| Liver Function Test: | | |
| Bilirubin-Total, serum by Diazo method | 0.70 | 0.10 - 1.20 mg/dL Neonates : Upto 15.0 mg/dL |
| Bilirubin-Conjugated, serum by Diazo method | 0.20 | Upto 0.5 mg/dL |
| Bilirubin-Unconjugated, serum by calculation | 0.50 | 0.1 to 1.0 mg/dL |
| SGOT (AST), serum by Enzymatic method | 21 | >or= 14 years : 8 - 43 U/Lt |
| SGPT (ALT), serum by Enzymatic Method | 18 | 7 to 45 U/Lt |
| Alkaline Phosphatase, serum by pNPP-kinetic | 41 | Adult Female : (Unit : U/Lt.). 15 - < 17 years : 50 - 117 > or =17 years: 35 - 104 |
| Protein (total), serum by Biuret method | 7.70 | 6.4 to 8.2 g/dL |
| Albumin, serum by Bromocresol purple method | 4.60 | 3.4 to 5.0 g/dL |
| Globulin, serum by calculation | 3.10 | 2.3 - 3.5 g/dL |
| | | |

--XX--



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Age:45.80 Years Sex:FEMALE

Observed Value Biological Reference Interval

TEST NAME

Test Description

Glycated Hemoglobin (HbA1C), by HPLC 5.60 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 |
|---|----------------|-------------------------------|
| Clinical Chemistry : | | |
| Urea, serum by GLDH-urease | 33 | 17 to 49 mg/dL |
| BUN-Blood Urea Nitrogen, serum by calculation | 15.42 | 8 to 23 mg/dL |
| Creatinine, serum by Jaffe w/o deproteinization | 0.89 | 0.6 to 1.2 mg/dL |
| Uric Acid, serum by Uricase method | 5.10 | Female: 2.60 to 6.00 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:



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^{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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06-05-2021 05:35 PM

Test Description Observed Value Biological Reference Interval

Clinical Chemistry:

Hormones

TSH(Ultrasensitive), serum by CMIA **2.41** For non pregnant female :

0.40 - $4.00 \,\mu\text{IU/mL}$ For pregnant female :

1st trimester : 0.1 - 2.5 μ IU/mL 2nd trimester : 0.2 - 3.0 μ IU/mL 3rd trimester : 0.3 - 3.0 μ IU/mL Ref : American Thyroid Association

guidelines 2017

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Carrying forward Dr. Ajit Golwilkar's legacy of Over Four Decades



Dr. Awanti GolwilkarMBBS, MD (Pathology)

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06-05-2021 05:35 PM

F----

Age:45.80 Years Sex:FEMALE

Observed Value Biological Reference Interval

TEST NAME

Test Description

Vitamin B12, serum by CMIA **377.0** 187 - 883 pg/mL

Interpretation:

- 1. Vitamin B12 (cobalamin) is necessary for hematopoiesis and normal neuronal function.
- 2. Vitamin B12 is decreased in

| Decre | eased Serum B12 |
|-------|---------------------|
| Preg | gnancy |
| Con | traceptive hormones |
| Mala | absorption |
| Etha | nol ingestion |
| Smo | oking |
| Stric | t vegan diet |
| Per | nicious 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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121060641

Test Description

Age:45.80 Years Sex:FEMALE

Observed value **Biological Reference Interval**

HOMA Index Insulin Resistance Test

Plasma glucose fasting, by Hexokinase method < 100 mg/dL 84

> 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 2020

Insulin Fasting, Serum by CMIA 2.90 Fasting: 2.5 to 25 µU/mL

Peak upto 150 µU/mL

HOMA IR Index > 2.5 indicates insulin resistance 0.60

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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MBBS, MD (Pathology)

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Carrying forward

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06-05-2021 12:59 pm Report Date:

Age:45.80 Years Sex:FEMALE

Observed Value Biological Reference Interval

TEST NAME

Test Description

25 - OH Vitamin D, serum by CMIA 25.40 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.

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> 121060641 Collection Date:

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Age:45.80 Years Sex:FEMALE 06-05-2021 05:35 PM **Urine Routine Examination** Result **Biological Reference Interval**

(Sample: Urine, Automated / Semiautomated)

Physical

Quantity Examined 5.0 ml

Method: Visual

Slightly Turbid **Appearance**

Method: Visual / Automated

Colour Pale yellow

Method: Visual / Automated

Chemical (Dipstick)

рΗ 5.5 4.6 - 8.0

Method: Indicator Principle

Absent Protein Absent

Method: Sulphosalycylic Acid/ pH Indicator

Glucose **Absent** Absent

Method: GOD-POD/Benedict's

Acetone **Absent** Absent

Method : Sodium Nitroprusside reaction

Absent Bile Pigments Absent

Method: Diazo Reaction / Fouchet's test

Urobilinogen Not significant Not Significant

Method: Modified Ehrlich / Watson Schwartz

Microscopy / Flow cytometry

R.B.Cs 1-2 0 - 2 per hpf

Pus cells 1-2 0 - 5 per hpf

Epithelial cells 2-3 0 - 5 per hpf

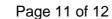
Not Detected Casts

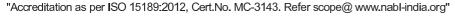
Crystals Not Detected

<-->

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CRP(hs) - C- Reactive Protein high sensitivity

PID: 1196622

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F----

Age:45.80 Years Sex:FEMALE

Observed Value

Biological Reference Interval

See clinical information below

Method: Nephelometry / Immunoturbidimetry

Clinical Information:

Test Description

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.

1.12

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/LHigh cardiovascular risk : >/= 2.0 mg/LAcute 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 level. 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

End of Report

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