Path Care®
COMPLETE DIAGNOSTIC SOLUTION
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DoctorC

REPORT

Patient Name	:	Ms. REHANA	Reg. No.	:	01532211250330
Age and Sex	:	55 Yrs / Female	PCC Code	:	PCL-TS-622
Referring Doctor	:	NA	Sample Drawn Date	:	25-Nov-2022 09:00 AM
Referring Customer	:	N/A	Registration Date	:	25-Nov-2022 01:37 PM
Vial ID	:	M2270824	Report Date	:	25-Nov-2022 09:58 PM
Sample Type	:	*Serum*	Report Status	:	Final Report
Client Address	:				

CLINICAL BIOCHEMISTRY

HEALTH CHECK AT HOME - 33 TESTS

Test Name	Obtained Value	Units	Bio. Ref. Intervals (Age/Gender specific)	Method
Lipid Profile				
Cholesterol Total	172	mg/dL	Adult: Desirable<200 mg/dL, Borderline: 200 – 239 mg/dL, High:>240 mg/dL	Enzymatic
Cholesterol HDL	48	mg / dL	40 - 60	Direct Homogenous
Cholesterol - LDL	84.2	mg/dL	<100 Optimal	Calculated
Cholesterol VLDL	39.8	mg/dL	7-40	Calculated
Non-HDL cholesterol	124	mg/dL	Optimal < 130	Calculated
Triglycerides	**199**	mg/dL	Normal: <150 Borderline High: 150–199 High: 200–499 Very High: >500	Glycerol Phosphate Oxidase
Cholesterol Total/Cholesterol HDL Ratio	3.58		0 - 4.0	Calculated
Cholesterol LDL/Cholesterol HDL	1.75		0 - 3.5	Calculated

COMMENTS: **Therapeutic target levels of lipids as per NCEP – ATP III recommendations:**

Total Cholesterol (mg/dL)	<200 - Desirable, 200-239 - Borderline High, >240 - High
HDL Cholesterol (mg/dL)	<40 - Low, >60 - High
LDL Cholesterol (mg/dL)	<100 Optimal, [Primary Target of Therapy], 100-129 - Near Optimal/Above Optimal, 130-159 - Borderline High, 160-189 - High, >190 Very High
Serum Triglycerides (mg/dL)	<150 Normal, 150-199 Borderline High, 200-499 High, >500 Very High

NCEP recommends lowering of LDL Cholesterol as the primary therapeutic target with Lipid lowering agents, however, if Triglycerides remain >200 mg/dL after LDL goal is reached, set secondary goal for non-HDL Cholesterol (total minus HDL) 30 mg/dL higher than LDL goal.

When Triglyceride level is > 400 mg/dL, Friedewald Equation is not applicable for calculation of LDL & VLDL. Hence the calculated values are not provided for such samples.

ATP III Guidelines:

Risk Category	LDL Goal	LDL Level at Which to Initiate Therapeutic Lifestyle Changes (TLC)	LDL Level at Which to Consider Drug Therapy
CHD or CHD RiskEquivalents(10-year risk >20%)	<100 mg/dL	>100 mg/dL	>130 mg/dL (100-129 mg/dL: drug optional)*
2+ Risk Factors (10-year risk <20%)	<130 mg/dL	>130 mg/dL	10-year risk 10-20%: >130 mg/dL 10-year risk <10%:>160mg/dL
0-1 Risk Factor	<160 mg/dL	>160 mg/dL	>190 mg/dL (160-189 mg/dL: LDL-lowering drug optional)

Urea / Creatinine Ratio				
Urea	21.4	mg/dL	21.0-43.0	Calculated
Creatinine	0.62	mg/dL	0.6-1.1	Kinetic Alkaline picrate
Urea / Creatinine Ratio	34.51	mg/mg	Elevated ratio: >100:1 Reduced ratio: <40:1	Calculated

DR. MANJUNATHA TM
M.B.B.S , DCP (Pathology)

Note: If the test results are alarming or unexpected,Client is advised to contact the laboratory immediately for possible remedial action.

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Referring Customer	:	N/A	Registration Date	:	25-Nov-2022 01:38 PM
Vial ID	:	M2270824, M2270848	Report Date	:	25-Nov-2022 09:46 PM
Sample Type	:	*Serum, Plasma-Sodium Fluoride-*	Report Status	:	Final Report
Client Address	:				

CLINICAL BIOCHEMISTRY

HEALTH CHECK AT HOME - 33 TESTS

Test Name	Obtained Value	Units	Bio. Ref. Intervals (Age/Gender specific)	Method
Urea	21.4	mg/dL	21.0-43.0	Calculated

Comments:

- Urea is the end product of the Protein metabolism. It is systhesised in Liver from the Ammonia produced by the catabolism of amino acids.
- It is transported by the Blood to the Kidneys from where it is excreted.
- Increased levels are found in renal diseases, urinary obstructions, shock, congestive Heart failure and burns.
- Decreased levels are found in Liver failure and pregnancy.

Creatinine	0.62	mg/dL	0.6-1.1	Kinetic Alkaline picrate

Comments:

- Creatinine is the catabolic product of Creatinine Phosphate which is used by the skeletal muscle.
- The daily production depends on muscular mass and it is excreted out of the body entirely by the Kidneys.
- Elevated levels are found in renal dysfunction, reduced renal blood flow (shock, dehydration, congestive Heart failure), Diabetes, Acromegaly.
- Decreased levels are found in Muscular Dystrophy.

Glucose-Blood-Fasting	**143.0**	mg/dL	Normal < 100 Pre-diabetic 100-125 Diabetic >= 126	Hexokinase

Comments:

- Glucose is the major carbohydrate present in blood. Its oxidation in the cells is the source of energy for the body. Increased levels of Glucose are found in Diabetes Mellitus, Hyperparathyroidism, Pancreatitis and renal failure.
- Decreased levels are found in Insulinoma, Hypothyroidism, Hypopituitarism and extensive Liver disease

Biological Reference Interval : Source: American Diabetic Association, Diabetes Care 2018:41 (Suppl.1) S13-S27

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CLINICAL BIOCHEMISTRY

HEALTH CHECK AT HOME - 33 TESTS

Test Name	Obtained Value	Units	Bio. Ref. Intervals (Age/Gender specific)	Method
Tri-Iodothyronine Total (TT3)	84.50	ng/dL	35-193	CMIA

Pregnancy	
1 Trimester	81 - 190
2 & 3rd Trimester	100 -260

Comments:

- T3 is a hormone that originates from direct thyroid synthesis and secretion from peripheral conversion of T4 to T3.
- T3 is secreted into the circulation in response to the pituitary hormone TSH.
- The secretion of T3 is regulated by a negative feedback mechanism involving the Thyroid Gland, Pituitary Gland and Hypothalamus.

Thyroxine - Total (TT4)	6.62	µg/dL	5.5-11.0	CMIA

Comments:

- T4 is major hormone synthesized and secreted by the Thyroid gland, and plays an important role in regulating metabolism. T4 is secreted into the circulation in response to the pituitary hormone TSH. The secretion of T4 is regulated by a negative feedback mechanism involving the Thyroid Gland, Hypothalamus and Pituitary Gland.
- In the circulation 99.95% of T4 is reversibly bound to transport proteins, primarily Throxine binding Globulin and to a lesser extent Albumin and Prealbumin. Unbound or free T4 is metabolically active and bound T4 is metabolically inactive, acting as a reserve.
- TBG concentrations remain reasonably constant is healthy individuals. However, pregnancy, excess Estrogens, Androgens, anabolic Steroids, and Glucocorticoids are known to alter TBG levels and may cause false Thyroid values for Thyroid function tests. Altered T4 levels in these situations may not accurately reflect Thyroid status.

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Sample Type	:	*Serum, Plasma-Sodium Fluoride-*	Report Status	:	Final Report
Client Address	:				

CLINICAL BIOCHEMISTRY

HEALTH CHECK AT HOME - 33 TESTS

Test Name	Obtained Value	Units	Bio. Ref. Intervals (Age/Gender specific)	Method
Thyroid Stimulating Hormone (TSH)	4.33	µlU/mL	0.5-8.9(Test performed on 4th Generation TSH kit)	CMIA

Biological Reference Intervals : TSH(µlU/mL)

Pregnancy (As per American Thyroid Association)

1 Trimester	0.10-2.50
2 Trimester	0.2-3.00
3 Trimester	0.3-3.00

Interpretation:

- Assay results should be interpreted in context to the clinical condition and associated results of other investigations.
- Previous treatment with Corticosteroid therapy may result in lower TSH levels while Thyroid hormone levels are normal.
- Results are invalidated if the client has undergone a radionuclide scan within 7-14 days before the test.
- Abnormal Thyroid test findings often found in critically ill clients should be repeated after the critical nature of the condition is resolved.
- The production, circulation, and disposal of Thyroid hormone are altered throughout the stages of pregnancy.

Uric Acid	3.6	mg/dL	2.6-6.0	Uricase

Comments:

- Uric acid is the end product of purine metabolism.
- Uric acid is excreted to a large degree by the Kidneys and to a smaller degree in the intestinal tract by microbial degradation.
- Increased levels are found in Gout, Arthiritis, impaired renal functions and starvation.
- Decreased levels are found in Wilson's Disease, Fanconis Syndrome and Yellow Atrophy of the Liver.

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Referring Customer	: N/A	Registration Date	: 25-Nov-2022 01:38 PM
Vial ID	: M2270828	Report Date	: 25-Nov-2022 03:50 PM
Sample Type	: *WB-EDTA*	Report Status	: Final Report
Client Address	:		

HEMATOLOGY

HEALTH CHECK AT HOME - 33 TESTS

Test Name	Obtained Value	Units	Bio. Ref. Intervals (Age/Gender specific)	Method
Complete Blood Count (CBC)				
Haemoglobin	12.5	g/dL	12-15	Colorimetric
RBC Count	4.2	10^12/L	3.8-4.8	Electrical Impedance
Haematocrit (HCT)	**36.3**	%	40-50	Calculated
MCV	87.4	fl	81-101	RBC Histogram
MCH	30.0	pg	27-32	Calculated
MCHC	34.3	g/dL	31.5-34.5	Calculated
RDW-CV	11.7	%	11.6-14.0	RBC Histogram
Platelet Count	327	10^9/L	150-410	Electrical Impedance/Microscopy
WBC count, Total	8.4	10^9/L	4.0-10.0	Impedance
Neutrophils	58.0	%	40-70	Microscopy
Neutrophil-Absolute Count	4.87	10^9/L	2.0-7.0	Calculated
Lymphocytes	30.0	%	20-40	Microscopy
Lymphocytes-Absolute Count	2.52	10^9/L	1.0-3.0	Calculated
Monocytes	9.0	%	2-10	Microscopy
Monocytes-Absolute Count	0.76	10^9/L	0.2-1.0	Calculated
Eosinophils	3.0	%	1-6	Microscopy
Eosinophils-Absolute Count	0.25	10^9/L	0.02-0.5	Calculated
Basophils	0.0	%	0-2	Microscopy
Basophils-Absolute Count	0.00	10^9/L	0.0-0.3	Calculated
Others	0.0	%	00	Microscopy
Remarks	.			

Sample is Processed on Automated CBC Analyzer
Note: *Haematocrit (HCT) is derived from calculated MCV based on RBC Histogram as per Manufacturer's Manual*

Correlate Clinically. Laboratory is NABL Accredited. Result rechecked and verified for abnormal cases.

*** End Of Report ***

DR. HAREESH CHANDRAN
MD PATHOLOGY