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	:	**Mr. SP602**	Billing Date	:	07/07/2023 12:33:01
Age	:	35 Yrs	Sample Collected on	:	10/07/2023 10:01:31
Sex	:	Male	Sample Received on	:	10/07/2023 11:02:13
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Accession No	:	**10002305046**	Barcode No.	:	10002305046-02, 10002305046-01
Referring Doctor	:	Self			
Referred By	:		Ref no.	:	

Report Status - Final

Test Name	Result	Biological Ref. Interval	Unit
BIOCHEMISTRY			
Gym Ready			
HbA1C (Glycosylated Hemoglobin)			
HbA1c *Sample: Whole Blood EDTA* *Method: High Perfomance Liquid Chromatography (HPLC)*	4.6	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*	85.3	<116.0	mg/dL
Fasting Plasma Glucose *Sample: Fluoride Plasma - F* *Method: Hexokinase*	85	74 - 99	mg/dL

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Test Name	Result	Biological Ref. Interval	Unit
HAEMATOLOGY			
Complete Blood Count (CBC)			
Haemoglobin (Hb) *Sample: Whole Blood EDTA* *Method: Photometric measurement*	13.0	13.0 - 17.0	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*	5.1	4.5 - 5.5	million/µL
PCV / Hematocrit *Sample: Whole Blood EDTA* *Method: Impedance*	42.6	40.0 - 50.0	%
MCV *Sample: Whole Blood EDTA* *Method: Calculated*	84.5	83.0 - 101.0	fL
MCH *Sample: Whole Blood EDTA* *Method: Calculated*	30.5	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*	12.6	11.8 - 15.6	%
DLC (Differential Leucocyte Count) *Method: Flowcytometry/Microscopy*			
Neutrophils *Sample: Whole Blood EDTA* *Method: VCS Technology & Microscopy*	60	40 - 80	%

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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*	214	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

Lipid Profile

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Test Name	Result	Biological Ref. Interval	Unit
Total Cholesterol *Sample: Serum* *Method: Spectrophometry-Esterase/CO/Peroxidase*	195	Desirable Level : < 200 Borderline : 200 - 239 High Risk : >/= 240	mg/dL
Triglycerides *Sample: Serum* *Method: Spectrophotometry-Enzymatic*	**158 H**	Desirable : < 150 Borderline High : 150 - 199 High : 200 - 499 Very High : >/= 500	mg/dL
LDL Cholesterol (Calculated) *Sample: Serum* *Method: Calculated*	45	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*	**65 H**	Low : < 40 Optimal : 40 - 60 High : > 60	mg/dL
Non HDL Cholesterol *Sample: Serum*	130	< 130	mg/dL
VLDL Cholesterol *Sample: Serum* *Method: Calculated*	31.6	Desirable 10 - 35	mg/dL
Total Cholesterol / HDL Ratio *Sample: Serum* *Method: Calculated*	**3.00 L**	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*	0.7	0.5 - 3.0 Low Risk : 0.5 - 3.0 Moderate Risk : 3.1 - 6.0 High Risk : > 6.0	
Calcium *Sample: Serum* *Method: Spectrophotometry - OCC*	9.6	8.6 - 10.0	mg/dL

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Test Name	Result	Biological Ref. Interval	Unit
TSH 3rd Generation *Sample: Serum* *Method: ECLIA*	**5.200 H**	0.270 - 4.200	µIU/mL
Phosphorus *Sample: Serum* *Method: Spectrophotometry-Phosphomolybdate Reduction*	3.5	2.6 - 4.5	mg/dL
# High-Sensitivity C-Reactive Protein (hs-CRP) *Sample: Serum* *Method: Immunoturbidimetry*	**3.60 H**	0.00 - 0.50	mg/dL
Vitamin D 25 - Hydroxy *Sample: Serum* *Method: ECLIA*	**15.2 L**	Deficiency < 20 Insufficiency 20 - 30 Sufficiency 30 - 100 Toxicity > 100	ng/mL

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.

Complete Blood Count (CBC)

Clinical Significance :

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

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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.

Lipid Profile

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 3. hypercholesterolemia 4. Diabetes with ≥2 major ASCVD risk factors∗/target organ damage	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 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	LDL-C goal of ≤30 mg/dl CAD with ≥1 of following: 1. Diabetes + polyvascular disease/≥2 2. major ASCVD risk factors∗/target organ 3. damage 4. Recurrent ACS (within 12 months) 5. despite on LDL-C goal 6. Homozygous familial 7. Hypercholesterolemia

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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 mg/dl, 4. Impaired fasting glucose, 5. Increased waist circumference, 6. Apolipoprotein B ≥ 110 mg/dl, 7. hsCRP ≥2 mg/L.

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

High-Sensitivity C-Reactive Protein

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HsCRP	Cardiovascular risk
<1	Low risk
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

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.

** End of Report**

Dr. Aarti Khanna Nagpal
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