TATA 1mg Labs

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CIN : U74140DL2015PTC279229

REGISTERED OFFICE:
LEVEL 3, Vasant Square Mall,
Pocket V, Sector B,
Vasant Kunj New Delhi - 110070

PO No :PO3469981132-641

Name	: Mr.MANISH LODHA	Client Name	: TATA 1MG AHMEDABAD
Age/Gender	: 48/Male DOB:	Registration Date	: 13-Apr-23 10:46 AM
Patient ID	: AMD23701	Collection Date	: 13/Apr/2023 06:29AM
Barcode ID/Order ID	: D2014178 / 7043735	Sample Receive Date	: 14/Apr/2023 08:44AM
Referred By	: Dr.	Report Status	: Final Report
Sample Type	: WHOLE BLOOD-EDTA	Report Date	: 14/Apr/2023 10:24AM

HAEMATOLOGY

COMPREHENSIVE GOLD FULL BODY CHECKUP

Test Name	Result	Unit	Bio. Ref. Interval	Method
Glycosylated Hemoglobin (HbA1c)	4.6	%	4-5.6	HPLC
Estimated average glucose (eAG)	85.32	mg/dL		Calculated

Comment:

Interpretation: HbA1c%

≤5.6	Normal
5.7-6.4	At Risk For Diabetes
≥6.5	Diabetes

Adapted from American Diabetes Association.

Comments:
A 3 to 6 monthly monitoring is recommended in diabetics. People with diabetes should get the test done more often if their blood sugar stays too high or if their healthcare provider makes any change in the treatment plan. HbA1c concentration represent the integrated values for blood glucose over the preceding 8-12 weeks and is not affected by daily glucose fluctuation, exercise & recent food intake.
Please note, Glycemic goal should be individualized based on duration of diabetes, age/life expectancy, comorbid conditions, known CVD or advanced microvascular complications, hypoglycemia unawareness, and individual patient considerations.

Factors that interfere with HbA1c Measurement: Hemoglobin variants, elevated fetal hemoglobin (HbF) and chemically modified derivatives of hemoglobin (e.g. carbamylated Hb in patients with renal failure) can affect the accuracy of HbA1c measurements.

Factors that affect interpretation of HbA1c Measurement: Any condition that shortens erythrocyte survival or decrease mean erythrocyte age (e. g., recovery from acute blood loss, hemolytic anemia, HbSS, HbCC, and HbSC) will falsely lower HbA1c test results regardless of the assay method used. Iron deficiency anemia is associated with higher HbA1c.

Note: Presence of Hemoglobin variants and/or conditions that affect red cell turnover must be considered, particularly when the HbA1c result does not correlate with the patient's blood glucose levels.

- HPLC - High performance liquid chromatography

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Barcode ID/Order ID	: D2014178 / 7043735	Sample Receive Date	: 14/Apr/2023 08:44AM
Referred By	: Dr.	Report Status	: Final Report
Sample Type	: Whole Blood-EDTA	Report Date	: 14/Apr/2023 10:45AM

HAEMATOLOGY

COMPREHENSIVE GOLD FULL BODY CHECKUP

Test Name	Result	Unit	Bio. Ref. Interval	Method
Complete Blood Count				
Hemoglobin	15.6	g/dL	13.0-17.0	Cyanide free SLS
RBC	5.16	10^6/cu.mm	4.5 - 5.5	Impedence variation
HCT	44.6	%	40 - 50	Pulse Height Average
MCV	86.5	fl	83 - 101	Calculated
MCH	30.3	pg	27 - 32	Calculated
MCHC	**35.0**	g/dL	31.5 - 34.5	Calculated
RDW-CV	**16.2**	%	11.6-14	Calculated
Total Leucocyte Count	6.26	10^3/µI	4 - 10	Flowmetry DHSS/ Microscopy
Differential Leucocyte Count				
Neutrophils	55.0	%	40-80	Flowcytometry DHSS/ Microscopy
Lymphocytes	34.0	%	20-40	Flowcytometry DHSS/ Microscopy
Monocytes	9.0	%	1-10	Flowcytometry DHSS/ Microscopy
Eosinophils	2.0	%	1-6	Flowcytometry DHSS/ Microscopy
Basophils	0.0	%	0-2	Flowcytometry DHSS/ Microscopy
Absolute Leucocyte Count				
Absolute Neutrophil Count	3.44	10^3/µI	2-7	Calculated
Absolute Lymphocyte Count	2.13	10^3/µI	1-3	Calculated
Absolute Monocyte Count	0.56	10^3/µI	0.1-1	Calculated
Absolute Eosinophil Count	0.13	10^3/µI	0.02-0.5	Calculated
Absolute Basophil Count	**0**	10^3/µI	0.02-0.1	Calculated
Platelet Count	281	10^3/µI	150 - 410	Impedence Variation /Microscopy
MPV	10.2	fl	6.5 - 12	Calculated
PDW	16	fl	11-22	Calculated

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Referred By	: Dr.	Report Status	: Final Report
Sample Type	: Whole Blood-EDTA	Report Date	: 14/Apr/2023 10:45AM

HAEMATOLOGY

COMPREHENSIVE GOLD FULL BODY CHECKUP

Test Name	Result	Unit	Bio. Ref. Interval	Method

Comment:

- As per the recommendation of International council for Standardization in Hematology, the differential leucocyte counts are additionally being reported as absolute numbers of each cell in per unit volume of blood.
- Test conducted on EDTA whole blood.

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Barcode ID/Order ID	: D2014178 / 7043735	Sample Receive Date	: 14/Apr/2023 08:44AM
Referred By	: Dr.	Report Status	: Final Report
Sample Type	: EDTA	Report Date	: 14/Apr/2023 11:10AM

HAEMATOLOGY

COMPREHENSIVE GOLD FULL BODY CHECKUP

Test Name	Result	Unit	Bio. Ref. Interval	Method
Erythrocyte Sedimentation Rate	4	mm/hr	<=10	Modified Westergren

Comment:

- ESR provides an index of progress of the disease and is widely used as an indicator of inflammation, infection, trauma, or malignant diseases. Changes are more significant than a single abnormal test
- It is specifically indicated to monitor the course or response to the treatment of diseases like rheumatoid arthritis, tuberculosis bacterial endocarditis ,acute rheumatic fever ,Hodgkins disease,temporal arthritis , and systemic lupus erythematosis; and to diagnose and monitor giant cell arteritis and polymyalgia rheumatica.
- An elevated ESR may also be associated with many other conditions, including autoimmune disease, anemia, infection,malignancy,pregnancy, multiple myeloma, menstruation, and hypothyroidism.
- Although a normal ESR cannot be taken to exclude the presence of organic disease, its rate is dependent on various physiologic and pathologic factors.
- The most important component influencing ESR is the composition of plasma. High level of C-Reactive Protein, fibrinogen, haptoglobin, alpha-1antitrypsin, ceruloplasmin and immunoglobulins causes the elevation of Erythrocyte Sedimentation Rate.
- Drugs that may cause increase ESR levels include: dextran, methyldopa, oral contraceptives, penicillamine, procainamide, theophylline, and Vitamin A. Drugs that may cause decrease levels include: aspirin, cortisone, and quinine

"Test conducted on Whole Blood - EDTA "

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Referred By	: Dr.	Report Status	: Final Report
Sample Type	: WHOLE BLOOD-EDTA	Report Date	: 14/Apr/2023 10:47AM

HAEMATOLOGY

COMPREHENSIVE GOLD FULL BODY CHECKUP

Peripheral Smear Examination

RBC- Predominantly Normocytic Normochromic.

WBC - Normal leucocyte count and morphology.

PLATELETS - Adequate on the smear.

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Age/Gender	: 48/Male DOB:	Registration Date	: 13-Apr-23 10:46 AM
Patient ID	: AMD23701	Collection Date	: 13/Apr/2023 06:29AM
Barcode ID/Order ID	: D2014170 / 7043735	Sample Receive Date	: 14/Apr/2023 08:52AM
Referred By	: Dr.	Report Status	: Final Report
Sample Type	: Urine	Report Date	: 14/Apr/2023 11:32AM

BIOCHEMISTRY

COMPREHENSIVE GOLD FULL BODY CHECKUP

Test Name	Result	Unit	Bio. Ref. Interval	Method
Microalbumin Creatinine Ratio, Urine				
Microalbumin	8.10	mg/L		Turbidimetric
Urinary Creatinine	75.70	mg/dL	22-328	Kinetic Alkaline Picrate
Microalbumin/Creatinine Ratio	10.7	mg/g Creatinine	< 30	Calculated

Comment:

Reference Range Ratio:		
Normal/Non Diabetic	<30.0	mg/g Creatinine
Microalbuminuria	30 - 300	mg/g Creatinine
Clinical Albuminuria	>=300	mg/g Creatinine

Note: Patient is considered to be within diagnostic category if atleast 2 out of 3 specimens collected within a period of 3-6 months show abnormal results.
Due to inherent day to day variability in albumin excretion, this ratio is a better indicator than isolated microalbumin levels.

Clinical Albuminuria is the small but abnormal increase in the excretion of urinary albumin [in the range of 30-300 mg/day in a 24 hrs collection or 30-300 mg/g creatinine in a random collection

Clinical Utility :This test is useful in the diagnosis of early nephropathy in diabetics .As a marker for generalized endothelial dysfunction and risk for stroke and heart disease .
Diabetic nephropathy ,a complication of diabetes is characterized by proteinuria .Since aggressive therapeutic measures can significantly delay/prevent deterioration of nephropathy, it is imperative to identify microalbuminuria.

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Patient ID	: AMD23701	Collection Date	: 13/Apr/2023 06:29AM
Barcode ID/Order ID	: D2014176 / 7043735	Sample Receive Date	: 14/Apr/2023 08:39AM
Referred By	: Dr.	Report Status	: Final Report
Sample Type	: Serum	Report Date	: 14/Apr/2023 11:32AM

BIOCHEMISTRY

COMPREHENSIVE GOLD FULL BODY CHECKUP

Test Name	Result	Unit	Bio. Ref. Interval	Method
C-Reactive Protein (Quantitative)	< 4.0	mg/L	0-10	Turbidimetric

Comment:

•C-Reactive Protein [CRP] is an acute phase reactant ,hepatic secretion of which is stimulated in response to inflammatory cytokines.
•CRP is a very sensitive but nonspecific marker of inflammation and infection.
•The CRP test is useful in patient with Inflammatory bowel disease, arthritis, Autoimmune diseases, Pelvic inflammatory disease (PID), tissue injury or necrosis and infections.
•CRP levels can be elevated in the later stages of pregnancy as well as with use of birth control pills or hormone replacement therapy i.e. estrogen. Higher levels of CRP have also been observed in the obese.
•As compared to ESR, CRP shows an earlier rise in inflammatory disorders which begins in 4-6 hrs, he intensity of the rise being higher than ESR and the recovery being earlier than ESR. Unlike ESR, CRP levels are not influenced by hematologic conditions like Anemia, Polycythemia.

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MC - 5596

PO No :PO3469981132-641

Name	: Mr.MANISH LODHA	Client Name	: TATA 1MG AHMEDABAD
Age/Gender	: 48/Male DOB:	Registration Date	: 13-Apr-23 10:46 AM
Patient ID	: AMD23701	Collection Date	: 13/Apr/2023 06:29AM
Barcode ID/Order ID	: D2014176 / 7043735	Sample Receive Date	: 14/Apr/2023 08:39AM
Referred By	: Dr.	Report Status	: Final Report
Sample Type	: Serum	Report Date	: 14/Apr/2023 11:26AM

BIOCHEMISTRY

COMPREHENSIVE GOLD FULL BODY CHECKUP

Test Name	Result	Unit	Bio. Ref. Interval	Method
Calcium	8.8	mg/dL	8.3-10.6	Arsenazo III

Comment:

Increased in: Hyperparathyroidism primary and secondary, Acute and chronic renal failure, Following renal transplantation, Osteomalacia with malabsorption, Acute osteoprosis, Malignant tumours (specially of breast, lung and kidney), Drugs: Vit. D and A intoxication, Diuretics, estrogen, androgen, tamoxifen, lithium

Decreased in: Hypoparathyroidism, Surgical and Idiopathic, Pseudohypoparathyroidism, Chronic renal disease with uremia and phophate retention, Malabsorption of Calcium and Vit.D, obstructive jaundice, Bone Disease (Osteomalacia and rickets), Drugs: Cancer chemotherapy drugs, calcitonin, loop-actives diuretics, Hypomagnesemia,Hypoalbuminemia

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Barcode ID/Order ID	: D2014172 / 7043735	Sample Receive Date	: 14/Apr/2023 08:41AM
Referred By	: Dr.	Report Status	: Final Report
Sample Type	: FLUORIDE PLASMA	Report Date	: 14/Apr/2023 11:26AM

BIOCHEMISTRY

COMPREHENSIVE GOLD FULL BODY CHECKUP

Test Name	Result	Unit	Bio. Ref. Interval	Method
Glucose - Fasting				
Glucose - Fasting	81	mg/dL	70-100	Hexokinase

Comment:

Impaired glucose tolerance (IGT) fasting, means a person has an increased risk of developing type 2 diabetes but does not have it yet. A level of 126 mg/dL or above, confirmed by repeating the test on another day, means a person has diabetes. IGT (2 hrs Post meal), means a person has an increased risk of developing type 2 diabetes but does not have it yet. A 2-hour glucose level of 200 mg/dL or above, confirmed by repeating the test on another day, means a person has diabetes

Plasma Glucose Goals	For people with Diabetes
Before meal	70-130 mg/dL
2 Hours after meal	Less than 180 mg/dL
HbA1c	Less than 7%

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Sample Type	: Serum	Report Date	: 14/Apr/2023 11:34AM

BIOCHEMISTRY

COMPREHENSIVE GOLD FULL BODY CHECKUP

Test Name	Result	Unit	Bio. Ref. Interval	Method
Iron Studies, Basic				
Iron Serum	81	µg/dL	65-175	Ferrozine
Unsaturated Iron Binding Capacity	**375**	µg/dL	111-343	Ferene
Total Iron Binding Capacity (TIBC)	**456**	µg/dL	240-450	Calculated
Transferrin Saturation	17.78	%	16 - 50	Calculated

Comment:

Iron is an essential trace mineral element which forms an important component of hemoglobin, metallocompounds and Vitamin A. Deficiency of iron is seen in iron deficiency and anaemia of chronic disorders.
Increased iron concentration are seen in hemolytic anaemias, hemochromatosis and acute liver disease. Serum Iron alone is unreliable due to considerable physiologic diurnal variation in the results with highest values in the morning and lowest values in the evening as well as variation in response to iron therapy .

Total Iron Binding capacity (TIBC) is a direct measure of the protein Transferrin which transports iron from the gut to storage sites in the bone marrow. Increased levels of TIBC suggest that total iron body stores are low, increased concentration may be the sign of Iron deficiency anaemia, polycythemia vera ,and may occur during the third trimester of pregnancy. Decreased levels may be seen in hemolytic anaemia, hemochromatosis, chronic liver disease, hypoproteinemia ,malnutrition.

Unsaturated Iron Binding Capacity (UIBC) is increased in low iron state and decreased in high iron concentration such as hemochromatosis. In case of anaemia of chronic disease the patient may be anaemic but has adequate iron reserve and a low uIBC.

Transferrin Saturation occurs in Idiopathic hemochromatosis and Transfusional hemosiderosis where no unsaturated iron binding capacity is available for iron mobilization. Similar condition is seen in congenital deficiency of Transferrin.

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Sample Type	: Serum	Report Date	: 14/Apr/2023 11:32AM

BIOCHEMISTRY

COMPREHENSIVE GOLD FULL BODY CHECKUP

Test Name	Result	Unit	Bio. Ref. Interval	Method
Lipid Profile				
Cholesterol - Total	160	mg/dL	Low (desirable): < 200 mg/dL Moderate (borderline) 200–239 mg/dL High: >/= 240 mg/dL	Enzymatic
Triglycerides	118	mg/dL	Normal: < 150, Borderline: 150 - 199, High:200 - 499, Very High >=500	GPO, Trinder without serum blank
Cholesterol - HDL	**39**	mg/dL	Low (undesirable, high risk): < 40 mg/dL High (desirable, low risk): >= 60 mg/dL	Direct Measure- PEG
Cholesterol - LDL	98	mg/dL	Desirable: <100 Above desirable: 100 - 129 Borderline high : 130 - 159 High : 160 - 189 Very high : >=190	Calculated
Cholesterol- VLDL	24	mg/dL	10-30	Calculated
Cholesterol : HDL Cholesterol	4.1	Ratio	Desirable : 3.5-4.5 High Risk : >5	Calculated
LDL : HDL Cholesterol	2.52	Ratio	Desirable : 2.5-3.0 High risk : >3.5	Calculated
Non HDL Cholesterol	121	mg/dl	Desirable:< 130, Above Desirable:130 - 159, Borderline High:160 - 189, High:190 - 219, Very High: >= 220	Calculated

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BIOCHEMISTRY

COMPREHENSIVE GOLD FULL BODY CHECKUP

Test Name	Result	Unit	Bio. Ref. Interval	Method

Comment:

- Indians are at a high risk of developing atherosclerotic cardiovascular disease (ASCVD); at a much earlier age; more severe in nature and have high mortality.
- Major risk factors have been found to be dyslipidemia (abnormal lipid profile), smoking, sedentary lifestyle, obesity, hypertension and diabetes. Dyslipidemia is most important and found to be very high in Indians (79%); hence control of dyslipidemia is the key healthcare target.
- **LDL-Cholesterol** (LDL-C) contributes most significantly to atherosclerosis and is the **primary target** of treatment.
- **Triglyceride** (TG) rich lipoprotein remnants also play a major role in CVD. Indians have higher triglyceride levels and lower **HDL-C** (good cholesterol) combined with increased proportion of small dense LDL-C; this pattern is called atherogenic dyslipidemia and is associated with diabetes, metabolic syndrome and insulin resistance.
- **Non-HDL-Cholesterol** (Non-HDLC) measures all atherogenic lipoproteins (LDL-C, VLDL, Lp(a), Apo-B). Monitoring of Non-HDLC is the **co-primary target** and is especially important in patients with elevated TG (e.g. diabetics, obese persons, metabolic syndrome) and those on statin therapy.
- **Lipid Association of India (LAI) recommendations (2020) -**
  - Screening of all Indians above the age of 20 years for CVD risk factors esp. lipid profile.
  - Risk factors known to promote atherosclerosis include: Age- male ≥45 years, female ≥55 years; Family h/o premature CAD (male <55 years, female <65 years), Smoking/tobacco use, Systemic hypertension, Low HDL (males <40 mg/dl and females <50 mg/dl.
  - Fasting lipid profile is not mandatory. Both fasting and non-fasting lipid profiles are important for managing Indian patients with dyslipidemia. Non-HDLC should be calculated in every subject.
  - Newer treatment goals have been laid down based on different risk categories (According to LAI algorithm). LAI recommends LCD-C as primary target and Non-HDL as co-primary treatment target.
  - Lifestyle modifications are integral for management and prevention of dyslipidemia.
  - In low risk patients, consider therapy after an initial non-pharmacological intervention for at least 3 months.
  - Additional testing for Apolipoprotein B, hsCRP, Lp(a) should be considered among patients with moderate risk for ASCVD for risk refinement

Note: Reference Interval as per National Cholesterol Education Program (NCEP) ATP-III Report.

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PO No :PO3469981132-641

Name	: Mr.MANISH LODHA	Client Name	: TATA 1MG AHMEDABAD
Age/Gender	: 48/Male DOB:	Registration Date	: 13-Apr-23 10:46 AM
Patient ID	: AMD23701	Collection Date	: 13/Apr/2023 06:29AM
Barcode ID/Order ID	: D2014176 / 7043735	Sample Receive Date	: 14/Apr/2023 08:39AM
Referred By	: Dr.	Report Status	: Final Report
Sample Type	: Serum	Report Date	: 14/Apr/2023 11:34AM

BIOCHEMISTRY

COMPREHENSIVE GOLD FULL BODY CHECKUP

Test Name	Result	Unit	Bio. Ref. Interval	Method
Liver Function Test				
Bilirubin-Total	**2.35**	mg/dL	0.3 – 1.2	Vanadate oxidation
Bilirubin-Direct	**0.64**	mg/dL	0.0-0.3	Vanadate oxidation
Bilirubin-Indirect	**1.71**	mg/dL	0.1 - 1.0	Calculated
Protein, Total	7.50	g/dL	5.7–8.2	Biuret
Albumin	4.50	g/dL	3.4-4.8	BCG Dye Binding
Globulin	3.0	g/dl	1.8-3.6	Calculated
A/G Ratio	1.50	Ratio		Calculated
Aspartate Transaminase (SGOT)	20	U/L	<34 U/L	Modified IFCC
Alanine Transaminase (SGPT)	27	U/L	10-49	Modified IFCC
SGOT/SGPT	0.74	Ratio		Calculated
Alkaline Phosphatase	115	U/L	45-129	IFCC Standardization
Gamma Glutamyltransferase (GGT)	22	U/L	<73	Modified IFCC

Comment:

•LFTS are based upon measurements of substances released from damaged hepatic cells into the blood that gives idea of the Existence, Extent and Type of Liver damage. - Acute Hepatocellular damage: ALT & AST levels are sensitive index of hepatocellular damage - Obstruction to the biliary tract,Cholestasis and blockage of bile flow:1) Serum Total Bilirubin concentration 2) Serum Alkaline Phosphatase (ALP) activity 3) Gamma Glutamyl Transpeptidase (GGTP) 4) 5`-Nucleotidase - Chronic liver disease: Serum Albumin concentration

•Bilirubin results from the enzymatic breakdown of heme. Jaundice is a yellowish discoloration of the skin and mucous membranes caused by hyperbilirubinemia.

•Pre-hepatic or hemolytic jaundice - Abnormal red cells, antibodies,drugs and toxins,Hemoglobinopathies, Gilbert's syndrome, Crigler-Najjar syndrome

•Hepatic or Hepatocellular jaundice-Viral hepatitis,toxic hepatitis, intrahepatic cholestasis

•Post-hepatic jaundice -Extrahepatic cholestasis, gallstones, tumors of the bile duct, carcinoma of pancreas

•In viral hepatitis and other forms of liver disease associated with acute hepatic necrosis, serum AST and ALT concentrations are elevated even before the clinical signs and symptoms of disease appear.

•ALT is the more liver-specific enzyme and elevations of ALT activity persist longer than AST activity.

•Peak values of aminotransferase activity occur between the seventh and twelfth days. Activities then gradually decrease, reaching normal activities by the third to fifth week. Peak activities bear no relationship to prognosis and may fall with worsening of the patient's condition.

•Aminotransferase activities observed in cirrhosis vary with the status of the cirrhotic process and range from the upper reference limit to four to five times higher, with an AST/ALT ratio greater than 1. The ratio's elevation can reflect the grade of fibrosis in these patients. Slight or moderate elevations of both AST and ALT activities have been observed after administration of various medications and chronic hepatic injury such as (1) hemochromatosis, (2) Wilson disease, (3) autoimmune hepatitis, (4) primary biliary cirrhosis, (5) sclerosing cholangitis, and (6) a1-antitrypsin deficiency.

•AST activity also is increased in acute myocardial infarction, progressive muscular dystrophy and dermatomyositis, reaching concentrations up to eight times the upper reference limit.Slight to moderate AST elevations are noted in hemolytic disease.

•GGT is a sensitive indicator of the presence of hepatobiliary disease, being elevated in most subjects with liver disease

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regardless of cause. Increased concentrations of the enzyme are also found in serum of subjects receiving anticonvulsant drugs, such as phenytoin and phenobarbital.

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BIOCHEMISTRY

COMPREHENSIVE GOLD FULL BODY CHECKUP

Test Name	Result	Unit	Bio. Ref. Interval	Method
Kidney Function Test.				
Blood Urea Nitrogen	10	mg/dL	9.0-23.0	Urease with GLDH
Urea	21.40	mg/dL	19.26-49.22	Calculated
Creatinine	0.80	mg/dL	0.7-1.3	Alkaline picrate-kinetic
Uric Acid	7.3	mg/dL	3.7-9.2	Uricase/Peroxidase
Sodium	140	mEq/L	132.0-146.0	Indirect ISE
Potassium	**3.10**	mEq/L	3.5-5.5	Indirect ISE
Chloride	100.0	mEq/L	99.0-109.0	Indirect ISE
BUN/Creatinine Ratio	12.5	Ratio		Calculated

Comment:

BUN is directly related to protein intake and nitrogen metabolism and inversely related to the rate of excretion of urea.Blood urea nitrogen (BUN) levels reflect the balance between the production and excretion of urea. Increased levels are seen in renal failure (acute or chronic), urinary tract obstruction, dehydration, shock, burns, CHF, GI bleeding, nephrotoxic drugs. Decreased levels are seen in hepatic failure, nephrotic syndrome, cachexia (low-protein and high-carbohydrate diets).

Urea is a non-proteinous nitrogen compound formed in the liver from ammonia as an end product of protein metabolism. Urea diffuses freely into extracellular and intracellular fluid and is ultimately excreted by the kidneys. Increased levels are found in acute renal failure, chronic glomerulonephritis, congestive heart failure, decreased renal perfusion, diabetes, excessive protein ingestion, gastrointestinal (GI) bleeding, hyperalimentation, hypovolemia, ketoacidosis, muscle wasting from starvation, neoplasms, pyelonephritis, shock, urinary tract obstruction, nephrotoxic drugs. Decreased levels are seen in inadequate dietary protein, low-protein/high-carbohydrate diet, malabsorption syndromes, pregnancy, severe liver disease, certain drugs.

Creatinine is catabolic product of creatinine phosphate, which is excreted by filtration through the glomerulus and by tubular secretion. Creatinine clearance is an acceptable clinical measure of glomerular filtration rate (GFR). Increased levels are seen in acute/chronic renal failure, urinary tract obstruction, hypothyroidism, nephrotoxic drugs, shock, dehydration, congestive heart failure, diabetes. Decreased levels are found in muscular dystrophy.

BUN/Creatinine ratio (normally 12:1–20:1) is decreased in acute tubular necrosis, advanced liver disease, low protein intake, and following hemodialysis. BUN/Creatinine ratio is increased in dehydration, GI bleeding, and increased catabolism.

Uric acid levels show diurnal variation. The level is usually higher in the morning and lower in the evening. Increased levels are seen in starvation, strenuous exercise, malnutrition, or lead poisoning, gout, renal disorders, increased breakdown of body cells in some cancers (including leukemia, lymphoma, and multiple myeloma) or cancer treatments, hemolytic anemia, sickle cell anemia, or heart failure, pre-eclampsia, liver disease (cirrhosis), obesity, psoriasis, hypothyroidism, low blood levels of parathyroid hormone (PTH), certain drugs, foods that are very high in purines - such as organ meats, red meats, some seafood and beer. Decreased levels are seen in liver disease, Wilson's disease, Syndrome of inappropriate antidiuretic hormone (SIADH), certain drugs.

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BIOCHEMISTRY

COMPREHENSIVE GOLD FULL BODY CHECKUP

Test Name	Result	Unit	Bio. Ref. Interval	Method
Rheumatoid Factor - Quantitative	< 8.4	IU/mL	0-14	Turbidimetry

Comment:

- The detection of Rheumatoid factor (RF) is one of the criteria of the American Rheumatism Association (ARA) for the diagnosis of Rheumatoid Arthritis (RA).
- RF are heterogeneous group of auto antibodies directed against Fc- region of IgG molecules.
- They are useful in diagnosis of Rheumatoid Arthritis, but can also be found in other inflammatory diseases and in various non-rheumatic diseases.
- These occur in all the immunoglobulin classes, although the usual analytical methods are limited to the detection of Rheumatoid Factors of the IgM type.Healthy individuals >65 years of age may also show positive RF results.

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Immunology

COMPREHENSIVE GOLD FULL BODY CHECKUP

Test Name	Result	Unit	Bio. Ref. Interval	Method
Thyroid Profile				
T3, Total	1.57	ng/mL	0.60 - 1.81	CLIA
T4, Total	8.8	µg/dl	4.5 - 12.6	CLIA
Thyroid Stimulating Hormone - Ultra Sensitive	**0.242**	uIU/ml	0.55 - 4.78	CLIA

Comment:

- Below mentioned are the guidelines for pregnancy related reference ranges for TSH, total T3 & Total T4.

Pregnancy			
	TSH (µIU/mL) (as per American Thyroid Association)	Total T3 (ng/mL)	Total T4(µg/dL)
1st trimester	0.1-2.5	0.81-1.90	7.33-14.8
2nd trimester	0.2-3.0	1.00-2.60	7.93-16.1
3rd trimester	0.3-3.0	1.00-2.60	6.95-15.7

- TSH levels are subject to circadian variation, reaching peak levels between 2 - 4.a.m. and at a minimum between 6-10 pm .
- The variation is of the order of 50%, hence time of the day has influence on the measured serum TSH concentrations.
- TSH is secreted in a dual fashion: Intermittent pulses constitute 60-70% of total amount, background continuous secretion is 30-40%.These pulses occur regularly every 1-3 hrs.
- Total T3 & T4 concentrations are altered by physiological or pathological changes in thyroxine binding globulin (TBG) capacity .
- The determination of free T3 & free T4 has the advantage of being independent of changes in the concentrations and binding properties of the binding proteins.
- Changes in thyroid status are typically associated with concordant changes in T3, T4 and TSH levels.
- Unexpectedly abnormal or discordant thyroid test values may be seen with some rare, but clinically significant conditions such as central hypothyroidism, TSH-secreting pituitary tumors, thyroid hormone resistance, or the presence of heterophilic antibodies (HAMA) or thyroid hormone autoantibodies.
- For diagnostic purposes, results should be used in conjunction with other data.

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Immunology

COMPREHENSIVE GOLD FULL BODY CHECKUP

Test Name **Result** **Unit** **Bio. Ref. Interval** **Method**

TSH	T3	T4	Interpretation
High	Normal	Normal	Subclinical Hypothyroidism
Low	Normal	Normal	Subclinical Hyperthyroidism
High	High	High	Secondary Hyperthyroidism
Low	High/Normal	High/Normal	Hyperthyroidism
Low	Low	Low	Non thyroidal illness / Secondary Hypothyroidism

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Immunology

COMPREHENSIVE GOLD FULL BODY CHECKUP

Test Name	Result	Unit	Bio. Ref. Interval	Method
Vitamin D (25-OH)	**24.7**	ng/ml	Deficiency:< 20, Insufficiency:20-29, Sufficiency:30 - 100, Hypervitaminosis:> 100	CLIA

Comment:

- Vitamin D is a fat-soluble steroid prohormone involved in the intestinal absorption of calcium and the regulation of calcium homeostasis.
- Two forms of vitamin D are biologically relevant - vitamin D3 (Cholecalciferol) and vitamin D2 (Ergocalciferol).
- Both vitamins D3 and D2 can be absorbed from food but only an estimated 10-20perc. of vitamin D is supplied through nutritional intake.
- Vitamin D is converted to the active hormone 1,25-(OH)2-vitamin D (Calcitriol) through two hydroxylation reactions. The first hydroxylation converts vitamin D into 25-OH vitamin D and occurs in the liver. The second hydroxylation converts 25-OH vitamin D into the biologically active 1,25-(OH)2-vitamin D and occurs in the kidneys as well as in many other cells of the body.
- Most cells express the vitamin D receptor and about 3perc. of the human genome is directly or indirectly regulated by the vitamin D endocrine system.
- The major storage form of vitamin D is 25-OH vitamin D and is present in the blood at up to 1,000 fold higher concentration compared to the active 1,25-(OH)2-vitamin D. 25-OH vitamin D has a half-life of 2-3 weeks vs. 4 hours for 1,25-(OH)2-vitamin D. Therefore, 25-OH vitamin D is the analyte of choice for determination of the vitamin D status.
- Risk factors for vitamin D deficiency include low sun exposure, inadequate intake, decreased absorption, abnormal metabolism, vitamin D resistance and and liver or kidney diseases.
- Vitamin D deficiency is a cause of secondary hyperparathyroidism and diseases resulting in impaired bone metabolism (like rickets, osteomalacia).
- Recently, many chronic diseases such as cancer, high blood pressure, osteoporosis and several autoimmune diseases have been linked to vitamin D deficiency.
- The assay measures both D2 (Ergocalciferol) and D3 (Cholecalciferol) metabolites of vitamin D

Utility Quantitative determination of 25-hydroxyvitamin D (25-OH vitamin D).

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Immunology

COMPREHENSIVE GOLD FULL BODY CHECKUP

Test Name	Result	Unit	Bio. Ref. Interval	Method
Vitamin B12	302.0	pg/ml	211 - 911	CLIA

Comment:

- **Vitamin B12** along with **folate** is essential for DNA synthesis and myelin formation.
- **Decreased levels** are seen in anaemia, term pregnancy, vegetarian diet, intrinsic factor deficiency, partial gastrectomy/ileal damage, celiac disease, oral contraceptive use, parasitic infestation, pancreatic deficiency, treated epilepsy, smoking, hemodialysis and advanced age.
- **Increased levels** are seen in renal failure, hepatocelluar disorders, myeloproliferative disorders and at times with excess supplementation of vitamins pills.

Vitamin B9 (Folic Acid)

Vitamin B9 (Folic Acid)	9.33	ng/ml	>5.38	CLIA

Comment:

Folate plays an important role in the synthesis of purine & pyrimidines in the body and is important for the maturation of erythrocytes. It is widely available from plants and to a lesser extent organ meats, but more than half the folate content of food is lost during cooking. Folate deficiency is commonly prevalent in alcoholic liver disease, pregnancy, and the elderly. It may result from poor intestinal absorption, nutrition deficiency, excessive demand as in pregnancy or in malignancy, and in response to certain drugs like Methotrexate & anticonvulsants. It is now routine practice to recommend dietary folate supplements from conception to the 12th week of pregnancy; such supplementation has been proven to reduce the incidence of neural tube defects.

Decreased Levels: Megaloblastic anemia, Infantile hyperthyroidism, Alcoholism, Malnutrition, Scurvy, Liver disease, B12 deficiency, dietary amino acid excess, adult Celiac disease, Tropical Sprue, Crohn's disease, Hemolytic anemias, Carcinomas, Myelofibrosis, vitamin B6 deficiency, pregnancy, Whipple's disease, extensive intestinal resection, and severe exfoliative dermatitis.

Note:
Certain drugs like Pyrimethamine, methotrexate, and trimethoprim are all folate antagonists i.e. they stop the action of the folic acid; phenytoin can decrease the intestinal absorption of folates, and ethanol both decreases absorption and increases excretion of folic acid.

To differentiate vitamin B12 & folate deficiency, measurement of Methylmalonic acid in urine & serum Homocysteine level is suggested.

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Referred By	: Dr.	Report Status	: Final Report
Sample Type	: Serum	Report Date	: 14/Apr/2023 11:16AM

SEROLOGY

COMPREHENSIVE GOLD FULL BODY CHECKUP

Test Name	Result	Unit	Bio. Ref. Interval	Method
Hepatitis Bs (Surface) Antigen	NON REACTIVE		Non - Reactive	Immunochromatographic

Comment:

Infection with HBV results in a wide spectrum of acute and chronic liver diseases that may lead to cirrhosis and hepatocellular carcinoma. Hepatitis B surface antigen (HBsAg), derived from the viral envelope, is the first antigen to appear following infection and is detectable in the serum.

Note:

- **This is a Rapid, Screening Test for Qualitative detection of HBsAg.**
- All Provisionally Reactive cases must be confirmed by confirmatory method to rule out false positives due to interfering substances.

Limitations:

- For diagnostic purposes, results should be used in conjunction with patient history and other hepatitis markers for diagnosis of acute and chronic infection.
- Additional follow up testing using other available methods is required ,if this test is Non- Reactive in the presence of persisting clinical symptoms of Hepatitis B.
- In few cases,false positive results can be obtained due to presence of other antigens or elevated levels of Rheumatoid factor.

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Referred By	: Dr.	Report Status	: Final Report
Sample Type	: Urine	Report Date	: 14/Apr/2023 11:48AM

CLINICAL PATHOLOGY

COMPREHENSIVE GOLD FULL BODY CHECKUP

Test Name	Result	Unit	Bio. Ref. Interval	Method
Urine Routine & Microscopy				
Colour	PALE YELLOW		Pale Yellow	Manual
Appearance	CLEAR		Clear	Manual
Specific gravity	1.005		1.003 - 1.035	pKa change
pH	6.0		4.6 - 8.0	Double Indicator
Glucose	NEGATIVE		Negative	GOD-POD
Protein	NEGATIVE		Negative	Protein Error Principle
Ketones	NEGATIVE		Negative	Nitroprusside
Blood	NEGATIVE		Negative	Peroxidase
Bilirubin	NEGATIVE		Negative	Diazonium
Urobilinogen	NORMAL		Normal	Ehrlich
Leucocyte Esterase	NEGATIVE		Negative	Pyrrole
Nitrite	NEGATIVE		Negative	P-arsanilic acid
Pus cells	1-2	/hpf	0-5	Microscopy
Red Blood Cells	NIL	/hpf	0-2	Microscopy
Epithelial cells	1-2	/hpf	Few	Microscopy
Casts	NIL	/lpf	Nil	Microscopy
Crystals	NIL		Nil	Microscopy
Yeast	NIL		Nil	Microscopy
Bacteria	NIL		Nil	Microscopy

Comment:

•Note: Pre-test condition to be observed while submitting the sample-first void, mid stream urine, collected in a clean, dry, sterile container is recommended for routine urine analysis, avoid contamination with any discharge from vaginal, urethra, perineum, Avoid prolonged transit time & undue exposure to sunlight.

•During interpretation, points to be considered are Negative nitrite test does not exclude the urinary tract infections. Trace proteinuria can be seen with many physiological conditions like prolonged recumbency, exercise, high protein diet. False positive reactions for bile pigments, proteins, glucose and nitrites can be caused by peroxidase like activity by disinfectants, therapeutic dyes, ascorbic acid and certain drugs.• Urine microscopy is done in centrifuged urine specimens

***** End Of Report *****

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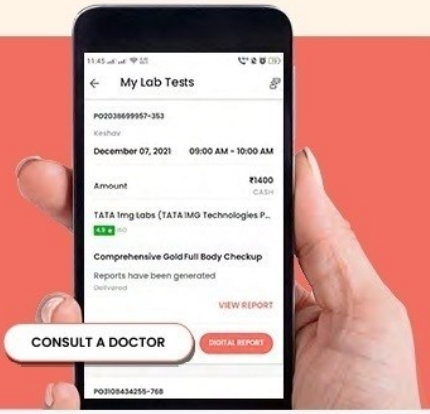

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