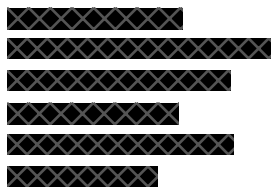


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Age:71.10 Years Sex:FEMALE

Reference:Dr.--

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



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Complete Blood Count Findings

R.B.C. : Normocytic, Normochromic

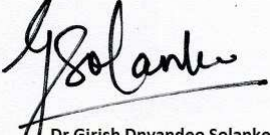
W.B.C. : No abnormality detected

Platelets : Adequate

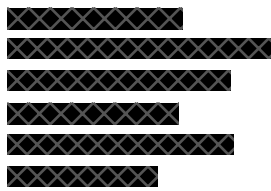
Remark : ON FOLLOW UP.

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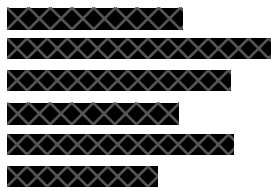
Test Description	Observed Value	Biological Reference Interval
Ferritin, serum by CMIA	36.08	Female : 4.63- 204 ng/mL

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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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

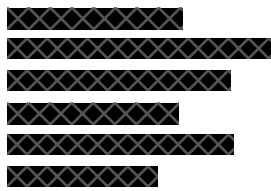
As per most international and national guidelines including Lipid Association of India 2016 :

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 <u>TEST NAME</u>	Observed Value	Biological Reference Interval
Glycated Hemoglobin (HbA1C), by HPLC	<u>7.30</u>	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 (\geq 18 yrs of age) :

5.7 % - 6.4 % : Increased risk for developing diabetes.

\geq 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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Test Description TEST NAME	Observed Value	Biological Reference Interval
Magnesium, serum by Calmagite dye	<u>1.50</u>	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

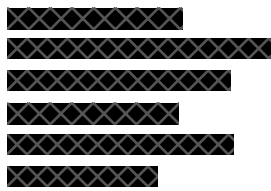
Interpretation :

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

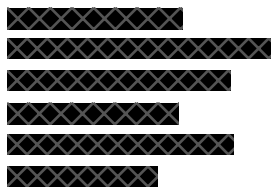
Creatinine, serum by Jaffe w/o deproteinization	0.61	0.6 to 1.2 mg/dL
Uric Acid, serum by Uricase method	5.00	Female : 2.60 to 6.00 mg/dL

** 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 therapies like 6-mercaptopurine, etc).



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Test Description
Clinical Chemistry :

Observed Value

Biological Reference Interval

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-cresolphthalein 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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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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Test Description
Clinical Chemistry :

Observed Value

Biological Reference Interval

Hormones

T3 (Total), serum by CMIA
T4 (Total), serum by CMIA
TSH(Ultrasensitive), serum by CMIA

0.75
12.49
0.05
suggested follow up

0.64 to 1.52 ng/ml
4.87 to 11.72 µg/dL
For non pregnant female :
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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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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Test Description	Observed Value	Reference range & Units
<u>Albumin Creatinine Ration (ACR)</u>		
Microalbumin, spot urine by Immunoturbidimetry	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.

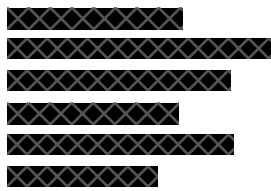
Reference : Mayo Medical Laboratories, 2018 Interpretive Handbook.



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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 Intravascular 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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Test Description

CRP(hs) - C- Reactive Protein high sensitivity

Observed Value11.20**Biological Reference Interval**

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.

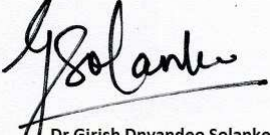
Low cardiovascular risk : < 2.0 mg/L

High cardiovascular risk : \geq 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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Test Description	Observed Value	Biological Reference Interval
Interleukin 6 (IL-6), serum by ECLIA	<u>31.86</u>	Upto 7 pg/mL

Kindly correlate clinically and follow up.

Note :

IL-6 assay results may be affected by :

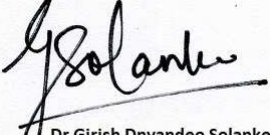
- Sample integrity
- Sample type (serum / plasma)
- Treatment given
- Assay platform used

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, septicemia
 - 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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Reference:Dr.--

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Collection Date:
05-07-2021 09:13 AM
Sample Date:
05-07-2021 09:13 am
Report Date:
05-07-2021 03:44 PM

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.



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Age:71.10 Years Sex:FEMALE

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05-07-2021 03:44 PM

Test Description
Auto Immunity :

Observed Value

Biological Reference Interval

End of Report



Mehendale
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