

PO No : PO2955319850-952



Name	: Mr.ASHISH GUPTA	Client Name	: TATA 1MG BANGALORE
Age/Gender	: 34/Male	Registration Date	: 20-Jan-24 02:28 PM
Patient ID	: MGB655293	Collection Date	: 20/Jan/2024 11:38AM
Barcode ID/Order ID	: D7898651 / 8818621	Sample Receive Date	: 20/Jan/2024 03:11PM
Referred By	: Dr.	Report Status	: Final Report
Sample Type	: WHOLE BLOOD-EDTA	Report Date	: 20/Jan/2024 08:26PM

HAEMATOLOGY

MENS HEALTH CHECKUP ADVANCED

Test Name	Result	Unit	Bio. Ref. Interval	Method
Glycosylated Hemoglobin (HbA1c)	6.2	%	4-5.6	HPLC (NGSP certified)
Estimated average glucose (eAG)	131.24	mg/dL		Calculated

Comment:

Interpretation: HbA1c%

≤5.6	Normal
5.7-6.4	At Risk For Diabetes
≥6.5	Diabetes

Adapted from American Diabetes Association.

Comments:

A 3 to 6 monthly monitoring is recommended in diabetics. People with diabetes should get the test done more often if their blood sugar stays too high or if their healthcare provider makes any change in the treatment plan. HbA1c concentration represent the integrated values for blood glucose over the preceding 8-12 weeks and is not affected by daily glucose fluctuation, exercise & recent food intake.


Please note, Glycemic goal should be individualized based on duration of diabetes, age/life expectancy, comorbid conditions, known CVD or advanced microvascular complications, hypoglycemia unawareness, and individual patient considerations.

Factors that interfere with HbA1c Measurement: Hemoglobin variants, elevated fetal hemoglobin (HbF) and chemically modified derivatives of hemoglobin (e.g. carbamylated Hb in patients with renal failure) can affect the accuracy of HbA1c measurements.

Factors that affect interpretation of HbA1c Measurement: Any condition that shortens erythrocyte survival or decrease mean erythrocyte age (e. g., recovery from acute blood loss, hemolytic anemia, HbSS, HbCC, and HbSC) will falsely lower HbA1c test results regardless of the assay method used. Iron deficiency anemia is associated with higher HbA1c.

Note: Presence of Hemoglobin variants and/or conditions that affect red cell turnover must be considered, particularly when the HbA1c result does not correlate with the patient's blood glucose levels.

- HPLC - High performance liquid chromatography

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Consultant Pathologist
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Referred By	: Dr.	Report Status	: Final Report
Sample Type	: EDTA	Report Date	: 20/Jan/2024 05:28PM

HAEMATOLOGY

MENS HEALTH CHECKUP ADVANCED

Test Name	Result	Unit	Bio. Ref. Interval	Method
Complete Blood Count				
Hemoglobin	14.8	g/dL	13.0-17.0	Cyanide-free SLS-Hemoglobin
RBC	4.82	mili/cu.mm	4.5 - 5.5	DC Impedence Method
HCT	45.5	%	40 - 50	Pulse height average
MCV	94.4	fL	83 - 101	Calculated
MCH	30.7	pg	27 - 32	Calculated
MCHC	32.6	g/dL	31.5 - 34.5	Calculated
RDW-CV	14.4	%	11.6-14.0	Calculated
Total Leucocyte Count	5.98	10 ³ /μl	4 - 10	Impedence / Microscopy
Differential Leucocyte Count				
Neutrophils	47.9	%	40-80	Double hydrodynamic sequential system/Microscopy
Lymphocytes	38.2	%	20-40	Flowcytometry DHSS/Microscopy
Monocytes	7.1	%	2-10	Flowcytometry DHSS/Microscopy
Eosinophils	5.7	%	1-6	Double hydrodynamic sequential system/Microscopy
Basophils	1.1	%	0-2	Double hydrodynamic sequential system/Microscopy
Absolute Leucocyte Count				
Absolute Neutrophil Count	2.86	10 ³ /μL	2-7	Calculated
Absolute Lymphocyte Count	2.28	10 ³ /μL	1-3	Calculated
Absolute Monocyte Count	0.42	10 ³ /μL	0.2-1	Calculated
Absolute Eosinophil Count	0.34	10 ³ /μL	0.02-0.5	Calculated
Absolute Basophil Count	0.07	10 ³ /μl	0.02-0.1	Calculated
Platelet Count	220	10 ³ /μl	150-410	Impedence Variation /Microscopy



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Test Name	Result	Unit	Bio. Ref. Interval	Method
MPV	10.8	fL	6.5 - 12	Calculated
PDW	22	fL	9-17	Calculated

Comment:

- 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.


Erythrocyte Sedimentation Rate

Erythrocyte Sedimentation Rate	6	mm/hour	<=10	Modified Westergren at 18C
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Comment:

- ESR provides an index of progress of the disease and is widely used as an indicator of inflammation, infection, trauma, or malignant diseases. Changes are more significant than a single abnormal test
- It is specifically indicated to monitor the course or response to the treatment of diseases like rheumatoid arthritis, tuberculosis bacterial endocarditis, acute rheumatic fever, Hodgkins disease, temporal arthritis, and systemic lupus erythematosus; and to diagnose and monitor giant cell arteritis and polymyalgia rheumatica.
- An elevated ESR may also be associated with many other conditions, including autoimmune disease, anemia, infection, malignancy, pregnancy, multiple myeloma, menstruation, and hypothyroidism.
- Although a normal ESR cannot be taken to exclude the presence of organic disease, its rate is dependent on various physiologic and pathologic factors.
- The most important component influencing ESR is the composition of plasma. High level of C-Reactive Protein, fibrinogen, haptoglobin, alpha-1antitrypsin, ceruloplasmin and immunoglobulins causes the elevation of Erythrocyte Sedimentation Rate.
- Drugs that may cause increase ESR levels include: dextran, methyl dopa, oral contraceptives, penicillamine, procainamide, theophylline, and Vitamin A. Drugs that may cause decrease levels include: aspirin, cortisone, and quinine

"Test conducted on Whole Blood - EDTA "

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HAEMATOLOGY**MENS HEALTH CHECKUP ADVANCED****Peripheral Smear Examination**

RBC- Predominantly Normocytic Normochromic.

WBC - Normal leucocyte count and morphology.

PLATELETS - Adequate on the smear.

IMPRESSION - Peripheral Smear within normal limits.

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Referred By	: Dr.	Report Status	: Final Report
Sample Type	: Urine	Report Date	: 20/Jan/2024 04:23PM

BIOCHEMISTRY

MENS HEALTH CHECKUP ADVANCED

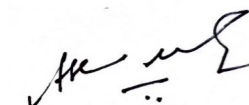
Test Name	Result	Unit	Bio. Ref. Interval	Method
Microalbumin Creatinine Ratio, Urine				
Microalbumin-Albumin	11.70	mg/L	<30	Immunoturbidimetry
Urinary Creatinine	162.16	mg/dL	24-392	Kinetic Alkaline Picrate
Microalbumin-Albumin/Creatinine Ratio	7.22	mg/g Creatinine	<30	Calculated

Comment:

Reference range

Category	Urine Albumin Creatinine ratio(mg/g) - Spot Urine
Normal	<30 mg/g
Microalbuminuria	30 - 300 mg/g
Clinical Albuminuria	>=300 mg/g

- As per ADA guidelines: Two to three specimens collected over a period of 3-6 months should be abnormal before considering a patient to have albuminuria in the absence of infection or acute metabolic crisis.
- Due to inherent day to day variability in albumin excretion, this ratio is a better indicator than isolated microalbumin levels.
- Microalbuminuria is the small but abnormal increase in the excretion of urinary albumin [in the range of 30-300 mg/day in a 24 hrs collection or 30-300 mg/g creatinine in a random collection]
- Factors that may cause an abnormal Microalbumin Creatinine ratio (independent of kidney damage) can be physiological like exercise within 24 hours, menstruation, pregnancy, benign postural proteinuria, water consumption & pathological like infection (UTI), hematuria, fever, marked hyperglycemia, cardiac decompensation, marked hypertension & poor metabolic control.
- A randomly collected urine sample can be used, but is associated with greater variability because of variable urine output, and rates of albumin & creatinine excretion. Hence, it is recommended that abnormal results be repeated using first morning sample or 24 hr urine collection.
- A high albumin/ creatinine ratio in persons with low muscle mass indicates low urinary creatinine more often than microalbuminuria.
- Persistent Albuminuria has been established as one of the diagnostic markers of kidney damage and is used for classification of chronic kidney disease (CKD), based on the categories of urine albumin-to-creatinine ratio (ACR). The ACR categories include A1 (ACR < 30 mg/g - normal to mildly increased); A2 (ACR 30-300 mg/g - moderately increased) and A3 (ACR >300 mg/g, - severely increased) (KDIGO 2012)
- Clinical Utility : This test is useful in the diagnosis of early nephropathy in diabetics, as a marker for generalized endothelial dysfunction and risk for stroke and heart disease. It is also used as a marker for classification and progression of CKD.



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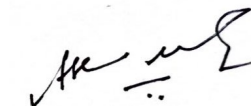


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BIOCHEMISTRY

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Test Name	Result	Unit	Bio. Ref. Interval	Method
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Referred By	: Dr.	Report Status	: Final Report
Sample Type	: Serum	Report Date	: 20/Jan/2024 06:53PM

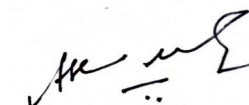
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MENS HEALTH CHECKUP ADVANCED

Test Name	Result	Unit	Bio. Ref. Interval	Method
C-Reactive Protein Quantitative				
C-Reactive Protein (Quantitative)	1.90	mg/L	<5.0	Turbidimetry

Comment:

- C-Reactive Protein [CRP] is an acute phase reactant, hepatic secretion of which is stimulated in response to inflammatory cytokines.
- CRP is a very sensitive but nonspecific marker of inflammation and infection.
- The CRP test is useful in patient with Inflammatory bowel disease, arthritis, Autoimmune diseases, Pelvic inflammatory disease (PID), tissue injury or necrosis and infections.
- CRP levels can be elevated in the later stages of pregnancy as well as with use of birth control pills or hormone replacement therapy i.e. estrogen. Higher levels of CRP have also been observed in the obese.
- As compared to ESR, CRP shows an earlier rise in inflammatory disorders which begins in 4-6 hrs, the intensity of the rise being higher than ESR and the recovery being earlier than ESR. Unlike ESR, CRP levels are not influenced by hematologic conditions like Anemia, Polycythemia.

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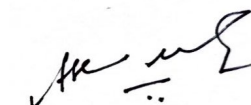
MENS HEALTH CHECKUP ADVANCED

Test Name	Result	Unit	Bio. Ref. Interval	Method
Calcium				
Calcium	9.3	mg/dL	8.4-10.2	Arsenazo III

Comment:

Increased in: Hyperparathyroidism primary and secondary, Acute and chronic renal failure, Following renal transplantation, Osteomalacia with malabsorption, Acute osteoporosis, Malignant tumours (specially of breast, lung and kidney), Drugs: Vit. D and A intoxication, Diuretics, estrogen, androgen, tamoxifen, lithium

Decreased in: Hypoparathyroidism, Surgical and Idiopathic, Pseudohypoparathyroidism, Chronic renal disease with uremia and phosphate retention, Malabsorption of Calcium and Vit.D, obstructive jaundice, Bone Disease (Osteomalacia and rickets), Drugs: Cancer chemotherapy drugs, calcitonin, loop-actives diuretics, Hypomagnesemia, Hypoalbuminemia



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Test Name	Result	Unit	Bio. Ref. Interval	Method
Glucose - Fasting				
Glucose - Fasting	104	mg/dL	70-99	Hexokinase/G-6-PDH

Fasting Plasma Glucose (mg/dL)	2 hr plasma Glucose (mg/dL)	Diagnosis
99 or below	139 or below	Normal
100 to 125	140 to 199	Pre-Diabetes (IGT)
126 or above	200 or above	Diabetes

Reference : American Diabetes Association

Comment:

Impaired glucose tolerance (IGT) fasting, means a person has an increased risk of developing type 2 diabetes but does not have it yet. A level of 126 mg/dL or above, confirmed by repeating the test on another day, means a person has diabetes. IGT (2 hrs Post meal), means a person has an increased risk of developing type 2 diabetes but does not have it yet. A 2-hour glucose level of 200 mg/dL or above, confirmed by repeating the test on another day, means a person has diabetes

Plasma Glucose Goals	For people with Diabetes
Before meal	70-130 mg/dL
2 Hours after meal	Less than 180 mg/dL
HbA1c	Less than 7%

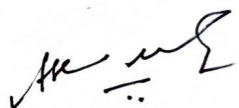
High Sensitive CRP

High sensitivity CRP	1.78	mg/L	<1.0 - Low Risk 1.0 - 3.0 Average risk >3.0 High Risk	Turbidimetry
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Comment:

High Sensitivity C- Reactive protein (hs-CRP) is used as a marker for determining and performing risk assessment of cardiovascular disease (good marker for inflammation), often along with tests for Lipid profile. The American Heart Association and US Centers for Disease Control and Prevention have defined risk groups as follows:

<1.0 Low Risk
1.0 - 3.0 - Average Risk
>3.0 High Risk


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These values are only a part of the total evaluation process for cardiovascular diseases.

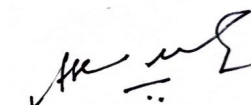
To assess vascular risk, it is recommended to test hsCRP levels 2 or more weeks apart and calculate the average

Additional risk factors to be considered are elevated levels of lipids & glucose, smoking, high blood pressure (hypertension). Anti inflammatory drugs (like aspirin, ibuprofen, and naproxen) or statins may reduce CRP levels in blood. It is important that any person undergoing this test must be in a healthy state in order for the results to be of diagnostic value in predicting the risk of coronary artery disease or heart attack. Any recent illness, tissue injury, infection, or other general inflammation will raise the amount of hsCRP and give a falsely elevated estimate of risk.

Women on hormone replacement therapy have been shown to have elevated hs-CRP levels.

Note:

Since the hs-CRP and CRP tests measure the same molecule, people with chronic inflammation, such as those with arthritis, should not have hs-CRP levels measured. Their CRP levels will be very high due to the arthritis/often too high to be measured or meaningful using the hs-CRP test.



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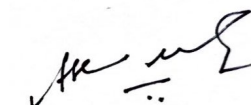
Test Name	Result	Unit	Bio. Ref. Interval	Method
Lipase				
Lipase	27.0	U/L	<60	kinetic colorimetric method

Comment:

Pancreas is the major and primary source of serum lipase, though lipase is also secreted by the gastric and intestinal mucosa. Lipase measurement in serum is used to diagnose acute pancreatitis. After an attack of acute pancreatitis, serum Lipase activity increases within 4 to 8 hours, peaks at about 24 hours, and decreases over 8 to 14 days. Concentrations often remain elevated longer than those of Amylase. The increase in serum Lipase activity is not necessarily proportional to the severity of the attack.

Increased levels are seen in:

- Acute & Chronic Pancreatitis.
- Obstruction of Pancreatic duct.
- Non pancreatic conditions like renal disease, intestinal obstruction, acute cholecystitis, duodenal ulcer, alcoholism, diabetic ketoacidosis and following endoscopic retrograde cholangiopancreatography (ERCP).



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Test Name	Result	Unit	Bio. Ref. Interval	Method
Lipid Profile				
Cholesterol - Total	262	mg/dL	Desirable <200, Borderline High 200 - 239, High ≥240 Normal: < 150, Borderline: 150 - 199, High: 200 - 499, Very High ≥500	Enzymatic
Triglycerides	400	mg/dL	40-60	Glycerol Phosphate Oxidase
Cholesterol - HDL	44	mg/dL	Desirable: <100 Above desirable: 100 - 129 Borderline high: 130 - 159 High: 160 - 189 Very high: ≥190	Accelerator Selective Detergent
Cholesterol - LDL	166	mg/dL	10 - 30	Liquid Selective Detergent
Cholesterol - VLDL	80	mg/dL	Desirable: 3.5-4.5 High Risk: >5	Calculated
Cholesterol : HDL Cholesterol	6.0	Ratio	Desirable: 2.5-3.0 High Risk: >3.5	Calculated
LDL : HDL Cholesterol	3.16	Ratio	Desirable: <130, Above Desirable: 130 - 159, Borderline High: 160 - 189, High: 190 - 219, Very High: ≥220	Calculated
Non HDL Cholesterol	218	mg/dL		

Since Triglycerides are more than 400mg/dL, LDL has been rechecked by Direct LDL method.

Advised- Repeat test after 10-12 hrs fasting if clinically indicated.

High triglycerides levels seen in obesity, physical inactivity, smoking, excess alcohol intake, high carbohydrate diet, type 2 diabetes, chronic renal failure, nephritic syndrome, certain drugs (e.g. corticosteroids, estrogens, retinoids, Beta blockers), and genetic disorders (e.g. familial combined hyperlipidemia, familial hypertriglyceridemia, familial dysbetalipoproteinemia)

Comment:

- Lipid profile measurements in the same patient can show physiological & analytical variations. It is recommended that 3 serial samples 1 week apart may be tested.
- Indians are at a high risk of developing atherosclerotic cardiovascular disease (ASCVD): at a much earlier age and more severe with high mortality. Dyslipidemia (abnormal lipid profile) is the major risk factor and found in almost 80% Indians.
- Total cholesterol is the total amount of cholesterol in blood comprising of HDL, LDL-C, and VLDL.
- LDL Cholesterol (LDL-C) or "bad" cholesterol contributes most significantly to atherosclerosis leading to heart disease or stroke and is the primary target for reducing risk for cardiovascular disease.
- High-density lipoprotein (HDL) or "good" cholesterol can lower risk of heart disease and stroke.
- Triglyceride (TG) level also plays a major role in CVD. Indians are more prone to Atherogenic dyslipidemia, a condition associated with high TG, low HDL-C and high LDL-C; this is associated with diabetes, metabolic syndrome and insulin resistance. Hence high triglyceride levels also need to be treated.
- Non-HDL-Cholesterol (Non-HDL-C) measures all plaque forming lipoproteins (e.g. remnants, LDL-C, VLDL, Lp(a), Apo-B). Monitoring of Non-HDL-C is important in patients with high TG (e.g. diabetics, obese persons) and those already on statin therapy.
- Lipid Association of India (LAI-2020) recommends:-
 - Screening of all Indians above the age of 20 years for CVD risk factors, esp. lipid profile.
 - Identification of Risk factors: Age (male ≥45 years, female ≥55 years); Family h/o heart disease at younger age (<55 yrs in males, <65 yrs in female), Smoking/tobacco use, High blood pressure, Low HDL (males <40 mg/dl and females <50mg/dl).
 - Fasting lipid profile is not mandatory for screening. Both fasting and non-fasting lipid profiles are equally important for managing Indian patients.
 - Non-HDL-C should be calculated in every subject. LAI recommends LDL-C as the primary target and Non-HDL-C as the co-primary target for initiating drug therapy.
 - Lifestyle modifications are of first and foremost importance for management and prevention of dyslipidemia. Among low risk groups, treatment is started only after 3 months of lifestyle changes.
 - Testing for Apolipoprotein B, hsCRP, Lp(a) should be considered for patients in moderate risk group.
 - Newer treatment goals based on Risk Groups and values of LDL-C and Non-HDL-C.

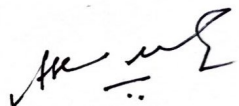
New treatment goals by Lipid Association of India (2020)

Risk groups	CONSIDER THERAPY (cut-off level)		TREATMENT GOALS	
	LDL-C (mg/dL)	Non-HDL-C (mg/dL)	LDL-C (mg/dL)	Non-HDL-C (mg/dL)
Extreme Risk Gp Cat. A	≥50	≥80	<50 (Optional ≤30)	<80 (Optional ≤60)
Extreme Risk Gp Cat. B	≥30	≥60	≤30	≤60
Very High Risk	≥50	≥80	<50	<80
High Risk	≥70	≥100	<70	<100
Moderate Risk	≥100	≥130	<100	<130
Low risk	≥130*	≥160*	<100	<130

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

As per NICEP Expert Panel (2011) guidelines, universal screening for dyslipidemia is recommended for children between 9 - 11 yrs (repeat at 17-21 yrs). Screening is not recommended before the age of 2yrs. Above the age of 2 yrs, selective screening is done in children with family history of premature CVD or risk factors like obesity, diabetes, and hypertension.

Note: Reference Interval as per National Cholesterol Education Program (NCEP) Report.


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Age/Gender	: 34/Male	Registration Date	: 20-Jan-24 02:28 PM
Patient ID	: MGB655293	Collection Date	: 20/Jan/2024 11:38AM
Barcode ID/Order ID	: D7898653 / 8818621	Sample Receive Date	: 20/Jan/2024 03:16PM
Referred By	: Dr.	Report Status	: Final Report
Sample Type	: Serum	Report Date	: 20/Jan/2024 06:53PM

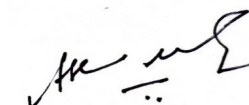
BIOCHEMISTRY

MENS HEALTH CHECKUP ADVANCED

Test Name	Result	Unit	Bio. Ref. Interval	Method
Liver Function Test				
Bilirubin-Total	0.60	mg/dL	0.3-1.2	Diazonium Salt
Bilirubin-Direct	0.17	mg/dL	0-0.5	Diazo
Bilirubin-Indirect	0.43	mg/dL	0 - 1.8	Calculated
Protein, Total	7.50	g/dL	6.4-8.3	Biuret
Albumin	4.77	g/dL	3.5-5.0	Bromocresol Green
Globulin	2.7	g/dl	1.8 - 3.6	Calculated
A/G Ratio	1.75	Ratio	0.8 - 2.1	Calculated
Aspartate Transaminase (SGOT)	28	U/L	5-34	NADH w/o P-5'-P
Alanine Transaminase (SGPT)	44	U/L	0-45	NADH w/o P-5'-P
SGOT/SGPT	0.64	Ratio	<1	Calculated
Alkaline Phosphatase	113	U/L	40-150	Para-Nitrophenyl Phosphate
Gamma Glutamyltransferase (GGT)	60	U/L	12-55	L-gamma-glutamyl-3-Carboxy-4-Nitroanilide

Comment:

- LFTS are based upon measurements of substances released from damaged hepatic cells into the blood that gives idea of the Existence, Extent and Type of Liver damage. - Acute Hepatocellular damage: ALT & AST levels are sensitive index of hepatocellular damage - Obstruction to the biliary tract, Cholestasis and blockage of bile flow: 1) Serum Total Bilirubin concentration 2) Serum Alkaline Phosphatase (ALP) activity 3) Gamma Glutamyl Transpeptidase (GGTP) 4) 5' - Nucleotidase - Chronic liver disease: Serum Albumin concentration
- Bilirubin results from the enzymatic breakdown of heme. Jaundice is a yellowish discoloration of the skin and mucous membranes caused by hyperbilirubinemia.
- Pre-hepatic or hemolytic jaundice - Abnormal red cells, antibodies, drugs and toxins, Hemoglobinopathies, Gilbert's syndrome, Crigler-Najjar syndrome
- Hepatic or Hepatocellular jaundice - Viral hepatitis, toxic hepatitis, intrahepatic cholestasis
- Post-hepatic jaundice - Extrahepatic cholestasis, gallstones, tumors of the bile duct, carcinoma of pancreas
- In viral hepatitis and other forms of liver disease associated with acute hepatic necrosis, serum AST and ALT concentrations are elevated even before the clinical signs and symptoms of disease appear.
- ALT is the more liver-specific enzyme and elevations of ALT activity persist longer than AST activity.
- Peak values of aminotransferase activity occur between the seventh and twelfth days. Activities then gradually decrease,



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BIOCHEMISTRY

MENS HEALTH CHECKUP ADVANCED

Test Name	Result	Unit	Bio. Ref. Interval	Method
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reaching normal activities by the third to fifth week. Peak activities bear no relationship to prognosis and may fall with worsening of the patient's condition.

- Aminotransferase activities observed in cirrhosis vary with the status of the cirrhotic process and range from the upper reference limit to four to five times higher, with an AST/ALT ratio greater than 1. The ratio's elevation can reflect the grade of fibrosis in these patients. Slight or moderate elevations of both AST and ALT activities have been observed after administration of various medications and chronic hepatic injury such as (1) hemochromatosis, (2) Wilson disease, (3) autoimmune hepatitis, (4) primary biliary cirrhosis, (5) sclerosing cholangitis, and (6) α 1-antitrypsin deficiency.
- AST activity also is increased in acute myocardial infarction, progressive muscular dystrophy and dermatomyositis, reaching concentrations up to eight times the upper reference limit. Slight to moderate AST elevations are noted in hemolytic disease.
- GGT is a sensitive indicator of the presence of hepatobiliary disease, being elevated in most subjects with liver disease regardless of cause. Increased concentrations of the enzyme are also found in serum of subjects receiving anticonvulsant drugs, such as phenytoin and phenobarbital.

Kidney Function Test.

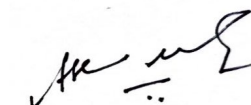
Blood Urea Nitrogen	10	mg/dL	8.9-20.6	Urease
Urea	20.33	mg/dL	19.0 - 44.0	Calculated
Creatinine	0.86	mg/dL	0.6-1.2	Kinetic Alkaline Picrate
Uric Acid	6.6	mg/dL	3.7-7.7	Uricase
Sodium	140	mmol/L	136-145	INDIRECT ISE
Potassium	4.62	mmol/L	3.5-5.1	INDIRECT ISE
Chloride	106.0	mmol/L	98-107	INDIRECT ISE
BUN/Creatinine Ratio	11.0	Ratio	12:1 - 20:1	Calculated

Comment:

BUN is directly related to protein intake and nitrogen metabolism and inversely related to the rate of excretion of urea. Blood urea nitrogen (BUN) levels reflect the balance between the production and excretion of urea. Increased levels are seen in renal failure (acute or chronic), urinary tract obstruction, dehydration, shock, burns, CHF, GI bleeding, nephrotoxic drugs. Decreased levels are seen in hepatic failure, nephrotic syndrome, cachexia (low-protein and high-carbohydrate diets).

Urea is a non-proteinous nitrogen compound formed in the liver from ammonia as an end product of protein metabolism. Urea diffuses freely into extracellular and intracellular fluid and is ultimately excreted by the kidneys. Increased levels are found in acute renal failure, chronic glomerulonephritis, congestive heart failure, decreased renal perfusion, diabetes, excessive protein ingestion, gastrointestinal (GI) bleeding, hyperalimentation, hypovolemia, ketoacidosis, muscle wasting from starvation, neoplasms, pyelonephritis, shock, urinary tract obstruction, nephrotoxic drugs. Decreased levels are seen in inadequate dietary protein, low-protein/high-carbohydrate diet, malabsorption syndromes, pregnancy, severe liver disease, certain drugs.

Creatinine is catabolic product of creatinine phosphate, which is excreted by filtration through the glomerulus and by tubular



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BIOCHEMISTRY

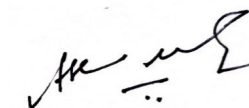
MENS HEALTH CHECKUP ADVANCED

Test Name	Result	Unit	Bio. Ref. Interval	Method
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secretion. Creatinine clearance is an acceptable clinical measure of glomerular filtration rate (GFR). Increased levels are seen in acute/chronic renal failure, urinary tract obstruction, hypothyroidism, nephrotoxic drugs, shock, dehydration, congestive heart failure, diabetes. Decreased levels are found in muscular dystrophy.

BUN/Creatinine ratio (normally 12:1-20:1) is decreased in acute tubular necrosis, advanced liver disease, low protein intake, and following hemodialysis. BUN/Creatinine ratio is increased in dehydration, GI bleeding, and increased catabolism.

Uric acid levels show diurnal variation. The level is usually higher in the morning and lower in the evening. Increased levels are seen in starvation, strenuous exercise, malnutrition, or lead poisoning, gout, renal disorders, increased breakdown of body cells in some cancers (including leukemia, lymphoma, and multiple myeloma) or cancer treatments, hemolytic anemia, sickle cell anemia, or heart failure, pre-eclampsia, liver disease (cirrhosis), obesity, psoriasis, hypothyroidism, low blood levels of parathyroid hormone (PTH), certain drugs, foods that are very high in purines - such as organ meats, red meats, some seafood and beer. Decreased levels are seen in liver disease, Wilson's disease, Syndrome of inappropriate antidiuretic hormone (SIADH), certain drugs.



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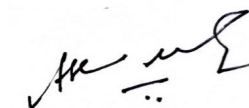
BIOCHEMISTRY

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Test Name	Result	Unit	Bio. Ref. Interval	Method
Amylase				
Amylase	38	U/L	28-100	CMPG3 Substrate

Comment:

- Amylase is produced by Pancreas and some salivary glands.
- Amylase levels are significantly increased in patients with acute pancreatitis, pancreatic duct obstruction, carcinoma pancreas, ovaries, or lungs, cholecystitis, macroamylasemia, renal disease, pancreatic pseudocyst, procedures like Endoscopic retrograde cholangiopancreatography(ERCP) and acute alcohol poisoning.
- Low Amylase levels are seen in Chronic Pancreatitis, Congestive Heart failure, 2nd & 3rd trimester of pregnancy, Gastrointestinal cancer & bone fractures.
- Drugs causing increased amylase levels are aspirin, diuretics, oral contraceptives, corticosteroids, indomethacin, ethyl alcohol and opiate intake.
- In acute pancreatitis, elevated amylase levels usually parallel lipase concentrations, although lipase levels may take a bit longer to rise, will remain elevated longer and are more specific than amylase as a marker for pancreatitis.

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Sample Type	: Serum	Report Date	: 20/Jan/2024 06:53PM

BIOCHEMISTRY

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Test Name	Result	Unit	Bio. Ref. Interval	Method
Lipoprotein(a)				
Lipoprotein(a)	49.90	mg/dl	<30	Turbidimetry

Comment:

Note: Lipoprotein(a) [Lp(a)] is considered an important risk factor for Coronary Heart Disease (CHD).

* Lipoprotein (a) consists of an LDL particle that is covalently bound to an additional protein, apolipoprotein (a). Apo(a) has high-sequence homology with the coagulation factor plasminogen and, like LDL, Lp(a) contains apolipoprotein B100. Thus, Lp(a) is both proatherogenic and prothrombotic. Lp(a) is an independent risk factor for CHD, Ischemic Stroke, and Aortic Valve Stenosis.

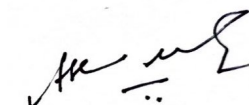
* Lp(a) is highly heterogeneous molecule; the degree of atherogenicity of the Lp(a) particle may depend on the molecular size of the Lp(a)-specific protein.

* Serum concentrations of Lp(a) are related to genetic factors, and are largely unaffected by diet, exercise and lipid -lowering pharmaceuticals. However, in a patient with additional modifiable CHD risk factors, more aggressive therapy to normalize these factors may be indicated if the Lp(a) value is also increased.

Usage:

Evaluation of increased risk for cardiovascular disease and events:

- * In individuals at intermediate risk for cardiovascular disease
- * In patients with early atherosclerosis
- * In patients with strong family history of early CHD



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Barcode ID/Order ID	: D7898655 / 8818621	Sample Receive Date	: 20/Jan/2024 03:09PM
Referred By	: Dr.	Report Status	: Final Report
Sample Type	: Urine	Report Date	: 20/Jan/2024 04:23PM

BIOCHEMISTRY

MENS HEALTH CHECKUP ADVANCED

Test Name	Result	Unit	Bio. Ref. Interval	Method
Chloride Random Urine				
Chloride, Random Urine	154.00	mmol/L	110-250	indirect ISE

Biological Ref. Interval

Infant	02 - 10	mmol/day
Child	15 - 40	mmol/day
Adult	110 - 250	mmol/day

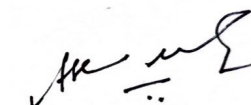
Comment:

Increased In: Massive diuresis from any cause, Salt-losing nephritis, Potassium depletion, Adrenocortical insufficiency, Tubulointerstitial disease, Batter syndrome, Postmenstrual diuresis

Decreased In: Excessive extrarenal chloride loss, Adrenocortical hyperfunction, Postoperative chloride retention

Note:

Dietary intake increases urine chloride excretion.



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MENS HEALTH CHECKUP ADVANCED

Test Name	Result	Unit	Bio. Ref. Interval	Method
Potassium Random Urine				
Potassium, Random urine	75.70	mmol/L	25-125	Indirect ISE

Biological Ref. Interval		
General	25 - 125	mmol/day
Varies with diet.		

Sodium Random Urine

Sodium, Random Urine	109	mmol/L	40-220	Indirect ISE
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Iron Studies, Comprehensive

Iron Serum	95	µg/dL	65-175	Ferene
Total Iron Binding Capacity (TIBC)	303	µg/dL	250 - 400	Calculated
Unsaturated Iron Binding Capacity	208	µg/dL	69 - 240	Ferrozine
Transferrin saturation	31.36	%	16-50	Calculated
Ferritin	229.21	ng/mL	21.81-274.66	CMIA

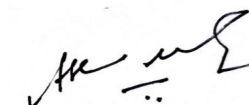
Comment:

Iron is an essential trace mineral element which forms an important component of hemoglobin, metallocompounds and Vitamin A. Deficiency of iron is seen in iron deficiency and anaemia of chronic disorders. Increased iron concentration are seen in hemolytic anaemias, hemochromatosis and acute liver disease. Serum Iron alone is unreliable due to considerable physiologic diurnal variation in the results with highest values in the morning and lowest values in the evening as well as variation in response to iron therapy .

Total Iron Binding capacity (TIBC) is a direct measure of the protein Transferrin which transports iron from the gut to storage sites in the bone marrow. Increased levels of TIBC suggest that total iron body stores are low, increased concentration may be the sign of Iron deficiency anaemia, polycythemia vera ,and may occur during the third trimester of pregnancy. Decreased levels may be seen in hemolytic anaemia, hemochromatosis, chronic liver disease, hypoproteinemia ,malnutrition.

Unsaturated Iron Binding Capacity (UIBC) is increased in low iron state and decreased in high iron concentration such as hemochromatosis. In case of anaemia of chronic disease the patient may be anaemic but has adequate iron reserve and a low uIBC.

Transferrin Saturation occurs in Idiopathic hemochromatosis and Transfusional hemosiderosis where no unsaturated iron



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Test Name	Result	Unit	Bio. Ref. Interval	Method
binding capacity is available for iron mobilization. Similar condition is seen in congenital deficiency of Transferrin.				
Apolipoprotein B & A1 Serum				
Apolipoprotein - A1	142.00	mg/dL	95-186	immunoturbidimetric
Apolipoprotein - B	135.00	mg/dL	49-173	immunoturbidimetric
Apolipoprotein B/A1 Ratio	0.95	Ratio		Calculated

Comment:

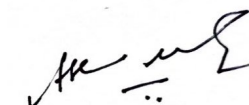
Apolipoprotein A1

- Apolipoproteins A1 (Apo A1) is the major apolipoprotein attached to HDL and is found in greater proportion than Apo A2 (3: 1).
- It is inversely related to the risk of coronary artery disease (CAD).
- It may be a better predictor of atherogenic risk than HDL.

Apo A1 may be increased with	Apo A1 may be decreased with
Drugs (carbamazepine, estrogens, ethanol, statins,niacin, oral contraceptives, phenobarbital)	Chronic renal failure
Familial hyper alpha-lipoproteinemia	Coronary artery disease and peripheral vascular disease
Physical exercise	Drugs (androgens, beta blockers, diuretics and progestins)
Pregnancy	Familial hypo alpha-lipoproteinemia
Weight reduction	Smoking & Uncontrolled diabetes

Apolipoprotein B

- Apolipoprotein B (Apo B) is a major protein component of low density lipoprotein (LDL), Comprising >90% of the LDL. It is a more powerful independent predictor of coronary artery disease (CAD) than LDL cholesterol. It is useful in assessing the risk of CAD and to classify Hyperlipidemias.
- Apolipoprotein studies help in monitoring coronary bypass surgery patients with regard to risk and severity of restenosis.They are also useful in assessing risk of re-infarction in patients with Myocardial infarction .
- In patients with hyperapobetalipoproteinemia (HALB), a disorder associated with increased risk of developing CHD and



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with an estimated prevalence of 30% in patients with premature CAD, Apo B is increased disproportionately in LDL cholesterol. Apo B quantitation is used in distinguishing HALB from another common lipoprotein abnormality, Familial combined hyperlipidemia.

Apolipoprotein B:A1 Ratio

Elevated ApoB/ApoA1 ratio confers increased risk of atherosclerotic cardiovascular disease independently of LDL and HDL cholesterol concentrations.

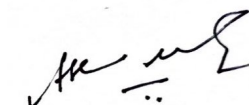
Apo B to A1 ratio	
Ratio	Remarks
0.35- 0.98	Desirable
>0.98	Increased CAD risk

Rheumatoid Factor - Quantitative

Rheumatoid Factor - Quantitative	< 20.0	IU/mL	<30 Normal 30-50 Weakly Positive >50 Reactive	Immunoturbidimetric
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Comment:

- The detection of Rheumatoid factor (RF) is one of the criteria of the American Rheumatism Association (ARA) for the diagnosis of Rheumatoid Arthritis (RA).
- RF are heterogeneous group of auto antibodies directed against Fc- region of IgG molecules.
- They are useful in diagnosis of Rheumatoid Arthritis, but can also be found in other inflammatory diseases and in various non-rheumatic diseases.
- These occur in all the immunoglobulin classes, although the usual analytical methods are limited to the detection of Rheumatoid Factors of the IgM type. Healthy individuals >65 years of age may also show positive RF results.



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Immunology

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Test Name	Result	Unit	Bio. Ref. Interval	Method
Immunoglobulin E (IgE) Total	< 15.70	IU/mL	< 100	Turbidimetry

Comment:

- Immunoglobulin E (IgE) is the most important trigger molecule for allergic information.
- As IgE is a mediator of allergic response, quantitative measurement can provide useful information for differential diagnosis of atopic and non-atopic disease.
- The level of IgE is low during the first year of life, gradually increases with age and reaches adult level after 10 years.

Uses

- For Allergy testing.
- Evaluation of children and adults suspected of having allergic respiratory disease
- To confirm clinical expression of sensitivity to foods in patients with Anaphylactic sensitivity or with Asthma, Angioedema or Cutaneous disease.
- To confirm the presence of IgE antibodies to certain occupational allergens

Increased Levels:

Atopic/Non-atopic allergy, Hyper IgE syndrome, Parasitic infections, IgE Myeloma, Bronchopulmonary Aspergillosis, Immunodeficiency states & Autoimmune diseases, Hodgkin's disease,etc.

Decreased Levels:

Hereditary deficiencies, Acquired immunodeficiency, Ataxia Telangiectasia, Non IgE Myeloma

Note:

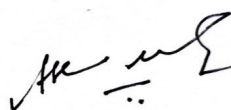
Normal levels of IgE does not eliminate the possibility of allergic diseases
 No close correlation has been demonstrated between severity of allergic reaction and IgE levels.

Testosterone Total

Testosterone, total	235.55	ng/dl	197.44- 669.58	CLIA
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Comment:

Stage	Male	Female
Tanner Stage I	<7.0 - 13.06 ng/dL	<7.0 - 10.06 ng/dL


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Immunology

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Test Name	Result	Unit	Bio. Ref. Interval	Method
Tanner Stage II	<7.0 - 79.13 ng/dL		<7.0 - 30.11 ng/dL	
Tanner Stage III	<7.0 - 499.18 ng/dL		<7.0 - 30.49 ng/dL	
Tanner Stage IV	79.10 - 747.17 ng/dL		<7.0 - 35.19 ng/dL	
Tanner Stage V	224.83 - 669.65 ng/dL		1.88 - 39.30 ng/dL	

- Testosterone is the major androgen in males produced by the Leydig cells of the testes. In females, it is secreted by adrenal cortex and ovaries.
- In serum, testosterone is largely bound to a specific steroid hormone-binding globulin (SHBG) (60% and to albumin (38%), but it is the free

hormone (2%) that is physiologically active.

- The total testosterone level measures both bound and free testosterone in the serum.

Increased in: Idiopathic sexual precocity, adrenal hyperplasia (boys), adrenocortical tumors, trophoblastic disease during pregnancy, idiopathic hirsutism, virilizing ovarian tumors, PCOD, arrhenoblastoma, virilizing luteoma, testicular feminization (normal or moderately elevated), hyperthyroidism, Cushing's Disease, drugs (anticonvulsants, barbiturates, estrogens, oral contraceptives).

Decreased in: Hypogonadism (primary and secondary), orchidectomy, Klinefelter syndrome, uremia, hemodialysis, hepatic insufficiency, ethanol, drugs (digoxin, spironolactone, acarbose), excessive exercise.

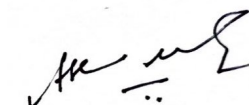
Note

- Free testosterone should be measured in symptomatic patients with normal total testosterone levels.
- In men, there is a diurnal variation in serum testosterone with a 20% elevation in levels in the evenings.
- Physiological episodic secretion of testosterone may lead to variation in serum levels.
- Time of day, age, sex, puberty, pre & post menopause have an influence on testosterone concentration.
- Please note test values may vary depending on the assay method used.

Thyroid Profile

T3, Total	0.86	ng/mL	0.60-1.81	CLIA
T4, Total	4.9	µg/dl	4.5-12.6	CLIA
Thyroid Stimulating Hormone - Ultra Sensitive	1.484	uIU/ml	0.55-4.78	CLIA

Comment:



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Reg No:68123



PO No :PO2955319850-952



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Age/Gender	: 34/Male	Registration Date	: 20-Jan-24 02:28 PM
Patient ID	: MGB655293	Collection Date	: 20/Jan/2024 11:38AM
Barcode ID/Order ID	: D7898653 / 8818621	Sample Receive Date	: 20/Jan/2024 03:16PM
Referred By	: Dr.	Report Status	: Final Report
Sample Type	: Serum	Report Date	: 20/Jan/2024 06:57PM

Immunology

MENS HEALTH CHECKUP ADVANCED

Test Name	Result	Unit	Bio. Ref. Interval	Method
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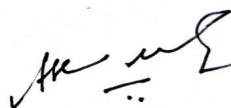
- Below mentioned are the guidelines for pregnancy related reference ranges for TSH, total T3 & Total T4.

Pregnancy			
	TSH (μIU/mL) (as per American Thyroid Association)	Total T3 (ng/mL)	Total T4(μg/dL)
1st trimester	0.1-2.5	0.81-1.90	7.33-14.8
2nd trimester	0.2-3.0	1.00-2.60	7.93-16.1
3rd trimester	0.3-3.0	1.00-2.60	6.95-15.7

- 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.
- TSH is secreted in a dual fashion: Intermittent pulses constitute 60-70% of total amount, background continuous secretion is 30-40%.These pulses occur regularly every 1-3 hrs.
- Total T3 & T4 concentrations are altered by physiological or pathological changes in thyroxine binding globulin (TBG) capacity .
- The determination of free T3 & free T4 has the advantage of being independent of changes in the concentrations and binding properties of the binding proteins.
- Changes in thyroid status are typically associated with concordant changes in T3, T4 and TSH levels.
- Unexpectedly abnormal or discordant thyroid test values may be seen with some rare, but clinically significant conditions such as central hypothyroidism, TSH-secreting pituitary tumors, thyroid hormone resistance, or the presence of heterophilic antibodies (HAMA) or thyroid hormone autoantibodies.
- For diagnostic purposes, results should be used in conjunction with other data.

TSH	T3	T4	Interpretation
High	Normal	Normal	Subclinical Hypothyroidism
Low	Normal	Normal	Subclinical Hyperthyroidism
High	High	High	Secondary Hyperthyroidism
Low	High/Normal	High/Normal	Hyperthyroidism
Low	Low	Low	Non thyroidal illness / Secondary Hypothyroidism

Vitamin D (25-OH)


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Immunology

MENS HEALTH CHECKUP ADVANCED

Test Name	Result	Unit	Bio. Ref. Interval	Method
Vitamin D (25-OH)	10.4	ng/mL	Deficiency:< 20, Insufficiency:20-29, Sufficiency:30 - 100, Toxicity possible:> 100	CLIA

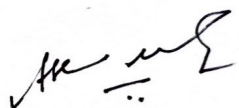
Comment:

- Vitamin D is a fat-soluble steroid prohormone involved in the intestinal absorption of calcium and the regulation of calcium homeostasis.
- Two forms of vitamin D are biologically relevant - vitamin D3 (Cholecalciferol) and vitamin D2 (Ergocalciferol).
- Both vitamins D3 and D2 can be absorbed from food but only an estimated 10-20perc. of vitamin D is supplied through nutritional intake.
- Vitamin D is converted to the active hormone 1,25-(OH)₂-vitamin D (Calcitriol) through two hydroxylation reactions. The first hydroxylation converts vitamin D into 25-OH vitamin D and occurs in the liver. The second hydroxylation converts 25-OH vitamin D into the biologically active 1,25-(OH)₂-vitamin D and occurs in the kidneys as well as in many other cells of the body.
- Most cells express the vitamin D receptor and about 3perc. of the human genome is directly or indirectly regulated by the vitamin D endocrine system.
- The major storage form of vitamin D is 25-OH vitamin D and is present in the blood at up to 1,000 fold higher concentration compared to the active 1,25-(OH)₂-vitamin D. 25-OH vitamin D has a half-life of 2-3 weeks vs. 4 hours for 1,25-(OH)₂-vitamin D. Therefore, 25-OH vitamin D is the analyte of choice for determination of the vitamin D status.
- Risk factors for vitamin D deficiency include low sun exposure, inadequate intake, decreased absorption, abnormal metabolism, vitamin D resistance and liver or kidney diseases.
- Vitamin D deficiency is a cause of secondary hyperparathyroidism and diseases resulting in impaired bone metabolism (like rickets, osteomalacia).
- Recently, many chronic diseases such as cancer, high blood pressure, osteoporosis and several autoimmune diseases have been linked to vitamin D deficiency.
- The assay measures both D2 (Ergocalciferol) and D3 (Cholecalciferol) metabolites of vitamin D

Utility Quantitative determination of 25-hydroxyvitamin D (25-OH vitamin D).

Prostate Specific Antigen (Total) PSA

Prostate Specific Antigen, total	0.684	ng/mL	≤4	CMIA
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Immunology

MENS HEALTH CHECKUP ADVANCED

Test Name	Result	Unit	Bio. Ref. Interval	Method
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Comment:

Results Interpretation:

- Prostate-specific antigen (PSA), a glycoprotein is produced by the prostate gland, the lining of the urethra, and the bulbourethral gland.
- Normally, very little PSA is secreted in the blood.
- PSA exists in serum in multiple forms: complexed to alpha-1-anti-chymotrypsin (PSA-ACT complex), unbound (free PSA), and enveloped by alpha-2-macroglobulin (not detected by immunoassays).
- Total PSA comprises of Free PSA and PSA-ACT complex.
- Both Free and Total PSA concentration determined on serum can be used to calculate Percent Free PSA and then are used for patient management.
- Higher total PSA levels and lower percentages of free PSA are associated with higher risks of prostate cancer.
- Probability of Prostate Carcinoma based on Percent Free PSA.

Clinical Use:

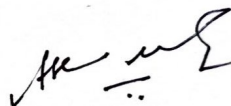
- Screening method to detect Prostate carcinoma
- For determining the extent of Prostate carcinoma
- Assessing the response to treatment of Prostate carcinoma.
- The total PSA range of 4.0 to 10.0 ng/ml has been described as a diagnostic "gray zone," in which the free:total PSA ratio helps to determine the relative risk of prostate cancer.
- When total PSA concentration is 10.0 ng/mL, the probability of cancer is high and prostate biopsy is generally recommended.

Elevated Total PSA levels are seen in

- Increases in glandular size and tissue damage caused by benign prostatic hypertrophy,
- Prostatitis
- Prostate carcinoma
- Prostate ischemia

Note:

- False negative / positive results are observed in patients receiving mouse monoclonal antibodies for diagnosis or therapy.
- PSA total and free levels may appear consistently elevated / depressed due to the interference by heterophilic antibodies and nonspecific protein binding.
- Results obtained with different assay kits cannot be used interchangeably.
- All results should be correlated with clinical findings and results of other investigations.


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Immunology

MENS HEALTH CHECKUP ADVANCED

Test Name	Result	Unit	Bio. Ref. Interval	Method
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- Values obtained with different assay methods cannot be used interchangeably.

Homocysteine

Homocysteine	22.66	μmol/L	3.7 - 13.9	CLIA
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Comment:

Interpretation:

Increased levels are seen in deranged Vit B12 metabolism and form an independent marker for risk of thromboembolic episodes in coronary artery disease (CAD)

Clinical Utility:

- Determine risk for heart disease, stroke and peripheral arterial blood vessel disease.
- Identify vitamin B12 deficiency or folic acid deficiency.
- Identify homocystinuria

The recommended use of Homocysteine (HCY) to assess risk factor for CAD are

- It is specially useful in young CAD patients (<40 years)
- In known cases of CAD,high HCYlevels should be used as a prognostic marker for CAD events and mortality.
- CAD patients with HCY levels >15 μmol/L belong to high risk group.
- Increased HCY levels with low vitamin concentrations should be handled as a potential vitamin deficiency case .

High values of HCY are found in dietary deficiency of folic acid, vitamin B6, or vitamin B12, homocystinuria, chronic liver and renal failure,post menopausal state , hypothyroidism, Alzheimer's disease,vaious neoplastic disease like cancers of ovary or breast and Acute lymphoblastic leukemia,drugs (anti-anticonvulsants, antibiotics, theophylline, birth control pills, and tamoxifen),alcoholism, smoking or tobacco usage.

Low values may be caused by some medicines or vitamins such as folic acid, vitamin B12, or niacin.

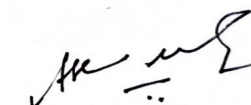
- Please note test values may vary depending on the assay method used.
- CLIA-Chemiluminescent Immunoassay

Vitamin B12

Vitamin B12	223.0	pg/mL	187-833	CMIA
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Comment:

- **Vitamin B12** along with **folate** is essential for DNA synthesis and myelin formation.
- **Decreased levels** are seen in anaemia, term pregnancy, vegetarian diet, intrinsic factor deficiency, partial gastrectomy/ileal damage, celiac disease, oral contraceptive use, parasitic infestation, pancreatic deficiency, treated epilepsy, smoking, hemodialysis and advanced age.



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Sample Type	: Serum	Report Date	: 20/Jan/2024 06:57PM

Immunology

MENS HEALTH CHECKUP ADVANCED

Test Name	Result	Unit	Bio. Ref. Interval	Method
• Increased levels are seen in renal failure, hepatocellular disorders, myeloproliferative disorders and at times with excess supplementation of vitamins pills.				

Vitamin B9 (Folic Acid)

Vitamin B9 (Folic Acid)	5.80	ng/mL	3.1-20.5	CMIA
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Comment:

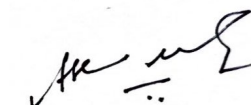
Folate plays an important role in the synthesis of purine & pyrimidines in the body and is important for the maturation of erythrocytes. It is widely available from plants and to a lesser extent organ meats, but more than half the folate content of food is lost during cooking. Folate deficiency is commonly prevalent in alcoholic liver disease, pregnancy, and the elderly. It may result from poor intestinal absorption, nutrition deficiency, excessive demand as in pregnancy or in malignancy, and in response to certain drugs like Methotrexate & anticonvulsants. It is now routine practice to recommend dietary folate supplements from conception to the 12th week of pregnancy; such supplementation has been proven to reduce the incidence of neural tube defects.

Decreased Levels: Megaloblastic anemia, Infantile hyperthyroidism, Alcoholism, Malnutrition, Scurvy, Liver disease, B12 deficiency, dietary amino acid excess, adult Celiac disease, Tropical Sprue, Crohn's disease, Hemolytic anemias, Carcinomas, Myelofibrosis, vitamin B6 deficiency, pregnancy, Whipple's disease, extensive intestinal resection, and severe exfoliative dermatitis.

Note:

Certain drugs like Pyrimethamine, methotrexate, and trimethoprim are all folate antagonists i.e. they stop the action of the folic acid; phenytoin can decrease the intestinal absorption of folates, and ethanol both decreases absorption and increases excretion of folic acid.

To differentiate vitamin B12 & folate deficiency, measurement of Methylmalonic acid in urine & serum Homocysteine level is suggested.



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Referred By	: Dr.	Report Status	: Final Report
Sample Type	: Serum	Report Date	: 20/Jan/2024 05:17PM

SEROLOGY

MENS HEALTH CHECKUP ADVANCED

Test Name	Result	Unit	Bio. Ref. Interval	Method
Hepatitis Bs (Surface) Antigen	NON REACTIVE		Non-Reactive	Immunochromatographic

Comment:

Infection with HBV results in a wide spectrum of acute and chronic liver diseases that may lead to cirrhosis and hepatocellular carcinoma. Hepatitis B surface antigen (HBsAg), derived from the viral envelope, is the first antigen to appear following infection and is detectable in the serum.

Note:

•This is a Rapid, Screening Test for Qualitative detection of HBsAg.

•All Provisionally Reactive cases must be confirmed by confirmatory method to rule out false positives due to interfering substances.

Limitations:

- For diagnostic purposes, results should be used in conjunction with patient history and other hepatitis markers for diagnosis of acute and chronic infection.
- Additional follow up testing using other available methods is required ,if this test is Non- Reactive in the presence of persisting clinical symptoms of Hepatitis B.
- In few cases,false positive results can be obtained due to presence of other antigens or elevated levels of Rheumatoid factor.



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MBBS, M.D (Microbiology)
Consultant Microbiologist
Reg No: 87170



PO No : PO2955319850-952



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Patient ID	: MGB655293	Collection Date	: 20/Jan/2024 11:38AM
Barcode ID/Order ID	: D7898655 / 8818621	Sample Receive Date	: 20/Jan/2024 03:09PM
Referred By	: Dr.	Report Status	: Final Report
Sample Type	: Urine	Report Date	: 20/Jan/2024 06:48PM

CLINICAL PATHOLOGY


MENS HEALTH CHECKUP ADVANCED

Test Name	Result	Unit	Bio. Ref. Interval	Method
Urine Routine & Microscopy				
Colour	YELLOW		Pale Yellow	
Appearance	CLEAR		Clear	Visual
Specific gravity	1.020		1.003 - 1.035	pKa change
pH	6.0		4.6 - 8.0	Double Indicator
Glucose	NEGATIVE		Negative	GOD-POD
Protein	NEGATIVE		Negative	Protein Error Principle
Ketones	NEGATIVE		Negative	Nitroprusside
Blood	NEGATIVE		Negative	Peroxidase
Bilirubin	NEGATIVE		Negative	Diazonium
Urobilinogen	NORMAL		Normal	Ehrlich
Leucocyte Esterase	NEGATIVE		Negative	Pyrrole
Nitrite	NEGATIVE		Negative	Diazonium Compound
Pus cells	2-3	/hpf	0-5	Microscopy
Red Blood Cells	NIL	/hpf	0-2	Microscopy
Epithelial cells	1-2	/hpf	Few	Microscopy
Casts	NIL	/lpf	Nil	Microscopy
Crystals	NIL		Nil	Microscopy
Yeast	NIL		Nil	Microscopy
Bacteria	NIL		Nil	Microscopy

Comment:

- Note: Pre-test condition to be observed while submitting the sample-first void, mid stream urine, collected in a clean, dry, sterile container is recommended for routine urine analysis, avoid contamination with any discharge from vaginal, urethra, perineum, Avoid prolonged transit time & undue exposure to sunlight.
- During interpretation, points to be considered are Negative nitrite test does not exclude the urinary tract infections. Trace proteinuria can be seen with many physiological conditions like prolonged recumbency, exercise, high protein diet. False positive reactions for bile pigments, proteins, glucose and nitrites can be caused by peroxidase like activity by disinfectants, therapeutic dyes, ascorbic acid and certain drugs. • Urine microscopy is done in centrifuged urine specimens

*** End Of Report ***



Dr. Pritha Aggarwal
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 Consultant Pathologist
 Reg No: 20120000011





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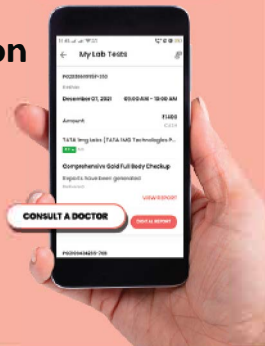
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