DIAGNOSTIC REPORT

MC-6515

agilus diagnostics

PATIENT NAME : ANKIT	**REF. DOCTOR :** SELF	
ANKIT GR SANKALP , D-415 560099	ACCESSION NO : **0278YA001822** PATIENT ID : ANKIM504584650 CLIENT PATIENT ID: ANKIM504584650 ABHA NO :	AGE/SEX : 37 Years Male DRAWN : 30/01/2025 10:30:00 RECEIVED : 30/01/2025 12:12:31 REPORTED : 30/01/2025 16:05:04

Test Report Status **Final**	Results	Biological Reference Interval	Units

HAEMATOLOGY - CBC

COMPLETE CARE ACTIVE MEN

BLOOD COUNTS, EDTA WHOLE BLOOD

HEMOGLOBIN (HB) METHOD : SLS METHOD	15.0	13.0 - 17.0	g/dL
RED BLOOD CELL (RBC) COUNT METHOD : AUTOMATED CELL COUNTER:HYDRO DYNAMIC FOUSING (DC DETECTION)	5.28	4.5 - 5.5	mil/µL
WHITE BLOOD CELL (WBC) COUNT METHOD : FLOW CYTOMETRY/MANUAL MICROSCOPY	9.23	4.0 - 10.0	thou/µL
PLATELET COUNT METHOD : AUTOMATED CELL COUNTER:HYDRO DYNAMIC FOUSING (DC DETECTION)	348	150 - 410	thou/µL

RBC AND PLATELET INDICES

HEMATOCRIT (PCV) METHOD : AUTOMATED CELL COUNTER :PULSE HEIGHT DETECTION	45.0	40 - 50	%
MEAN CORPUSCULAR VOLUME (MCV) METHOD : CALCULATED PARAMETER	85.2	83.0 - 101.0	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	28.4	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC) METHOD : AUTOMATED CELL COUNTER : CALCULATED PARAMETER	33.3	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW) METHOD : AUTOMATED CELL COUNTER : CALCULATED PARAMETER	13.8	11.6 - 14.0	%
MEAN PLATELET VOLUME (MPV) METHOD : AUTOMATED CELL COUNTER : CALCULATED PARAMETER	9.6	6.8 - 10.9	fL

WBC DIFFERENTIAL COUNT

NEUTROPHILS METHOD : FLOW CYTOMETRY/MANUAL MICROSCOPY	64	40 - 80	%
LYMPHOCYTES METHOD : FLOW CYTOMETRY/MANUAL MICROSCOPY	26	20 - 40	%
MONOCYTES METHOD : FLOW CYTOMETRY/MANUAL MICROSCOPY	7	2 - 10	%
EOSINOPHILS	3	1 - 6	%

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ULR No.775000010990001-0081

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agilus diagnostics

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ANKIT
GR SANKALP , D-415
560099

ACCESSION NO : **0278YA001822**
PATIENT ID : ANKIM504584650
CLIENT PATIENT ID: ANKIM504584650
ABHA NO :

AGE/SEX : 37 Years Male
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METHOD : FLOW CYTOMETRY/MANUAL MICROSCOPY			
BASOPHILS	0	< 1 - 2	%
METHOD : FLOW CYTOMETRY/MANUAL MICROSCOPY			
ABSOLUTE NEUTROPHIL COUNT	5.91	2.0 - 7.0	thou/µL
METHOD : FLOW CYTOMETRY METHOD / MICROSCOPY			
ABSOLUTE LYMPHOCYTE COUNT	2.40	1.0 - 3.0	thou/µL
METHOD : FLOW CYTOMETRY METHOD / MICROSCOPY			
ABSOLUTE MONOCYTE COUNT	0.65	0.2 - 1.0	thou/µL
METHOD : FLOW CYTOMETRY METHOD / MICROSCOPY			
ABSOLUTE EOSINOPHIL COUNT	0.28	0.02 - 0.50	thou/µL
METHOD : FLOW CYTOMETRY METHOD / MICROSCOPY			
ABSOLUTE BASOPHIL COUNT	0.00	0.0 - 0.1	thou/µL
METHOD : FLOW CYTOMETRY METHOD / MICROSCOPY			

Interpretation(s)
RBC AND PLATELET INDICES-Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia(>13) from Beta thalassaemia trait (<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.
WBC DIFFERENTIAL COUNT-The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR < 3.3, COVID-19 patients tend to show mild disease. (Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients A.-P. Yang, et al. International Immunopharmacology 84 (2020) 106504
This ratio element is a calculated parameter and out of NABL scope.

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HAEMATOLOGY

COMPLETE CARE ACTIVE MEN

GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

HBA1C	5.6	Non-diabetic Adult < 5.7 Pre-diabetes 5.7 - 6.4 Diabetes diagnosis: > or = 6.5 Therapeutic goals: < 7.0 Action suggested : > 8.0 (ADA Guideline 2021)	%
METHOD : HPLC			
ESTIMATED AVERAGE GLUCOSE(EAG)	114.0	< 116.0	mg/dL

Interpretation(s)
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD-**Used For**:

1. Evaluating the long-term control of blood glucose concentrations in diabetic patients.
2. Diagnosing diabetes.
3. Identifying patients at increased risk for diabetes (prediabetes).

The ADA recommends measurement of HbA1c (typically 3-4 times per year for type 1 and poorly controlled type 2 diabetic patients, and 2 times per year for well-controlled type 2 diabetic patients) to determine whether a patients metabolic control has remained continuously within the target range.

1. eAG (Estimated average glucose) converts percentage HbA1c to md/dl, to compare blood glucose levels.
2. eAG gives an evaluation of blood glucose levels for the last couple of months.
3. eAG is calculated as eAG (mg/dl) = 28.7 * HbA1c - 46.7

HbA1c Estimation can get affected due to :
1. Shortened Erythrocyte survival : Any condition that shortens erythrocyte survival or decreases mean erythrocyte age (e.g. recovery from acute blood loss,hemolytic anemia) will falsely lower HbA1c test results.Fructosamine is recommended in these patients which indicates diabetes control over 15 days.
2.Vitamin C & E are reported to falsely lower test results.(possibly by inhibiting glycation of hemoglobin.
3. Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia,uremia, hyperbilirubinemia, chronic alcoholism,chronic ingestion of salicylates & opiates addiction are reported to interfere with some assay methods,falsely increasing results.
4. Interference of hemoglobinopathies in HbA1c estimation is seen in

a) Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.
b) Heterozygous state detected (D10 is corrected for HbS & HbC trait.)
c) HbF > 25% on alternate paltform (Boronate affinity chromatography) is recommended for testing of HbA1c.Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy

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BIOCHEMISTRY

COMPLETE CARE ACTIVE MEN

GLUCOSE FASTING,FLUORIDE PLASMA

FBS (FASTING BLOOD SUGAR)	95	(Normal <100,Impaired fasting glucose:100 to 125,Diabetes mellitus:>=126(on more than 1 occasion)(ADA guidelines 2024)	mg/dL

METHOD : HEXOKINASE

LIVER FUNCTION PROFILE, SERUM

BILIRUBIN, TOTAL	0.49	Upto 1.2	mg/dL
METHOD : DIAZO COLORIMETRIC			
BILIRUBIN, DIRECT	0.25	< or = 0.3	mg/dL
METHOD : COLORIMETRIC DIAZO METHOD			
BILIRUBIN, INDIRECT	0.24	0.1 - 1.0	mg/dL
METHOD : CALCULATED PARAMETER			
TOTAL PROTEIN	6.7	6.0 - 8.0	g/dL
METHOD : BIURET, END POINT			
ALBUMIN	4.4	3.97 - 4.94	g/dL
METHOD : BROMOCRESOL GREEN (BCG)DYE BINDING			
GLOBULIN	2.3	2.0 - 3.5	g/dL
METHOD : CALCULATED PARAMETER			
ALBUMIN/GLOBULIN RATIO	1.9	1.0 - 2.1	RATIO
METHOD : CALCULATED PARAMETER			
ASPARTATE AMINOTRANSFERASE(AST/SGOT)	19	< OR = 50	U/L
METHOD : SPECTROPHOTOMETRY, WITH PYRIDOXAL PHOSPHATE ACTIVATION-IFCC			
ALANINE AMINOTRANSFERASE (ALT/SGPT)	34	< OR = 50	U/L
METHOD : SPECTROPHOTOMETRY, WITH PYRIDOXAL PHOSPHATE ACTIVATION-IFCC			
ALKALINE PHOSPHATASE	129	40 - 129	U/L
METHOD : PNPP, AMP BUFFER-IFCC			
GAMMA GLUTAMYL TRANSFERASE (GGT)	29	0 - 60	U/L
METHOD : G-GLUTAMYL-CARBOXY-NITROANILIDE			
LACTATE DEHYDROGENASE	141	125 - 220	U/L
METHOD : SPECTROPHOTOMETRY, LACTATE TO PYRUVATE - UV-IFCC			

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PHOSPHORUS, SERUM			
PHOSPHORUS	3.1	2.5 - 4.5	mg/dL
METHOD : SPECTROPHOTOMETRY, MOLYBDATE UV METHOD			
MAGNESIUM, SERUM			
MAGNESIUM, SERUM	2.3	1.6 - 2.6	mg/dL
METHOD : XYLIDYL BLUE			

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COMPLETE CARE ACTIVE MEN			
KIDNEY FUNCTION TEST, SERUM			
BLOOD UREA NITROGEN	14	6 - 20	mg/dL
METHOD : KINETIC TEST WITH UREASE AND GLUTAMATE DEHYDROGENASE			
CREATININE	**0.83 Low**	0.90 - 1.30	mg/dL
METHOD : SPECTROPHOTOMETRY, ALKALINE PICRATE KINETIC JAFFE'S			
BUN/CREAT RATIO	**16.87 High**	8.0 - 15.0	
METHOD : CALCULATED PARAMETER			
URIC ACID	6.4	3.4 - 7.0	mg/dL
METHOD : SPECTROPHOTOMETRY, URICASE			
TOTAL PROTEIN	6.7	6.0 - 8.0	g/dL
METHOD : BIURET, END POINT			
ALBUMIN	4.4	3.97 - 4.94	g/dL
METHOD : BROMOCRESOL GREEN (BCG)DYE BINDING			
GLOBULIN	2.3	2.0 - 3.5	g/dL
METHOD : CALCULATED PARAMETER			
CALCIUM	9.5	8.6 - 10.0	mg/dL
METHOD : NM-BAPTA			
SODIUM, SERUM	139	135 - 145	mmol/L
METHOD : ISE INDIRECT			
POTASSIUM, SERUM	4.44	3.5 - 5.3	mmol/L
METHOD : ISE INDIRECT			
CHLORIDE, SERUM	102	97 - 110	mmol/L
METHOD : ISE INDIRECT			
APOLIPOPROTEIN A1/B RATIO, SERUM			
APOLIPOPROTEIN A1	1.27	1.04 - 2.02	g/L
METHOD : IMMUNOTURBIDIMETRIC ASSAY			
APOLIPOPROTEIN - B	1.32	0.66 - 1.44	g/L
METHOD : IMMUNOTURBIDIMETRIC ASSAY			
APOLIPOPROTEIN B / A1 RATIO	1.0		RATIO

Interpretation(s)
GLUCOSE FASTING,FLUORIDE PLASMA-**TEST DESCRIPTION**

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Normally, the glucose concentration in extracellular fluid is closely regulated so that a source of energy is readily available to tissues and sothat no glucose is excreted in the urine.
Increased in:Diabetes mellitus, Cushing' s syndrome (10 – 15%), chronic pancreatitis (30%). Drugs:corticosteroids,phenytoin, estrogen, thiazides.
Decreased in :Pancreatic islet cell disease with increased insulin,insulinoma,adrenocortical insufficiency,hypopituitarism,diffuse liver disease, malignancy(adrenocortical,stomach,fibrosarcoma),infant of a diabetic mother,enzyme deficiency diseases(e.g.galactosemia),Drugs-insulin,ethanol,propranolol sulfonylureas,tolbutamide,and other oral hypoglycemic agents.
NOTE: While random serum glucose levels correlate with home glucose monitoring results (weekly mean capillary glucose values),there is wide fluctuation within individuals.Thus, glycosylated hemoglobin(HbA1c) levels are favored to monitor glycemic control.
High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment,Renal Glyosuria,Glycaemic index & response to food consumed,Alimentary Hypoglycemia,Increased insulin response & sensitivity etc.
LIVER FUNCTION PROFILE, SERUM-
Bilirubin is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. Bilirubin is excreted in bile and urine, and elevated levels may give yellow discoloration in jaundice.**Elevated levels** results from increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Conjugated (direct) bilirubin is elevated more than unconjugated (indirect) bilirubin in Viral hepatitis, Drug reactions, Alcoholic liver disease Conjugated (direct) bilirubin is also elevated more than unconjugated (indirect) bilirubin when there is some kind of blockage of the bile ducts like in Gallstones getting into the bile ducts, tumors &Scarring of the bile ducts. Increased unconjugated (indirect) bilirubin may be a result of Hemolytic or pernicious anemia, Transfusion reaction & a common metabolic condition termed Gilbert syndrome, due to low levels of the enzyme that attaches sugar molecules to bilirubin.
AST is an enzyme found in various parts of the body. AST is found in the liver, heart, skeletal muscle, kidneys, brain, and red blood cells, and it is commonly measured clinically as a marker for liver health. AST levels increase during chronic viral hepatitis, blockage of the bile duct, cirrhosis of the liver,liver cancer,kidney failure,hemolytic anemia,pancreatitis,hemochromatosis. AST levels may also increase after a heart attack or strenuous activity.ALT test measures the amount of this enzyme in the blood.ALT is found mainly in the liver, but also in smaller amounts in the kidneys,heart,muscles, and pancreas.It is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health.AST levels increase during acute hepatitis,sometimes due to a viral infection,ischemia to the liver,chronic hepatitis,obstruction of bile ducts,cirrhosis.
ALP is a protein found in almost all body tissues.Tissues with higher amounts of ALP include the liver,bile ducts and bone.Elevated ALP levels are seen in Biliary obstruction, Osteoblastic bone tumors, osteomalacia, hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, Pagets disease,Rickets,Sarcoidosis etc. Lower-than-normal ALP levels seen in Hypophosphatasia,Malnutrition,Protein deficiency,Wilsons disease.
GGT is an enzyme found in cell membranes of many tissues mainly in the liver,kidney and pancreas.It is also found in other tissues including intestine,spleen,heart, brain and seminal vesicles.The highest concentration is in the kidney,but the liver is considered the source of normal enzyme activity.Serum GGT has been widely used as an index of liver dysfunction.Elevated serum GGT activity can be found in diseases of the liver,biliary system and pancreas.Conditions that increase serum GGT are obstructive liver disease,high alcohol consumption and use of enzyme-inducing drugs etc.
Total Protein also known as total protein,is a biochemical test for measuring the total amount of protein in serum.Protein in the plasma is made up of albumin and globulin.Higher-than-normal levels may be due to:Chronic inflammation or infection,including HIV and hepatitis B or C,Multiple myeloma,Waldenstroms disease.Lower-than-normal levels may be due to: Agammaglobulinemia,Bleeding (hemorrhage),Burns,Glomerulonephritis,Liver disease, Malabsorption,Malnutrition,Nephrotic syndrome,Protein-losing enteropathy etc.
Albumin is the most abundant protein in human blood plasma.It is produced in the liver.Albumin constitutes about half of the blood serum protein.Low blood albumin levels (hypoalbuminemia) can be caused by:Liver disease like cirrhosis of the liver, nephrotic syndrome,protein-losing enteropathy,Burns,hemodilution,increased vascular permeability or decreased lymphatic clearance,malnutrition and wasting etc
MAGNESIUM, SERUM-Description- Magnesium is primariliy an intracellular ion associated with GI absorption and renal excretion. Second most abundant ion in bone.It functions as co-factor in numerous enzymes e.g. ATPase . 65-70% of Mg is in ionized state and nearly 35% is protein bound.

Interpretation-
Increased in- Dehydration, Tissue trauma, Renal failure, Hypothyroidism, excessive intake of antacid.
Decrease in- Chronic diarrhea, Enteric fistula, Starvation, Chronic alcoholism, Total parenteral Nutrition, Diuretics.

Note- Hypomagnesemia is associated with weakness, tetany, disorientation and somnolence

Limitation-
• Hemolysis yields elevated levels of Mg being an intracellular ion.
• Serum magnesium levels may remain normal even when total body stores of magnesium are depleted upto 20%

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BIOCHEMISTRY - LIPID

COMPLETE CARE ACTIVE MEN

LIPID PROFILE WITH CALCULATED LDL, SERUM

CHOLESTEROL, TOTAL	**207 High**	Desirable : < 200 Borderline : 200 - 239 High : > / = 240	mg/dL
METHOD : ENZYMATIC (CHE/CHO/POD)			
TRIGLYCERIDES	138	Normal: < 150 Borderline high: 150 - 199 High: 200 - 499 Very High: >/= 500	mg/dL
METHOD : ENZYMATIC COLORIMETRIC ASSAY			
HDL CHOLESTEROL	**29 Low**	At Risk: < 40 Desirable: > or = 60	mg/dL
METHOD : HOMOGENEOUS ENZYMATIC COLORIMETRIC ASSAY			
CHOLESTEROL LDL	**150 High**	Adult levels: Optimal < 100 Near optimal/above optimal: 100-129 Borderline high : 130-159 High : 160-189 Very high : = 190	mg/dL
METHOD : CALCULATED PARAMETER			
NON HDL CHOLESTEROL	**178 High**	Desirable : < 130 Above Desirable : 130 -159 Borderline High : 160 - 189 High : 190 - 219 Very high : > / = 220	mg/dL
METHOD : CALCULATED PARAMETER			
VERY LOW DENSITY LIPOPROTEIN	27.6	< OR = 30.0	mg/dL
METHOD : CALCULATED PARAMETER			
CHOL/HDL RATIO	**7.1 High**	Low Risk : 3.3 - 4.4 Average Risk : 4.5 - 7.0 Moderate Risk : 7.1 - 11.0 High Risk : > 11.0	
METHOD : CALCULATED PARAMETER			
LDL/HDL RATIO	**5.2 High**	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
METHOD : CALCULATED PARAMETER			

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Interpretation(s)

Serum lipid profile is measured for cardiovascular risk prediction. Lipid Association of India recommends LDL-C as primary target and Non HDL-C as co-primary treatment target.

Risk Stratification for ASCVD (Atherosclerotic cardiovascular disease) by Lipid Association of India

Risk Category	
Extreme risk group	A.CAD with > 1 feature of high risk group
	B. CAD with > 1 feature of Very high risk group or recurrent ACS (within 1 year) despite LDL-C < or = 50 mg/dl or polyvascular disease
Very High Risk	1. Established ASCVD 2. Diabetes with 2 major risk factors or evidence of end organ damage 3. Familial Homozygous Hypercholesterolemia
High Risk	1. Three major ASCVD risk factors. 2. Diabetes with 1 major risk factor or no evidence of end organ damage. 3. CKD stage 3B or 4. 4. LDL >190 mg/dl 5. Extreme of a single risk factor. 6. Coronary Artery Calcium - CAC >300 AU. 7. Lipoprotein a >/= 50mg/dl 8. Non stenotic carotid plaque
Moderate Risk	2 major ASCVD risk factors
Low Risk	0-1 major ASCVD risk factors

Major ASCVD (Atherosclerotic cardiovascular disease) Risk Factors	
1. Age > or = 45 years in males and > or = 55 years in females	3. Current Cigarette smoking or tobacco use
2. Family history of premature ASCVD	4. High blood pressure
5. Low HDL	

Newer treatment goals and statin initiation thresholds based on the risk categories proposed by LAI in 2020.

Risk Group	**Treatment Goals**		**Consider Drug Therapy**	
	LDL-C (mg/dl)	**Non-HDL (mg/dl)**	**LDL-C (mg/dl)**	**Non-HDL (mg/dl)**
Extreme Risk Group Category A	<50 (Optional goal < OR = 30)	< 80 (Optional goal <OR = 60)	>OR = 50	>OR = 80
Extreme Risk Group Category B	<OR = 30	<OR = 60	> 30	>60
Very High Risk	<50	<80	>OR= 50	>OR= 80
High Risk	<70	<100	>OR= 70	>OR= 100
Moderate Risk	<100	<130	>OR= 100	>OR= 130
Low Risk	<100	<130	>OR= 130*	>OR= 160

*After an adequate non-pharmacological intervention for at least 3 months.

References: Management of Dyslipidaemia for the Prevention of Stroke: Clinical Practice Recommendations from the Lipid Association of India. Current Vascular Pharmacology, 2022, 20, 134-155.

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Bangalore, 560076
Karnataka, India
Tel : 80-66214444, Fax :
CIN - U74899PB1995PLC045956

ULR No.775000010990001-0081

DIAGNOSTIC REPORT

MC-6515

agilus diagnostics

PATIENT NAME : ANKIT	**REF. DOCTOR :** SELF	
ANKIT GR SANKALP , D-415 560099	ACCESSION NO : **0278YA001822** PATIENT ID : ANKIM504584650 CLIENT PATIENT ID: ANKIM504584650 ABHA NO :	AGE/SEX : 37 Years Male DRAWN : 30/01/2025 10:30:00 RECEIVED : 30/01/2025 12:12:31 REPORTED : 30/01/2025 16:05:04

Test Report Status **Final**	Results	Biological Reference Interval	Units

NEPHELOMETRY

COMPLETE CARE ACTIVE MEN

HIGH SENSITIVITY C-REACTIVE PROTEIN, SERUM

HIGH SENSITIVITY CRP	**3.81 High**	Low risk for CAD: < 1.00 Average risk for caD: 1.00 - 3.00 High risk for CAD: > 3.00	mg/L

METHOD : PARTICLE ENHANCED IMMUNOTURBIDIMETRIC ASSAY

Interpretation(s)
HIGH SENSITIVITY C-REACTIVE PROTEIN, SERUM-High sensitivity CRP measurements may be used as an independent risk marker for the identification of individuals at risk for future cardiovascular disease. Measurement of hs- CRP, when used in conjunction with traditional clinical laboratory evaluation of acute coronary syndromes, may be useful as an independent marker of prognosis for recurrent events, in patients with stable coronary disease or acute coronary syndromes.
When using this assay for risk assessment, patients with persistently unexplained, marked elevation of hs- CRP (> 10mg/l) after repeated testing should be evaluated for non cardiovascular etiologies. In Rheumatic and other inflammatory diseases, value of CRP less than 10 mg/l is considered satisfactory. More than 10 mg/l suggests disease activity. Patients with evidence of active infection, systemic inflammatory processes or trauma should not be tested for cardiovascular disease risk assessment until these conditions have abated
Hs- CRP levels should not be substituted for assessment of traditional cardiovascular risk factors.
Turbidity and particles in the sample may interfere with the determination. Patient samples which contain heterophilic antibodies could react in immunoassays to give a falsely elevated or depressed result.
Results of this test should always be interpreted in conjunction with the patient's medical history, clinical presentation and other findings.

References:

1. Teitz textbook of clinical chemistry and Molecular diagnostics, edited by Carl A Burtis, Edward R. Ashrwood, David E Bruns, 4th edition, Elseiver publication, 2006,962-966
2. Parson TA, Mensah GA, et al. Marker of inflammation and cardiovascular disease: application to clinical and public health practice. Circulation 2003,107,499-511
3. Rheumatoid arthritis disease activity measures: American College of Rheumatology recommendations for use in clinical practice: Jacyln Anderson, Liron Caplin et al, Wiley online, 2012.

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ENDOCRINOLOGY

COMPLETE CARE ACTIVE MEN

THYROID PANEL II (FT3,FT4,TSH) SERUM

FREE TRIIODOTHYRONINE (FT3)	3.50	2 - 4.4	pg/mL
METHOD : ELECTROCHEMILUMINESCENCE IMMUNO ASSAY			
FREE THYROXINE (FT4)	1.32	0.93 - 1.7	ng/dL
METHOD : ELECTROCHEMILUMINESCENCE IMMUNO ASSAY			
TSH (ULTRASENSITIVE)	3.010	0.27 - 4.2	µIU/mL
METHOD : ELECTROCHEMILUMINESCENCE IMMUNO ASSAY			

Interpretation(s)

Sr. No.	TSH	FT4	FT3	Possible Conditions
1	High	Low	Low	(1) Primary Hypothyroidism (2) Chronic autoimmune Thyroiditis (3) Post Thyroidectomy (4) Post Radio-Iodine treatment
2	High	Normal	Normal	(1)Subclinical Hypothyroidism (2) Patient with insufficient thyroid hormone replacement therapy (3) In cases of Autoimmune/Hashimoto thyroiditis (4). Isolated increase in TSH levels can be due to Subclinical inflammation, drugs like amphetamines, Iodine containing drug and dopamine antagonist e.g. domperidone and other physiological reasons.
3	Normal/Low	Low	Low	(1) Secondary and Tertiary Hypothyroidism
4	Low	High	High	(1) Primary Hyperthyroidism (Graves Disease) (2) Multinodular Goitre (3)Toxic Nodular Goitre (4) Thyroiditis (5) Over treatment of thyroid hormone (6) Drug effect e.g. Glucocorticoids, dopamine, T4 replacement therapy (7) First trimester of Pregnancy
5	Low	Normal	Normal	(1) Subclinical Hyperthyroidism
6	High	High	High	(1) TSH secreting pituitary adenoma (2) TRH secreting tumor
7	Low	Low	Low	(1) Central Hypothyroidism (2) Euthyroid sick syndrome (3) Recent treatment for Hyperthyroidism
8	Normal/Low	Normal	High	(1) T3 thyrotoxicosis (2) Non-Thyroidal illness
9	Low	High	Normal	(1) T4 Ingestion (2) Thyroiditis (3) Interfering Anti TPO antibodies

REF: 1. TIETZ Fundamentals of Clinical chemistry 2.Guidlines of the American Thyroid association duriing pregnancy and Postpartum, 2011.

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SPECIALISED CHEMISTRY - ANEMIA

COMPLETE CARE ACTIVE MEN

SERUM IRON AND TIBC STUDIES

IRON	111	59 - 158	µg/dL
METHOD : FEROZINE			
TOTAL IRON BINDING CAPACITY	381	250 - 400	µg/dL
METHOD : CALCULATED PARAMETER			
% SATURATION	29	20 - 50	%
METHOD : CALCULATED PARAMETER			

Interpretation(s)
SERUM IRON AND TIBC STUDIES-Total iron binding capacity (TIBC) measures the blood's capacity to bind iron with transferrin and thus is an indirect way of assessing transferrin level.
Taken together with serum iron and percent transferrin saturation this test is performed when they is a concern about anemia, iron deficiency or iron deficiency anemia. However, because the liver produces transferrin, alterations in liver function (such as cirrhosis, hepatitis, or liver failure) must be considered when performing this test.
Increased in:
- iron deficiency
- acute and chronic blood loss
- acute liver damage
- progesterone birth control pills

Decreased in:
- hemochromatosis
- cirrhosis of the liver
- thalassemia
- anemias of infection and chronic diseases
- nephrosis
- hyperthyroidism

The percent Transferrin saturation = Serum Iron/TIBC x 100
Unsaturated Binding Capacity (UIBC)=TIBC - Serum Iron.
Limitations: Estrogens and oral contraceptives increase TIBC and Asparaginase, chloramphenicol, corticotropin, cortisone and testosterone decrease the TIBC level.

Reference:
1.Tietz Textbook of Clinical Chemistry and Molecular Diagnostics, edited by Carl A Burtis, Edward R.Ashwood, David E Bruns, 4th Edition, Elsevier publication, 2006, 563, 1314-1315.
2. Wallach's Interpretation of Diagnostic tests, 9th Edition, Ed Mary A Williamson and L Michael Snyder. Pub Lippincott Williams and Wilkins, 2011, 234-235.

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CLINICAL PATH - URINALYSIS

COMPLETE CARE ACTIVE MEN

PHYSICAL EXAMINATION, URINE

COLOR	PALE YELLOW		
APPEARANCE	**SLIGHTLY HAZY**		

CHEMICAL EXAMINATION, URINE

PH	5.5	4.6 - 8.0	
SPECIFIC GRAVITY	1.025	1.003 - 1.035	
PROTEIN	NOTDETECTED		
GLUCOSE	NOTDETECTED		
KETONES	NOTDETECTED		
BLOOD	**DETECTED (+)**	NOT DETECTED	
BILIRUBIN	NOTDETECTED		
UROBILINOGEN	NOTDETECTED		
NITRITE	NOTDETECTED		
LEUKOCYTE ESTERASE	NOTDETECTED		

MICROSCOPIC EXAMINATION, URINE

RED BLOOD CELLS	**3 - 5**	NOT DETECTED	/HPF
PUS CELL (WBCS)	0-1	0-5	/HPF
EPITHELIAL CELLS	0-1	0-5	/HPF
CASTS	NOT DETECTED		
CRYSTALS	NOT DETECTED		
BACTERIA	NOT DETECTED	NOT DETECTED	
YEAST	NOT DETECTED	NOT DETECTED	

Interpretation(s)

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The following table describes the probable conditions, in which the analytes are present in urine

Presence of	Conditions
Proteins	Inflammation or immune illnesses
Pus (White Blood Cells)	Urinary tract infection, urinary tract or kidney stone, tumors or any kind of kidney impairment
Glucose	Diabetes or kidney disease
Ketones	Diabetic ketoacidosis (DKA), starvation or thirst
Urobilinogen	Liver disease such as hepatitis or cirrhosis
Blood	Renal or genital disorders/trauma
Bilirubin	Liver disease
Erythrocytes	Urological diseases (e.g. kidney and bladder cancer, urolithiasis), urinary tract infection and glomerular diseases
Leukocytes	Urinary tract infection, glomerulonephritis, interstitial nephritis either acute or chronic, polycystic kidney disease, urolithiasis, contamination by genital secretions
Epithelial cells	Urolithiasis, bladder carcinoma or hydronephrosis, ureteric stents or bladder catheters for prolonged periods of time
Granular Casts	Low intratubular pH, high urine osmolality and sodium concentration, interaction with Bence-Jones protein
Hyaline casts	Physical stress, fever, dehydration, acute congestive heart failure, renal diseases
Calcium oxalate	Metabolic stone disease, primary or secondary hyperoxaluria, intravenous infusion of large doses of vitamin C, the use of vasodilator naftidrofuryl oxalate or the gastrointestinal lipase inhibitor orlistat, ingestion of ethylene glycol or of star fruit (Averrhoa carambola) or its juice
Uric acid	arthritis
Bacteria	Urinary infectionwhen present in significant numbers & with pus cells.
Trichomonas vaginalis	Vaginitis, cervicitis or salpingitis

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SPECIALISED CHEMISTRY - TUMOR MARKER

COMPLETE CARE ACTIVE MEN

PROSTATE SPECIFIC ANTIGEN, SERUM

PROSTATE SPECIFIC ANTIGEN	0.488	< or = 1.40	ng/mL

METHOD : ELECTROCHEMILUMINESCENCE IMMUNO ASSAY

Interpretation(s)
PROSTATE SPECIFIC ANTIGEN, SERUM-- PSA is detected in the male patients with normal, benign hyperplastic and malignant prostate tissue and in patients with prostatitis.
- PSA is not detected (or detected at very low levels) in the patients without prostate tissue (because of radical prostatectomy or cystoprostatectomy) and also in the female patients.
- It a suitable marker for monitoring of patients with Prostate Cancer and it is better to be used in conjunction with other diagnostic procedures.
- Serial PSA levels can help determine the success of prostatectomy and the need for further treatment, such as radiation, endocrine or chemotherapy and useful in detecting residual disease and early recurrence of tumor.
- Elevated levels of PSA can be also observed in the patients with non-malignant diseases like Prostatitis and Benign Prostatic Hyperplasia.
- Specimens for total PSA assay should be obtained before biopsy, prostatectomy or prostatic massage, since manipulation of the prostate gland may lead to elevated PSA (false positive) levels persisting up to 3 weeks.
- As per American urological guidelines, PSA screening is recommended for early detection of Prostate cancer above the age of 40 years. Following Age specific reference range can be used as a guide lines.
- Measurement of total PSA alone may not clearly distinguish between benign prostatic hyperplasia (BPH) from cancer, this is especially true for the total PSA values between 4-10 ng/mL.
- Total PSA values determined on patient samples by different testing procedures cannot be directly compared with one another and could be the cause of erroneous medical interpretations. Recommended follow up on same platform as patient result can vary due to differences in assay method and reagent specificity.

References-
1. Burtis CA, Ashwood ER, Bruns DE. Teitz textbook of clinical chemistry and Molecular Diagnostics. 4th edition.
2. Williamson MA, Snyder LM. Wallach's interpretation of diagnostic tests. 9th edition.

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SPECIALISED CHEMISTRY - VITAMIN

COMPLETE CARE ACTIVE MEN

25 - HYDROXYVITAMIN D(VITAMIN D TOTAL), SERUM

25 - HYDROXYVITAMIN D	26.7	Deficiency: < 20.0 Insufficiency: 20.0 - < 30.0 Sufficiency: 30.0 -100.0 Toxicity > 100.0	ng/mL

METHOD : ELECTROCHEMILUMINESCENCE IMMUNO ASSAY

VITAMIN B12(CYANOCOBALAMINE), SERUM

VITAMIN B12	**157 Low**	197 - 771	pg/mL

METHOD : ELECTROCHEMILUMINESCENCE IMMUNO ASSAY

Interpretation(s)
25 - HYDROXYVITAMIN D(VITAMIN D TOTAL), SERUM-**Test description**
Vitamin D has anti-inflammatory and immune-modulating properties and it works towards the bones, teeth, intestines, immune system, pancreas, muscles and brain. It helps to maintain normal calcium and phosphate levels.Vitamin D is a fat-soluble vitamin. Also called as "Sunshine Vitamin".Two main forms as Cholecalciferol (vitamin D3) which is synthesized in skin from 7-dehydrocholesterol in response to sunlight (Type B UV) exposure & Ergocalciferol (vitamin D2) present mainly in dietary sources.
Vit D25(OH)D deficiency is seen due to poor or inadequate sunlight exposure, Nutritional or dietary deficiency or fat malabsorption, Severe Hepatocellular disease, Secondary hyperparathyroidism, Hypocalcemia tetany which can cause involuntary contraction of muscles, leading to cramps and spasms, Rickets in children, Osteomalacia in adults- due to vitamin D deficiency mainly, Older adults- osteoporosis. (Increased risk of bone fractures)due to long-term effect of calcium and/or vitamin D deficiency, Other conditions that are precipitated by Vit D deficiency included increased cardiovascular risk, low immunity & chronic renal failure.
Elevated levels may be seen in patients taking supplements(hence recommended to repeat after 3 months for estimation of accurate levels), Vitamin D intoxication, sarcoidosis and malignancies containing non regulated 1-alpha hydroxylase in the lesion.
Recommendations
1.To prevent biotin interference the patient should be atleast 8 hours fasting before submitting the sample 2.25(OH)D is the analyte of choice for determination of the Vitamin D status as it is the major storage & active form of Vitamin D and has longer half-life. 3. Kidney Disease Outcomes Quality Initiatives (KDOQI) and Kidney Disease Improving Global Outcomes (KDIGO) recommend activated vitamin D testing for CKD patients.
Note-Our Vitamin D assays is standardized to be in alignment with the ID-LC/MS/MS 25(OH)vitamin D Reference Method Procedure (RMP), the reference procedure for the Vitamin D Standardization Program (VDSP). The VDSP, a collaboration of the National Institutes of Health Office of Dietary Supplements, National Institute of Technology and Standards, Centers for Disease Control and Ghent University, is an initiative to standardize 25(OH)vitamin D measurement across methods.
Reference: 1.Wallach Interpretation of diagnostic test, 10th edition.
VITAMIN B12(CYANOCOBALAMINE), SERUM-**Test description**
1.Measures the amount of Vitamin B12/ Cyanocobalamin or Methyl cobalamin in blood.2. Done in Anemic conditions like Megaloblastic anemia, pernicious anemia, dietary folate deficiencies,3.Workup of neuropathies especially due to diabetes.4.Nerve health and it is monitored in treatment of nerve damage.5.Important vitamin for women of childbearing age and for older people.
1.Part of water-soluble B complex of vitamins. 2. It is essential in DNA synthesis, hematopoiesis & CNS integrity.3.Source for B12 is dietary foods like milk, yoghurt, eggs, meat, fortified cereals, bread. 4.Absorption depends on the HCl secreted by the stomach and occurs in intestines. 5. It is part of enterohepatic circulation, hence excreted in feces(approx. 0.1% per day)
Test interpretation
Higher than normal levels are in patients on Vitamin supplements or patients with COPD, CRF, Diabetes, Liver cell damage, Obesity, Polycythemia.
Decreased levels seen in
Inflammatory bowel disease, Pernicious anemia - genetic deficiency of intrinsic factor - necessary for Vit B12 absorption, Strict vegetarianslead to sub-clinical B12 deficiency- high among elderly patients, Malabsorption due to gastrectomy, smoking, pregnancy, multiple myeloma & hemodialysis, Alcohol & drugs like amino salicylic acid, anticonvulsants, cholestyramine, cimetidine, Hyperthyroidism (High levels of thyroid), Seen in mothers of children with (NTD) Neural tube defects- hence fortification and

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supplements are advised in expecting mothers
Recommendations-1.To prevent biotin interference the patient should be atleast 8 hours fasting before submitting the sample. 2. Vit B12 and Folic acid evaluated together in macrocytic anemias to avoid methyl folate trap. Carmel's composite criteria for inadequate Vit B12 status: Serum vitamin B12 < 148 pmol/L, or 148–258 pmol/L and MMA > 0.30µmol/L, or tHcy > 13 nmol/L (females) and >15 nmol/L (males).
Associated Test-Holo-TC: Marker of vitamin B12 status -specificity and sensitivity better than serum vitamin B12, hence recommended in boderline and deficient cases for confirmation.
References-O-Leary F, Samman S. Vitamin B12 in health and disease. Nutrients. 2010 Mar 2(3):299-316.

****End Of Report****
Please visit www.agilusdiagnostics.com for related Test Information for this accession

CONDITIONS OF LABORATORY TESTING & REPORTING

1. It is presumed that the test sample belongs to the patient named or identified in the test requisition form.
2. All tests are performed and reported as per the turnaround time stated in the AGILUS Directory of Services.
3. Result delays could occur due to unforeseen circumstances such as non-availability of kits / equipment breakdown / natural calamities / technical downtime or any other unforeseen event.
4. A requested test might not be performed if:
   i. Specimen received is insufficient or inappropriate
   ii. Specimen quality is unsatisfactory
   iii. Incorrect specimen type
   iv. Discrepancy between identification on specimen container label and test requisition form
5. AGILUS Diagnostics confirms that all tests have been performed or assayed with highest quality standards, clinical safety & technical integrity.
6. Laboratory results should not be interpreted in isolation; it must be correlated with clinical information and be interpreted by registered medical practitioners only to determine final diagnosis.
7. Test results may vary based on time of collection, physiological condition of the patient, current medication or nutritional and dietary changes. Please consult your doctor or call us for any clarification.
8. Test results cannot be used for Medico legal purposes.
9. In case of queries please call customer care (91115 91115) within 48 hours of the report.

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