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Reference:Dr.--

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Collection Date: 03-07-2021 05:06 PM
Sample Date: 03-07-2021 05:06 pm
Report Date: 03-07-2021 09:57 PM

REPORT

Age:71.10 Years Sex:FEMALE

Complete Blood Count	Result	Biological Reference Interval
(EDTA Whole Blood)		
Hemoglobin (Hb), EDTA whole blood	**12.70**	12.3 - 15.3 g/dL
Method: Photometry		
Total Leucocytes (WBC) count	**8,700**	4000-10000/µL
Method : Coulter Principle / Microscopy		
Platelet count	**267,000**	150000 - 450000 /µL
Method : Coulter Principle / Microscopy		
Red blood cell (RBC) count	**4.47**	4.10 - 5.10 x 10^6 /µL
Method: Coulter Principle		
PCV (Packed Cell Volume)	**38.60**	35.9 - 44.6 %
Method: Calculated		
MCV (Mean Corpuscular Volume)	**86.20**	80.0 - 96.0 fL
Method: Derived from RBC histogram		
MCH (Mean Corpuscular Hb)	**28.50**	27.5 - 33.2 pgms
Method: Calculated		
MCHC (Mean Corpuscular Hb Conc.)	**33.00**	33.4 - 35.5 g/dL
Method: Calculated		
RDW (RBC distribution width)	**15.10**	11.6 - 14.6 %
Method: Derived from RBC Histogram		
WBC Differential Count		
Method: VCSn / Microscopy / Calculated		
Neutrophils	**80**	40 - 80 %
Absolute Neutrophils	**6,960**	2000 - 7000 /µL
Eosinophils	**2**	1 - 6 %
Absolute Eosinophils	**174**	20 - 500 /µL
Basophils	**0**	0 - 2 %
Absolute Basophils	**0**	0 - 100 /µL
Lymphocytes	**13**	20 - 40 %
Absolute Lymphocytes	**1,131**	1000 - 3000 /µL
Monocytes	**5**	2 - 10 %
Absolute Monocytes	**435**	200 - 1000 /µL
-	+	

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REPORT

Age:71.10 Years Sex:FEMALE

Complete Blood Count Findings

R.B.C. : **Normocytic, Normochromic**

W.B.C. : **No abnormality detected**

Platelets : **Adequate**

Remark : ON FOLLOW UP.

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Test Description	Observed Value	Biological Reference Interval
Ferritin, serum by CMIA	**36.08**	Female : 4.63- 204 ng/mL

Ferritin is the major iron storage protein for the body. Ferritin is found chiefly in the cytoplasm of cells of the reticuloendothelial system and is a constituent of normal human serum. Generally the concentration of ferritin is directly proportional to the total iron stores in the body. There is a significant positive correlation between age and serum ferritin concentrations in females, but not in males. Patients with iron deficiency anemia have serum ferritin concentration approximately one-tenth of normal while patients with iron overload (hemochromatosis, hemosiderosis) have serum ferritin concentrations much higher than normal. Ferritin is a positive acute phase reactant in both adults and children, whereby chronic inflammation results in a disproportionate increase in ferritin in relation to iron reserves. Elevated ferritin is also observed in acute and chronic liver disease, chronic renal failure, and in some types of neoplastic disease.

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REPORT

Age:71.10 Years Sex:FEMALE

Test Description	Observed Value	Biological Reference Interval
Lipid Profile Mini :		
Cholesterol (Total), serum by Enzymatic method	**112**	Desirable : < 200 mg/dL Borderline high : 200 - 239 mg/dL High : >/= 240 mg/dL
Triglycerides, serum by Enzymatic method	**116**	Normal : < 150 mg/dL Borderline high : 150-199 mg/dL High : 200-499 mg/dL Very high : >/= 500 mg/dL
HDL Cholesterol, serum by Enzymatic method	**43**	Men : > 40 mg/dL Women : > 50 mg/dL
VLDL Cholestrol, serum by calculation	**23**	< 30 mg/dL
LDL Cholesterol, serum by calculation	**46**	Optimal : <100 mg/dL Near optimal/above optimal : 100-129 mg/dL Borderline high : 130-159 mg/dL High : 160-189 mg/dL Very high : >/= 190 mg/dL
Cholesterol(Total)/HDL Cholesterol Ratio	**2.60**	Males : Acceptable ratio </= 5.00 Females : Acceptable ratio </= 4.50
LDL Cholesterol/HDL Cholesterol Ratio	**1.07**	Males : Acceptable ratio </= 3.60 Females : Acceptable ratio </= 3.20

Reference : ATP III, NCEP Guidelines and National Lipid Association (NLA) 2014 Recommendations

As per most international and national guidelines including Lipid Association of India 2016 :

1. Lipoprotein and lipid levels should be considered in conjunction with other atherosclerotic cardiovascular disease (ASCVD) risk determinants to assess treatment goals and strategies.
2. Non-fasting lipid levels can be used in screening and in general risk estimation.

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Test Description	Observed Value	Biological Reference Interval
TEST NAME		
Glycated Hemoglobin (HbA1C), by HPLC	**7.30**	4.0 to 5.6 %

Interpretation :
HbA1C level reflects the mean glucose concentration over previous 8-12 weeks and provides better indication of long term glycemic control.

For diagnosis of Diabetes Mellitus (>/= 18 yrs of age) :
5.7 % - 6.4 % : Increased risk for developing diabetes.
>/= 6.5 % : Diabetes

Therapeutic goals for glycemic control :
Adults : < 7%
Toddlers and Preschoolers : < 8.5% (but > 7.5 %)
School age (6-12 yrs) : < 8%
Adolescents and young adults (13 - 19 yrs) : < 7.5 %

Levels of HbA1C may be low as result of shortened RBC life span in case of hemolytic anemia.
Increased HbA1C values may be found in patients with polycythemia or post splenectomy patients.
Patients with Homozygous forms of rare variant Hb(CC,SS,EE,SC) HbA1c can not be quantitated as there is no HbA. In such circumstances glycemic control can be monitored using plasma glucose levels or serum Fructosamine.

The A1c target should be individualized based on numerous factors, such as age, life expectancy, comorbid conditions, duration of diabetes, risk of hypoglycemia or adverse consequences from hypoglycemia, patient motivation and adherence.

Ref : ADA (Standards of Medical Care in Diabetes - 2017)

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REPORT

Age:71.10 Years Sex:FEMALE

Test Description	Observed Value	Biological Reference Interval
TEST NAME		
Magnesium, serum by Calmagite dye	**1.50**	0-2 Yrs : 1.6 - 2.7 mg/dL 3-5 Yrs : 1.6 - 2.6 mg/dL 6-8 Yrs : 1.6 - 2.5 mg/dL 9-11 Yrs : 1.6 - 2.4 mg/dL 12-17 Yrs : 1.6 - 2.3 mg/dL Adult : 1.8 to 2.4 mg/dL

Interpretation :

1. Magnesium is a major intracellular cation.

2. Regulation takes place mainly via the kidneys, primarily via the ascending loop of Henle.

3. Conditions that interfere with glomerular filtration result in retention of magnesium and, hence, elevation of serum concentrations. Hypermagnesemia is found in acute and chronic renal failure, magnesium overload, and magnesium release from the intracellular space.

4. Conditions that have been associated with hypomagnesemia include chronic alcoholism, childhood malnutrition, lactation, malabsorption, acute pancreatitis, hypothyroidism, chronic glomerulonephritis, aldosteronism, and prolonged intravenous feeding.

5. Magnesium toxicity may result in central nervous system (CNS) depression, cardiac arrest, and respiratory arrest.

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Test Description	Observed Value	Biological Reference Interval
Enzymes :		
LDH-Lactate Dehydrogenase,serum by UV Kinetic	**155.00**	81 to 234 U/Lt.
Clinical Chemistry		
Creatinine, serum by Jaffe w/o deproteinization	**0.61**	0.6 to 1.2 mg/dL
Uric Acid, serum by Uricase method	**5.00**	Female : 2.60 to 6.00 mg/dL

** Uric acid is useful for 1. Diagnosis and follow up of renal failure. 2. Monitoring patients receiving cytotoxic drugs and a variety of other disorders, including gout, leukemia, psoriasis, starvation and other wasting conditions . * Increased uric acid is seen in following conditions : 1. Increased purine synthesis 2. Inherited metabolic disorders 3. Excess dietary purine intake 4. Increased nucleic acid turnover 5. Malignancy, cytotoxic drugs 6. Decreased urinary excretion (due to CRF) 7. Increased renal reabsorption . * Uric acid is decreased in : 1. Hepatocellular disease with reduced purine synthesis 2. Defective renal reabsorption 3. Overtreatment of uricemia (allopurinol or cancer therpies like 6-mercaptopurine, etc).*

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Test Description	Observed Value	Biological Reference Interval
Clinical Chemistry :		
Sodium, serum by IMT Indirect	**140.00**	136 to 145 mmol/Lt
Potassium, serum by IMT Indirect	**4.00**	3.50 to 5.10 mmol/Lt
Chloride, serum by IMT Indirect	**104.00**	98 to 107 mmol/Lt
Alkaline Phosphatase,serum by pNPP-kinetic	**55**	Adult Female : (Unit : U/Lt.). 15 - < 17 years : 50 - 117 > or =17 years: 35 - 104
Bicarbonate, serum by Biochemical method	**29.00**	21 to 32 mmol / Lt
Urea, serum by GLDH-urease	**25**	17 to 49 mg/dL
Calcium, serum by OCPC method	**8.60**	Adult : 8.4 to 10.2 mg/dL

Method : Colorimetric (o-cresolpthalein substrate) .
1. Calcium is useful for diagnosis and monitoring of a wide range of disorders including diseases of bone, kidney, parathyroid gland, or gastrointestinal tract .
2. Calcium ions play an important role in blood clotting, bone mineralization, musculature contractility and CNS functioning. .
3. Hypocalcemia is due to the absence or impaired function of the parathyroid glands or impaired vitamin-D synthesis. Chronic renal failure is also frequently associated with hypocalcemia due to decreased vitamin-D synthesis as well as hyperphosphatemia and skeletal resistance to the action of parathyroid hormone (PTH).
4. Hypercalcemia is mainly due to primary hyperparathyroidism (pHPT), and bone metastasis of carcinoma of the breast, thyroid gland, or lung. Severe hypercalcemia may result in cardiac arrhythmia.

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Age:71.10 Years Sex:FEMALE

Test Description	Observed Value	Biological Reference Interval
Clinical Chemistry :		
Phosphorus,serum by Ammonium molybdate UV	**3.70**	14 - 15 yrs : 3.5 to 4.9 mg/dL 16 - 17 yrs : 3.1 to 4.7 mg/dL >/= 18 yrs : 2.5 to 4.5 mg/dL

1. Phosphorus is useful for diagnosis of a variety of disorders including bone, parathyroid, and renal disease.
2. Hypophosphatemia may have 4 general causes: shift of phosphate from extracellular to intracellular, renal phosphate wasting, loss from the gastrointestinal tract, and loss from intracellular stores.
3. Hyperphosphatemia is usually secondary to an inability of the kidneys to excrete phosphate. Other factors may relate to increased intake or a shift of phosphate from the tissues into the extracellular fluid.
4. The most acute problem associated with rapid elevations of serum phosphate levels is hypocalcemia.
5. Phosphorus levels below 1.0 mg/dL are potentially life-threatening.
6. Phosphorus has a very strong biphasic circadian rhythm.

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Age:71.10 Years Sex:FEMALE

Test Description	Observed Value	Biological Reference Interval
Clinical Chemistry :		
Hormones		
T3 (Total), serum by CMIA	**0.75**	0.64 to 1.52 ng/ml
T4 (Total), serum by CMIA	**12.49**	4.87 to 11.72 µg/dL
TSH(Ultrasensitive), serum by CMIA	**0.05**	For non pregnant female :
	suggested follow up	0.40 - 4.00 µIU/mL For pregnant female : 1st trimester : 0.1 - 2.5 µIU/mL 2nd trimester : 0.2 - 3.0 µIU/mL 3rd trimester : 0.3 - 3.0 µIU/mL Ref : American Thyroid Association guidelines 2017

On follow up; ? On therapy

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"Accreditation as per ISO 15189:2012, Cert.No. MC-3143. Refer scope@ www.nabl-india.org"

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REPORT

Age:71.10 Years Sex:FEMALE

Test Description	Observed Value	Reference range & Units
TEST NAME		
Vitamin B12, serum by CMIA	**> 2000**	187 - 883 pg/mL
Folic acid, Serum by CMIA	**> 20**	3.10 - 20.50 ng/mL

Interpretation :

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

Decreased Serum B12
Pregnancy
Contraceptive hormones
Malabsorption
Ethanol ingestion
Smoking
Strict vegan diet
Pernicious anemia

3. Serum methylmalonic acid and homocysteine levels are also elevated in vitamin B12 deficiency states. Active B12 (Holotranscobalamin) is low in Vitamin B12 deficiency.
4. Please correlate in case of patients taking vitamin B12 supplementation.

Folate deficiency is most commonly due to insufficient dietary intake and is most frequently encountered in pregnant women or in alcoholics.
Causes of low serum folate concentration include:
- Excessive utilization (eg, liver disease, hemolytic disorders, and malignancies)
- Rare inborn errors of metabolism.
Rapid rise may be seen after a full balanced meal or recent folic acid administration.
Additional serum testing with homocysteine and methylmalonic acid (MMA) determinations may help distinguish between vitamin B12 and folate deficiency states.
Recent folic acid administration or dietary folate intake could result in normal or elevated values and possibly mask an underlying folate deficiency.

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REPORT

Age:71.10 Years Sex:FEMALE

Test Description	Observed Value	Reference range & Units
Albumin Creatinine Ration (ACR)		
Microalbumin, spot urine by Immunoturbidimetery	**5.40**	Upto 30 mg/Lt
Creatinine,spot urine byJaffe w/o deproteinization	**19.00**	Female: 20 - 320 mg/dL
Albumin/Creat Ratio, urine by Jaffe	**28.42**	Normal : 0 - 30 µg/mg Microalbuminuria : 30 - 300 µg/mg Clinical albuminuria : Above 300 µg/mg

Interpretation :

1.Microalbumin is useful assessing the potential for early onset of nephropathy in diabetic patients.

2. Before overt proteinuria develops, albumin excretion increases in those diabetic patients who are destined to develop diabetic nephropathy. Therapeutic maneuvers (eg, aggressive blood pressure maintenance, particularly with angiotensin-converting enzyme inhibitors; aggressive blood sugar control; and possibly decreased protein intake) can significantly delay, or possibly prevent, development of nephropathy.

3.The preferred specimen is a 24-hour collection, but a random collection is acceptable.

4. Correcting albumin for creatinine excretion rates has similar discriminatory value with respect to diabetic renal involvement. The albumin:creatinine ratio from a random urine specimen is also considered a valid screening tool.

5. Microalbuminuria is a marker of generalized vascular disease and is associated with stroke and heart disease.

6. Due to biologic variability, positive results should be confirmed by a second, first-morning random or 24-hour timed urine specimen.

7. Urine collected during menses may contain excess albumin and collection during this time should be avoided.

8. Heavy exercise may increase albumin excretion and should be avoided during collection. Normal values apply to a nonexercised state.

Reference : Mayo Medical Laboratories, 2018 Interpretive Handbook.

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REPORT

Age:71.10 Years Sex:FEMALE

Test Description	Observed Value	Biological Reference Interval
Coagulation :		
D-Dimer, Citrate plasma	**483.00**	0 to 500 ng/ml (FEU) Upto four fold higher results may be observed in normal pregnancy. Method : ELFA / CLIA

Note :

D-Dimer assay results may be affected by sample integrity, drug history and assay platform used.
Kindly interpret the result in view of above factors and clinical details. In case of any discrepancy, repeat the estimation on fresh sample for confirmation.

D-Dimer is a fibrin degradation product.

D-Dimer is increased in : 1) DIC (Disseminated Intavascular Coagulation).

2) DVT (Deep Vein Thrombosis).

3) Hypercoagulable states.

4) Recent surgery, trauma, infection.

Increased levels may also be seen in the following conditions :

Liver disease, cardiac disease, rheumatoid arthritis, eclampsia, malignancy, hemolysis, lipemia & hyperbilirubinemia.

Please interpret with caution if patient is on anticoagulant therapy.

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Age:71.10 Years Sex:FEMALE

Test Description	Observed Value	Biological Reference Interval
CRP(hs) - C- Reactive Protein high sensitivity	**11.20**	See clinical information below . Method : Nephelometry / Immunoturbidimetry

Kindly correlate clinically and follow up.

Clinical Information :

1. C-reactive protein (CRP) is a biomarker of inflammation. Plasma CRP concentrations increase rapidly and dramatically (100-fold or more) in response to tissue injury or inflammation.

2. High-sensitivity CRP (hs-CRP) is more precise than standard CRP when measuring baseline (i.e. normal) concentrations and enables a measure of chronic inflammation. It is recommended for cardiovascular risk assessment. Atherosclerosis is an inflammatory disease and hs-CRP has been endorsed by multiple guidelines as a biomarker of atherosclerotic cardiovascular disease risk.

Low cardiovascular risk : < 2.0 mg/L
High cardiovascular risk : >/= 2.0 mg/L
Acute inflammation : > 10.0 mg/L

3. A single test for high-sensitivity CRP (hs-CRP) may not reflect an individual patient's basal hs-CRP level. Repeat measurement may be required to firmly establish an individual's basal hs-CRP concentration. The lowest of the measurements should be used as the predictive value.

Reference : Mayo Medical Laboratories

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Age:71.10 Years Sex:FEMALE

Test Description	Observed Value	Biological Reference Interval
Interleukin 6 (IL-6), serum by ECLIA	**31.86**	Upto 7 pg/mL

Kindly correlate clinically and follow up.

Note :

IL-6 assay results may be affected by :

- Sample integrity
- Sample type (serum / plasma)
- Treatment given
- Assay platform used

Kindly interpret the result in view of the above factors and clinical details.

Please repeat on fresh sample if required. (Serum should be separated immediately after clotting).

* Interleukin-6 (IL-6) is produced by different cell types, including macrophages, endothelial cells and T cells, in response to microbial invasion or other cytokines such as tumour necrosis factor (TNF).

* IL-6 induces expression of C-reactive protein (CRP), fibrinogen and serum amyloid A also known as acute phase response.

* Elevated IL-6 seen in :
  - Infections
  - Sepsis, septicimia
  - Rheumatoid arthritis
  - Systemic lupus erythematosus
  - Ankylosing spondylitis
  - Inflammatory Bowel Disease

* IL-6 concentration correlate with severity of sepsis.

End of Report

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Collection Date:
05-07-2021 09:13 AM
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REPORT

Age:71.10 Years Sex:FEMALE

Test Description	Observed Value	Biological Reference Interval
Clinical Chemistry :		
Thyroglobulin level, serum by ECLIA	**<0.04**	3.5 to 77 ng/mL
Kindly correlate clinically.		
Auto Immunity		
Thyroglobulin Antibody (ATA),serum by CMIA	**Negative (<3)**	Negative : < 4.11 IU/mL

Thyroglobulin autoantibodies bind thyroglobulin (Tg), a major thyroid-specific protein. Tg plays a crucial role in thyroid hormone synthesis, storage, and release. Follicular destruction through inflammation, hemorrhage , or rapid disordered growth of thyroid tissue can result in leakage of Tg into the blood stream. This results in the formation of autoantibodies to Tg (anti-Tg) in some individuals. The same processes also result in the formation of autoantibodies particularly Anti TPO. In individuals with autoimmune hypothyroidism, 30% to 50% will have detectable anti-Tg autoantibodies, while 50% to 90% will have Anti-Tg values determined by different methodologies might detectable anti-TPO autoantibodies. In Graves disease, both types of autoantibodies are observed at approximately half these rates.

MC-3143

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REPORT

Age:71.10 Years Sex:FEMALE

Test Description	Observed Value	Biological Reference Interval
Auto Immunity :		

End of Report

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