DIAGNOSTIC REPORT

CLIENT CODE : C000071168

CLIENT'S NAME AND ADDRESS :
DHEERAJ PATANGE

8291041193

SRL LIMITED
S.K. Tower,Hari Niwas, LBS Marg
THANE, 400602
MAHARASHTRA, INDIA
Tel : 02225301181,02225301182,02225301183, Fax : CIN - U74899PB1995PLC045956
Email : customercare.thane@srl.in

PATIENT NAME : DHEERAJ PATANGE PATIENT ID : **DHEEM16057127**

ACCESSION NO : **0181RE002163** AGE : 47 Years SEX : Male DATE OF BIRTH :

DRAWN : 17/05/2018 08:50 RECEIVED : 17/05/2018 15:07 REPORTED : 17/05/2018 17:21

REFERRING DOCTOR : DR. nikhil nashikkar CLIENT PATIENT ID :

Test Report Status **Final**	Results		Biological Reference Interval	Units
DIABETES CHECK				
GLUCOSE, POST-PRANDIAL, PLASMA				
GLUCOSE, POST-PRANDIAL, PLASMA	112		70 - 139	mg/dL
METHOD : SPECTROPHOTOMETRY				
GLUCOSE, FASTING, PLASMA				
GLUCOSE, FASTING, PLASMA	**72**	**Low**	74 - 99	mg/dL
METHOD : SPECTROPHOTOMETRY				
SERUM BLOOD UREA NITROGEN				
BLOOD UREA NITROGEN	12		6 - 20	mg/dL
METHOD : SPECTROPHOTOMETRY				
CREATININE, SERUM				
CREATININE	1.18		0.90 - 1.30	mg/dL
CORONARY RISK PROFILE (LIPID PROFILE), SERUM				
CHOLESTEROL	120		< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
METHOD : SPECTROPHOTOMETRY				
TRIGLYCERIDES	64		< 150 Normal 150 - 199 Borderline High 200 - 499 High >/=500 Very High	mg/dL
METHOD : SPECTROPHOTOMETRY				
HDL CHOLESTEROL	48		< 40 Low >/=60 High	mg/dL
METHOD : SPECTROPHOTOMETRY				
DIRECT LDL CHOLESTEROL	71		< 100 Optimal 100 - 129 Near or above optimal 130 - 159 Borderline High 160 - 189 High >/= 190 Very High	mg/dL
METHOD : CALCULATED PARAMETER				
NON HDL CHOLESTEROL	72		Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
CHOL/HDL RATIO	**2.5**	**Low**	3.3 - 4.4 Low Risk 4.5 - 7.0 Average Risk 7.1 - 11.0 Moderate Risk > 11.0 High Risk	
LDL/HDL RATIO	1.5		0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	

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VERY LOW DENSITY LIPOPROTEIN	12.8	</= 30.0	mg/dL
METHOD : CALCULATED PARAMETER			
URINALYSIS			
COLOR	PALE YELLOW		
METHOD : PHYSICAL			
APPEARANCE	CLEAR		
METHOD : PHYSICAL			
PH	5.5	4.7 - 7.5	
METHOD : DOUBLE INDICATOR PRINCIPLE			
SPECIFIC GRAVITY	1.015	1.003 - 1.035	
METHOD : PKA CHANGE IN RELATION TO IONIC CONCENTRATION			
GLUCOSE	**DETECTED (+)**	NOT DETECTED	
METHOD : GOD-POD METHOD			
PROTEIN	NOT DETECTED	NOT DETECTED	
METHOD : 0.3% TETRABROMPHENOL BLUE INDICATOR			
KETONES	NOT DETECTED	NOT DETECTED	
METHOD : REACTION OF ACETOACETIC ACID WITH NITROPRUSSIDE			
BLOOD	NOT DETECTED	NOT DETECTED	
METHOD : REACTION OF DISOPROPYLBENZENE DIHYDROPEROXIDE AND 3,3',5,5' TETRAMETHYL BENZIDINE			
BILIRUBIN	NOT DETECTED	NOT DETECTED	
METHOD : COUPLING OF BILIRUBIN WITH DIAZOTIZED DICHLOROANALINE			
UROBILINOGEN	NORMAL	NORMAL	
METHOD : EHRLICH REACTION REFLECTANCE			
NITRITE	NOT DETECTED	NOT DETECTED	
METHOD : REACTION WITH P-ARSANILIC ACID & COUPLING WITH TETRAHYDROBENZOQUINOLINOL			
WBC	0-1	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION			
EPITHELIAL CELLS	1-2	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION			
RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
METHOD : MICROSCOPIC EXAMINATION			
CASTS	NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION			
CRYSTALS	NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION			
BACTERIA	NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION			

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REMARKS NOTE:-URINALYSIS MICROSCOPIC EXAMINATION IS CARRIED OUT ON CENTRIFUGED URINARY SEDIMENT.

METHOD : MICROSCOPY DONE FROM URINE SEDIMENT

GLYCOSYLATED HEMOGLOBIN, EDTA WHOLE BLOOD

GLYCOSYLATED HEMOGLOBIN (HBA1C)	**7.9**	**High**	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 ADA Target: 7.0 Action suggested: > 8.0	%
MEAN PLASMA GLUCOSE	**180.0**	**High**	< 116.0	mg/dL

Interpretation(s)
GLUCOSE, POST-PRANDIAL, PLASMA-
ADA Guidelines for 2hr post prandial glucose levels is only after ingestion of 75grams of glucose in 300 ml water,over a period of 5 minutes.
GLUCOSE, FASTING, PLASMA-
ADA 2012 guidelines for adults as follows:
Pre-diabetics: 100 - 125 mg/dL
Diabetic: > or = 126 mg/dL

(Ref: Tietz 4th Edition & ADA 2012 Guidelines)
SERUM BLOOD UREA NITROGEN-
Causes of Increased levels
Pre renal
• High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal
• Renal Failure
Post Renal
• Malignancy, Nephrolithiasis, Prostatism

Causes of decreased levels
• Liver disease
• SIADH.
CREATININE, SERUM-
Higher than normal level may be due to:
• Blockage in the urinary tract
• Kidney problems, such as kidney damage or failure, infection, or reduced blood flow
• Loss of body fluid (dehydration)
• Muscle problems, such as breakdown of muscle fibers
• Problems during pregnancy, such as seizures (eclampsia)), or high blood pressure caused by pregnancy (preeclampsia)

Lower than normal level may be due to:
• Myasthenia Gravis
• Muscular dystrophy
CORONARY RISK PROFILE (LIPID PROFILE), SERUM-
Serum cholesterol is a blood test that can provide valuable information for the risk of coronary artery disease This test can help determine your risk of the build up of plaques in your arteries that can lead to narrowed or blocked arteries throughout your body (atherosclerosis). High cholesterol levels usually don't cause any signs or symptoms, so a cholesterol test is an important tool. High cholesterol levels often are a significant risk factor for heart disease and important for diagnosis of hyperlipoproteinemia, atherosclerosis, hepatic and thyroid diseases.

Serum Triglyceride are a type of fat in the blood. When you eat, your body converts any calories it doesn't need into triglycerides, which are stored in fat cells. High triglyceride levels are associated with several factors, including being overweight, eating too many sweets or drinking too much alcohol, smoking, being sedentary, or having diabetes with elevated blood sugar levels. Analysis has proven useful in the diagnosis and treatment of patients with diabetes mellitus, nephrosis, liver obstruction, other diseases involving lipid metabolism, and various endocrine disorders. In conjunction with high density lipoprotein and total serum cholesterol, a triglyceride determination provides valuable information for the assessment of coronary heart disease risk.It is done in fasting state.

High-density lipoprotein (HDL) cholesterol. This is sometimes called the ""good"" cholesterol because it helps carry away LDL cholesterol, thus keeping arteries open and blood flowing more freely.HDL cholesterol is inversely related to the risk for cardiovascular disease. It increases following regular exercise, moderate alcohol consumption and with oral estrogen therapy. Decreased levels are associated with obesity, stress, cigarette smoking and diabetes mellitus.

SERUM LDL The small dense LDL test can be used to determine cardiovascular risk in individuals with metabolic syndrome or established/progressing coronary artery disease, individuals with triglyceride levels between 70 and 140 mg/dL, as well as individuals with a diet high in trans-fat or carbohydrates. Elevated sdLDL levels are associated with metabolic syndrome and an ‘atherogenic lipoprotein profile’, and are a strong, independent predictor of cardiovascular disease.

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Elevated levels of LDL arise from multiple sources. A major factor is sedentary lifestyle with a diet high in saturated fat. Insulin-resistance and pre-diabetes have also been implicated, as has genetic predisposition. Measurement of sdLDL allows the clinician to get a more comprehensive picture of lipid risk factors and tailor treatment accordingly. Reducing LDL levels will reduce the risk of CVD and MI.

Non HDL Cholesterol - Adult treatment panel ATP III suggested the addition of Non-HDL Cholesterol as an indicator of all atherogenic lipoproteins (mainly LDL and VLDL). NICE guidelines recommend Non-HDL Cholesterol measurement before initiating lipid lowering therapy. It has also been shown to be a better marker of risk in both primary and secondary prevention studies.

Recommendations:
Results of Lipids should always be interpreted in conjunction with the patient's medical history, clinical presentation and other findings.

NON FASTING LIPID PROFILE includes Total Cholesterol, HDL Cholesterol and calculated non-HDL Cholesterol. It does not include triglycerides and may be best used in patients for whom fasting is difficult.
URINALYSIS-Routine urine analysis assists in screening and diagnosis of various metabolic, urological, kidney and liver disorders
Protein: Elevated proteins can be an early sign of kidney disease. Urinary protein excretion can also be temporarily elevated by strenuous exercise, orthostatic proteinuria, dehydration, urinary tract infections and acute illness with fever
Glucose: Uncontrolled diabetes mellitus can lead to presence of glucose in urine. Other causes include pregnancy, hormonal disturbances, liver disease and certain medications.
Ketones: Uncontrolled diabetes mellitus can lead to presence of ketones in urine. Ketones can also be seen in starvation, frequent vomiting, pregnancy and strenuous exercise.
Blood: Occult blood can occur in urine as intact erythrocytes or haemoglobin, which can occur in various urological, nephrological and bleeding disorders.
Leukocytes: An increase in leukocytes is an indication of inflammation in urinary tract or kidneys. Most common cause is bacterial urinary tract infection.
Nitrite: Many bacteria give positive results when their number is high. Nitrite concentration during infection increases with length of time the urine specimen is retained in bladder prior to collection.
pH: The kidneys play an important role in maintaining acid base balance of the body. Conditions of the body producing acidosis/ alkalosis or ingestion of certain type of food can affect the pH of urine.
Specific gravity: Specific gravity gives an indication of how concentrated the urine is. Increased specific gravity is seen in conditions like dehydration, glycosuria and proteinuria while decreased specific gravity is seen in excessive fluid intake, renal failure and diabetes insipidus.
Bilirubin: In certain liver diseases such as biliary obstruction or hepatitis, bilirubin gets excreted in urine.
Urobilinogen: Positive results are seen in liver diseases like hepatitis and cirrhosis and in cases of hemolytic anemia
GLYCOSYLATED HEMOGLOBIN, EDTA WHOLE BLOOD-
Glycosylated hemoglobin (GHb) has been firmly established as an index of long-term blood glucose concentrations and as a measure of the risk for the development of complications in patients with diabetes mellitus. Formation of GHb is essentially irreversible, and the concentration in the blood depends on both the life span of the red blood cell (average 120 days) and the blood glucose concentration. Because the rate of formation of GHb is directly proportional to the concentration of glucose in the blood, the GHb concentration represents the integrated values for glucose over the preceding 6-8 weeks.
Any condition that alters the life span of the red blood cells has the potential to alter the GHb level. Samples from patients with hemolytic anemias will exhibit decreased glycated hemoglobin values due to the shortened life span of the red cells. This effect will depend upon the severity of the anemia. Samples from patients with polycythemia or post-splenectomy may exhibit increased glycated hemoglobin values due to a somewhat longer life span of the red cells.
Glycosylated hemoglobins results from patients with HbSS, HbCC, and HbSC and HbD must be interpreted with caution, given the pathological processes, including anemia, increased red cell turnover, transfusion requirements, that adversely impact HbA1c as a marker of long-term glycemic control. In these conditions, alternative forms of testing such as glycated serum protein (fructosamine) should be considered.
References
1. Tietz Textbook of Clinical Chemistry and Molecular Diagnostics, edited by Carl A Burtis, Edward R.Ashwood, David E Bruns, 4th Edition, Elsevier publication, 2006, 879-884.
2. Forsham PH. Diabetes Mellitus:A rational plan for management. Postgrad Med 1982, 71,139-154.
3. Mayer TK, Freedman ZR: Protein glycosylation in Diabetes Mellitus: A review of laboratory measurements and their clinical utility. Clin Chim Acta 1983, 127, 147-184.

****End Of Report****
Please visit www.srlworld.com for related Test Information for this accession

Dr. Padmaja Patil
Pathologist

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CONDITIONS OF LABORATORY TESTING & REPORTING

1. It is presumed that the test sample belongs to the patient named or identified in the test requisition form.
2. All Tests are performed and reported as per the turnaround time stated in the SRL Directory of services (DOS).
3. SRL confirms that all tests have been performed or assayed with highest quality standards, clinical safety & technical integrity.
4. A requested test might not be performed if:
   a. Specimen received is insufficient or inappropriate specimen quality is unsatisfactory
   b. Incorrect specimen type
   c. Request for testing is withdrawn by the ordering doctor or patient
   d. There is a discrepancy between the label on the specimen container and the name on the test requisition form
5. The results of a laboratory test are dependent on the quality of the sample as well as the assay technology.
6. Result delays could be because of uncontrolled circumstances. e.g. assay run failure.
7. Tests parameters marked by asterisks are excluded from the "scope" of NABL accredited tests. (If laboratory is accredited).
8. Laboratory results should be correlated with clinical information to determine Final diagnosis.
9. Test results are not valid for Medico- legal purposes.
10. In case of queries or unexpected test results please call at SRL customer care (Toll free: 1800-222-000). Post proper investigation repeat analysis may be carried out.

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