Name	: **Mr. Mr Aman Ankur**	Age / Sex	: 33 Year(s) / Male	Collected On	: 07/03/2025 08:07 AM
Patient ID	: OHP46D3D1252442	Ref. Doctor	:	Received On	: 07/03/2025 11:17 AM
Visit No.	: BL126133001	Client	: Getvisit TPA	Reported On	: 07/03/2025 01:47 PM

BL126133001

CLINICAL PATHOLOGY

Urine Routine Analysis
Urine

PHYSICAL EXAMINATION
Manual

Volume	50	ml	
Colour	Pale yellow		Pale yellow
Appearance	Clear		Clear

CHEMICAL EXAMINATION

pH Double indicator method	6.0		5.0-8.0
Specific gravity Refractive Index	1.030		1.001-1.035
Urine Protein Protein error of pH indicator	Nil		Nil
Glucose Enzyme method GOD POD	Nil		Nil
Ketone bodies Dipstick	Nil		Nil
Bilirubin Azo coupling method	Nil		Nil

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BL126133001

Blood Peroxidase activity	Negative	Negative
Urobilinogen Azo coupling method	Normal	Normal
Leucocyte Esterase Granulocyte esterase method	Negative	Negative
Nitrites Griess method	Negative	Negative

-- End of Report --

Tests marked with NABL symbol are accredited by NABL vide Certificate no MC-6367

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MD Pathologist

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BL126133002

BIOCHEMISTRY

Fasting Glucose F- fluoride plasma,GOD-POD	85	mg/dL	Normal Fasting Glucose: 70-99 Impaired Fasting Glucose: 100-125 Diabetes : on more than one occasion: > 126

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BL126133002

LFT - LIVER FUNCTION TEST

Serum

Total Bilirubin DSA	0.65	mg/dL	Adult: 0.2-1.3 Neonate: 1.0-10.5
Direct Bilirubin Calculated	0.33	mg/dL	Neonate: 0.0-0.6 Adult: 0.0-0.3
Indirect Bilirubin Dual wavelength	0.32	mg/dL	Adult: 0.1-1.1 Neonate: 0.6-10.5
Aspartate Transaminase(AST/ SGOT) MDH, UV Kinetic	26	U/L	17-49
Alanine Transaminase(ALT/ SGPT) LDH, UV kinetic	30	U/L	< 50
Alkaline Phosphatase PNPP, AMP Buffer	70	U/L	38-126
Gamma-Glutamyl Transferase (GGT) SZAZ Carboxylated Substrate	17	U/L	15-73
Total Protein Biuret	7.2	g/dL	6.0-8.3
Albumin Bromo-Cresol Green	4.4	g/dL	3.5-5.0
Globulin Calculated	2.7	g/dL	2.3-3.5
A/G ratio Calculated	1.6		0.8-2.0

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SGOT/SGPT- RATIO Calculated	0.9	0.7-1.4

Total bilirubin is invariably increased in jaundice. Causes of jaundice are prehepatic, resulting from various hemolytic diseases; hepatic, resulting from hepatocellular injury or obstruction; and posthepatic, resulting from obstruction of the hepatic or common bile ducts.
Aspartate aminotransferase is present in high activity in heart, skeletal muscle, and liver. Increased serum AST activity commonly follows myocardial infarction, pulmonary emboli, skeletal muscle trauma, alcoholic cirrhosis, viral hepatitis, and drug-induced hepatitis.
Alanine aminotransferase is present in high activity in liver, skeletal muscle, heart, and kidney. Serum ALT increases rapidly in liver cell necrosis, hepatitis, hepatic cirrhosis, liver tumours, obstructive jaundice, Reye's syndrome, extensive trauma to skeletal muscle, myositis, myocarditis, and myocardial infarction.
Alkaline phosphatase is elevated in fever and increased bone metabolism, for example, in adolescents and during the healing of a fracture; primary and secondary hyperparathyroidism; Paget's disease of bone; carcinoma metastatic to bone; osteogenic sarcoma; and Hodgkin's disease if bones are invaded. Hepatobiliary diseases involving cholestasis, inflammation, or cirrhosis increased ALP activity; also increased in renal infarction and failure and in the complications of pregnancy. Low ALP activity may occasionally be seen in hypothyroidism.
Serum GGT is a sensitive indicator of hepatobiliary disease and is useful in the diagnosis of obstructive jaundice and chronic alcoholic liver disease, in the follow-up of chronic alcoholics undergoing treatment, and in the detection of hepatotoxicity. GGT is more responsive to biliary obstruction than AST, ALT, or ALP.
Total serum protein levels can be used for evaluation of nutritional status. Causes of high total serum protein concentration include dehydration, Waldenström's macroglobulinemia, multiple myeloma, hyperglobulinemia, granulomatous diseases, and some tropical diseases. Causes of low total serum protein concentration include pregnancy, excessive intravenous fluid administration, cirrhosis or other liver diseases, chronic alcoholism, heart failure, nephrotic syndrome, glomerulonephritis, neoplasia, protein-losing enteropathies, malabsorption, and severe malnutrition.

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Glycosylated Haemoglobin - (HbA1c)

Whole Blood

Glycosylated Haemoglobin (HbA1c) HPLC	4.8	%	Normal: < 5.7 Pre-Diabetes: 5.7-6.4 Diabetes: >= 6.5
Mean Blood Glucose Calculated	91	mg/dL	

HbA1C is used to monitor fluctuations in blood glucose concentration in the past 8 to 12 week's period.
The reference interval defined as per American Diabetes Association guidelines 2016:

a) Less than 5.7% : Non Diabetic
b) 5.7 to 6.4% : at increased risk of developing diabetes in the future
c) More than 6.5% : Diabetic
d) Therapeutic glycemic target:
i. Adults: less than 7%
ii. Children with Type 1 diabetes : less than 7 %
e) Pregnant diabetic patients : less than 6.5%

Note:
• Targets may be individualized based on: Age/life expectancy, Comorbid conditions, Diabetes duration , Hypoglycemia status, Individual patient considerations
Reference: American Diabetes Association. Standards of medical care in diabetes—2021.
Mean Blood Glucose is average Blood glucose which directly correlates with A1C, reported in the same units as blood sugar levels (mg/dl). Thus it reflects the average glucose concentration in the past 8 to 12 weeks period. This should not be compared with Fasting or Post prandial or random blood sugar which measures glucose concentration at that point of time of testing.

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Kidney Function Test Mini

Serum

Urea Urease	43	mg/dL	19-43 Newborn: 6.5-25.5
Creatinine Enzymatic	1.0	mg/dL	0.66-1.25
Blood Urea Nitrogen (BUN) Calculated	**20.1**	mg/dL	6-20
BUN Creatinine Ratio Calculated	**20.10**	Ratio	10-20
Calcium Arsenazo Method	9.3	mg/dL	8.4-10.2
Uric Acid Uricase	6.0	mg/dL	3.5-8.5
eGFR CKD EPI	103	ml/min/1.73 sq m	Normal: >= 90 Mild decrease: 60-89 Mild moderate decrease: 45-59 Severe decrease: 15-29 End stage kidney disease: < 15

Lipid Profile with calculated LDL

Serum

Total Cholesterol CHOD-POD	**224**	mg/dl	< 200
Triglycerides GPO-POD	**198**	mg/dL	< 150
HDL Cholesterol Direct	**34**	mg/dL	> 50

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Non-HDL Cholesterol Calculated	**190**	mg/dL	< 130
LDL Cholesterol Calculated	**150**	mg/dL	< 100
VLDL Cholesterol Calculated	**40**	mg/dL	< 30
Cholesterol / HDL Ratio Calculated	**6.6**		3.30-4.40
LDL:HDL RATIO Calculated	**4.4**		0.5-3.0
HDL/LDL RATIO Calculated	**0.2**	Ratio	> 0.4

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REMARKS	TOTAL CHOLESTEROL(mg/dL)	TRIGLYCERIDE(mg/dL)	LDL CHOLESTEROL(mg/dL)
Optimal	<200	<150	<100
Above Optimal	-	-	100-129
Borderline	200-239	150-199	130-159
High	>=240	200-499	160-189
Very High	-	>=500	>=190

Lipid profile is a group test consisting of various lipids. Lipid profiles are generally collected with overnight fasting. **However, Recent guidelines have recommended non fasting samples for lipid profile for assessment of cardiovascular risk. The details for the study can be checked at** https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2733560

In certain instances measurements in the same patient can show physiological and analytical variations. In such cases three serial samples at an interval of 1 week each are recommended for Total cholesterol, TG, HDL and LDL.

Cholesterol levels are increased in primary hypercholesterolemia; secondary hyperlipoproteinemia, including nephrotic syndrome; primary biliary cirrhosis; hypothyroidism; and in some cases, diabetes mellitus. Low cholesterol levels may be found in malnutrition, malabsorption, advanced malignancy, and hyperthyroidism.

Triglyceride levels are used in the diagnosis and treatment of patients with diabetes mellitus, nephrosis, liver obstruction, other diseases involving lipid metabolism, or various endocrine disorders.

High Density Lipoprotein (HDL) cholesterol levels is used to evaluate the risk of developing coronary heart disease (CHD). The risk of CHD increases with lower HDL cholesterol concentrations.

LDL (low-density lipoprotein) cholesterol level, sometimes called “bad” cholesterol, makes up most of our body’s cholesterol. High levels of LDL cholesterol raise your risk for heart disease and stroke.

Very-low-density lipoprotein (VLDL) cholesterol is produced in the liver and released into the bloodstream to supply body tissues with triglycerides. High levels of VLDL cholesterol have

been associated with the development of plaque deposits on artery walls, which narrow the passage and restrict blood flow.

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IMMUNOLOGY

Thyroid Stimulating Hormone (TSH) Serum,CLIA	2.486	µIU/mL	0.400-4.049

Thyroid Stimulating Hormone (TSH), also called Thyrotropin is a hormone secreted into the blood by the Pituitary gland (a gland present in the brain)). It signals the thyroid gland to make and release the thyroid hormones (T3 & T4) into the blood.

High TSH level indicates that the thyroid gland is not making enough thyroid hormone (primary hypothyroidism).

Low TSH level usually indicates that the thyroid is producing too much thyroid hormone (hyperthyroidism).

Factors influencing TSH levels

Fasting: TSH level shows a significant decline after meal intake in comparison to fasting values. This may have clinical implications in the diagnosis and management of hypothyroidism, especially Subclinical hypothyroidism.1

Circadian Rhythm: TSH levels follow a circadian variation, reaching peak levels between Morning 2 – 4 am and at a minimum between Evening 6-10 pm. The variation is of the order of 50%. hence time of sample collection during a day can significantly influence on the measured serum TSH concentrations.2

Other Factors: Genetics, Poisonous substances and radiation exposure, Inflammation of the thyroid gland, Deficiency or excess of iodine in the diet, Pregnancy, Certain medications – antidepressants, cholesterol lowering drugs, chemotherapy drugs, steroids, Thyroid cancer.

References:

1. Indian Journal of Endocrinology and Metabolism 18(5):p 705-707, Sep–Oct 2014.)

2. efaidnbmnnnibpcajpcglclefindmkaj/http://www.pnei-it.com/1/upload/thyrotropin_secretion_patterns_i n_health_and_disease.pdf

In pregnant females the reference range of TSH differs. Please refer the table below for the same:-

Pregnancy	TSH Reference Range (uIU/mL)
1st Trimester	0.129-3.120
2nd Trimester	0.274-2.652
3rd Trimester	0.312-2.947

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Vitamin D (25 OH Cholecalciferol) Serum,CLIA	33.1	ng/mL	Deficient: < 20 Insufficient: 20-30 Sufficient: 30-100 Toxicity: > 100

For the diagnosis of vitamin D deficiency it is recommended to have clinical correlation with serum 25 (OH)vitamin D, serum calcium, serum PTH & serum alkaline phosphatase.
During the monitoring of oral vitamin D therapy - suggested testing of serum 25(OH)vitamin D is after 12 weeks or 3 months of treatment. However, the required dosage of vitamin D supplements & time to achieve sufficient vitamin D levels show significant seasonal (especially winter) & individual variability depending on age, body fat, sun exposure, physical activity, genetic factors (especially variable vitamin D receptor responses), associated liver or renal disease, malabsorption syndromes and calcium or magnesium deficiency influencing the vitamin D metabolism.

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MD Pathologist

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HEMATOLOGY

Complete Blood Count with ESR

Whole Blood

RBC count DC Impedance method	5.32	mill/cu.mm	4.5-5.5
Haemoglobin (Hb) Cyanide-free SLS method	15.1	gm/dL	13.0-17.0
Haematocrit(PCV) Calculated	46.0	%	40-50
Mean Corpuscular Volume (MCV) Calculated	86.4	fL	83-101
Mean Corpuscular Haemoglobin(MCH) Calculated	28.4	pg	27-32
Mean Corpuscular Haemoglobin Concentration (MCHC) Calculated	32.8	g/dL	31.5-34.5
Red cell distribution width (RDW) Calculated	13.5	%	11.6-14.0
Mentzer Index Calculated	16.2	Index	Beta Thalassemia trait: < 14 Iron deficiency anaemia: >= 14
Sehgal index Calculated	1403.2	Index	Beta Thalassemia trait: < 972 Iron deficiency anaemia: >= 972

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Total WBC count - TC DC Impedance method	6940	cells/cu.mm	4000-10000

Differential Leucocyte Count - DC
Flow Cytometry

Neutrophils	65.6	%	40-80
Lymphocytes	24.7	%	20-40
Monocytes	6.8	%	2-10
Eosinophils	2.6	%	1-6
Basophils	0.3	%	0-2
Absolute Neutrophil Count Calculated	4553	/ cu.mm	2000-7000
Absolute Lymphocyte Count Calculated	1714	/ cu.mm	1000-3000
Absolute Monocyte Count Calculated	472	/ cu.mm	200-1000
Absolute Eosinophil Count Calculated	180	/ cu.mm	20-500
Absolute Basophil Count Calculated	21	/ cu.mm	0-100
Neutrophil Lymphocyte Ratio (NLR) Calculated	2.7	Ratio	1.0-3.0

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Platelet count DC Impedance method	283	10^3/ul	150-450
Platelet hematocrit Calculated	0.285	%	0.20-0.50
Mean Platelet Volume (MPV) Calculated	10.1	fL	7-13
Erythrocyte Sedimentation Rate (ESR) Quantitative Capillary Photometry	4	mm/hr	0-10

1. Reference Ranges are in accordance with Dacie & Lewis Practical Hematology International Edition (12th).
2. As per International Council for Standardization in Hematology's recommendations Differential Leucocyte counts are additionally reported in Absolute numbers in each cell per unit volume of blood.

-- End of Report --

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