Client

Gurugram

Pathkind Diagnostics Pvt. Ltd.

Plot No. 55-56, Udhyog Vihar Ph-IV, Gurugram - 122015

Processed By

Pathkind Diagnostics Pvt. Ltd.

Plot No. 55-56, Udhyog Vihar Ph-IV, Gurugram - 122015

Name	: **Mrs. PL103**	Billing Date	:	07/07/2023 12:27:14
Age	: 35 Yrs	Sample Collected on	:	10/07/2023 10:01:31
Sex	: Female	Sample Received on	:	10/07/2023 11:02:13
P. ID No.	: P1000100012843	Report Released on	:	20/07/2023 18:39:01
Accession No	: **10002304899**	Barcode No.	:	10002304899-02
Referring Doctor	: Self			
Referred By	:	Ref no.	:	

Report Status - Final

Test Name	Result	Biological Ref. Interval	Unit
FITKIND			
HAEMATOLOGY			
Complete Blood Count (CBC)			
Haemoglobin (Hb) *Sample: Whole Blood EDTA* *Method: Photometric measurement*	14.0	12.0 - 15.0	gm/dL
Total WBC Count / TLC *Sample: Whole Blood EDTA* *Method: Impedance*	6.0	4.0 - 10.0	thou/µL
RBC Count *Sample: Whole Blood EDTA* *Method: Impedance*	4.1	3.8 - 4.8	million/µL
PCV / Hematocrit *Sample: Whole Blood EDTA* *Method: Impedance*	40.1	36.0 - 46.0	%
MCV *Sample: Whole Blood EDTA* *Method: Calculated*	90.4	83.0 - 101.0	fL
MCH *Sample: Whole Blood EDTA* *Method: Calculated*	31.4	27.0 - 32.0	pg
MCHC *Sample: Whole Blood EDTA* *Method: Calculated*	32.6	31.5 - 34.5	g/dL
RDW (Red Cell Distribution Width) *Sample: Whole Blood EDTA* *Method: Calculated*	12.9	11.9 - 15.5	%
DLC (Differential Leucocyte Count) *Method: Flowcytometry/Microscopy*			
Neutrophils *Sample: Whole Blood EDTA* *Method: VCS Technology & Microscopy*	60	40 - 80	%

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Accession No	:	**10002304899**	Barcode No.	:	10002304899-02
Referring Doctor	:	Self			
Referred By	:		Ref no.	:	

Report Status - Final

Test Name	Result	Biological Ref. Interval	Unit
Lymphocytes *Sample: Whole Blood EDTA* *Method: VCS Technology & Microscopy*	30	20 - 40	%
Eosinophils *Sample: Whole Blood EDTA* *Method: VCS Technology & Microscopy*	05	01 - 06	%
Monocytes *Sample: Whole Blood EDTA* *Method: VCS Technology & Microscopy*	05	02 - 10	%
Basophils *Sample: Whole Blood EDTA* *Method: VCS Technology & Microscopy*	00	00 - 02	%
Absolute Neutrophil Count *Sample: Whole Blood EDTA*	3600	2000 - 7000	/µL
Absolute Lymphocyte Count *Sample: Whole Blood EDTA*	1800	1000 - 3000	/µL
Absolute Eosinophil Count *Sample: Whole Blood EDTA*	300	20 - 500	/µL
Absolute Monocyte Count *Sample: Whole Blood EDTA*	300	200 - 1000	/µL
Absolute Basophil Count *Sample: Whole Blood EDTA*	**00** L	20 - 100	/µL
Platelet Count *Sample: Whole Blood EDTA* *Method: Impedance*	210	150 - 410	thou/µL
MPV (Mean Platelet Volume) *Sample: Whole Blood EDTA* *Method: Calculated*	8.9	6.8 - 10.9	fL
Sample: Whole Blood EDTA **Erythrocyte Sedimentation Rate (ESR)** *Sample: Whole Blood EDTA* *Method: Modified Westergren Method*	04	<12	mm 1st Hour

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Report Status - Final

Test Name	Result	Biological Ref. Interval	Unit
Fasting Plasma Glucose *Sample: Fluoride Plasma - F* *Method: Hexokinase*	**115 H**	74 - 99	mg/dL
HbA1C (Glycosylated Hemoglobin)			
HbA1c *Sample: Whole Blood EDTA* *Method: High Perfomance Liquid Chromatography (HPLC)*	**6.9 H**	Non Diabetic : < 5.7 % Prediabetic Range : 5.7 - 6.4 % Diabetic Range : >= 6.5 % Goal of Therapy :<7.0 % Action suggested :>8.0 %	%
Mean Plasma Glucose *Sample: Whole Blood EDTA* *Method: Calculated*	**151.3 H**	<116.0	mg/dL
Lipid Profile Direct			
Total Cholesterol *Sample: Serum* *Method: Spectrophometry-Esterase/CO/Peroxidase*	**255 H**	Desirable Level : < 200 Borderline : 200 - 239 High Risk : >/= 240	mg/dL
Triglycerides *Sample: Serum* *Method: Spectrophotometry-Enzymatic*	**168 H**	Desirable : < 150 Borderline High : 150 - 199 High : 200 - 499 Very High : >/= 500	mg/dL
LDL Cholesterol (Direct) *Sample: Serum* *Method: Spectrophometry-Esterase/CO/Peroxidase*	38	Optimal : <100 Near Optimal : 100 - 129 Borderline High : 130 - 160 High : 161 - 189 Very High : >/=190	mg/dL
HDL Cholesterol *Sample: Serum* *Method: Spectrophometry-Esterase/CO/Peroxidase*	58	Low : < 40 Optimal : 40 - 60 High : > 60	mg/dL
VLDL Cholesterol *Sample: Serum* *Method: Calculated*	33.6	Desirable 10 - 35	mg/dL

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Report Status - Final

Test Name	Result	Biological Ref. Interval	Unit
Total Cholesterol / HDL Ratio *Sample: Serum* *Method: Calculated*	4.40	Low Risk : 3.3 - 4.4 Average Risk : 4.5 - 7.0 Moderate Risk : 7.1 - 11.0 High Risk : > 11.0	
LDL / HDL Ratio *Sample: Serum* *Method: Calculated*	0.66	Low Risk : 0.5 - 3.0 Moderate Risk : 3.1 - 6.0 High Risk : > 6.0	
# High-Sensitivity C-Reactive Protein (hs-CRP) *Sample: Serum* *Method: Immunoturbidimetry*	**3.96 H**	0.00 - 0.50	mg/dL
Creatine Phosphokinase (CPK) *Sample: Serum* *Method: Spectrophometry*	155	0 - 180	U/L
Liver Function Extended Panel			
Bilirubin Total *Sample: Serum* *Method: Spectrophotometry-Diazo*	**1.3 H**	0.0 - 1.2	mg/dL
Bilirubin Direct *Sample: Serum* *Method: Spectrophotometry-Diazo*	**0.4 H**	0.0 - 0.2	mg/dL
Serum Bilirubin (Indirect) *Sample: Serum* *Method: Calculated*	0.90	0.00 - 0.90	mg/dL
SGOT / AST *Sample: Serum* *Method: Spectrophotometry-IFCC Without Pyridoxal PO4*	**35 H**	0 - 27	U/L
SGPT / ALT *Sample: Serum* *Method: Spectrophotometry-IFCC Without Pyridoxal PO4*	**36 H**	0 - 33	U/L
Alkaline Phosphatase (ALP) *Sample: Serum* *Method: IFCC*	100	35 - 104	U/L

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Report Status - Final

Test Name	Result	Biological Ref. Interval	Unit
Lactate Dehydrogenase (LDH) *Sample: Serum* *Method: IFCC*	280	0 - 480	U/L
Gamma-Glutamyl Transferase (GGT) *Sample: Serum* *Method: Spectrophotometry-GGCNA*	**43 H**	0 - 42	U/L
Total Protein *Sample: Serum* *Method: Spectrophotometry Biuret*	7.3	6.4 - 8.3	g/dL
Albumin *Sample: Serum* *Method: Spectrophotometry-Bromocresol Purple*	4.3	3.5 - 4.8	g/dL
Globulin *Sample: Serum* *Method: Calculated*	3.0	1.9 - 3.7	g/dL
Albumin : Globulin Ratio *Sample: Serum* *Method: Calculated*	1.4	1.0 - 2.1	
Blood Urea Nitrogen (BUN) *Sample: Serum* *Method: Spectrophotometry-Urease / GLDH*	17.60	7.00 - 18.69	mg/dL
Creatinine *Sample: Serum* *Method: Spectrophotometry Alkaline Picrate*	1.10	0.50 - 1.10	mg/dL
BUN Creatinine Ratio *Sample: Serum* *Method: Calculated*	16	10 - 20	
Uric Acid *Sample: Serum* *Method: Uricase-Peroxidase*	5.3	2.3 - 6.1	mg/dL
Electrolytes (Na/K/Cl)			
Sodium *Sample: Serum* *Method: ISE*	**148 H**	136 - 145	mmol/L

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Report Status - Final

Test Name	Result	Biological Ref. Interval	Unit
Potassium *Sample: Serum* *Method: ISE*	4.7	3.5 - 5.1	mmol/L
Chloride *Sample: Serum* *Method: ISE*	**108 H**	97 - 107	mmol/L
Calcium *Sample: Serum* *Method: Spectrophotometry - OCC*	8.9	8.6 - 10.0	mg/dL
Phosphorus *Sample: Serum* *Method: Spectrophotometry-Phosphomolybdate Reduction*	3.6	2.6 - 4.5	mg/dL
Magnesium *Method: Spectrophotometry-Xylidyl blue*	**2.9 H**	1.6 - 2.6	mg/dL
Iron Studies **Sample: Serum** *Method: Method: Spectrophotometry-Ferrozine*			
Iron *Sample: Serum* *Method: Spectrophotometry-Ferrozine*	57	37 - 145	µg/dL
UIBC **Unsaturated Iron Binding Capacity** *Sample: Serum* *Method: Spectrophotometry*	258	110 - 370	µg/dL
Total Iron Binding Capacity (TIBC) *Sample: Serum* *Method: Calculated*	315	228 - 428	µg/dL
% Saturation *Sample: Serum* *Method: Calculated*	**18 L**	20 - 50	%
Vitamin D 25 - Hydroxy *Sample: Serum* *Method: ECLIA*	56.0	Deficiency < 20	ng/mL

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Report Status - Final

Test Name	Result	Biological Ref. Interval	Unit
		Insufficiency 20 - 30 Sufficiency 30 - 100 Toxicity > 100	
Vitamin B12 *Sample: Serum* *Method: ECLIA*	265	211 - 946	pg/mL
Ferritin *Sample: Serum* *Method: ECLIA*	150.00	15.00 - 150.00	ng/mL
Folic Acid *Sample: Serum* *Method: ECLIA*	16.5	3.1 - 17.5	ng/mL
Thyroid Profile Free			
FT3 (Free Triiodothyronine 3) *Sample: Serum* *Method: ECLIA*	4.20	2.30 - 4.20	pg/mL
FT4 (Free Thyroxine 4) *Sample: Serum* *Method: ECLIA*	**2.30 H**	1.00 - 1.60	ng/dL
TSH 3rd Generation *Sample: Serum* *Method: ECLIA*	4.200	0.270 - 4.200	µIU/mL
Testosterone Free *Sample: Serum* *Method: ELISA*	0.90	Pre- Menopausal : 0.0 - 1.70 Post- Menopausal : 0.0 - 2.34	pg/mL
Testosterone Total *Sample: Serum* *Method: ECLIA*	0.82	0.06 - 0.82	ng/mL
Serum Cortisol			
Serum Cortisol (Morning) *Sample: Serum* *Method: Chemiluminescence*	16.50	6.24 - 18.00	µg/dL

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Report Status - Final

Test Name	Result	Biological Ref. Interval	Unit
Serum Cortisol (Evening) *Sample: Serum cortisol - Eve* *Method: ECLIA*	10.00	2.69 - 10.40	µg/dL
Insulin Fasting *Sample: Serum* *Method: ECLIA*	12.60	2.60 - 24.90	µU/mL

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Report Status - Final

Test Name	Result	Biological Ref. Interval	Unit

CLINICAL PATHOLOGY

Urine Routine & Microscopic Examination

Method: Reflectance Photometry

Physical Examination

Colour *Sample: Urine* *Method: Physical Examination*	Pale Yellow	Pale Yellow	
Appearance *Sample: Urine* *Method: Physical Examination*	Clear	Clear	
Specific Gravity *Sample: Urine* *Method: pKa change of pretreated polyelectrolytes*	1.010	1.003 - 1.035	
pH *Sample: Urine* *Method: Double indicator principle*	6.0	4.7 - 7.5	

Chemical Examination

Glucose *Sample: Urine* *Method: Glucose oxidase/peroxidase*	Not Detected	Not Detected	
Protein *Sample: Urine* *Method: Protein-error-of-indicators principle*	Not Detected	Not Detected	
Ketones *Sample: Urine* *Method: Sodium nitroprusside reaction*	Not Detected	Not Detected	
Blood *Sample: Urine* *Method: Peroxidase*	Not Detected	Not Detected	
Bilirubin *Sample: Urine* *Method: Diazo reaction*	Not Detected	Not Detected	

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Report Status - Final

Test Name	Result	Biological Ref. Interval	Unit
Urobilinogen *Sample: Urine* *Method: Ehrlich's reaction*	Normal	Normal	
Nitrite *Sample: Urine* *Method: Nitrite Test*	Not Detected	Not Detected	
Microscopic Examination *Method: Microscopy*			
Pus Cells *Sample: Urine*	0 - 5	0 - 5	/hpf
RBC *Sample: Urine*	Not Detected	Not Detected	/hpf
Epithelial Cells *Sample: Urine*	2 - 3	0 - 5	/hpf
Casts *Sample: Urine*	Not Detected	Not Detected	/hpf
Crystals *Sample: Urine*	Not Detected	Not Detected	/hpf
Bacteria *Sample: Urine*	Not Detected	Not Detected	/hpf
Remarks *Sample: Urine*			

Remarks : Microscopic Examination is performed on urine sediment

Complete Blood Count (CBC)

Clinical Significance :

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CBC comprises of estimation of the cellular componenets of blood including RBCs, WBCs and Platelets. Mean corpuscular volume (MCV) is a measure of the size of the average RBC, MCH is a measure of the hemoglobin cointent of the average RBC and MCHC is the hemoglobin concentration per RBC. The red cell distribution width (RDW) is a measure of the degree of variation in RBC size (anisocytosis) and is helpful in distinguishing between some anemias. CBC examination is used as a screening tool to confirm a hematologic disorder, to establish or rule out a diagnosis, to detect an unsuspected hematologic disorder, or to monitor effects of radiation or chemotherapy. Abnormal results may be due to a primary disorder of the cell-producing organs or an underlying disease. Results should be interpreted in conjunction with the patient's clinical picture and appropriate additional testing performed.

HbA1C (Glycosylated Hemoglobin)

Clinical Significance :

Hemoglobin A1c (HbA1c) level reflects the mean glucose concentration over the previous period (approximately 8-12 weeks) and provides a much better indication of long-term glycemic control than blood and urinary glucose determinations. American Diabetes Association (ADA) include the use of HbA1c to diagnose diabetes, using a cutpoint of 6.5%. The ADA recommends measurement of HbA1c 3-4 times per year for type 1 and poorly controlled type 2 diabetic patients, and 2 times per year for well-controlled type 2 diabetic patients) to assess whether a patient's metabolic control has remained continuously within the target range. Falsely low HbA1c results may be seen in conditions that shorten erythrocyte life span. and may not reflect glycemic control in these cases accurately.

Lipid Profile Direct

Proposed LDL-C goals in very high risk and extreme risk group patients by the Lipid Association of India.

Very High Risk group(VHRG)	Extreme Risk group	
	Category A	Category B
LDL-C goal of <50 mg/dl High-risk conditions Any one of following: 1. ASCVD (CAD/PAD/TIA or stroke) 2. Homozygous familial	LDL-C goal of <50 mg/dl (recommended) LDL-C goal of ≤30 mg/dl (optional) CAD with ≥1 of following: 1. Diabetes without target organ	LDL-C goal of ≤30 mg/dl CAD with ≥1 of following: 1. Diabetes + polyvascular disease/≥2 2. major ASCVD risk factors∗/target organ

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P. ID No.	:	P1000100012843	Report Released on	:	20/07/2023 18:39:01
Accession No	:	**10002304899**	Barcode No.	:	10002304899-01, 10002304899-02, 10002304899-03, 10002304899-04, 10002304899-05
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Report Status - Final

Test Name	Result	Biological Ref. Interval	Unit
3. hypercholesterolemia 4. Diabetes with ≥2 major ASCVD risk factors∗/target organ damage	damage/≤1 major 2. ASCVD risk factors 3. Familial hypercholesterolemia 4. ≥3 major ASCVD risk factors 5. CKD stage 3B and 4 6. ≥2 major ASCVD risk factors with ≥1 moderate 7. non-conventional risk factor# 8. Lp(a) ≥50 mg/dl 9. Coronary calcium score ≥300 HU 10. Extreme of a single risk factor 11. PAD 12. H/o TIA or stroke 13. Non-stenotic carotid plaque	3. damage 4. Recurrent ACS (within 12 months) 5. despite on LDL-C goal 6. Homozygous familial 7. Hypercholesterolemia	

The LDL-C goal of ≤30 mg/dl must be pursued after detailed risk-benefit discussion between physician and patient.

Clinical judgment to be used in decision making if the patient has disease/risk factors not covered in the table, eg. peripheral arterial disease or cerebrovascular disease.

∗Major ASCVD risk factors: 1. Age- male ≥45 years, female ≥55 years, 2. Family h/o premature CAD- male <55 years, female <65 years, 3. Smoking/tobacco use, 4. Systemic hypertension, 5.Low HDL (males <40 mg/dl and females <50 mg/dl).

#Moderate non-conventional risk factors: 1. Coronary calcium score 100-299 HU, 2. Increased carotid intima-media thickness, 3. Lp(a) ≥20-49

High-Sensitivity C-Reactive Protein

HsCRP	Cardiovascular risk
<1	Low risk

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Name	:	**Mrs. PL103**	Billing Date	:	07/07/2023 12:27:14
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1-3	Average risk
3-10	High risk
>10	Very high risk

HsCRP is a more sensitive test than the standard CRP test and can detect smaller increases in the levels. This test confirms the presence of inflammation due to infection, injury or after surgery. It is also used to monitor the effect of treatment. HsCRP is a very good indicator of risk of coronary heart disease.

Liver Function Extended Panel

COMMENTS / INTERPRETATION :

- Liver function test aid in the diagnosis of various extra hepatic, hepatic & post hepatic causes of disfunction like hemolytic anemias, viral & alcoholic hepatitis, cholestasis obstructive causes.
- The test encompass excretory, synthesis & parenchymal cell damage.

Uric Acid

Clinical Significance :

Uric acid is the final product of purine metabolism. Serum uric acid levels are raised in case of increased purine synthesis, inherited metabolic disorder, excess dietary purine intake, increased nucleic acid turnover, malignancy and cytotoxic drugs. Decreased levels are seen in chronic renal failure, severe hepatocellular disease with reduced purine synthesis, defective renal tubular reabsorption, overtreatment of hyperuricemia with allopurinol, as well as some cancer therapies.

Electrolytes (Na/K/Cl)

COMMENTS / INTERPRETATION :

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Sodium
- Useful in the diagnosis and treatment of dehydration, overhydration. Hypernatremia suggests dehydration and Hyponatremia (<130 mmol/L) suggests overhydration.
- Levels of sodium when evaluated with electrolytes aid in assessing acid base balance, water balance and water in toxication.

Potassium
- Useful in evaluation of electrolyte balance, cardiac arrhythmia, muscular weakness, hepatic encephalopathy, and renal failure.

Chloride
- Useful, when assayed along with Sodium, Potassium and bicarbonate in assesment of electrolyte, acid based and water balance.

-

Iron Studies

Iron is an essential trace mineral element which forms an important component of hemoglobin, metallocompounds and Vitamin A. Deficiency of iron, leads to microcytic hypochromic anemia. The toxic effects of iron are deposition of iron in various organs of the body and hemochromatosis.
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. In iron deficiency anemia, serum iron is reduced and TIBC increases.
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.

Vitamin D 25 - Hydroxy

Clinical Significance :
The 25-hydroxy vitamin D test is used to detect bone weakness or other bone malfunctions or disorders that occur as a result of a vitamin D deficiency.Those who are at high risk of having low levels of vitamin D include people who don't get much exposure to the sun, older adult, people with obesity, babies who are breastfed only, post gastric bypass surgery, Crohn's disease and other intestinal malabsorption conditions. Hypervitaminosis D usually occurs due to over intake of Vitamin D supplementation.

Vitamin B12

Clinical Significance :

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Vitamin B12 is necessary for hematopoiesis and normal neuronal function. It requires intrinsic factor (IF) for absorption. Vitamin B12 deficiency may be due to lack of IF secretion by gastric mucosa (eg, gastrectomy, gastric atrophy) or intestinal malabsorption (eg, ileal resection, small intestinal diseases). Vitamin B12 deficiency results in macrocytic anemia, glossitis, peripheral neuropathy, weakness, hyperreflexia, ataxia, loss of proprioception, poor coordination, and affective behavioral changes.

-

Ferritin

Clinical Significance :

Decreased levels of serum Ferritin is associated with increased risk for developing iron deficiency which in turn cn lead to anaemia. Increased levels of serum ferritin is associated with iron overload conditions(like hereditary hemochromatosis), common liver disorders, neoplasms, acute or chronic inflammation and hereditary hyperferritinemia-cataract syndrome.

TSH 3rd Generation

Clinical Significance :

TSH levels are elevated in primary hypothyroidism and low in primary hyperthyroidism. Evaluation of TSH is useful in the differential diagnosis of primary from secondary and tertiary hypothyroidism. In primary hypothyroidism, TSH levels are elevated, whil secondary and tertiary hypothyroidism, TSH levels are low or normal. High TSH level in the presence of normal FT4 is subclinical hypothyroidism and low TSH with normal FT4 is called subclinical hyperthyroidism. Sick, hospitalized patients may have falsely low or transiently elevated TSH. Significant diurnal variation is also seen in TSH levels.

Guidelines for TSH levels in pregnancy, as per American Thyroid Association, are as follows:

PREGNANCY TRIMESTER	BIOLOGICAL REFERENCE INTERVAL	UNIT
FIRST TRIMESTER	0.100 - 2.500	µIU/mL
SECOND TRIMESTER	0.200 - 3.000	µIU/mL
THIRD TRIMESTER	0.300 - 3.000	µIU/mL

Testosterone Free

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Customer Care: 75000-75111

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COMMENTS / INTERPRETATION :

- Free testosterone is a measure of biologically active testosterone, the value of which is unaffected by the variations in the transport proteins.
- The measurement of Free Testosterone is useful mainly in the evaluation of male hypogonadism and female hyperandrogenic states.
- Only 2-3 % of testosterone is unbound and free.

Testosterone Total

Clinical Significance :

Testosterone is the major androgenic hormone and is responsible for the development of the external genitalia and secondary sexual characteristics in males. It is an estrogen precursor in females, and in both genders, it has some anabolic effects and also influences behavior. High levels of testosterone during childhood leads to premature puberty in boys and masculinization in girls. Elevated levels in adult women results in varying degrees of virilization, including hirsutism, acne, oligo-amenorrhea and infertility. Mild-to-moderate testosterone elevations may be asymptomatic in males.Common causes of pronounced elevations of testosterone include congenital adrenal hyperplasia, adrenal, testicular, and ovarian tumors and abuse of testosterone or gonadotrophins by athletes.Low levels of testosterone is usually due to testicular failure in males, which can be primary, secondary or tertiary. It causes partial or complete hypogonadism and also causes some changes in the secondary sexual characteristics and the reprodictive function.In females, low levels of teststerone causes decline in libido and nonspecific mood changes.

Insulin Fasting

Clinical Significance :

Insulin is a hormone produced in the pancreas and it regulates the uptake and utilization of glucose. Type 1 diabetes (insulin-dependent diabetes) is caused by insulin deficiency due to destruction of insulin-producing pancreatic islet cells. Type 2 diabetes is characterized by insulin resistance. Insulin levels may be increased in patients with pancreatic beta cell tumors (insulinoma).

Insulin levels generally decline in patients with type 1 diabetes mellitus. In the early stage of type 2 diabetes, insulin levels are either normal or elevated. In the late stage of type 2 diabetes, insulin levels decline.

Urine Routine & Microscopic Examination

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Clinical Significance :

Urine routine examination and microscopy comprises of a set of screening tests that can detect some common diseases like urinary tract infections, kidney disorders, liver problems, diabetes or other metabolic conditions. Physical characteristics (colour and appearance), chemical composition (glucose, protein, ketone, blood, bilirubin and urobilinogen) and microscopic content (pus cells, epithelial cells, RBCs, casts and crystals) are analyzed and reported.

** End of Report**

Dr. Aarti Khanna Nagpal
DNB (Pathology)
Senior Consultant

Dr. Saloni Garg
MD
Consultant Microbiology

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PATHKIND DIAGNOSTICS PVT. LTD.
Plot No. 55-56, Udyog Vihar, Phase-4, Gurugram
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