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

NAME	**: Mr. BOONDI**		
AGE/ GENDER	: 43 YRS/MALE	**PATIENT ID**	: 1644689
COLLECTED BY	:	**REG. NO./LAB NO.**	**: 012410160010**
REFERRED BY	:	**REGISTRATION DATE**	: 16/Oct/2024 08:30 AM
BARCODE NO.	: 01518968	**COLLECTION DATE**	: 16/Oct/2024 08:33AM
CLIENT CODE.	: KOS DIAGNOSTIC LAB	**REPORTING DATE**	: 16/Oct/2024 11:41AM
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval

CLINICAL CHEMISTRY/BIOCHEMISTRY

GLUCOSE FASTING (F) AND POST PRANDIAL (PP)

GLUCOSE FASTING (F): PLASMA *by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)*	**108.68^{H}**	**mg/dL**	**NORMAL: < 100.0** **PREDIABETIC: 100.0 - 125.0** **DIABETIC: > 0R = 126.0**
GLUCOSE POST PRANDIAL (PP): PLASMA *by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)*	**173.76^{H}**	**mg/dL**	**NORMAL: < 140.00** **PREDIABETIC: 140.0 - 200.0** **DIABETIC: > 0R = 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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Test Name	Value	Unit	Biological Reference interval
	LIPID PROFILE : BASIC		
CHOLESTEROL TOTAL: SERUM *by CHOLESTEROL OXIDASE PAP*	**260.57^{H}**	**mg/dL**	**OPTIMAL: < 200.0** **BORDERLINE HIGH: 200.0 - 239.0** **HIGH CHOLESTEROL: > OR = 240.0**
TRIGLYCERIDES: SERUM *by GLYCEROL PHOSPHATE OXIDASE (ENZYMATIC)*	**247.66^{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 *by SELECTIVE INHIBITION*	41.54	mg/dL	LOW HDL: < 30.0 BORDERLINE HIGH HDL: 30.0 - 60.0 HIGH HDL: > OR = 60.0
LDL CHOLESTEROL: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	**169.5^{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 *by CALCULATED, SPECTROPHOTOMETRY*	**219.03^{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 *by CALCULATED, SPECTROPHOTOMETRY*	**49.53^{H}**	**mg/dL**	**0.00 - 45.00**
TOTAL LIPIDS: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	**768.8^{H}**	**mg/dL**	**350.00 - 700.00**
CHOLESTEROL/HDL RATIO: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	**6.27^{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 *by CALCULATED, SPECTROPHOTOMETRY*	**4.08^{H}**	**RATIO**	**LOW RISK: 0.50 - 3.0** **MODERATE RISK: 3.10 - 6.0** **HIGH RISK: > 6.0**

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Test Name	Value	Unit	Biological Reference interval
TRIGLYCERIDES/HDL RATIO: SERUM ***by CALCULATED, SPECTROPHOTOMETRY***	**5.96^{H}**	**RATIO**	**3.00 - 5.00**

INTERPRETATION:

1.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.
2. 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.
3. 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.
4. NLA-2014 identifies Non HDL Cholesterol (an indicator of all atherogeniclipoproteins such as LDL , VLDL, IDL, Lpa, 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.
5. Additional testing for Apolipoprotein B, hsCRP,Lp(a) & LP-PLA2 should be considered among patients with moderate risk for ASCVD for risk refinement

*** End Of Report ***

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