HEALTHSPACE DIAGNOSTICS PVT. LTD.
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IAF 9001:2015 24/7 Call @ 8168844289

Test Report

Visit ID	: RDDPL311151	Registration	: 02-Aug-2024
UHID/MR No	: 311601	Collected	: 02-Aug-2024
Patient Name	: MR. SHYAM LAL	Received	: 02-Aug-2024
Age/Gender	: 62Y 0M 0D/Male	Reported	: 03-Aug-2024
Ref Doctor	: SELF	Status	: Final report
Client Name	: HEALTHSPACE DIAGNOSTICS	Client Code	: RDHR15
Ref.Lab	: GANESH LAB	Barcode No	: 00357439

DEPARTMENT OF HEMATOLOGY

RD HEALTHCARE 1.1

Test Name	Result	Unit	Bio.Ref.Range	Method Name
CBC-COMPLETE BLOOD COUNT WITH ESR				
Sample Type : WB EDTA				
BLOOD CELLS PARAMETER DONE BY BC 6000 (Flow Cytometer)				
Haemoglobin (Hb)	11.0 L	g/dL	13.0-17.0	Photometric/Non Cyanmethemoglobin Method
RBC Count(Red Blood Count)	3.5 L	10^6/uL	4.5-5.9	Optical Flowcytomet
Packed Cell Volume (PCV)-Hematocrit	35.6	%	30.0-55.0	RBC Pulse Height Detection
Mean Corpuscular Volume (MCV)	100.7 H	fL	80 - 96	Automated/Calculat
Mean Corpuscular Hemoglobin (MCH)	31.1	pg/cell	28 - 33	Automated/Calculat
Mean Corpuscular Hb concentration (MCHC)	30.90 L	g/dL	31 - 36	Automated/Calculat
Red Blood Cell Distribution Width Cofficient of Variation (RDW-CV)	17.5 H	%	11.7 - 14.4	Automated/Calculat
Red Blood Cell Distribution Width Standard Deviation (RDW-SD)	61.9 H	fL	35.0- 46.0	Automated/Calculate
White Blood Count (WBC) PARAMETERS				
Total Leukocyte Count (TLC/WBC COUNT)	6.20	10^3/µL	4.00-10.0	Automated optical Flo cytometry/Manual
DIFFERENTIAL LEUKOCYTE COUNT(DLC) BY FLOW CYTOMETERY/MICROSCOPIC				
Neutrophils	54.0	%	40.0-80.0	Impedance Flow cytometry/Microscopy
Lymphocytes	31.0	%	20.0-40.0	Impedance Flow cytometry/Microscopy
Monocytes	10.0	%	2 .0- 10 .0	Impedance Flow cytometry/Microscopy
Eosinophils	5.0	%	1.0 - 6.0	Impedance Flow cytometry/Microscopy
Basophils	0.0	%	0.00 - 2.00	Impedance Flow cytometry/Microscop

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DEPARTMENT OF HEMATOLOGY

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Test Name	Result	Unit	Bio.Ref.Range	Method Name
ABSOLUTE LEUKOCYTE COUNTS				
Absolute Neutrophil Count	3.62	10^3/µL	2.00-7.00	Automated Calculated
Absolute Lymphocyte Count	2.08	10^3/µL	1.00-3.00	Automated Calculated
Absolute Monocyte Count	0.67	10^3ul	0.20 - 1.00	Automated Calculated
Absolute Eosinophils Count	0.34	10^3/ul	0.02-0.50	Automated Calculated
Absolute Basophil Count	00	10^3/µL	0.00-0.10	Automated Calculated
PLATELET PARAMETERS				
Platelet Count	125 L	10^3/µL	150-410	Automated Optical Flowcytometer
Plateletcrit (PCT)	0.15 L	%	0.18 - 0.39	Automated Optical Flowcytometer
Platelet Distribution Width(PDW)	17.2	fL	8.30-18.0	Calculated
Mean Platelet Volume (MPV)	12.1	fL	7.10-12.50	Automated Calculated
Platelet-Large Cell Count (P-LCC)	52	10^3/µL	45.0-95.0	Automated Calculated
Mentzer Index	28.53	Ratio		Calculated
Neutrophil to Lymphocyte Ratio	1.74			Calculated
Lymphocyte to Monocyte Ratio	3.1			Calculated
SED RATE				
Erythrocyte Sedimentation Rate (ESR)	23 H	mm/1st hr.	0 - 15	Modified /Advance Westergren Method

INTERPRETATION: A complete blood count (CBC) is a blood test used to evaluate your overall health and detect a wide range of disorders, including anemia, infection and leukemia. A complete blood count test measures several components and features of your blood, including: Red blood cells, which carry oxygen. Some of the most common diseases a CBC detects include anemia, inflammation disorders, bone marrow disorders, dehydration, infections, inflammation, leukemia, lymphoma, myeloproliferative neoplasms, myelodysplastic syndrome, sickle cell disease, thalassemia, nutritional deficiencies. WBC They are important for fighting infections. A lower than normal WBC count may be due to: Bone marrow deficiency or failure (for example, due to infection, tumor, or abnormal cells) Cancer treating drugs, or other medicines. MCC The differential count represents the percentages of each type of leukocyte present. WBCs are composed of granulocytes [eosinophils, neutrophils, and basophils] and lymphocytes [lymphocytes and monocytes]. White blood cells are a major component of the body's immune system. When the MCV is high, they are called macrocytic. When the MCHC is abnormally high, hyperchromic.Sed rate, or erythrocyte sedimentation rate (ESR), is a blood test that can reveal inflammatory activity in your body. A sed rate test finds a nonspecific, called hypochromic, and when the MCHC is abnormally high, hyperchromic.Sed rate, or erythrocyte sedimentation rate (ESR), is a blood test that can reveal inflammatory activity in your body. A sed rate test finds a nonspecific, diagnostic tool, but it can help your doctor diagnose or monitor the progress of an inflammatory disease.A PCV (Packed Cell Volume) Test is done to diagnose anemia or polycythemia in patients. It is generally done along with a full blood count test that is conducive to estimate the need for any blood transfusion and monitor the response to the blood transfusion treatment. Blood is a mix of plasma as well as cells. The HHDB test is commonly used to help diagnose anemia, a condition in which your red blood cells don't carry enough oxygen to the rest of your body. PCT A high platelet count can occur when something causes the bone marrow to make too many platelets. When the reason is unknown, it is called primary or essential thrombocytosis. When excess platelets are due to an infection or other condition, it is called secondary thrombocytosis. An erythrocyte sedimentation rate (ESR) is a blood test that can show if you have inflammation in your body. Inflammation is your immune system's response to injury, infection, and many types of conditions, including immune system disorders, certain cancers, and blood disorders. Erythrocyte sedimentation rate. Lymphocyte to Neutrophil Ratio acts as a marker of subclinical inflammation. It is calculated by dividing the number of neutrophils by number of lymphocytes, usually from peripheral blood samples, but sometimes also from cells that infiltrate tissue, such as tumor. Mentzer Index is differentiating iron deficiency anemia from beta thalassemia. The Index is calculated from the results of a complete blood count. If the quotient of the mean corpuscular volume (MCV, in fL) divided by the red blood cell count (RBC, in Millions per microLiter) is less than 13, thalassemia is said to be more likely. If the result is greater than 13, iron-deficiency anemia is said to be more likely.

ADVISE:- PHYSIOLOGICAL BLOOD VALUE WITH CHO

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DEPARTMENT OF HEMATOLOGY

RD HEALTHCARE 1.1

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DEPARTMENT OF CLINICAL BIOCHEMISTRY

RD HEALTHCARE 1.1

Test Name	Result	Unit	Bio.Ref.Range	Method Name
GFR -(ESTIMATED GLOMERULAR FILTRATION RATE)				
mple Type : SERUM				
rum Creatinine	4.84 H	mg/dL	0.60-1.50	Jaffes Reaction
imated gfr By ckd	11.93	mL/min/1.73m2		Calculated
imated gfr By Mdrd	13.04	mL/min/1.73m2		Calculated

INTENEDE USE

eGFR can be estimated from prediction equations that take into account the serum creatinine concentration and some or all variables like age, gender, race and body size. GFR estimation is the best overall index of kidney function.

INTERPRETATION OF RESULTS

KD STAGE	DESCRIPTION	GFR (mL/min/1.73m2)	ASSOCIATED FINDINGS
0	Normal kidney function	>90	No proteinuria
1	Kidney damage with normal or high GFR	>90	Presence of Protein, albumin, cells or casts in urine
2	Mild decrease in GFR	60-89	-
3	Moderate decrease in GFR	30-59	-
4	Severe decrease in GFR	15-29	-
5	END STAGE RENAL DISEASE	<15	-

COMMENTS

Modification of diet in renal disease, (MDRD) equation is most thoroughly validated and superior **to all** the other methods for estimation of GFR. It does not require weight as a variable and yields an estimated GFR normalized to 1.73m2 body surface area. Using serum creatinine alone gives a poor inference of GFR because they are inversely related and effects of age, sex and race on creatinine production complicate interpretation.

NOTE

1.National Kidney Disease Education program recommends the use of MDRD equation **to** estimate or predict GFR in adults (>=20 years) with Chronic Kidney Disease (CKD)

2. MDRD equation is most accurate for GFR <=60 mL/min/1.73m2 .

3.Recalculation of estimated GFR is required for African American race.

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DEPARTMENT OF CLINICAL BIOCHEMISTRY

RD HEALTHCARE 1.1

Test Name	Result	Unit	Bio.Ref.Range	Method Name
LIVER FUNCTION TEST (LFT)				
Sample Type : SERUM				
JAUNDICE PROFILE				
Bilirubin Total	0.45	mg/dL	0.20 -1.20	DSA
Bilirubin Direct	0.21	mg/dL	0.00 - 0.30	DSA
Bilirubin Indirect	0.24	mg/dL	0.00 - 1.10	Calculated
HEPATIC ENZYME				
Aspartate Transaminase (AST/SGOT)	25.30	U/L	0.00 - 40.0	UV without P5P
Alanine Amino Transferase (ALT/SGPT)	17.25	U/L	5.00-45.0	UV without P5P
Alkaline Phosphatase (ALP)	114.27	IU/L	44-147	IFCC
SGOT/SGPT Ratio	1.47	g/dL	0.00 - 3.50	Calculated
LIVER PLASMA PROTEIN				
Total Protein	7.34	g/dL	6.4-8.3	Biuret
Serum Albumin	4.11	g/dL	3.5 - 5.5	Bromocresol Green
Serum Globulin	3.23	g/dL	2.3-4.5	Calculated
Albumin/Globulin Ratio (A/G)	1.27	g/dL	1.00-2.50	Calculated

CLINICAL COMMENTS:Liver function tests can be suggested in case of hepatitis, liver cirrhosis and monitor possible side effects of medications. A variety of diseases and infections can cause acute or chronic damage to the liver, causing inflammation (hepatitis), scarring (cirrhosis), bile duct obstruction, liver cancers, and liver dysfunction. Alcohol, drugs, some herbal supplements, and toxins can also cause the liver. A significant amount of liver damage can occur before symptoms such as jaundice, dark urine, light-colored stools, itching (pruritus), nausea, fatigue, diarrhea, and unexplained weight loss or gain appear. Early detection of liver injury is essential in order to minimize damage and preserve liver function.Alanine aminotransferase (ALT) A very high level of ALT is frequently seen with acute hepatitis. Moderate increases may be seen with chronic hepatitis. People with blocked bile ducts, cirrhosis, and liver cancer may have ALT concentrations that are only moderately elevated or close to normal. Aspartate aminotransferase (AST) A very high level of AST is frequently seen with acute hepatitis. AST may be normal to moderately increased with chronic hepatitis. In people with blocked bile ducts, cirrhosis, or liver cancer, AST concentrations may be moderately increased or even in normal. When liver damage is due to alcohol, AST often increases more than ALT (this is a pattern seen with few other liver diseases). AST is also increased after heart attacks and with muscle injury.AST is a less sensitive and less specific marker of liver injury than ALT. AST remains elevated (as ALT does) in alcohol-induced liver injury. AST may be elevated more than ALT like (1)alcoholic liver disease results in mitochondrial toxicity and peroxisomal disruption, which is a co-factor for AST; (2) When disease results in substantial hepatocyte damage and release of AST; (3) the presence of liver cirrhosis, once liver cirrhosis is established, AST remains higher than ALT because of destroyed sinusoidal architecture, which results in impaired clearance of AST. Alkaline phosphatase (ALP) may be significantly increased with obstructed bile ducts, cirrhosis, liver cancer, and cholestatic liver disease. Bilirubin is increased in the blood when too much is being produced, or is being removed, due to bile duct obstruction, cirrhosis. Total protein (TP) is typically normal with liver disease. Gamma-glutamyl transferase (GGT) test may be used to help determine the cause of an elevated ALP. Both ALP and GGT are elevated in bile duct and liver disease, but only ALP will be elevated in bone disease. Increased GGT levels are associated with alcohol consumption and with conditions, such as congestive heart failure.

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DEPARTMENT OF CLINICAL BIOCHEMISTRY

RD HEALTHCARE 1.1

Test Name	Result	Unit	Bio.Ref.Range	Method Name
KIDNEY FUNCTION TEST (KFT) WITH CALCIUM				
Sample Type : SERUM				
RENAL PARAMETER				
Blood Urea	84.80 H	mg/dl.	15-40	Urease - UV
Serum Creatinine	4.84 H	mg/dL	0.60-1.50	Jaffes Reaction
Blood Urea Nitrogen (BUN)	39.63 H	mg/dL	6.0 - 20.0	Calculated
Urea / Creatinine Ratio	17.52	Ratio	10.7-42.8	Calculated
Bun/ Creatinine Ratio	8.19	Ratio	10.0-20.0	Calculated
PURINE COMPOUND (Break Down Product)				
Uric Acid (UA)	4.12	mg/dL	3.50 - 7.20	Uricase
CHEMICAL ELEMENTS (MINERALS)				
Total Calcium	8.90	mg/dL	8.5- 10.5	Arsenazo III Method
ELECTROLYTE PROFILE (*)				
*Sodium (Na+)	141.80	mmol/L	135 - 150	Indirect Potentiometery ISE
*Potassium (K+)	4.23	mmol/L	3.5 - 5.5	Indirect Potentiometery ISE
*Serum Chloride (Cl-)	97.70	mmol/L	94 - 110	Indirect Potentiometery ISE

Note: *Electrolyte profile(Profile is not a scope of nabl)

COMMENTS- Urea is a non-proteinous nitrogen compound formed in the liver from ammonia as an end product of protein metabolism. Increased levels are found in acute renal failure, chronic glomerulonephritis, congestive heart failure, decreased renal perfusion, diabetes, excessive protein ingestion, gastrointestinal (GI) bleeding, hyperalimentation, hypervolemia, 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 and 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 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). BUN/Creatinineratio 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 diuretics, 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 ant diuretic hormone (SIADH), certain drugs.Electrolyte profile(* profile is not a scope of nabl) disturbance showing Extreme fatigue. A prolonged

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of diarrhea or vomiting. Signs of dehydration. Unexplained confusion, muscle cramps, numbness or tingling.certain electrolyte is too high, the kidney might try to release more of it in your
e. Electrolyte imbalances can cause problems with many different bodily systems, which may even be life-threatening. Symptoms of severe electrolyte disorders can include Dizziness,Brea
ling,Shock, A fast or abnormal heart rate,Confusion,Irritability,Nausea and vomiting,Lethargy.

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Test Name	Result	Unit	Bio.Ref.Range	Method Name
LIPID PROFILE (CIRCULATING LIPOPROTEIN)				
Total Cholesterol	140.10	mg/dL	Desirable <200 Moderate Risk 200-239 High >240	Cholesterol Oxidase,Esterase,Peroxidase
BODY FAT STUDY (COMMON)				
Triglycerides (TG)	**209.61 H**	mg/dL	Optimal <150 Border line 150-199 High 200-499 Very High >500	Enzymatic End Point
GOOD CHOLESTEROL				
HDL Cholesterol	45.50	mg/dL	40 - 60	Direct measure
BAD CHOLESTEROL				
LDL Cholesterol	52.68	mg/dL	Optimal 100 Near Optimal 100-129 Boerder Line High 130-159 High 160-189 very High >190	CALCULATED
VLDL - Cholesterol	**41.92 H**	mg/dL	Less than 33.0 mg/dL	Calculated
Cholestrol/HDL-Cholestro Ratio	3.08	mg/dL	Less than 4.0 mg/dL	Calculated
LDL / HDL Cholestrol Ratio	**1.16 L**	Ratio	1.5-3.5	Calculated
HDL / LDL Cholestrol Ratio	0.86	Ratio	<3.50	Calculated

CLINICAL COMMENTS: Lipid Profile in the blood test useful in screening the abnormalities associated with lipids. The results of this test can assist approximate risks for cardiovascular disease (Heart attack, Heart failure, stroke, coronary artery disease), certain forms of pancreatitis, Hyperglycemia (indicative of insulin resistance) and certain genetic disorders. Total cholesterol is an estimate of all the cholesterol in the blood. Thus, higher total cholesterol may be due to high levels of HDL or high levels of LDL. So knowing the breakdown is important. High-density lipoprotein (HDL) is good cholesterol. HDL helps carry bad cholesterol out of the bloodstream and arteries. It plays a very important role in preventing clogged arteries. So, the higher the HDL number, the better. Low-density lipoprotein (LDL) is bad cholesterol. High LDL levels increase the risk of heart disease. Your serum LDL goal depends on whether or not you have existing risk factors for heart disease, such as diabetes or high blood pressure. Very Low-density lipoprotein (VLDL) is a type of bad cholesterol that contains the highest amount of triglycerides. The higher your VLDL level, the more likely you are to have a heart attack or stroke. Triglycerides are a type of blood fat that has been linked to heart disease and diabetes. If you have high triglycerides, your total cholesterol and LDL levels may be high, as well. Lifestyle plays a large role in your triglyceride level. Smoking, excessive drinking, uncontrolled diabetes, and medications such as estrogen, steroids, and beta-blockers can contribute to high triglyceride levels. Total cholesterol to HDL ratio is useful in predicting the risk of developing atherosclerosis (plaque build-up inside the arteries).

NOTE: 10-12 hours fasting is mandatory for lipid profile.In case of the lipemic or highly turbid due to lipoproteins mainly chylomicrons,the test cannot be performed on the specimen but the patient can request for this test again after consuming a fat free diet for at least a week.

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MBBS,MD(PATHOLOGY)

Result Enter By: HIMANSHU NEGI

HEALTHSPACE DIAGNOSTICS PVT. LTD.
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Test Report

Visit ID	: RDDPL311151	Registration	: 02-Aug-2024
UHID/MR No	: 311601	Collected	: 02-Aug-2024
Patient Name	: **MR. SHYAM LAL**	Received	: 03-Aug-2024
Age/Gender	: **62Y 0M 0D/Male**	Reported	: 03-Aug-2024
Ref Doctor	: SELF	Status	: Final report
Client Name	: HEALTHSPACE DIAGNOSTICS	Client Code	: RDHR15
Ref Lab	: GANESH LAB	Barcode No	: **00357440**

DEPARTMENT OF IMMUNOLOGY

RD HEALTHCARE 1.1

Test Name	Result	Unit	Bio.Ref.Range	Method Name
THYROID PROFILE - T3, T4 & TSH (TFT)				
Sample Type : SERUM				
Triiodothyronine (T3)	1.12	ng/mL	0.58-1.62	Chemiluminescent immunoassay (CLIA)
Thyroxine (T4)	8.26	µg/dl	5.0-14.5	Chemiluminescent immunoassay (CLIA)
Thyroid Stimulating Hormone	1.570	µIU/ml	0.35-5.1	Chemiluminescent immunoassay (CLIA)

Comments:

Thyroid tests to check how well your thyroid is working and to find the cause of problems such as hyperthyroidism or hypothyroidism. The thyroid is a small, butterfly-shaped gland in the front of your neck that makes two thyroid hormones: thyroxine (T_4) and triiodothyronine (T_3).Having more thyroid hormones than you need speeds up your body functions and causes symptoms that include: Weight loss, even though you may be eating more than usual. Rapid or irregular heartbeat. Feeling nervous or irritable.thyroid function test, looks at levels of thyroid-stimulating hormone (TSH) and thyroxine (T4) in the blood. Doctors may refer to this as "free" T4 (FT4). A high level of TSH and a low level of T4 in the blood could mean you have an underactive thyroid. If you have a thyroid problem that is not treated properly, serious health complications can result. An overactive thyroid (hyperthyroidism) can lead to a number of problems including: eye problems, such as bulging eyes, blurred or double vision or even vision loss.T3 is physiologically more active than T4 & plays an important role in maintaining euthyroidism.T3 circulates in free form (0.3 %) and in bound form (99.7%). T4 is predominantly bound to carrier protein - thyroid binding globulin (TBG-99.9%). T4 assay aids in diagnosis of hyperthyroidism - primary or secondary hypothyroidism & thyroid hormone resistances. T4 are must also be associated with the other tire of the thyroid assessment, such as TSH & T3 as well as with the clinical examina on to the patient TSH levels are subject to circadian varia on, reaching peak levels between 2am to 4am and at a minimum between 6pm to 10pm. The varia on is of the order of 50%; hence time of the day has influence on the measured serum TSH concentrations. Significant numbers of parents particularly those above 55 years of age have a serum TSH level between 4.68 & 10 µIU/ml. This borderline eleva on may be due to presence of SUBCLINICAL HYPOTHYROIDISM. Thyroid profile and an -thyroid [an TPO & TG] an bodies as ma on is suggested in all such cases. Very low serum TSH values are observed in patients who are being treated for hypothyroidism. In such pa ents Serum Free T3 & Free T4 estimation may also be performed.

In Pregancy as per American Thyroid Association Reference range for TSH is as follows:

Level	Total T3(ng/ml)	Total T4(ug/dl)	TSH(uTL/ml)	Free T3(pmol/L)	Free T4(ng/dl)
1st Trimester	1.25-2.93	4.60-10.50	0.10-2.5	3.2-6.8	0.7-2.0
2nd Trimester	1.54-4.00	6.92-12.38	0.20-3.0	3.1-5.9	0.5-1.60
3rd Trimester	1.54-4.00	5.98-12.98	0.30-3.0	3.1-5.9	0.6-1.60

All reports must be interpreted by treating physician only.

- **Disclaimer:The test results mentioned here should be interpreted in view of clinical situation of patient. In case of any suspicion regarding any parameter, repeat test with fresh sample essential to conclude. As per company policy, Sample storage is only for 24hrs after that recheck will not be possible.**

*** End of Report ***

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