Lab No.	012407300354	**Age/Gender**	47 YRS/FEMALE	**Coll. ON**	30/Jul/2024 09:06AM
NAME	Ms. POOJA SHARMA			**Reg. ON**	30/Jul/2024
Ref. Dr.	INDER KASTURIA	**BarcodeNo**	01300354	**Approved ON**	30/Jul/2024 10:23AM
Rpt. Centre	INDER KASTURIA			**Printed ON**	30/Jul/2024 01:36PM

Test Name	Value	Unit	Biological Reference Interval
Complete Haemogram, EDTA whole blood			
Haemoglobin (Hb) *Method : Colorimetry*	**10.90**	gm/dl	12.0 - 15.0
RBC count *Method : Electrical impedence*	4.39	Millons/cmm	3.8 - 4.8
PCV / Haematocrit *Method : Calculated*	**34.10**	%	36.0 - 46.0
MCV *Method : Calculated*	**77.60**	fl	83.0 - 101.0
MCH *Method : Calculated*	**24.90**	picogram	27.0 - 32.0
MCHC *Method : Calculated*	32.10	%	31.5 - 34.5
RDW - CV *Method : Calculated*	**17.50**	%	11.6 - 14.0
Mentzer Index *Method : Calculated*	17.68		>= 13.0
The Mentzer index (MCV/ RBC count) is a useful tool for initial screening of patients with a microcytic hypochromic blood picture to rule out a thalassemia trait. If the index is less than 13, thalassemia is said to be more likely. If the result is greater than 13, then iron-deficiency anemia is said to be more likely. All patients with a low normal to low hemoglobin and a Mentzer index below 13 should be screened for thalassemia trait by HPLC.			
TLC (Total Leucocyte Count) *Method : Flowcytometry*	4,980	/cmm	4000 - 10000
DLC (Flowcytometry)			
Neutrophils	49.30	%	35.0 - 75.0
Lymphocytes	42.20	%	25.0 - 45.0
Eosinophils	1.90	%	1.0 - 5.0
Monocytes	5.80	%	1.0 - 6.0
Basophils	0.80	%	0 - 1
Absolute Leucocyte Count (Calculated)			
Absolute Neutrophil Count	2,455.14	/cmm	2000 - 7000
Absolute Lymphocyte Count	2,101.56	/cmm	1000 - 3000
Absolute Eosinophil count	94.62	/cmm	20 - 500
Absolute Monocyte count	288.84	/cmm	200 - 1000
Absolute Basophil count	39.84	/cmm	0 - 100
Platelet count *Method : Electrical impedence*	2.29	Lakh/cmm	1.5 - 4.1
ESR (Erythrocyte Sedimentation Rate) *Method : Westergren method*	25	mm/1st hr	0 - 29

Peripheral Smear

Red blood cells are predominantly microcytic and hypochromic. No significant anisopoiekilocytosis is seen.
Leucocytic series is numerically and morphologically within normal limits.
Platelets are adequate in number and are normal in morphology.
No atypical cells or haemoparasites seen.
Impression: Microcytic hypochromic anaemia.

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Test Name	Value	Unit	Biological Reference Interval

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Test Name	Value	Unit	Biological Reference Interval
Glucose Fasting, *plasma* *Method : GOD POD*	85.00	mg/dL	60 - 100

Interpretation (In accordance with the American diabetes association guidelines):

- A fasting plasma glucose level below 100 mg/dl is considered normal.
- A fasting plasma glucose level between 100-126 mg/dl is considered as glucose intolerant or pre diabetic. A fasting and post-prandial blood sugar test (after consumption of 75 gm of glucose) is recommended for all such patients.
- A fasting plasma glucose level of above 126 mg/dl is highly suggestive of a diabetic state. A repeat fasting test is strongly recommended for all such patients. A fasting plasma glucose level in excess of 126 mg/dl on both the occasions is confirmatory of a diabetic state.

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Test Name	Value	Unit	Biological Reference Interval
HbA1c (Glycosylated haemoglobin), *EDTA whole blood* *Method : HPLC*	4.90	%	< 5.7
Estimated average plasma Glucose *Method : Calculated*	93.93	mg/dL	65 - 136

The test is approved by NGSP for patient sample testing.

Interpretation:

Metabolically normal patients	%	< 5.7
Pre-diabetic	%	5.7 - 6.4
Diabetic	%	> 6.4

Glycosylated hemoglobin or HbA1C is a reliable indicator of mean plasma glucose levels for a period of 8-12 weeks preceeding the date on which the test is performed and is a more reliable indicator of overall blood sugar control in known diabetic patients than blood sugar levels. A value of less than 5.7 % is usually seen in metabolically normal patients, however diabetics with very good control can also yield similar values. The HbA1c test, thus can not be used to differentiate between diabetic patients with very good control over the plasma glucose levels from metabolically normal, non-diabetic subjects as both groups may reveal very similar values in the assay.

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Test Name	Value	Unit	Biological Reference Interval
LFT (Liver Function Test)			
Serum Bilirubin Total *Method : Diazotized Sulfanilic Acid (DSA)*	0.60	mg/dl	0.1 - 1.2
Serum Bilirubin Direct *Method : Diazotized Sulfanilic Acid (DSA)*	0.21	mg/dl	0.0 - 0.3
Serum Bilirubin Indirect *Method : Calculated*	0.39	mg/dl	0.1 - 1.1
Serum SGOT/AST *Method : IFCC without P5P*	17.50	U/l	<= 31.0
Serum SGPT/ALT *Method : IFCC without P5P*	11.80	U/l	<= 34.0
Serum Alkaline Phosphatase *Method : PNP, AMP Buffer*	71.20	U/l	30.0 - 120.0
Serum GGT (Gamma Glutamyl Transpeptidase) *Method : UV-assay according to Szasz*	12.30	U/l	9.0 - 39.0
Serum total Protein *Method : Biuret*	6.91	g/dl	6.6 - 8.3
Serum Albumin *Method : Bromo Cresol Green*	4.40	g/dl	3.5 - 5.2
Serum Globulin *Method : Calculated*	2.51	g/dl	2.0 - 3.5
Albumin / Globulin ratio *Method : Calculated*	1.75		1.5 - 2.5

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Test Name	Value	Unit	Biological Reference Interval
KFT (Kidney Function Test) including S. electrolytes and ionised calcium			
Urea *, serum* *Method : Urease-GLDH, UV Method*	21.69	mg/dl	16.9 - 43.4
Blood Urea Nitrogen (BUN) *Method : Calculated*	10.14	mg/dl	7.8 - 20.2
Serum Creatinine *Method : Jaffe kinetic*	0.64	mg/dl	0.5 - 0.9
Serum Uric Acid *Method : Uricase-Peroxidase*	4.52	mg/dl	2.3 - 6.1
Serum total Protein *Method : Biuret*	6.91	g/dl	6.6 - 8.3
Serum Albumin *Method : Bromo Cresol Green*	4.40	g/dl	3.5 - 5.2
Serum Globulin *Method : Calculated*	2.51	g/dl	2.0 - 3.5
Albumin / Globulin ratio *Method : Calculated*	1.75		1.5 - 2.5
Serum Sodium *Method : Direct measurement with ISE*	143.30	mmol/L	135 - 150
Serum Potassium *Method : Direct measurement with ISE*	4.14	mmol/L	3.5 - 5.0
Serum Chloride *Method : Direct measurement with ISE*	100.20	mmol/L	94 - 110
Calcium Ionized *, serum* *Method : Direct measurement with ISE*	1.30	mmol/L	1.10 - 1.35

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Test Name	Value	Unit	Biological Reference Interval
Lipid Profile basic (direct HDL,calculated LDL)			
Total Cholesterol, *, serum* *Method : CHOD-POD*	161.00	mg/dl	< 200.0
Triglycerides *, serum* *Method : GPO-POD*	66.10	mg/dl	< 150
HDL Cholesterol *, serum* *Method : Direct measure PEG (CHE-CHO)*	63.30	mg/dl	> 50
VLDL Cholesterol *, serum* *Method : Calculated*	13.22	mg/dl	< 30
L.D.L Cholesterol *, serum* *Method : Calculated*	84.48	mg/dl	< 100
Cholesterol, Non HDL *, serum* *Method : Calculated*	97.70	mg/dl	< 130
Total Cholesterol / HDL Cholesterol Ratio *, serum* *Method : Calculated*	2.54		< 5.0
LDL / HDL Cholesterol ratio *, serum* *Method : Calculated*	1.33		< 3.5

Interpretation:

National Lipid Association Recommendation (NLA-2014)	
Total Cholesterol Desirable: <200 mg/dL Borderline high: 200-239 mg/dL High: > or =240 mg/dL	**Triglycerides** Normal: <150 mg/dL Borderline high: 150-199 mg/dL High: 200-499 mg/dL Very high: > or =500 mg/dL
Non HDL Cholesterol Desirable: <130 mg/dL Borderline high: 130-159 mg/dL High: 160-189 mg/dL Very high: > or =190 mg/dL	**LDL Cholesterol** Optimal: <100 mg/dL Near Optimal: 100-129 mg/dL Borderline high: 130-159 mg/dL High: 160-189 mg/dL Very high: > or =190 mg/dL
HDL Cholesterol Low (Men) <40 mg/dL Low (Women) <50 mg/dL	

Serum Iron *Method : FerroZine*	38.00	µg/dL	37 - 145

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Test Name	Value	Unit	Biological Reference Interval
Vitamin B 12, *serum* *Method : CLIA Microparticles*	544.15	pg/ml	183.0 - 822.0

Please note change in biological reference interval.

Interpretation:

Vitamin B12 (cobalamin) is necessary for hematopoiesis and normal neuronal function. In humans, it is obtained only from animal proteins and requires intrinsic factor (IF) for absorption. The body uses its vitamin B12 stores very economically, reabsorbing vitamin B12 from the ileum and returning it to the liver; very little is excreted.

Vitamin B12 deficiency may be due to lack of IF secretion by gastric mucosa (eg, gastrectomy, gastric atrophy) or intestinal malabsorption (eg, ileal resection, small intestinal diseases).

Vitamin B12 deficiency frequently causes macrocytic anemia, glossitis, peripheral neuropathy, weakness, hyperreflexia, ataxia, loss of proprioception, poor coordination, and affective behavioral changes. These manifestations may occur in any combination; many patients have the neurologic defects without macrocytic anemia.

Serum methylmalonic acid and homocysteine levels are also elevated in vitamin B12 deficiency states.

Follow-up testing for antibodies to intrinsic factor (IF) is recommended to identify this potential cause of vitamin B12 malabsorption.

A normal serum concentration of vitamin B12 does not rule out tissue deficiency of vitamin B12. The most sensitive test for vitamin B12 deficiency at the cellular level is the assay for MMA. If clinical symptoms suggest deficiency, measurement of MMA and homocysteine should be considered, even if serum vitamin B12 concentrations are normal.

The commonest cause of increased level of vitamin B12 is therapeutic intake of vitamin B12 in the form of multivitamin tablets or as intramuscular injections.

Many other conditions are known to cause an increase or decrease in the serum vitamin B12 concentration including:

Increased Serum B12	Decreased Serum B12
Ingestion of vitamin C	Pregnancy
Ingestion of estrogens	Aspirin
Ingestion of vitamin A	Anticonvulsants
Hepatocellular injury	Colchicine
Myeloproliferative disorder	Ethanol ingestion
Uremia	Contraceptive hormones
	Smoking
	Hemodialysis
	Multiple myeloma

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Test Name	Value	Unit	Biological Reference Interval
Vitamin D (25 Hydroxy), *serum* *Method : CLIA Microparticles*	37.74	ng/ml	30.0 - 100.0

Interpretation:

Deficiency	ng/ml	< 20
Insufficiency	ng/ml	21 - 29
Sufficiency	ng/ml	30 - 100
Intoxication	ng/ml	> 150

Vitamin D compounds are derived from dietary ergocalciferol (from plants, VitD2) or cholecalciferol (from animals, VitD3), or by conversion of 7-dihydrocholesterol to VitD3 in the skin upon ultraviolet exposure. VitD2 and VitD3 are subsequently 25-hydroxylated in the liver to 25-OH-VitD. 25-OH-VitD represents the main body reservoir and transport form of vitamin D, being stored in adipose tissue and tightly bound by a transport protein while in circulation. A fraction of circulating 25-OH-VitD is converted to its active metabolites 1,25-dihydroxy vitamin D2 and D3 (1,25-OH-VitD), mainly by the kidneys. This process is regulated by parathyroid hormone (PTH).
VitD plays a primary role in the maintenance of calcium homeostasis. It promotes intestinal calcium absorption and, in concert with PTH, skeletal calcium deposition, or less commonly, calcium mobilization. Renal calcium and phosphate reabsorption are also promoted. In addition to its effects on calcium and bone metabolism, 1,25-OH-VitD regulates the expression of a multitude of genes in many other tissues including immune cells, muscle, vasculature, and reproductive organs.
The exact 25-OH-VitD level reflecting optimal body stores remains unknown. Mild-to-modest deficiency can be associated with osteoporosis or secondary hyperparathyroidism. Severe deficiency may lead to failure to mineralize newly formed osteoid in bone, resulting in rickets in children and osteomalacia in adults. The consequences of vitamin D deficiency on organs other than bone are not fully known, but may include increased susceptibility to infections, muscular discomfort, and an increased risk of colon, breast, and prostate cancer.
Reasons for suboptimal 25-OH-VitD levels include lack of sunshine exposure, a particular problem in India; inadequate intake; malabsorption (eg, due to Celiac disease); depressed hepatic vitamin D 25-hydroxylase activity, secondary to advanced liver disease; and enzyme-inducing drugs, in particular many antiepileptic drugs, including phenytoin, phenobarbital, and carbamazepine, that increase 25-OH-VitD metabolism.
Hypervitaminosis D is rare, and is only seen after prolonged exposure to extremely high doses of vitamin D. When it occurs, it can result in severe hypercalcemia and hyperphosphatemia.
Caution: Replacement therapy in deficient individuals must be monitored by periodic assessment of Vitamin D levels in order to prevent hypervitaminosis D.

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Test Name	Value	Unit	Biological Reference Interval
Thyroid Profile Total (T3, T4, TSH)			
T3, (Triiodothyronine) , *serum* *Method : ECLIA*	1.29	ng/mL	0.80 - 2.0
T4, (Thyroxine) , *serum* *Method : ECLIA*	7.00	ug/dL	5.1 - 14.1
TSH (Thyroid Stimulating Hormone) , *serum* *Method : ECLIA*	3.19	uIU/ml	0.27 - 4.2

Interpretation:

- Primary hyperthyroidism is accompanied by elevated serum T3 and T4 values alongwith depressed TSH levels
- Primary hypothyroidism is accompanied by depressed serum T3 and T4 values and elevated serum TSH levels.
- High T3 levels coupled with normal T4 and suppressed TSH may be seen in T3 toxicosis.

Note: Total T3 and total T4 are highly bound to plasma proteins and are amenable to fluctuations with plasma protein content as well as due to binding defects in the thyroid hormone binding proteins.

The following ranges are recommended for pregnant females:

Gestation period	TSH (uIU/ml)
First trimester	0.1 - 2.5
Second trimester	0.2 - 3.0
Third trimester	0.3 - 3.0

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Test Name	Value	Unit	Biological Reference Interval
Urine Routine & Microscopic Examination			
Physical examination			
Volume	10	mL	
Colour	Pale Yellow		Pale yellow
Transparency	TURBID		Clear
Specific gravity *Method : pKa change*	1.030		1.003 - 1.035
Chemical examination			
Protein *Method : error-of-indicator*	Nil		Nil
Glucose *Method : GOD-POD*	Nil		Nil
pH *Method : Double indicator*	5.0		
Bilirubin *Method : Azo-coupling reaction*	Negative		Negative
Urobilinogen *Method : Azo- coupling reaction*	Normal		Normal
Ketone *Method : Legals test*	Negative		Negative
Erythrocytes *Method : Peroxidase*	Absent		Absent
Microscopic examination			
WBC	8 - 10	/ HPF	0 - 5
RBC	Nil	/ HPF	0 - 2
Casts	Nil	/ HPF	Nil
Crystals	Nil	/ HPF	Nil
Epithelial cells	4 - 6	/ HPF	0 - 15
Bacteria	Absent		Absent
Others *Method : Light microscopy*	Nil		

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LIFOTRONIC Graph Report

Name :	Case :	Patient Type :		Test Date : 30/07/2024 10:18:33
Age :	Department :	Sample Type : Whole Blood EDTA		Sample Id : 01300354
Gender :				Total Area : 11425

Peak Name	Retention Time(s)	Absorbance	Area	Result (Area %)
HbA0	69	3545	10425	88.8
HbA1c	38	51	581	4.9
La1c	24	27	209	1.8
HbF	19	16	22	0.2
Hba1b	13	35	111	0.9
Hba1a	11	27	77	0.6