PO No :PO3209854612-916

Name	: Mr.KARTIKEYA SINGH	Client Name	: 1 MG INTEGRATION - GURUGRAM
Age/Gender	: 42/Male	Registration Date	: 05/Mar/2024 10:29AM
Patient ID	: 1MG508430	Collection Date	: 05/Mar/2024 08:39AM
Barcode ID/Order ID	: D8005024 / 9100082	Sample Receive Date	: 05/Mar/2024 04:07PM
Referred By	: Dr.	Report Status	: Final Report
Sample Type	: Serum	Report Date	: 05/Mar/2024 07:16PM

BIOCHEMISTRY

COMPREHENSIVE PLATINUM FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method
Lipoprotein(a)				
Lipoprotein(a)	0.72	mg/dL	<30	Immunoturbidimetric Assay

Comment:

Note: Lipoprotein(a)[Lp(a)] is considered an important risk factor for Coronary Heart Disease (CHD).

* Lipoprotein (a) consists of an LDL particle that is covalently bound to an additional protein, apolipoprotein (a). Apo(a) has high-sequence homology with the coagulation factor plasminogen and, like LDL, Lp(a) contains apolipoprotein B100 . Thus, Lp(a) is both proatherogenic and prothrombotic. Lp(a) is an independent risk factor for CHD, Ischemic Stroke, and Aortic Valve Stenosis.
* Lp(a) is highly heterogeneous molecule; the degree of atherogenicity of the Lp(a) particle may depend on the molecular size of the Lp(a)-specific protein.
* Serum concentrations of Lp(a) are related to genetic factors, and are largely unaffected by diet, exercise and lipid -lowering pharmaceuticals. However, in a patient with additional modifiable CHD risk factors, more aggressive therapy to normalize these factors may be indicated if the Lp(a) value is also increased.

Usage:

Evaluation of increased risk for cardiovascular disease and events:
* In individuals at intermediate risk for cardiovascular disease
* In patients with early atherosclerosis
* In patients with strong family history of early CHD

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Referred By	: Dr.	Report Status	: Final Report
Sample Type	: Serum	Report Date	: 05/Mar/2024 06:40PM

BIOCHEMISTRY

COMPREHENSIVE PLATINUM FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method
Apolipoprotein B & A1 Serum				
Apolipoprotein - A1	126.00	mg/dL	95-186	Immunoturbidimetric
Apolipoprotein - B	76.00	mg/dL	49-173	Immunoturbidimetric
Apolipoprotein B/A1 Ratio	0.60	Ratio		Calculated

Comment:

Apolipoprotein A1

- Apolipoproteins A1 (Apo A1) is the major apolipoprotein attached to HDL and is found in greater proportion than Apo A2 (3:1).
- It is inversely related to the risk of coronary artery disease (CAD).
- It may be a better predictor of atherogenic risk than HDL.

Apo A1 may be increased with	Apo A1 may be decreased with
Drugs (carbamazepine, estrogens, ethanol, statins,niacin, oral contraceptives, phenobarbital)	Chronic renal failure
Familial hyper alpha-lipoproteinemia	Coronary artery disease and peripheral vascular disease
Physical excercise	Drugs (androgens, beta blockers, diuretics and progestins)
Pregnancy	Familial hypo alpha-lipoproteinemia
Weight reduction	Smoking & Uncontrolled diabetes 2

Apolipoprotein B

- Apolipoprotein B (Apo B) is a major protein component of low density lipoprotien (LDL), Comprising >90% of the LDL. It is a more powerful independent predictor of coronary artery disease (CAD) than LDL cholesterol. It is useful in assessing the risk of CAD and to classify Hyperlipidemias.
- Apolipoprotein studies help in monitoring coronary bypass surgery patients with regard to risk and severity of restenosis.They are also useful in assessing risk of re-infarction in patients with Myocardial infarction .
- In patients with hyperapobetalipoproteinemia (HALB), a disorder associated with increased risk of developing CHD and with an estimated prevalence of 30% in patients with premature CAD, Apo B is increased disproportionately in LDL

NABL certificate and scope

MC - 5424

This test has been performed at
TATA 1MG OKHLA
Address: 2nd Floor, B-225, Okhla Phase I, Okhla Industrial Estate, New Delhi, Delhi 110020

Dr. Reema Agrawal
MBBS, MD (Pathology)
Consultant Pathologist
Reg No: 56096

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PO No :PO3209854612-916

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COMPREHENSIVE PLATINUM FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method

cholesterol. Apo B quantitation is used in distinguishing HALB from another common lipoprotein abnormality, Familial combined hyperlipidemia.

Apolipoprotein B:A1 Ratio

Elevated ApoB/ApoA1 ratio confers increased risk of atherosclerotic cardiovascular disease independently of LDL and HDL cholesterol concentrations.

Apo B to A1 ratio	
Ratio	Remarks
0.35- 0.98	Desirable
>0.98	Increased CAD risk

TATA 1mg | Labs

PO No :PO3209854612-916

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Referred By	: Dr.	Report Status	: Final Report
Sample Type	: WHOLE BLOOD-EDTA	Report Date	: 05/Mar/2024 04:24PM

HAEMATOLOGY

COMPREHENSIVE PLATINUM FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method
Glycosylated Hemoglobin (HbA1c)	**7.5**	%	4 - 5.6	HPLC (NGSP certified)
Estimated average glucose (eAG)	168.55	mg/dL		Calculated

Comment:

Interpretation: HbA1c%

≤5.6	Normal
5.7-6.4	At Risk For Diabetes
≥6.5	Diabetes

Adapted from American Diabetes Association.

Comments:

A 3 to 6 monthly monitoring is recommended in diabetics. People with diabetes should get the test done more often if their blood sugar stays too high or if their healthcare provider makes any change in the treatment plan. HbA1c concentration represent the integrated values for blood glucose over the preceding 8-12 weeks and is not affected by daily glucose fluctuation, exercise & recent food intake.
Please note, Glycemic goal should be individualized based on duration of diabetes, age/life expectancy, comorbid conditions, known CVD or advanced microvascular complications, hypoglycemia unawareness, and individual patient considerations.

Factors that interfere with HbA1c Measurement: Hemoglobin variants, elevated fetal hemoglobin (HbF) and chemically modified derivatives of hemoglobin (e.g. carbamylated Hb in patients with renal failure) can affect the accuracy of HbA1c measurements.

Factors that affect interpretation of HbA1c Measurement: Any condition that shortens erythrocyte survival or decrease mean erythrocyte age (e. g., recovery from acute blood loss, hemolytic anemia, HbSS, HbCC, and HbSC) will falsely lower HbA1c test results regardless of the assay method used. Iron deficiency anemia is associated with higher HbA1c.

Note: Presence of Hemoglobin variants and/or conditions that affect red cell turnover must be considered, particularly when the HbA1c result does not correlate with the patient's blood glucose levels.

- HPLC - High performance liquid chromatography

NABL certificate and scope

This test has been performed at
TATA 1MG GURGAON
Address: 82/A, Ground Floor, Udyog Vihar, Phase-4, Behind Airtel Building, Gurgaon - 122015

Dr. Vidushi Sachdeva
MBBS, DNB (Pathology)
Consultant Pathologist
Reg No: DMC/80891

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PO No :PO3209854612-916

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Barcode ID/Order ID	: D8005022 / 9100082	Sample Receive Date	: 05/Mar/2024 03:53PM
Referred By	: Dr.	Report Status	: Final Report
Sample Type	: EDTA	Report Date	: 05/Mar/2024 04:16PM

HAEMATOLOGY

COMPREHENSIVE PLATINUM FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method
Complete Blood Count				
Hemoglobin	14.8	g/dL	13.0-17.0	Spectrophotometry
RBC	4.52	10^6/cu.mm	4.5 - 5.5	Electrical Impedance
HCT	43.2	%	40 - 50	Calculated
MCV	95.5	fL	83 - 101	RBC pulse measurement
MCH	**32.6**	pg	27 - 32	Calculated
MCHC	34.1	g/dL	31.5 - 34.5	Calculated
RDW-CV	13.0	%	11.5-14	Calculated
Total Leucocyte Count	8.71	10^3/µL	4 - 10	Impedance
Differential Leucocyte Count				
Neutrophils	47.3	%	40-80	DHSS Flowcytometry / Microscopy
Lymphocytes	**41.1**	%	20-40	DHSS Flowcytometry / Microscopy
Monocytes	7.8	%	2-10	DHSS Flowcytometry / Microscopy
Eosinophils	3.4	%	1-6	DHSS Flowcytometry / Microscopy
Basophils	0.4	%	0-2	Impedance/Microscopy
Absolute Leucocyte Count				
Absolute Neutrophil Count	4.12	10^3/µL	2-7	Calculated
Absolute Lymphocyte Count	**3.58**	10^3/µL	1-3	Calculated
Absolute Monocyte Count	0.68	10^3/µL	0.2-1	Calculated
Absolute Eosinophil Count	0.3	10^3/µL	0.02-0.5	Calculated
Absolute Basophil Count	0.03	10^3/µL	0.02-0.1	Calculated
Platelet Count	238	10^3/µL	150-410	Impedance/Microscopy
MPV	10.1	fL	6.5 - 12	Calculated
PDW	**17**	fL	9-17	Calculated

Comment:

NABL certificate and scope

This test has been performed at
TATA 1MG GURGAON
Address: 82/A, Ground Floor, Udyog Vihar, Phase-4, Behind Airtel Building, Gurgaon - 122015

Vidushi
Dr. Vidushi Sachdeva
MBBS, DNB (Pathology)
Consultant Pathologist
Reg No: DMC/80891

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HAEMATOLOGY

COMPREHENSIVE PLATINUM FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method

- As per the recommendation of International council for Standardization in Hematology, the differential leucocyte counts are additionally being reported as absolute numbers of each cell in per unit volume of blood.

Erythrocyte Sedimentation Rate

Erythrocyte Sedimentation Rate	6	mm/hr	0-10	Modified Westergren

Comment:

- ESR provides an index of progress of the disease and is widely used as an indicator of inflammation, infection, trauma, or malignant diseases. Changes are more significant than a single abnormal test
- It is specifically indicated to monitor the course or response to the treatment of diseases like rheumatoid arthritis, tuberculosis bacterial endocarditis ,acute rheumatic fever ,Hodgkins disease,temporal arthritis , and systemic lupus erythematosis; and to diagnose and monitor giant cell arteritis and polymyalgia rheumatica.
- An elevated ESR may also be associated with many other conditions, including autoimmune disease, anemia, infection,malignancy,pregnancy, multiple myeloma, menstruation, and hypothyroidism.
- Although a normal ESR cannot be taken to exclude the presence of organic disease, its rate is dependent on various physiologic and pathologic factors.
- The most important component influencing ESR is the composition of plasma. High level of C-Reactive Protein, fibrinogen, haptoglobin, alpha-1antitrypsin, ceruloplasmin and immunoglobulins causes the elevation of Erythrocyte Sedimentation Rate.
- Drugs that may cause increase ESR levels include: dextran, methyldopa, oral contraceptives, penicillamine, procainamide, theophylline, and Vitamin A. Drugs that may cause decrease levels include: aspirin, cortisone, and quinine

"Test conducted on Whole Blood - EDTA "

PO No :PO3209854612-916

Name	: Mr.KARTIKEYA SINGH	Client Name	: Tata 1mg
Age/Gender	: 42/Male	Registration Date	: 05/Mar/2024 10:29AM
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HAEMATOLOGY

COMPREHENSIVE PLATINUM FULL BODY CHECKUP WITH SMART REPORT

Peripheral Smear Examination

RBC - Predominantly Normocytic Normochromic

WBC - Total leucocyte count is normal with mildly increased lymphocytes.

Platelets - Adequate on smear.

Impression - Normocytic Normochromic Blood picture; Lymphocytosis.

Advice - Correlate clinically.

TATA 1mg | Labs

NABL certificate and scope

This test has been performed at
TATA 1MG GURGAON
Address: 82/A, Ground Floor, Udyog Vihar, Phase-4, Behind Airtel Building, Gurgaon - 122015

Vidushi
Dr. Vidushi Sachdeva
MBBS, DNB (Pathology)
Consultant Pathologist
Reg No: DMC/80891

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PO No :PO3209854612-916

Name	: Mr.KARTIKEYA SINGH	Client Name	: 1 MG INTEGRATION - GURUGRAM
Age/Gender	: 42/Male	Registration Date	: 05/Mar/2024 10:29AM
Patient ID	: 1MG508430	Collection Date	: 05/Mar/2024 03:45PM
Barcode ID/Order ID	: D8005017 / 9100082	Sample Receive Date	: 05/Mar/2024 03:45PM
Referred By	: Dr.	Report Status	: Final Report
Sample Type	: Urine	Report Date	: 05/Mar/2024 05:48PM

BIOCHEMISTRY

COMPREHENSIVE PLATINUM FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method
Microalbumin Creatinine Ratio, Urine				
Microalbumin-Albumin	12.90	mg/L	<30	Immunoturbidimetry
Urinary Creatinine	151.10	mg/dL	22-328	Kinetic Alkaline Picrate
Microalbumin-Albumin/Creatinine Ratio	8.54	mg/g Creatinine	<30	Calculated

Comment:

Reference range

Category	Urine Albumin Creatinine ratio(mg/g) - Spot Urine
Normal	<30 mg/g
Microalbuminuria	30 - 300 mg/g
Clinical Albuminuria	>=300 mg/g

- As per ADA guidelines: Two to three specimens collected over a period of 3-6 months should be abnormal before considering a patient to have albuminuria in the absence of infection or acute metabolic crisis.
- Due to inherent day to day variability in albumin excretion, this ratio is a better indicator than isolated microalbumin levels.
- Microalbuminuria is the small but abnormal increase in the excretion of urinary albumin [in the range of 30-300 mg/day in a 24 hrs collection or 30-300 mg/g creatinine in a random collection]
- Factors that may cause an abnormal Microalbumin Creatinine ratio (independent of kidney damage) can be physiological like exercise within 24 hours, menstruation, pregnancy, benign postural proteinuria, water consumption & pathological like infection (UTI), hematuria, fever, marked hyperglycemia, cardiac decompensation, marked hypertension & poor metabolic control.
- A randomly collected urine sample can be used, but is associated with greater variability because of variable urine output, and rates of albumin & creatinine excretion. Hence, it is recommended that abnormal results be repeated using first morning sample or 24 hr urine collection.
- A high albumin/ creatinine ratio in persons with low muscle mass indicates low urinary creatinine more often than microalbuminuria.
- Persistent Albuminuria has been established as one of the diagnostic markers of kidney damage and is used for classification of chronic kidney disease (CKD), based on the categories of urine albumin-to-creatinine ratio (ACR). The ACR categories include A1 (ACR < 30 mg/g - normal to mildly increased); A2 (ACR 30-300 mg/g - moderately increased) and A3 (ACR >300 mg/g, - severely increased) (KDIGO 2012)
- Clinical Utility :This test is useful in the diagnosis of early nephropathy in diabetics, as a marker for generalized endothelial dysfunction and risk for stroke and heart disease. It is also used as a marker for classification and progression of CKD.

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BIOCHEMISTRY

COMPREHENSIVE PLATINUM FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method

TATA 1mg | Labs

NABL certificate and scope

This test has been performed at
TATA 1MG GURGAON
Address: 82/A, Ground Floor, Udyog Vihar, Phase-4, Behind Airtel Building, Gurgaon - 122015

Vidushi
Dr. Vidushi Sachdeva
MBBS, DNB (Pathology)
Consultant Pathologist
Reg No: DMC/80891

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Referred By	: Dr.	Report Status	: Final Report
Sample Type	: Serum	Report Date	: 05/Mar/2024 08:32PM

BIOCHEMISTRY

COMPREHENSIVE PLATINUM FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method
C-Reactive Protein Quantitative				
C-Reactive Protein (Quantitative)	0.76	mg/L	0 - 5.0	Turbidimetric

Comment:

•C-Reactive Protein [CRP] is an acute phase reactant ,hepatic secretion of which is stimulated in response to inflammatory cytokines.
•CRP is a very sensitive but nonspecific marker of inflammation and infection.
•The CRP test is useful in patient with Inflammatory bowel disease, arthritis, Autoimmune diseases, Pelvic inflammatory disease (PID), tissue injury or necrosis and infections.
•CRP levels can be elevated in the later stages of pregnancy as well as with use of birth control pills or hormone replacement therapy i.e. estrogen. Higher levels of CRP have also been observed in the obese.
•As compared to ESR, CRP shows an earlier rise in inflammatory disorders which begins in 4-6 hrs, he intensity of the rise being higher than ESR and the recovery being earlier than ESR. Unlike ESR, CRP levels are not influenced by hematologic conditions like Anemia, Polycythemia.

Calcium				
Calcium	10.0	mg/dL	8.4-10.2	Arsenazo III complex

Comment:

Increased in: Hyperparathyroidism primary and secondary, Acute and chronic renal failure, Following renal transplantation, Osteomalacia with malabsorption, Acute osteoprosis, Malignant tumours (specially of breast, lung and kidney), Drugs: Vit. D and A intoxication, Diuretics, estrogen, androgen, tamoxifen, lithium

Decreased in: Hypoparathyroidism, Surgical and Idiopathic, Pseudohypoparathyroidism, Chronic renal disease with uremia and phophate retention, Malabsorption of Calcium and Vit.D, obstructive jaundice, Bone Disease (Osteomalacia and rickets), Drugs: Cancer chemotherapy drugs, calcitonin, loop-actives diuretics, Hypomagnesemia,Hypoalbuminemia

NABL certificate and scope

This test has been performed at
TATA 1MG GURGAON
Address: 82/A, Ground Floor, Udyog Vihar, Phase-4, Behind Airtel Building, Gurgaon - 122015

Dr. Swati Gupta Anand
MBBS, MD (Lab Medicine)
Consultant Pathologist
Reg No: DMC/7396

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Barcode ID/Order ID	: D8005020 / 9100082	Sample Receive Date	: 05/Mar/2024 03:52PM
Referred By	: Dr.	Report Status	: Final Report
Sample Type	: Fluoride Plasma F	Report Date	: 05/Mar/2024 07:31PM

BIOCHEMISTRY

COMPREHENSIVE PLATINUM FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method
Glucose - Fasting				
Glucose - Fasting	**160**	mg/dL	70-99	Hexokinase

Fasting Plasma Glucose (mg/dL)	2 hr plasma Glucose (mg/dL)	Diagnosis
99 or below	139 or below	Normal
100 to 125	140 to 199	Pre-Diabetes (IGT)
126 or above	200 or above	Diabetes

Reference : American Diabetes Association

Comment:

Impaired glucose tolerance (IGT) fasting, means a person has an increased risk of developing type 2 diabetes but does not have it yet. A level of 126 mg/dL or above, confirmed by repeating the test on another day, means a person has diabetes. IGT (2 hrs Post meal), means a person has an increased risk of developing type 2 diabetes but does not have it yet. A 2-hour glucose level of 200 mg/dL or above, confirmed by repeating the test on another day, means a person has diabetes

Plasma Glucose Goals	For people with Diabetes
Before meal	70-130 mg/dL
2 Hours after meal	Less than 180 mg/dL
HbA1c	Less than 7%

NABL certificate and scope

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TATA 1MG GURGAON
Address: 82/A, Ground Floor, Udyog Vihar, Phase-4, Behind Airtel Building, Gurgaon - 122015

Dr. Swati Gupta Anand
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Reg No: DMC/7396

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Referred By	: Dr.	Report Status	: Final Report
Sample Type	: Serum	Report Date	: 05/Mar/2024 08:38PM

BIOCHEMISTRY

COMPREHENSIVE PLATINUM FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method
High Sensitive CRP				
High sensitivity CRP	0.40	mg/L	<1.0	Immunoturbidimetric

Comment:

High Sensitivity C- Reactive protein (hs-CRP)is used as a marker for determining and performing risk assessment of cardiovascular disease (good marker for inflammation), often along with tests for Lipid profile.
The American Heart Association and US Centers for Disease Control and Prevention have defined risk groups as follows:

<1.0 Low Risk
1.0 - 3.0 - Average Risk
>3.0 High Risk

These values are only a part of the total evaluation process for cardiovascular diseases.
To assess vascular risk ,it is recommended to test hsCRP levels 2 or more weeks apart and calculate the average

Additional risk factors to be considered are elevated levels of lipids & glucose, smoking, high blood pressure (hypertension). Anti inflammatory drugs (like aspirin, ibuprofen, and naproxen) or statins may reduce CRP levels in blood. It is important that any person undergoing this test must be in a healthy state in order for the results to be of diagnostic value in predicting the risk of coronary artery disease or heart attack. Any recent illness, tissue injury, infection, or other general inflammation will raise the amount of hsCRP and give a falsely elevated estimate of risk.
Women on hormone replacement therapy have been shown to have elevated hs-CRP levels.

Note:
Since the hs-CRP and CRP tests measure the same molecule, people with chronic inflammation, such as those with arthritis, should not have hs-CRP levels measured. Their CRP levels will be very high due to the arthritis/often too high to be measured or meaningful using the hs-CRP test.

Lipase				
Lipase	27.2	U/L	8-78	Quinone Dye

Comment:

Pancreas is the major and primary source of serum lipase, though lipase is also secreted by the gastric and intestinal mucosa. Lipase measurement in serum is used to diagnose acute pancreatitis.
After an attack of acute pancreatitis, serum Lipase activity increases within 4 to 8 hours,peaks at about 24 hours, and decreases over 8 to 14 days. Concentrations often remain elevated longer than those of Amylase.The increase in serum Lipase activity is not necessarily proportional to the severity of the attack.

Increased levels are seen in:

- Acute & Chronic Pancreatitis.
- Obstruction of Pancreatic duct.

NABL certificate and scope

This test has been performed at
TATA 1MG GURGAON
Address: 82/A, Ground Floor, Udyog Vihar, Phase-4, Behind Airtel Building, Gurgaon - 122015

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BIOCHEMISTRY

COMPREHENSIVE PLATINUM FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method
• Non pancreatic conditions like renal disease,intestinal obstruction,acute cholecystitis,duodenal ulcer,alcoholism,diabetic ketoacidosis and following endoscopic retrograde cholangiopancreatography(ERCP).				
Lipid Profile				
Cholesterol - Total	170	mg/dL	Desirable <200, Borderline High 200-239, High >=240	Enzymatic
Triglycerides	**319**	mg/dL	Normal: <150, Borderline: 150 - 199, High:200-499, Very High>=500	Glycerol Phosphate Oxidase
Cholesterol - HDL	40	mg/dL	Undesirable/high risk <=40mg/dL Desirable/low risk>=60mg/dl	Accelerator Selective Detergent
Cholesterol - LDL	66	mg/dl	Desirable: <100 Above desirable: 100 - 129 Borderline high : 130 - 159 High : 160 - 189 Very high : >=190	Calculated
Cholesterol- VLDL	**64**	mg/dL	<30	Calculated
Cholesterol : HDL Cholesterol	4.2	Ratio	Desirable : 3.5-4.5 High Risk : >5	Calculated
LDL : HDL Cholesterol	1.65	Ratio	Desirable : 2.5-3.0 High risk : >3.5	Calculated
Non HDL Cholesterol	130	mg/dL	Desirable:< 130, Above Desirable:130 - 159, Borderline High:160 - 189, High:190 - 219,	Calculated

NABL certificate and scope

This test has been performed at
TATA 1MG GURGAON
Address: 82/A, Ground Floor, Udyog Vihar, Phase-4, Behind Airtel Building, Gurgaon - 122015

Dr. Swati Gupta Anand
MBBS, MD (Lab Medicine)
Consultant Pathologist
Reg No: DMC/7396

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PO No :PO3209854612-916

Name	: Mr.KARTIKEYA SINGH	Client Name	: 1 MG INTEGRATION - GURUGRAM
Age/Gender	: 42/Male	Registration Date	: 05/Mar/2024 10:29AM
Patient ID	: 1MG508430	Collection Date	: 05/Mar/2024 03:53PM
Barcode ID/Order ID	: D8005024 / 9100082	Sample Receive Date	: 05/Mar/2024 03:53PM
Referred By	: Dr.	Report Status	: Final Report
Sample Type	: Serum	Report Date	: 05/Mar/2024 08:38PM

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COMPREHENSIVE PLATINUM FULL BODY CHECKUP WITH SMART REPORT

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			Very High: >= 220	

Comment:

●Lipid profile measurements in the same patient can show physiological & analytical variations. It is recommended that 3 serial samples 1 week apart may be tested.
●Indians are at a high risk of developing atherosclerotic cardiovascular disease (ASCVD); at a much earlier age and more severe with high mortality. Dyslipidemia (abnormal lipid profile) is the major risk factor and found in almost 80% Indians.
●**Total cholesterol** is the total amount of cholesterol in blood comprising of HDL, LDL-C, and VLDL.
●**LDL Cholesterol (LDL-C)** or "bad"cholesterol contributes most significantly to atherosclerosis leading to heart disease or stroke and is the primary target for reducing risk for cardiovascular disease.
●**High-density lipoprotein (HDL)** or "good" cholesterol can lower risk of heart disease and stroke.
●**Triglyceride (TG)** level also plays a major role in CVD. Indians are more prone to Atherogenic dyslipidemia, a condition associated with high TG, low HDL-C and high LDL-C; this is associated with diabetes, metabolic syndrome and insulin resistance. Hence high triglyceride levels also need to be treated.
●**Non-HDL-Cholesterol (Non-HDLC)** measures all plaque forming lipoproteins (e.g. remnants, LDL-C, VLDL, Lp(a), Apo-B). Monitoring of Non-HDLC is important in patients with high TG (e.g. diabetics, obese persons) and those already on statin therapy.
●**Lipid Association of India (LAI-2020) recommends:-**

- Screening of all Indians above the age of 20 years for CVD risk factors, esp. lipid profile.
- Identification of Risk factors: Age (male ≥45 years, female ≥55 years); Family h/o heart disease at younger age (<55 yrs in males, <65 yrs in female), Smoking/tobacco use, High blood pressure, Low HDL (males <40 mg/dl and females <50mg/dl).
- Fasting lipid profile is not mandatory for screening. Both fasting and non-fasting lipid profiles are equally important for managing Indian patients.
- Non-HDLC should be calculated in every subject. LAI recommends LDL-C as the primary target and Non-HDLC as the co-primary target for initiating drug therapy.
- Lifestyle modifications are of first and foremost importance for management and prevention of dyslipidemia. Among low risk groups, treatment is started only after 3 months of lifestyle changes.
- Testing for Apolipoprotein B, hsCRP, Lp(a) should be considered for patients in moderate risk group.
- Newer treatment goals based on Risk Groups and values of LDL-C and Non-HDLC

New treatment goals by Lipid Association of India (2020)

	CONSIDER THERAPY (cut-off level)		TREATMENT GOALS	
Risk groups	**LDL-C (mg/dL)**	**Non-HDLC (mg/dL)**	**LDL-C (mg/dL)**	**Non-HDLC (mg/dL)**
Extreme Risk Gp Cat. A	≥50	≥80	<50 (Optional ≤30)	<80 (Optional ≤60)
Extreme Risk Gp Cat. B	>30	>60	≤30	≤60
Very High Risk	≥50	≥80	<50	<80
High Risk	≥70	≥100	<70	<100
Moderate Risk	≥100	≥130	<100	<130
Low risk	≥130*	≥160*	<100	<130

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*After an adequate non-pharmacological intervention for at least 3 months				

●**As per NCEP Expert Panel (2011) guidelines**, universal screening for dyslipidemia is recommended for children between 9 - 11 yrs (repeat at 17-21 yrs). Screening is not recommended before the age of 2yrs. Above the age of 2 yrs, selective screening is done in children with family history of premature CVD or risk factors like obesity, diabetes, and hypertension.

Note: Reference Interval as per National Cholesterol Education Program (NCEP) Report.

Liver Function Test

Bilirubin-Total	0.63	mg/dL	0.2-1.2	Diazo
Bilirubin-Direct	0.21	mg/dL	0-0.5	Colorimetric, Diazo Dye
Bilirubin-Indirect	0.42	mg/dL	0.1-1	Calculated
Protein, Total	7.60	g/dL	6.0-8.3	Biuret
Albumin	4.95	g/dL	3.5-5.2	Bromcresol Green
Globulin	2.6	g/dl	1.8 - 3.6	Calculated
A/G Ratio	1.87	Ratio	0.8 - 2.1	Calculated
Aspartate Transaminase (SGOT)	**37**	U/L	5-34	NADH w/o P-5'-P
Alanine Transaminase (SGPT)	**56**	U/L	<45	NADH w/o P-5-P
SGOT/SGPT	0.67	Ratio	<1	Calculated
Alkaline Phosphatase	110	U/L	50-116	Para-nitrophenyl phosphate
Gamma Glutamyltransferase (GGT)	**98**	U/L	<55	L-gamma-glutamyl-3-Carboxy-4-Nitroanilide

Comment:

- LFTS are based upon measurements of substances released from damaged hepatic cells into the blood that gives idea of the Existence, Extent and Type of Liver damage. - Acute Hepatocellular damage: ALT & AST levels are sensitive index of hepatocellular damage - Obstruction to the biliary tract,Cholestasis and blockage of bile flow:1) Serum Total Bilirubin concentration 2) Serum Alkaline Phosphatase (ALP) activity 3) Gamma Glutamyl Transpeptidase (GGTP) 4) 5`-Nucleotidase - Chronic liver disease: Serum Albumin concentration
- Bilirubin results from the enzymatic breakdown of heme. Jaundice is a yellowish discoloration of the skin and mucous membranes caused by hyperbilirubinemia.
- Pre-hepatic or hemolytic jaundice - Abnormal red cells, antibodies,drugs and toxins,Hemoglobinopathies, Gilbert's syndrome, Crigler-Najjar syndrome

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- Hepatic or Hepatocellular jaundice-Viral hepatitis,toxic hepatitis, intrahepatic cholestasis
- Post-hepatic jaundice -Extrahepatic cholestasis, gallstones, tumors of the bile duct, carcinoma of pancreas
- In viral hepatitis and other forms of liver disease associated with acute hepatic necrosis, serum AST and ALT concentrations are elevated even before the clinical signs and symptoms of disease appear.
- ALT is the more liver-specific enzyme and elevations of ALT activity persist longer than AST activity.
- Peak values of aminotransferase activity occur between the seventh and twelfth days. Activities then gradually decrease, reaching normal activities by the third to fifth week. Peak activities bear no relationship to prognosis and may fall with worsening of the patient's condition.
- Aminotransferase activities observed in cirrhosis vary with the status of the cirrhotic process and range from the upper reference limit to four to five times higher, with an AST/ALT ratio greater than 1. The ratio's elevation can reflect the grade of fibrosis in these patients. Slight or moderate elevations of both AST and ALT activities have been observed after administration of various medications and chronic hepatic injury such as (1) hemochromatosis, (2) Wilson disease, (3) autoimmune hepatitis, (4) primary biliary cirrhosis, (5) sclerosing cholangitis, and (6) a1-antitrypsin deficiency.
- AST activity also is increased in acute myocardial infarction, progressive muscular dystrophy and dermatomyositis, reaching concentrations up to eight times the upper reference limit.Slight to moderate AST elevations are noted in hemolytic disease.
- GGT is a sensitive indicator of the presence of hepatobiliary disease, being elevated in most subjects with liver disease regardless of cause. Increased concentrations of the enzyme are also found in serum of subjects receiving anticonvulsant drugs, such as phenytoin and phenobarbital.

Kidney Function Test.

Blood Urea Nitrogen	8	mg/dL	6.0-20	Urease
Urea	17.89	mg/dL	12.1-42.8	Calculated
Creatinine	0.73	mg/dL	0.60-1.3	Kinetic Alkaline Picrate
Uric Acid	5.0	mg/dL	3.7-7.7	Uricase
Sodium	140	mmol/L	136-145	indirect ISE
Potassium	4.70	mmol/L	3.5-5.1	indirect ISE
Chloride	103.9	mmol/L	98 - 107	indirect ISE
BUN/Creatinine Ratio	11.4	Ratio	12:1 - 20:1	Calculated

Comment:

BUN is directly related to protein intake and nitrogen metabolism and inversely related to the rate of excretion of urea.Blood urea nitrogen (BUN) levels reflect the balance between the production and excretion of urea. Increased levels are seen in renal

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COMPREHENSIVE PLATINUM FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method

failure (acute or chronic), urinary tract obstruction, dehydration, shock, burns, CHF, GI bleeding, nephrotoxic drugs. Decreased levels are seen in hepatic failure, nephrotic syndrome, cachexia (low-protein and high-carbohydrate diets).

Urea is a non-proteinous nitrogen compound formed in the liver from ammonia as an end product of protein metabolism. Urea diffuses freely into extracellular and intracellular fluid and is ultimately excreted by the kidneys. Increased levels are found in acute renal failure, chronic glomerulonephritis, congestive heart failure, decreased renal perfusion, diabetes, excessive protein ingestion, gastrointestinal (GI) bleeding, hyperalimentation, hypovolemia, ketoacidosis, muscle wasting from starvation, neoplasms, pyelonephritis, shock, urinary tract obstruction, nephrotoxic drugs. Decreased levels are seen in inadequate dietary protein, low-protein/high-carbohydrate diet, malabsorption syndromes, pregnancy, severe liver disease, certain drugs.

Creatinine is catabolic product of creatinine phosphate, which is excreted by filtration through the glomerulus and by tubular secretion. Creatinine clearance is an acceptable clinical measure of glomerular filtration rate (GFR). Increased levels are seen in acute/chronic renal failure, urinary tract obstruction, hypothyroidism, nephrotoxic drugs, shock, dehydration, congestive heart failure, diabetes. Decreased levels are found in muscular dystrophy.

BUN/Creatinine ratio (normally 12:1–20:1) is decreased in acute tubular necrosis, advanced liver disease, low protein intake, and following hemodialysis. BUN/Creatinine ratio is increased in dehydration, GI bleeding, and increased catabolism.

Uric acid levels show diurnal variation. The level is usually higher in the morning and lower in the evening. Increased levels are seen in starvation, strenuous exercise, malnutrition, or lead poisoning, gout, renal disorders, increased breakdown of body cells in some cancers (including leukemia, lymphoma, and multiple myeloma) or cancer treatments, hemolytic anemia, sickle cell anemia, or heart failure, pre-eclampsia, liver disease (cirrhosis), obesity, psoriasis, hypothyroidism, low blood levels of parathyroid hormone (PTH), certain drugs, foods that are very high in purines - such as organ meats, red meats, some seafood and beer. Decreased levels are seen in liver disease, Wilson's disease, Syndrome of inappropriate antidiuretic hormone (SIADH), certain drugs.

Amylase

Amylase	**24**	U/L	28-100	Enzymatic/Colorimetric

Comment:

- Amylase is produced by Pancreas and some salivary glands.
- Amylase levels are significantly increased in patients with acute pancreatitis, pancreatic duct obstruction, carcinoma pancreas, ovaries, or lungs, cholecystitis, macroamylasemia, renal disease, pancreatic pseudocyst, procedures like Endoscopic retrograde cholangiopancreatography(ERCP) and acute alcohol poisoning.
- Low Amylase levels are seen in Chronic Pancreatitis,Congestive Heart failure, 2nd & 3rd trimester of pregnancy, Gastrointestinal cancer & bone fractures.
- Drugs causing increased amylase levels are aspirin,diuretics,oral contraceptives,corticosteroids,indomethacin,ethyl alcohol and opiate intake.
- In acute pancreatitis, elevated amylase levels usually parallel lipase concentrations, although lipase levels may take a bit longer to rise,will remain elevated longer and are more specific than amylase as a marker for pancreatitis.

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Age/Gender	: 42/Male	Registration Date	: 05/Mar/2024 10:29AM
Patient ID	: 1MG508430	Collection Date	: 05/Mar/2024 03:45PM
Barcode ID/Order ID	: D8005017 / 9100082	Sample Receive Date	: 05/Mar/2024 03:45PM
Referred By	: Dr.	Report Status	: Final Report
Sample Type	: Urine	Report Date	: 05/Mar/2024 05:48PM

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COMPREHENSIVE PLATINUM FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method
Chloride Random Urine				
Chloride, Random Urine	235.90	mmol/L		indirect ISE

Biological Ref. Interval		
Infant	02 - 10	mmol/day
Child	15 - 40	mmol/day
Adult	110 - 250	mmol/day

Comment:

Increased In: Massive diuresis from any cause, Salt-losing nephritis, Potassium depletion, Adrenocortical insufficiency, Tubulointerstitial disease, Batter syndrome, Postmenstrual diuresis

Decreased In: Excessive extrarenal chloride loss, Adrenocortical hyperfunction, Postoperative chloride retention

Note:
Dietary intake increases urine chloride excretion.

Potassium Random Urine			
Potassium, Random urine	130.71	mmol/L	indirect ISE
Sodium Random Urine			
Sodium, Random Urine	149	mmol/L	indirect ISE

Age Wise	Biological Ref. Interval			
	Male		Female	
06 -10 years	41 - 115	mmol/day	20 - 69	mmol/day
10 -14 years	63 - 177	mmol/day	48 - 168	mmol/day
Adult	40 - 220	mmol/day	40 - 220	mmol/day

NABL certificate and scope

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Dr. Vidushi Sachdeva
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Test Name	Result	Unit	Bio. Ref. Interval	Method
Full- term, 7 to 14 day old neonates have sodium clearance of about 20% of adult values.				

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Test Name	Result	Unit	Bio. Ref. Interval	Method
Iron Studies, Comprehensive				
Iron Serum	130	µg/dL	65-175	Ferene
Total Iron Binding Capacity (TIBC)	335	µg/dL	255-450	Calculated
Unsaturated Iron Binding Capacity	205	µg/dl	110 - 370	Ferozine
Transferrin saturation	38.77	%	16 - 50	Calculated
Ferritin	181.10	ng/mL	22 - 322	CLIA

Comment:

Iron is an essential trace mineral element which forms an important component of hemoglobin, metallocompounds and Vitamin A. Deficiency of iron is seen in iron deficiency and anaemia of chronic disorders.
Increased iron concentration are seen in hemolytic anaemias, hemochromatosis and acute liver disease. Serum Iron alone is unreliable due to considerable physiologic diurnal variation in the results with highest values in the morning and lowest values in the evening as well as variation in response to iron therapy .

Total Iron Binding capacity (TIBC) is a direct measure of the protein Transferrin which transports iron from the gut to storage sites in the bone marrow. Increased levels of TIBC suggest that total iron body stores are low, increased concentration may be the sign of Iron deficiency anaemia, polycythemia vera ,and may occur during the third trimester of pregnancy. Decreased levels may be seen in hemolytic anaemia, hemochromatosis, chronic liver disease, hypoproteinemia ,malnutrition.

Unsaturated Iron Binding Capacity (UIBC) is increased in low iron state and decreased in high iron concentration such as hemochromatosis. In case of anaemia of chronic disease the patient may be anaemic but has adequate iron reserve and a low uIBC.

Transferrin Saturation occurs in Idiopathic hemochromatosis and Transfusional hemosiderosis where no unsaturated iron binding capacity is available for iron mobilization. Similar condition is seen in congenital deficiency of Transferrin.

Rheumatoid Factor - Quantitative				
Rheumatoid Factor - Quantitative	< 15.0	IU/mL	<30 - Normal 30-50 - Weakly positive >50 - Reactive	Immunoturbidimetric

Comment:

- The detection of Rheumatoid factor (RF) is one of the criteria of the American Rheumatism Association (ARA) for the diagnosis of Rheumatoid Arthritis (RA).
- RF are heterogeneous group of auto antibodies directed against Fc- region of IgG molecules.

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- They are useful in diagnosis of Rheumatoid Arthritis, but can also be found in other inflammatory diseases and in various non-rheumatic diseases.
- These occur in all the immunoglobulin classes, although the usual analytical methods are limited to the detection of Rheumatoid Factors of the IgM type.Healthy individuals >65 years of age may also show positive RF results.

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Sample Type	: Serum	Report Date	: 05/Mar/2024 07:21PM

Immunology

COMPREHENSIVE PLATINUM FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method
Immunoglobulin E (IgE) Total	52	IU/mL	0 - 158	CLIA

Comment:

- Immunoglobulin E (IgE) is the most important trigger molecule for allergic information.
- As IgE is a mediator of allergic response, quantitative measurement can provide useful information for differential diagnosis of atopic and non-atopic disease.
- The level of IgE is low during the first year of life, gradually increases with age and reaches adult level after 10 years.

Uses

- For Allergy testing.
- Evaluation of children and adults suspected of having allergic respiratory disease
- To confirm clinical expression of sensitivity to foods in patients with Anaphylactic sensitivity or with Asthma, Angioedema or Cutaneous disease.
- To confirm the presence of IgE antibodies to certain occupational allergens

Increased Levels:

Atopic/Non-atopic allergy, Hyper IgE syndrome, Parasitic infections, IgE Myeloma, Bronchopulmonary Aspergillosis, Immunodeficiency states & Autoimmune diseases, Hodgkin's disease,etc.

Decreased Levels:

Hereditary deficiencies, Acquired immunodeficiency, Ataxia Telangiectasia, Non IgE Myeloma

Note:

Normal levels of IgE does not eliminate the possibility of allergic diseases
No close correlation has been demonstrated between severity of allergic reaction and IgE levels.

Thyroid Profile

T3, Total	1.34	ng/mL	0.60 - 1.81	CLIA
T4, Total	8.1	µg/dl	4.5-12.6	CLIA
Thyroid Stimulating Hormone - Ultra Sensitive	2.075	uIU/ml	0.55 - 4.78	CLIA

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Barcode ID/Order ID	: D8005024 / 9100082	Sample Receive Date	: 05/Mar/2024 03:53PM
Referred By	: Dr.	Report Status	: Final Report
Sample Type	: Serum	Report Date	: 05/Mar/2024 07:21PM

Immunology

COMPREHENSIVE PLATINUM FULL BODY CHECKUP WITH SMART REPORT

Test Name **Result** **Unit** **Bio. Ref. Interval** **Method**

Comment:

- Below mentioned are the guidelines for pregnancy related reference ranges for TSH, total T3 & Total T4.

Pregnancy			
	TSH (µIU/mL) (as per American Thyroid Association)	Total T3 (ng/mL)	Total T4(µg/dL)
1st trimester	0.1-2.5	0.81-1.90	7.33-14.8
2nd trimester	0.2-3.0	1.00-2.60	7.93-16.1
3rd trimester	0.3-3.0	1.00-2.60	6.95-15.7

- TSH levels are subject to circadian variation, reaching peak levels between 2 - 4.a.m. and at a minimum between 6-10 pm .
- The variation is of the order of 50%, hence time of the day has influence on the measured serum TSH concentrations.
- TSH is secreted in a dual fashion: Intermittent pulses constitute 60-70% of total amount, background continuous secretion is 30-40%.These pulses occur regularly every 1-3 hrs.
- Total T3 & T4 concentrations are altered by physiological or pathological changes in thyroxine binding globulin (TBG) capacity .
- The determination of free T3 & free T4 has the advantage of being independent of changes in the concentrations and binding properties of the binding proteins.
- Changes in thyroid status are typically associated with concordant changes in T3, T4 and TSH levels.
- Unexpectedly abnormal or discordant thyroid test values may be seen with some rare, but clinically significant conditions such as central hypothyroidism, TSH-secreting pituitary tumors, thyroid hormone resistance, or the presence of heterophilic antibodies (HAMA) or thyroid hormone autoantibodies.
- For diagnostic purposes, results should be used in conjunction with other data.

TSH	T3	T4	Interpretation
High	Normal	Normal	Subclinical Hypothyroidism
Low	Normal	Normal	Subclinical Hyperthyroidism
High	High	High	Secondary Hyperthyroidism
Low	High/Normal	High/Normal	Hyperthyroidism
Low	Low	Low	Non thyroidal illness / Secondary Hypothyroidism

NABL certificate and scope

This test has been performed at
TATA 1MG GURGAON
Address: 82/A, Ground Floor, Udyog Vihar, Phase-4, Behind Airtel Building, Gurgaon - 122015

Dr. Swati Gupta Anand
MBBS, MD (Lab Medicine)
Consultant Pathologist
Reg No: DMC/7396

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PO No :PO3209854612-916

Name	: Mr.KARTIKEYA SINGH	Client Name	: 1 MG INTEGRATION - GURUGRAM
Age/Gender	: 42/Male	Registration Date	: 05/Mar/2024 10:29AM
Patient ID	: 1MG508430	Collection Date	: 05/Mar/2024 03:53PM
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Immunology

COMPREHENSIVE PLATINUM FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method
Vitamin D (25-OH)				
Vitamin D (25-OH)	**11.2**	ng/ml	Deficiency:< 20, Insufficiency:20-29, Sufficiency:30 - 100, Toxicity possible:> 100	CLIA

Comment:

- Vitamin D is a fat-soluble steroid prohormone involved in the intestinal absorption of calcium and the regulation of calcium homeostasis.
- Two forms of vitamin D are biologically relevant - vitamin D3 (Cholecalciferol) and vitamin D2 (Ergocalciferol).
- Both vitamins D3 and D2 can be absorbed from food but only an estimated 10-20perc. of vitamin D is supplied through nutritional intake.
- Vitamin D is converted to the active hormone 1,25-(OH)2-vitamin D (Calcitriol) through two hydroxylation reactions. The first hydroxylation converts vitamin D into 25-OH vitamin D and occurs in the liver. The second hydroxylation converts 25-OH vitamin D into the biologically active 1,25-(OH)2-vitamin D and occurs in the kidneys as well as in many other cells of the body.
- Most cells express the vitamin D receptor and about 3perc. of the human genome is directly or indirectly regulated by the vitamin D endocrine system.
- The major storage form of vitamin D is 25-OH vitamin D and is present in the blood at up to 1,000 fold higher concentration compared to the active 1,25-(OH)2-vitamin D. 25-OH vitamin D has a half-life of 2-3 weeks vs. 4 hours for 1,25-(OH)2-vitamin D. Therefore, 25-OH vitamin D is the analyte of choice for determination of the vitamin D status.
- Risk factors for vitamin D deficiency include low sun exposure, inadequate intake, decreased absorption, abnormal metabolism, vitamin D resistance and and liver or kidney diseases.
- Vitamin D deficiency is a cause of secondary hyperparathyroidism and diseases resulting in impaired bone metabolism (like rickets, osteomalacia).
- Recently, many chronic diseases such as cancer, high blood pressure, osteoporosis and several autoimmune diseases have been linked to vitamin D deficiency.
- The assay measures both D2 (Ergocalciferol) and D3 (Cholecalciferol) metabolites of vitamin D

Utility Quantitative determination of 25-hydroxyvitamin D (25-OH vitamin D).

NABL certificate and scope

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Immunology

COMPREHENSIVE PLATINUM FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method
Homocysteine				
Homocysteine	**23.01**	µmol/L	3.7 - 13.9	CLIA

Comment:

Interpertation:
Increased levels are seen in deranged Vit B12 metabolism and form an independent marker for risk of thromboembolic episodes in coronary artery disease (CAD)

Clinical Utility:
•Determine risk for heart disease, stroke and peripheral arterial blood vessel disease.
•Identify vitamin B12 deficiency or folic acid deficiency.
•Identify homocystinuria

The recommended use of Homocysteine (HCY) to assess risk factor for CAD are
•It is specially useful in young CAD patients (<40 years)
•In known cases of CAD,high HCYlevels should be used as a prognostic marker for CAD events and mortality.
•CAD patients with HCY levels >15 umol/L belong to high risk group.
•Increased HCY levels with low vitamin concentrations should be handled as a potential vitamin deficiency case .

High values of HCY are found in dietary deficiency of folic acid, vitamin B6, or vitamin B12, homocystinuria, chronic liver and renal failure,post menopausal state , hypothyroidism, Alzheimer's disease,vaious neoplastic disease like cancers of ovary or breast and Acute lymphoblastic leukemia,drugs (anti-anticonvulsants, antibiotics, theophylline, birth control pills, and tamoxifen),alcoholism, smoking or tobacco usage.
Low values may be caused by some medicines or vitamins such as folic acid, vitamin B12, or niacin.

• Please note test values may vary depending on the assay method used.
• CLIA-Chemiluminescent Immunoassay

Vitamin B12				
Vitamin B12	**185.0**	pg/ml	211 - 911	CLIA

Comment:

- **Vitamin B12** along with **folate** is essential for DNA synthesis and myelin formation.
- **Decreased levels** are seen in anaemia, term pregnancy, vegetarian diet, intrinsic factor deficiency, partial gastrectomy/ileal damage, celiac disease, oral contraceptive use, parasitic infestation, pancreatic deficiency, treated epilepsy, smoking, hemodialysis and advanced age.
- **Increased levels** are seen in renal failure, hepatocelluar disorders, myeloproliferative disorders and at times with excess supplementation of vitamins pills.

NABL certificate and scope

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Dr. Swati Gupta Anand
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Immunology

COMPREHENSIVE PLATINUM FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method
Vitamin B9 (Folic Acid)				
Vitamin B9 (Folic Acid)	15.68	ng/mL	>5.38	CLIA

Comment:

Folate plays an important role in the synthesis of purine & pyrimidines in the body and is important for the maturation of erythrocytes. It is widely available from plants and to a lesser extent organ meats, but more than half the folate content of food is lost during cooking. Folate deficiency is commonly prevalent in alcoholic liver disease, pregnancy, and the elderly. It may result from poor intestinal absorption, nutrition deficiency, excessive demand as in pregnancy or in malignancy, and in response to certain drugs like Methotrexate & anticonvulsants. It is now routine practice to recommend dietary folate supplements from conception to the 12th week of pregnancy; such supplementation has been proven to reduce the incidence of neural tube defects.

Decreased Levels: Megaloblastic anemia, Infantile hyperthyroidism, Alcoholism, Malnutrition, Scurvy, Liver disease, B12 deficiency, dietary amino acid excess, adult Celiac disease, Tropical Sprue, Crohn's disease, Hemolytic anemias, Carcinomas, Myelofibrosis, vitamin B6 deficiency, pregnancy, Whipple's disease, extensive intestinal resection, and severe exfoliative dermatitis.

Note:
Certain drugs like Pyrimethamine, methotrexate, and trimethoprim are all folate antagonists i.e. they stop the action of the folic acid; phenytoin can decrease the intestinal absorption of folates, and ethanol both decreases absorption and increases excretion of folic acid.

To differentiate vitamin B12 & folate deficiency, measurement of Methylmalonic acid in urine & serum Homocysteine level is suggested.

NABL certificate and scope

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Address: 82/A, Ground Floor, Udyog Vihar, Phase-4, Behind Airtel Building, Gurgaon - 122015

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Referred By	: Dr.	Report Status	: Final Report
Sample Type	: Serum	Report Date	: 05/Mar/2024 04:29PM

SEROLOGY

COMPREHENSIVE PLATINUM FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method
Hepatitis Bs (Surface) Antigen	NON REACTIVE		Non-Reactive	Immunochromatographic

Comment:

Infection with HBV results in a wide spectrum of acute and chronic liver diseases that may lead to cirrhosis and hepatocellular carcinoma. Hepatitis B surface antigen (HBsAg), derived from the viral envelope, is the first antigen to appear following infection and is detectable in the serum.

Note:

- **This is a Rapid, Screening Test for Qualitative detection of HBsAg.**
- All Provisionally Reactive cases must be confirmed by confirmatory method to rule out false positives due to interfering substances.

Limitations:

- For diagnostic purposes, results should be used in conjunction with patient history and other hepatitis markers for diagnosis of acute and chronic infection.
- Additional follow up testing using other available methods is required ,if this test is Non- Reactive in the presence of persisting clinical symptoms of Hepatitis B.
- In few cases,false positive results can be obtained due to presence of other antigens or elevated levels of Rheumatoid factor.

PO No :PO3209854612-916

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Age/Gender	: 42/Male	Registration Date	: 05/Mar/2024 10:29AM
Patient ID	: 1MG508430	Collection Date	: 05/Mar/2024 03:45PM
Barcode ID/Order ID	: D8005017 / 9100082	Sample Receive Date	: 05/Mar/2024 03:45PM
Referred By	: Dr.	Report Status	: Final Report
Sample Type	: Urine	Report Date	: 05/Mar/2024 04:04PM

CLINICAL PATHOLOGY

COMPREHENSIVE PLATINUM FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method
Urine Routine & Microscopy				
Colour	PALE YELLOW		Pale Yellow	Manual
Appearance	CLEAR		Clear	Manual
Specific gravity	1.020		1.003 - 1.035	pKa change
pH	6.5		4.6 - 8.0	Double Indicator
Glucose	NEGATIVE		Negative	GOD-POD
Protein	NEGATIVE		Negative	Protein Error Principle
Ketones	NEGATIVE		Negative	Nitroprusside
Blood	NEGATIVE		Negative	Peroxidase
Bilirubin	NEGATIVE		Negative	Diazonium
Urobilinogen	NORMAL		Normal	Ehrlich
Leucocyte Esterase	NEGATIVE		Negative	Pyrrole
Nitrite	NEGATIVE		Negative	P-arsanilic acid
Pus cells	1-2	/hpf	0-5	Microscopy
Red Blood Cells	NIL	/hpf	0-2	Microscopy
Epithelial cells	1-2	/hpf	Few	Microscopy
Casts	NIL	/lpf	Nil	Microscopy
Crystals	NIL		Nil	Microscopy
Yeast	NIL		Nil	Microscopy
Bacteria	NIL		Nil	Microscopy

Comment:

•Note: Pre-test condition to be observed while submitting the sample-first void, mid stream urine, collected in a clean, dry, sterile container is recommended for routine urine analysis, avoid contamination with any discharge from vaginal, urethra, perineum, Avoid prolonged transit time & undue exposure to sunlight.

•During interpretation, points to be considered are Negative nitrite test does not exclude the urinary tract infections. Trace proteinuria can be seen with many physiological conditions like prolonged recumbency, exercise, high protein diet. False positive reactions for bile pigments, proteins, glucose and nitrites can be caused by peroxidase like activity by disinfectants, therapeutic dyes, ascorbic acid and certain drugs.• Urine microscopy is done in centrifuged urine specimens

***** End Of Report *****

Conditions of Laboratory Testing & Reporting:

NABL certificate and scope

This test has been performed at
TATA 1MG GURGAON
Address: 82/A, Ground Floor, Udyog Vihar, Phase-4, Behind Airtel Building, Gurgaon - 122015

Dr. Vidushi Sachdeva
MBBS, DNB (Pathology)
Consultant Pathologist
Reg No: DMC/80891

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CLINICAL PATHOLOGY

COMPREHENSIVE PLATINUM FULL BODY CHECKUP WITH SMART REPORT

Test Name	Result	Unit	Bio. Ref. Interval	Method

Test results released pertain to the sample, as received. Laboratory investigations are only a tool to facilitate in arriving at a diagnosis and should be clinically correlated by the interpreting clinician. Result delays may happen because of unforeseen or uncontrollable circumstances. Test report may vary depending on the assay method used. Test results may show inter-laboratory variations. Test results are not valid for medico-legal purposes. Please mail your queries related to test results to Customer Care mall ID cs.labs@1mg.com

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NABL certificate and scope

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Address: 82/A, Ground Floor, Udyog Vihar, Phase-4, Behind Airtel Building, Gurgaon - 122015

Vidushi
Dr. Vidushi Sachdeva
MBBS, DNB (Pathology)
Consultant Pathologist
Reg No: DMC/80891

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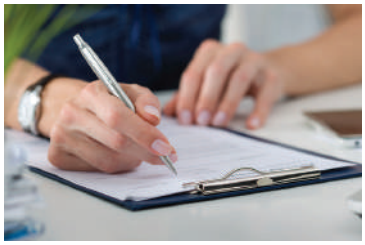

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