

PATIENT NAME : ZARINA Q SIDDIQUI	REF. DOCTOR : SELF
CODE/NAME & ADDRESS : CS00008327 MEDICARE DIAGNOSTIC CENTRE(MAHIM) 129 GOVERNOR LANE NEAR VAIBHAV APT OPP. GHAZI RESTAURANT, MAIN ROAD, MAHIM (E) MUMBAI 400017 7718982967 9702341601	ACCESSION NO : 5047WF048653 PATIENT ID : ZARIF2706835047 CLIENT PATIENT ID: ABHA NO :
	AGE/SEX : 40 Years Female
	DRAWN : 27/06/2023 17:13:22
	RECEIVED : 27/06/2023 17:16:13
	REPORTED : 27/06/2023 21:58:20

Test Report Status	Final	Results	Biological Reference Interval	Units
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ENDOCRINOLOGY

AMH / MIS, SERUM

ANTI-MULLERIAN HORMONE / MULLERIAN INHIBITING SUBS	2.83	2.02 - 6.7 ng/mL Optimal Fertility: 4.0 - 6.793 Low Fertility : 0.308 - 2.198 High Level: >6.793 Satisfactory Fertility: 2.198 - 4.0 Very low / Undetectable 0.0 - 0.308
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METHOD : CLIA

Interpretation(s)

AMH / MIS, SERUM-Anti mullerian hormone (AMH) or Mullerian inhibiting substances (MIS) is a glycoprotein dimer composed of two 72 kDa monomers linked by disulfide bonds. AMH belongs to the transforming growth factor β (TGF - β) superfamily. AMH is a hormone marker for quantitative prediction of ovarian reserve, ovarian aging, ovarian dysfunction and ovarian responsiveness. The levels of AMH decrease in pre-menopausal women as the quality and number of ovarian follicles decline with age.

Clinical Utility:

- Evaluating Fertility Potential – Serum AMH levels correlate with the number of early antral follicles with greater specificity than Inhibin B, Oestradiol, Follicle Stimulating Hormone and Luteinizing Hormone on cycle day 3. Thus, Day 3 AMH may reflect ovarian follicular status better than these hormone markers.
- Measuring Ovarian Aging – Diminished ovarian reserve, associated with poor response to IVF, is signaled by reduced baseline serum AMH concentrations. AMH would appear to be a useful marker for predicting ovarian aging and the potential for successful IVF.
- Predicting Onset of Menopause – The duration of the menopausal transition can vary significantly in individuals and reproductive capacity may be seriously compromised prior to clinical diagnosis. AMH can predict the occurrence of the menopausal transition.
- Assessing Polycystic Ovary Syndrome – Serum AMH levels are elevated in patients with polycystic ovary syndrome and may be useful as a marker for the extent of the disease.

Interpretation:

AMH levels do not change significantly throughout the menstrual cycle and decrease with age.

"Below mentioned reference interval is applicable for evaluating fertility potential."

Ovarian Fertility Potential	pmol/L	ng/mL
Optimal Fertility	28.6 - 48.5	4.0 - 6.8
Satisfactory Fertility	15.7 - 28.6	2.2 - 4.0
Low Fertility	2.2 - 15.7	0.3 - 2.2
Very Low / undetectable	0.0 - 2.2	0.0 - 0.3
High Level	> 48.5	> 6.8

The interpretation guide provided above are only suggestions which are based upon examination of multiple published studies. It is expected in the near future that refinement of these ranges may occur.

References:

- Durlinger ALL, Visser JA, Themmen APN. Regulation of ovarian function: the role of anti-Müllerian hormone. Reproduction 2002; 124:601-609.
- Ficicioglu C, Kutlu T, Baglam E, Bakacak Z. Early follicular antimüllerian hormone as an indicator of ovarian reserve. Fertility and Sterility 2006; 85:592-6.
- Human Reproduction 2007; 22(9):2414-2421 doi:10.1093/humrep/dem204.
- Fertil Steril. 2005; 83(4):979-87 (ISSN: 1556-5653)

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F.S.H., SERUM

1.13 Low

Follicular Phase : 3.03 - 8.08mIU/mL
 Mid Cycle Phase : 2.55 - 16.69
 Luteal Phase : 1.38 - 5.47
 Post Menopausal Phase : 26.72
 - 133.41

METHOD : CMIA

Comments

Rechecked
 Kindly Correlate Clinically And With Treatment History.

ESTIMATION OF LUTEINIZING HORMONE

LUTEINIZING HORMONE (SERUM)

5.46

Follicular Phase : 1.80-11.78mIU/mL
 Midcycle Peak : 7.59-89.08
 Luteal Phase : 0.56-14.00
 Post Menopausal Women : 5.16
 -61.99
 (Without HRT)

METHOD : CMIA

ESTIMATION OF PROLACTIN

ESTIMATION OF PROLACTIN. (SERUM)

10.73

5.18 - 26.53 ng/mL
 PREGNANT WOMEN : 9.0 -
 200.0

METHOD : CMIA

Interpretation(s)**INTERPRETATION**

Prolactin is a protein hormone secreted by anterior pituitary gland & placenta(in pregnancy). The secretion is regulated physiologically by inhibitory & releasing factors of hypothalamus. The major physiologic action of prolactin is the initiation & maintenance of lactation in women. High levels of prolactin are seen in hypothalamic or pituitary tumors, antidepressant therapy, hypothyroidism & stress. Hyperprolactinemia inhibits gonadotrophin secretion & can produce hypogonadism in men & women. The clinical use of prolactin levels is in the diagnosis &

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Test Report Status Final**Results****Biological Reference Interval Units**

management of male & female hypogonadism.

Increased levels seen in :

1. Pituitary tumour.
2. Hypothalamic lesions.
3. Hypothyroidism.
4. Antidepressants.
5. Stress.

NOTE : Various drugs & physiological factor can give rise to falsely elevated levels; high results should be rechecked with fresh tripoled sample.

MALE : - Biological Reference Interval : 3.46 - 19.4 ng/ml Hyperprolactinaemia in males may be associated with decreased libido, impotence, infertility, gynaecomastia.

FEMALE : - Prolactin secretion from pituitary shows significant diurnal, episodic & cyclical variations. Following is a suggested approach to hyperprolactinaemia in females:

Serum Prolactin Levels 5.18 - 26.53 ng/ml	Interpretation Normal	Remarks Biological Reference Range
26.53 - 50 ng/ml	Mild Prolactin excess	Often seen with physiological conditions like stress, exercise, pregnancy, lactation, etc. This may not be associated with clinical hyperprolactinaemia & needs review after a month

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51 - 75 ng/ml	Moderate Prolactin Excess	Often associated with clinical hyperprolactinaemia-short luteal phase, oligomenorrhea		
Above 100 ng/ml	Marked prolactin excess	Often associated with clinical hyperprolactinaemia-hypogonadism, amenorrhea ,galactorrhea		
Above 200 ng/ml	Marked prolactin excess	Often associated with pituitary adenoma requiring further workup. High levels may be repeated with tripoled sample.		
References : 1. Diagnosis & Treatment of hyperprolactinaemia.The endocrine society clinical practice guideline, 2011 2. Diagnosis & Management of hyperprolactinemia.Canadian Medical Association CMAJ. Sept.16,2003;169(6)				

Interpretation(s)

FOLLICULAR STIMULATING HORMONE-FSH is a glycoprotein produced by anterior pituitary gland. FSH stimulates follicular growth, prepares ovarian follicles for the action of LH & enhances LH induced release of estrogens. In males FSH stimulates seminiferous tubules & testicular growth & is involved in the early stage of spermatogenesis.

HIGH LEVELS are seen in Primary hypogonadism including primary testicular failure, Gonadotrophin secreting pituitary tumors, Menopause. LOW LEVELS are seen in Hypothalamic gonadotrophin releasing hormone deficiency, Pituitary FSH deficiency, Ectopic steroid hormone production.

Thus, FSH is used in the diagnosis of gonadal function disorders and in gynecology to check for cause of irregular periods.

ESTIMATION OF LUTEINIZING HORMONE-hormone (FSH), thyroid-stimulating hormone (TSH), and human chorionic gonadotropin (hCG). LH is a hormone produced by gonadotroph cells in the anterior pituitary gland. In females, an acute rise of LH ("LH surge") triggers ovulation and development of the corpus luteum. In males, where LH had also been called interstitial cell-stimulating hormone (ICSH), it stimulates Leydig cell production of testosterone. It acts synergistically with FSH.

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T3 97.2 Euthyroid : 35 - 193 ng/dL
 Hypothyroid : < 35
 Hyperthyroid : > 193

Please note change in reference range.

METHOD : CMIA

T4 8.14 Euthyroid : 4.87 - 11.72 µg/dL
 Hypothyroid : < 4.87
 Hyperthyroid : > 11.72

Please note change in reference range.

METHOD : CMIA

TSH (ULTRASENSITIVE) 1.950 Euthyroid : 0.35 - 4.94 µIU/mL
 Hypothyroid : > 4.94
 Hyperthyroid : < 0.35

METHOD : CMIA

Interpretation(s)

Triiodothyronine T3 , Thyroxine T4, and Thyroid Stimulating Hormone TSH are thyroid hormones which affect almost every physiological process in the body, including growth, development, metabolism, body temperature, and heart rate.

Production of T3 and its prohormone thyroxine (T4) is activated by thyroid-stimulating hormone (TSH), which is released from the pituitary gland. Elevated concentrations of T3, and T4 in the blood inhibit the production of TSH.

Excessive secretion of thyroxine in the body is hyperthyroidism, and deficient secretion is called hypothyroidism.

In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hyperthyroidism, TSH levels are low.

Below mentioned are the guidelines for Pregnancy related reference ranges for Total T4, TSH & Total T3. Measurement of the serum TT3 level is a more sensitive test for the diagnosis of hyperthyroidism, and measurement of TT4 is more useful in the diagnosis of hypothyroidism. Most of the thyroid hormone in blood is bound to transport proteins. Only a very small fraction of the circulating hormone is free and biologically active. It is advisable to detect Free T3, FreeT4 along with TSH, instead of testing for albumin bound Total T3, Total T4.

Sr. No.	TSH	Total T4	FT4	Total T3	Possible Conditions
1	High	Low	Low	Low	(1) Primary Hypothyroidism (2) Chronic autoimmune Thyroiditis (3) Post Thyroidectomy (4) Post Radio-Iodine treatment

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2	High	Normal	Normal	Normal	(1) Subclinical Hypothyroidism (2) Patient with insufficient thyroid hormone replacement therapy (3) In cases of Autoimmune/Hashimoto thyroiditis (4). Isolated increase in TSH levels can be due to Subclinical inflammation, drugs like amphetamines, Iodine containing drug and dopamine antagonist e.g. domperidone and other physiological reasons.
3	Normal/Low	Low	Low	Low	(1) Secondary and Tertiary Hypothyroidism
4	Low	High	High	High	(1) Primary Hyperthyroidism (Graves Disease) (2) Multinodular Goitre (3) Toxic Nodular Goitre (4) Thyroiditis (5) Over treatment of thyroid hormone (6) Drug effect e.g. Glucocorticoids, dopamine, T4 replacement therapy (7) First trimester of Pregnancy
5	Low	Normal	Normal	Normal	(1) Subclinical Hyperthyroidism
6	High	High	High	High	(1) TSH secreting pituitary adenoma (2) TRH secreting tumor
7	Low	Low	Low	Low	(1) Central Hypothyroidism (2) Euthyroid sick syndrome (3) Recent treatment for Hyperthyroidism
8	Normal/Low	Normal	Normal	High	(1) T3 thyrotoxicosis (2) Non-Thyroidal illness
9	Low	High	High	Normal	(1) T4 Ingestion (2) Thyroiditis (3) Interfering Anti TPO antibodies

REF: 1. TIETZ Fundamentals of Clinical chemistry 2.Guidlines of the American Thyroid association during pregnancy and Postpartum, 2011.

NOTE: It is advisable to detect Free T3,FreeT4 along with TSH, instead of testing for albumin bound Total T3, Total T4.TSH is not affected by variation in thyroid - binding protein. TSH has a diurnal rhythm, with peaks at 2:00 - 4:00 a.m. And troughs at 5:00 - 6:00 p.m. With ultradian variations.

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Test Report Status**Final****Results****Biological Reference Interval****Units****SPECIALISED CHEMISTRY - VITAMIN****25 - HYDROXYVITAMIN D(VITAMIN D TOTAL), SERUM**

25 - HYDROXYVITAMIN D

20.4

Deficiency(seriously deficient) $\mu\text{g}/\text{mL}$
 <10
Insufficiency(deficient): 10-30
Sufficiency(adequately supplied) : 30 - 100
Toxicity > 100

METHOD : ECLA

Interpretation(s)**25 - HYDROXYVITAMIN D(VITAMIN D TOTAL), SERUM-Test description**

Vitamin D has anti-inflammatory and immune-modulating properties and it works towards the bones, teeth, intestines, immune system, pancreas, muscles and brain. It helps to maintain normal calcium and phosphate levels. Vitamin D is a fat-soluble vitamin. Also called as "Sunshine Vitamin". Two main forms as Cholecalciferol (vitamin D3) which is synthesized in skin from 7-dehydrocholesterol in response to sunlight (Type B UV) exposure & Ergocalciferol (vitamin D2) present mainly in dietary sources.

Vit D_{25(OH)D} deficiency is seen due to poor or inadequate sunlight exposure, Nutritional or dietary deficiency or fat malabsorption, Severe Hepatocellular disease, Secondary hyperparathyroidism, Hypocalcemia tetany which can cause involuntary contraction of muscles, leading to cramps and spasms, Rickets in children, Osteomalacia in adults- due to vitamin D deficiency mainly, Older adults- osteoporosis. (Increased risk of bone fractures) due to long-term effect of calcium and/or vitamin D deficiency, Other conditions that are precipitated by Vit D deficiency included increased cardiovascular risk, low immunity & chronic renal failure.

Elevated levels may be seen in patients taking supplements(hence recommended to repeat after 3 months for estimation of accurate levels), Vitamin D intoxication, sarcoidosis and malignancies containing non regulated 1-alpha hydroxylase in the lesion.

Recommendations

1.To prevent biotin interference the patient should be atleast 8 hours fasting before submitting the sample. 2.25(OH)D is the analyte of choice for determination of the Vitamin D status as it is the major storage & active form of Vitamin D and has longer half-life. 3. Kidney Disease Outcomes Quality Initiatives (KDOQI) and Kidney Disease Improving Global Outcomes (KDIGO) recommend activated vitamin D testing for CKD patients.

Note-Our Vitamin D assays is standardized to be in alignment with the ID-LC/MS/MS 25(OH)vitamin D Reference Method Procedure (RMP), the reference procedure for the Vitamin D Standardization Program (VDSP). The VDSP, a collaboration of the National Institutes of Health Office of Dietary Supplements, National Institute of Technology and Standards, Centers for Disease Control and Ghent University, is an initiative to standardize 25(OH)vitamin D measurement across methods.

Reference:

1.Wallach Interpretation of diagnostic test, 10th edition.

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