

Dr. Vinay Chopra
MD (Pathology & Microbiology)
Chairman & Consultant Pathologist

Dr. Yugam Chopra
MD (Pathology)
CEO & Consultant Pathologist

NAME : Mrs. ANURADHA
AGE/ GENDER : 51 YRS/FEMALE
COLLECTED BY :
REFERRED BY :
BARCODE NO. : 01518739
CLIENT CODE. : KOS DIAGNOSTIC LAB
CLIENT ADDRESS : 6349/1, NICHOLSON ROAD, AMBALA CANTT

PATIENT ID : 1641349
REG. NO./LAB NO. : 012410120017
REGISTRATION DATE : 12/Oct/2024 10:45 AM
COLLECTION DATE : 12/Oct/2024 10:46AM
REPORTING DATE : 12/Oct/2024 03:04PM

Test Name	Value	Unit	Biological Reference interval
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CLINICAL CHEMISTRY/BIOCHEMISTRY

GLUCOSE FASTING (F) AND POST PRANDIAL (PP)

GLUCOSE FASTING (F): PLASMA by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)	107.01 ^H	mg/dL	NORMAL: < 100.0 PREDIABETIC: 100.0 - 125.0 DIABETIC: > OR = 126.0
GLUCOSE POST PRANDIAL (PP): PLASMA by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)	186.29 ^H	mg/dL	NORMAL: < 140.00 PREDIABETIC: 140.0 - 200.0 DIABETIC: > OR = 200.0

INTERPRETATION:

IN ACCORDANCE WITH AMERICAN DIABETES ASSOCIATION GUIDELINES:

1. A fasting plasma glucose below 100 mg/dL and post-prandial plasma glucose level below 140 mg/dl is considered normal.
2. A fasting plasma glucose level between 100 - 125 mg/dl and post-prandial plasma glucose level between 140 – 200 mg/dL is considered as glucose intolerant or pre diabetic. A fasting and post-prandial blood test (after consumption of 75 gms of glucose) is recommended for all such patients.
3. A fasting plasma glucose level of above 125 mg/dL and post-prandial plasma glucose level above 200 mg/dL is highly suggestive of diabetic state. A repeat post-prandial is strongly recommended for all such patients. A fasting plasma glucose level in excess of 125 mg/dl on both occasions is confirmatory for diabetic state.



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REFERRED BY	:	COLLECTION DATE	: 12/Oct/2024 10:44AM
BARCODE NO.	: 01518739	REPORTING DATE	: 12/Oct/2024 12:05PM
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LIPID PROFILE : BASIC			
CHOLESTEROL TOTAL: SERUM <i>by CHOLESTEROL OXIDASE PAP</i>	247.1 ^H	mg/dL	OPTIMAL: < 200.0 BORDERLINE HIGH: 200.0 - 239.0 HIGH CHOLESTEROL: > OR = 240.0
TRIGLYCERIDES: SERUM <i>by GLYCEROL PHOSPHATE OXIDASE (ENZYMATIC)</i>	217.97 ^H	mg/dL	OPTIMAL: < 150.0 BORDERLINE HIGH: 150.0 - 199.0 HIGH: 200.0 - 499.0 VERY HIGH: > OR = 500.0
HDL CHOLESTEROL (DIRECT): SERUM <i>by SELECTIVE INHIBITION</i>	27.84 ^L	mg/dL	LOW HDL: < 30.0 BORDERLINE HIGH HDL: 30.0 - 60.0 HIGH HDL: > OR = 60.0
LDL CHOLESTEROL: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	175.67 ^H	mg/dL	OPTIMAL: < 100.0 ABOVE OPTIMAL: 100.0 - 129.0 BORDERLINE HIGH: 130.0 - 159.0 HIGH: 160.0 - 189.0 VERY HIGH: > OR = 190.0
NON HDL CHOLESTEROL: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	219.26 ^H	mg/dL	OPTIMAL: < 130.0 ABOVE OPTIMAL: 130.0 - 159.0 BORDERLINE HIGH: 160.0 - 189.0 HIGH: 190.0 - 219.0 VERY HIGH: > OR = 220.0
VLDL CHOLESTEROL: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	43.59	mg/dL	0.00 - 45.00
TOTAL LIPIDS: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	712.17 ^H	mg/dL	350.00 - 700.00
CHOLESTEROL/HDL RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	8.88 ^H	RATIO	LOW RISK: 3.30 - 4.40 AVERAGE RISK: 4.50 - 7.0 MODERATE RISK: 7.10 - 11.0 HIGH RISK: > 11.0
LDL/HDL RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	6.31 ^H	RATIO	LOW RISK: 0.50 - 3.0 MODERATE RISK: 3.10 - 6.0 HIGH RISK: > 6.0



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TRIGLYCERIDES/HDL RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	7.83 ^H	RATIO	3.00 - 5.00

INTERPRETATION:

- Measurements in the same patient can show physiological & analytical variations. Three serial samples 1 week apart are recommended for Total Cholesterol, Triglycerides, HDL & LDL Cholesterol.
- As per NLA-2014 guidelines, all adults above the age of 20 years should be screened for lipid status. Selective screening of children above the age of 2 years with a family history of premature cardiovascular disease or those with at least one parent with high total cholesterol is recommended.
- Low HDL levels are associated with increased risk for Atherosclerotic Cardiovascular disease (ASCVD) due to insufficient HDL being available to participate in reverse cholesterol transport, the process by which cholesterol is eliminated from peripheral tissues.
- NLA-2014 identifies Non HDL Cholesterol (an indicator of all atherogenic lipoproteins such as LDL, VLDL, IDL, Lp(a), Chylomicron remnants) along with LDL-cholesterol as co-primary target for cholesterol lowering therapy. Note that major risk factors can modify treatment goals for LDL & Non HDL.
- Additional testing for Apolipoprotein B, hsCRP, Lp(a) & LP-PLA2 should be considered among patients with moderate risk for ASCVD for risk refinement




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URIC ACID

URIC ACID: SERUM	4.45	mg/dL	2.50 - 6.80
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by URICASE - OXIDASE PEROXIDASE

INTERPRETATION:-

1.GOUT occurs when high levels of Uric Acid in the blood cause crystals to form & accumulate around a joint.
 2.Uric Acid is the end product of purine metabolism . Uric acid is excreted to a large degree by the kidneys and to a smaller degree in the intestinal tract by microbial degradation.

INCREASED:-

(A).DUE TO INCREASED PRODUCTION:-

- 1.Idiopathic primary gout.
- 2.Excessive dietary purines (organ meats,legumes,anchovies, etc).
- 3.Cytolytic treatment of malignancies especially leukemias & lymphomas.
- 4.Polycythemia vera & myeloid metaplasia.
- 5.Psoriasis.
- 6.Sickle cell anaemia etc.

(B).DUE TO DECREASED EXCRETION (BY KIDNEYS)

- 1.Alcohol ingestion.
- 2.Thiazide diuretics.
- 3.Lactic acidosis.
- 4.Aspirin ingestion (less than 2 grams per day).
- 5.Diabetic ketoacidosis or starvation.
- 6.Renal failure due to any cause etc.

DECREASED:-

(A).DUE TO DIETARY DEFICIENCY


- 1.Dietary deficiency of Zinc, Iron and molybdenum.
- 2.Fanconi syndrome & Wilsons disease.
- 3.Multiple sclerosis .
- 4.Syndrome of inappropriate antidiuretic hormone (SIADH) secretion & low purine diet etc.


(B).DUE TO INCREASED EXCRETION

- 1.Drugs:-Probenecid , sulphinpyrazone, aspirin doses (more than 4 grams per day), corticosteroids and ACTH, anti-coagulants and estrogens etc.

*** End Of Report ***




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