LABORATORY REPORT

Redcliffe labs

Patient Name	: **Mr MR.DUMMY**		
DOB/Age/Gender	: 23 Y/Male	Sample Collected	: Apr 26, 2024, 01:00 PM
Patient ID / UHID	: 8053328/RCL7248084	Report Date	: May 08, 2024, 12:51 PM
Referred By	: Dr. Dr. X	Barcode No	: ZC666383
Sample Type	: Serum	Report Status	: Final Report

Acne (Pimples) Panel

Lipid Profile

Test Description	Value(s)	Unit(s)	Reference Range
Total Cholesterol *CHOD-PAP*	123.0	mg/dL	<200
Triglycerides *Enzymatic colorimetric*	101.0	mg/dL	<150
HDL Cholesterol *CHOD-POD*	56.0	mg/dL	> 40
Non HDL Cholesterol *Calculated*	67	mg/dL	<130
LDL Cholesterol *Calculated*	46.8	mg/dL	<100
V.L.D.L Cholesterol *Calculated*	20.2	mg/dL	< 30
Chol/HDL Ratio *Calculated*	2.2	Ratio	-
HDL/ LDL Ratio *Calculated*	1.2	Ratio	-
LDL/HDL Ratio *Calculated*	0.84	Ratio	-

Interpretation:
Lipid level assessments must be made following 9 to 12 hours of fasting, otherwise assay results might lead to erroneous interpretation. NCEP recommends of 3 different samples to be drawn at intervals of 1 week for harmonizing biological variables that might be encountered in single assays.

National Lipid Association Recommendations (NLA-2014)	Total Cholesterol (mg/dL)	Triglyceride (mg/dL)	LDL Cholesterol (mg/dL)	Non HDL Cholesterol (mg/dL)
Optimal	<200	<150	<100	<130
Above Optimal			100-129	130 - 159
Borderline High	200-239	150-199	130-159	160 - 189
High	>=240	200-499	160-189	190 - 219
Very High	-	>=500	>=190	>=220

HDL Cholesterol	
Low	High
<40	>=60

Risk Stratification for ASCVD (Atherosclerotic Cardiovascular Disease) by Lipid Association of India.

Risk Category	A. CAD with > 1 feature of high risk group

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Test Description	Value(s)	Unit(s)	Reference Range

Extreme risk group	B. CAD with >1 feature of very high risk group of recurrent ACS (within 1 year) despite LDL-C <or = 50 mg/dl or poly vascular disease
Very High Risk	1.Established ASCVD 2.Diabetes with 2 major risk factors of evidence of end organ damage 3. Familial Homozygous Hypercholesterolemia
High Risk	1. Three major ASCVD risk factors 2. Diabetes with 1 major risk factor or no evidence of end organ damage 3. CHD stage 3B or 4. 4 LDL >190 mg/dl 5. Extreme of a single risk factor 6. Coronary Artery Calcium - CAC > 300 AU 7. Lipoprotein a >/= 50 mg/dl 8. Non stenotic carotid plaque
Moderate Risk	2 major ASCVD risk factors
Low Risk	0-1 major ASCVD risk factors
Major ASCVD (Atherosclerotic cardiovascular disease) Risk Factors	
1. Age >/=45 years in Males & >/= 55 years in Females	3. Current Cigarette smoking or tobacco use
2. Family history of premature ASCVD	4. High blood pressure
5. Low HDL	

Newer treatment goals and statin initiation thresholds based on the risk categories proposed by Lipid Association of India in 2020.

Risk Group	Treatment Goals		Consider Drug Therapy	
	LDL-C (mg/dl)	Non-HDL (mg/dl)	LDL-C (mg/dl)	Non-HDL (mg/dl)
Extreme Risk Group Category A	<50 (Optional goal <OR = 30)	<80 (Optional goal <OR = 60)	>OR = 50	>OR = 80
Extreme Risk Group Category B	>OR = 30	>OR = 60	> 30	> 60
Very High Risk	<50	<80	>OR = 50	>OR = 80
High Risk	<70	<100	>OR = 70	>OR = 100
Moderate Risk	<100	<130	>OR = 100	>OR = 130
Low Risk	<100	<130	>OR = 130*	>OR = 160

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

References : Management of Dyslipidaemia for the Prevention of Stroke : Clinical practice Recommendations from the Lipid Association of India. Current Vascular Pharmacology,2022,20,134-155.

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Sample Type	: Serum	Report Status	: Final Report

Test Description	Value(s)	Unit(s)	Reference Range

Vitamin B12 / Cyanocobalamin

Vitamin - B12 *CMIA*	390.0	pg/mL	187 - 883

Interpretation:

Low Values are a sign of a vitamin B12 deficiency. People with this deficiency are likely to have or develop symptoms.

Causes of vitamin B12 deficiency include:Not enough vitamin B12 in diet (rare except with a strict vegetarian diet), Diseases that cause malabsorption (for example, celiac disease and Crohn's disease), Lack of intrinsic factor, Above normal heat production (for example, with hyperthyroidism), Pregnancy. Increased vitamin B12 levels are uncommon. Usually excess vitamin B12 is removed in the urine. Conditions that can increase B12 levels include: Liver disease (such as cirrhosis or hepatitis), Myeloproliferative disorders (for example, polycythemia vera and chronic myelocytic leukemia).

Vitamin B12: Low Levels can cause malabsorption, Lack of intrinsic factor, Above normal heat production (for example, with hyperthyroidism), Pregnancy.High Level Liver disease, Myeloproliferative disorders (for example, polycythemia vera and chronic myelocytic leukemia).

1. Out of 140 healthy indian population, 91% of Vitamin B 12 concentrations was at lower level: 59.00 pg/ml and upper level: 700.00 pg/ml

"Patients on Biotin supplement may have interference in some immunoassays. Ref: Arch Pathol Lab Med—Vol 141, November 2017. With individuals taking high dose Biotin (more than 5 mg per day) supplements, at least 8-hour wait time before blood draw is recommended."

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Follicle Simulating Hormone (FSH)

Test Description	Value(s)	Unit(s)	Reference Range
Follicle Stimulating Hormone-FSH *CMIA*	7.98	mIU/mL	Males 0.95 - 11.95

Interpretation:
Clinical Use
· Diagnosis of gonadal function disorders
· Management and treatment of infertility in both genders
Increased levels
· Primary hypogonadism
· Gonadotropin secreting pituitary tumors
Decreased levels
· Hypothalamic GnRH deficiency
· Pituitary FSH deficiency
· Ectopic steroid hormone production

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Test Description	Value(s)	Unit(s)	Reference Range

Prolactin (PRL)

Prolactin *CMIA*	17.8	ng/mL	3.46 - 19.40

Interpretation:

Note:

1. Since prolactin is secreted in a pulsatile manner and is also influenced by a variety of physiologic stimuli, it is recommended to test 3 specimens at 20-30 minute intervals after pooling.
2. Major circulating form of Prolactin is a nonglycosylated monomer, but several forms of Prolactin linked with immunoglobulin occur which can give falsely high Prolactin results.
3. Macroprolactin assay is recommended if prolactin levels are elevated, but signs and symptoms of hyperprolactinemia are absent or pituitary imaging studies are normal

Clinical Use

· Diagnosis & management of pituitary adenomas
· Differential diagnosis of male & female hypogonadism

Increased Levels

· **Physiologic**: Sleep, stress, postprandially, pain, coitus
· **Systemic disorders**: Chest wall or thoracic spinal cord lesions, Primary / Secondary hypothyroidism, Adrenal insufficiency, Chronic renal failure, Cirrhosis
· **Medications**: **Psychiatric medications** like Phenothiazine, Haloperidol, Risperidone, Domperidone, Fluoexetine, Amitriptylene, MAO inhibitors etc.,

Antihypertensives: Alphamethyldopa, Reserpine, Verapamil

Opiates: Heroin, Methadone, Morphine, Apomorphine

Cimetidine / Ranitidine

· Prolactin secreting pituitary tumors: Prolactinoma, Acromegaly
· Miscellaneous: Epileptic seizures, Ectopic secretion of prolactin by non-pituitary tumors, pressure / transaction of pituitary stalk, macroprolactinemia
· Idiopathic

Decreased levels

· Pituitary deficiency: Pituitary necrosis / infarction
· Bromocriptine administration
· Pseudohypoparathyroidism

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Testosterone Total

Test Description	Value(s)	Unit(s)	Reference Range
Testosterone Total *ECLIA*	654.0	ng/dL	Males(20-49 years of age) 249 - 836 Males (>=50 years of age) 193 - 740

Interpretation:

Reference values for Males (7-18 years) characterized by Tanner Stage

Tanner Stage	5-95th percentiles (ng/dL)
1	< 2.5
2	< 2.5 - 432
3	64.9 - 778
4	180 - 763
5	188 - 882

Reference values for females (8-18 years) characterized by Tanner Stage

Tanner Stage	5-95th percentiles (ng/dL)
1	<2.5 - 6.1
2	<2.5 - 10.4
3	<2.5 - 23.7
4	<2.5 - 26.8
5	4.6 - 38.3

Note

1. All applications that require measurement of very low level of testosterone (eg hypogonadal men, children, virilization or intersex disorders in women etc) recommended test is Testosterone total, Ultrasensitive
2. LC-MS/MS is the gold standard for steroid hormone assays due to increased sensitivity & specificity as compared to immunoassays

Clinical Use

Assessment of testicular function in males

Increased levels

1. Precocious puberty (Males)
2. Androgen resistance
3. Testotoxicosis
4. Congenital Adrenal Hyperplasia

Decreased levels

1. Delayed puberty (Males)
2. Gonadotropin deficiency
3. Testicular defects
4. Systemic diseases

*** End Of Report ***

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Disclaimer: Method given in report are only indicative and can be changed depending upon type of machine and kit available at time of testing.

Not all tests at all locations are under NABL scope. Availability of tests under NABL scope varies from lab to lab.

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2. It is to be presumed that the tests performed pertain to the specimen/sample attributed to the Customer's name or identification. It is presumed that the verification particulars have been cleared out by the customer or his/her representation at the point of generation of said specimen / sample. It is hereby clarified that the reports furnished are restricted solely to the given specimen only.

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