

KOS Diagnostic Lab





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

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

NAME : Mrs. RENU SHARMA

AGE/ GENDER : 45 YRS/FEMALE **PATIENT ID** : 1813702

COLLECTED BY : 012504010045 REG. NO./LAB NO.

REFERRED BY **REGISTRATION DATE** : 01/Apr/2025 11:05 AM BARCODE NO. :01528159 **COLLECTION DATE** : 01/Apr/2025 11:46AM CLIENT CODE. : KOS DIAGNOSTIC LAB REPORTING DATE : 01/Apr/2025 02:10PM

CLIENT ADDRESS : 6349/1, NICHOLSON ROAD, AMBALA CANTT

Value Unit Test Name **Biological Reference interval**

CLINICAL CHEMISTRY/BIOCHEMISTRY GLUCOSE FASTING (F) AND POST PRANDIAL (PP)

GLUCOSE FASTING (F): PLASMA 87.05 mg/dL NORMAL: < 100.0

by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD) PREDIABETIC: 100.0 - 125.0

DIABETIC: > 0R = 126.0

GLUCOSE POST PRANDIAL (PP): PLASMA 88.64 mg/dL NORMAL: < 140.00

by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD) 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.



CONSULTANT PATHOLOGIST MBBS, MD (PATHOLOGY & MICROBIOLOGY)

DR.YUGAM CHOPRA CONSULTANT PATHOLOGIST





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(A Unit of KOS Healthcare)



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Test Name	Value	Unit	Biological Reference interval		
LIPID PROFILE : BASIC					
CHOLESTEROL TOTAL: SERUM by CHOLESTEROL OXIDASE PAP	206.75 ^H	mg/dL	OPTIMAL: < 200.0 BORDERLINE HIGH: 200.0 - 239.0 HIGH CHOLESTEROL: > OR = 240.0		
TRIGLYCERIDES: SERUM by GLYCEROL PHOSPHATE OXIDASE (ENZYMATIC)	84.22	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	64.72	mg/dL	LOW HDL: < 30.0 BORDERLINE HIGH HDL: 30.0 - 60.0 HIGH HDL: > OR = 60.0		
LDL CHOLESTEROL: SERUM by CALCULATED, SPECTROPHOTOMETRY	125.19	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	142.03 ^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	16.84	mg/dL	0.00 - 45.00		
TOTAL LIPIDS: SERUM by CALCULATED, SPECTROPHOTOMETRY	497.72	mg/dL	350.00 - 700.00		
CHOLESTEROL/HDL RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	3.19	RATIO	LOW RISK: 3.30 - 4.40 AVERAGE RISK: 4.50 - 7.0		



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Test Name	Value	Unit	Biological Reference interval
			MODERATE RISK: 7.10 - 11.0 HIGH RISK: > 11.0
LDL/HDL RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	1.93	RATIO	LOW RISK: 0.50 - 3.0 MODERATE RISK: 3.10 - 6.0 HIGH RISK: > 6.0
TRIGLYCERIDES/HDL RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	1.3 ^L	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

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 LDL.

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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