

Patient Name	: Mr. MANDEEP KUMAR	Sample UID No.	: 4044634
Age / Gender	: 28 Y / Male	Sample Collected On	: 09-01-2025 19:04
Patient ID	: QLD044583	Registered On	: 09-01-2025 21:36
Referred By	: Dr.ENOMEN	Reported on	: 10-01-2025 06:55
Referral Client	: CITICARE MEDICAL CENTER	External Patient ID	: 45486
Emirates ID / Passport No	:	Print Version	: V.1

Department of BIOCHEMISTRY

ELECTROLYTE PANEL

<u>Investigation</u>	<u>Results</u>	<u>Flag</u>	<u>Units</u>	<u>Biological Reference Interval</u>	<u>Method</u>
SODIUM (NA)	137		mmol/L	136-145	ISE (Indirect)
POTASSIUM (K)	6	H	mmol/L	3.5-5.1	ISE (Indirect)
CHLORIDE (CL)	102		mmol/L	98-107	ISE (Indirect)

Comments :

Kindly correlate clinically. Sample partially hemolyzed.

Interpretation Notes :

Clinical Implication:

- 1.Sodium levels detect changes in water balance rather than sodium balance and sodium levels are used to determine electrolytes, acid base balance, water balance, water intoxication, and dehydration.
- 2.Potassium,electrolytes of intracellular fluid is important to diagnose acid-base and water imbalance and the value varies with circulatory volume.
- 3.Chloride,blood electrolytes is helpful in diagnosing disorders of acid base, water balance and has reciprocal rise (or) fall in response to concentration of other anions.

Interfering factors:

- 1.Drugs like steroids, calcium, fluoride, iron can cause increase in sodium level. Drugs like heparin, laxative, sulphate, diuretics cause decrease in sodium level. High Triglycerides or low protein falsely decrease in sodium level.
2. Blood drawing procedure affect the values of potassium. Drugs like diuretics and NSAID increase values and excess intake of licorice decrease potassium level.
- 3.Plasma chloride concentration in infants is higher than in children and adults. Drugs may alter chloride levels. Increased values is associated with IV Saline infusion.

Reference -

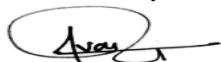
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Sample: Serum

- END OF REPORT -

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Verified By



Vaishnav Jayamohan
Lab Technologist

DHA No. 87250933-002



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Department of CLINICAL PATHOLOGY

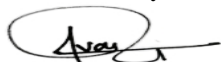
URINE ANALYSIS (ROUTINE)

<u>Investigation</u>	<u>Results</u>	<u>Flag</u>	<u>Units</u>	<u>Biological Reference Interval</u>	<u>Method</u>
Sample: URINE					
PHYSICAL & CHEMICAL EXAMINATION					
COLOR	Dark yellow	--		Pale yellow	
APPEARANCE	Clear	--		Clear	
SPECIFIC GRAVITY	1.020	--		1.005-1.030	pKa Change
pH	6	--		5-7	Double Indicator
GLUCOSE	Nil	--		Nil	Glucose oxidase
PROTEIN	Trace	--		Nil	Turbidometric Method
NITRITE	Nil	--		Nil	Diazo dye
UROBILINOGEN	Nil	--		Nil	Modified Erlich
BILIRUBIN	Nil	--		Nil	
KETONE BODIES	Nil	--		Nil	Nitroprusside
LEUCOCYTES	Nil	--		Trace	Granulocyte Esterase
CHEMISTRY EXAMINATION					
BLOOD	Nil	--		Nil	
MICROSCOPIC EXAMINATION					
PUS CELLS	0 - 2		/HPF	Occasional	Microscopy
RBC	Nil		/HPF	Nil	
EPITHELIAL CELLS	Nil		/HPF	Occasional	
MUCUS	Few	--		Nil	
CAST	Nil		/HPF	Occasional	
CRYSTALS	Nil	--		Nil	
BACTERIA	Few		/HPF	Nil	
YEAST	Nil		/HPF	Nil	
AMORPHOUS SEDIMENTS	Nil	--		Nil	
OTHERS	Nil		/HPF	Nil	

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**Department of BIOCHEMISTRY
GENERAL WELLNESS CHECK-UP(PESHAWAR)**

<u>Investigation</u>	<u>Results</u>	<u>Flag</u>	<u>Units</u>	<u>Biological Reference Interval</u>	<u>Method</u>
IRON	73		µg/dl	33-193	Ferrozine-no deproteinization

Sample: Serum

Comments :

CLINICAL IMPLICATIONS:

1. The combined results of iron, transferrin, and TIBC are helpful in the differential diagnosis of anaemia ,in assessment of iron deficiency anemia and in the evaluation of thalassemia, sideroblastic anemia and haemochromatosis.
2. Transferrin saturation is a better index of iron saturation. Percent saturation is a better index of iron stores than serum alone. Saturation <15% denotes iron deficiency.

INTERFERING FACTORS:

1. Hemolysis of the blood sample may interfere with testing. Drugs like aspirin, antibiotics, testosterone may cause decreased levels and drugs like ethanol, estrogen may cause an increased iron level.
2. Diurnal variation in iron. Normal values in the morning, low in mid-afternoon, very low in the evening.
3. Serum iron and TIBC may be normal in iron deficiency anemia if Hb is >than 9.0g/dl or >90g/L.

RECOMMENDATION:

In patients receiving folate or Vitamin B12 recommended to repeat iron studies after 1 to 3 months of completion of treatment.

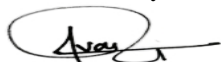
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**Department of BIOCHEMISTRY
GENERAL WELLNESS CHECK-UP(PESHAWAR)
LIPID PROFILE TEST**

Investigation	Results	Flag	Units	Biological Reference Interval	Method
CHOLESTEROL (TOTAL)	191		mg/dl	Desirable: < 200 Borderline High: 200-239 High: > 240	Enzymatic colorimetric assay
TRIGLYCERIDES	131		mg/dl	Normal Up to 150 Borderline-High 150-199 High 200-499 Very High > 500	Enzymatic colorimetric test
HDL CHOLESTEROL	48		mg/dl	High risk up to 40 Low risk > 60	Homogeneous Enzymatic Colorimetric
LDL CHOLESTEROL DIRECT	109		mg/dl	Optimal up to < 100 Near Optimal: 100-129 Borderline : 130-159 High: 160-189 Very High: > 190	Enzymatic, colorimetric method
VLDL CHOLESTEROL	26		mg/dl	10-35	Calculation
NON-HDL CHOLESTEROL	143	H	mg/dl	Desirable < 130 Borderline 130 – 159 High >159	Calculation
TOTAL CHOLESTEROL / HDL RATIO	4.0		--	< 4.5	Calculation
LDL / HDL RATIO	2.3	L	--	Low Risk < 3.0 Borderline 3.1-6.0 High Risk >6.0	Calculation

Interpretation Notes :

CLINICAL IMPLICATIONS:

1. Cholesterol testing evaluates the risk for atherosclerosis, myocardial occlusion, and coronary artery occlusion. Elevated cholesterol levels are a major component in the hereditary hyper lipoproteinemia. It is also used to monitor effectiveness of diet, medications, lifestyle, and stress management.
2. The cholesterol to HDL ratio provides more information than does either value alone. When a slightly increased cholesterol is due to high HDL, therapy is not indicated.
3. LDL cholesterol has a longer shelf life and determines the CHD risk.

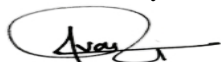
INTERFERING FACTORS:

1. Seasonal and positional variations may alter cholesterol levels. Estrogens, ascorbic acid, bilirubin decrease the cholesterol levels. Pregnancy, bile salt, high saturated fat, and high cholesterol diet may increase the cholesterol values. Prolonged fasting with ketosis may increase the value.
2. Increased levels of HDL may be associated with estrogen therapy, drugs like steroids, alcohol and insulin therapy. Decreased levels are associated with stress, recent illness, starvation, obesity, smoking, hyper triglyceridemia, lack of exercise.
3. Increased LDL may be associated with pregnancy, drugs like steroids. Decreased LDL are found in women under estrogen therapy. No fasting may cause false elevation.

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Department of BIOCHEMISTRY
GENERAL WELLNESS CHECK-UP(PESHAWAR)
LIPID PROFILE TEST

Investigation	Results	Flag	Units	Biological Reference Interval	Method
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4. A transient increase in triglycerides occurs following heavy meal, alcohol ingestion, pregnancy, acute illness like cold ,flu, obesity, physical inactivity ,smoking. Transient decrease occurs after strenuous exercise, weight loss.

RECOMMENDATION:

1. Cholesterol levels >200 mg/dl should be retested and the results averaged and if the results differ by > than 10%, a third test need to be done for confirmation. Perform a comprehensive lipoprotein analysis if cholesterol levels are not lowered within 6 months after start of therapy. If the values are altered in a normal condition, recommended to follow a stable diet for 1 week and overnight fasting (9 to 12 hours) before repeating the test.
2. Cholesterol and HDL should not be measured immediately after MI. A 3 month wait is suggested.
3. If triglyceride levels are more than 400mg/dl or >10.36mmol/L recommended to fast overnight(9 to 12 hours) and retest .Because of biological and analytical variation, at least 2 serial sample may be necessary for clinical decision making. VLDL cannot be calculated if triglycerides are more than 400mg/dl

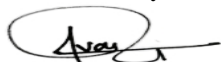
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Sample: Serum

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Department of BIOCHEMISTRY
GENERAL WELLNESS CHECK-UP(PESHAWAR)
Renal Function Test

<u>Investigation</u>	<u>Results</u>	<u>Flag</u>	<u>Units</u>	<u>Biological Reference Interval</u>	<u>Method</u>
UREA (SERUM)	19.4		mg/dl	16.6-48.5	Kinetic test,Urease
CREATININE (SERUM)	1.02		mg/dl	0.7 - 1.2	Alkaline picrate
URIC ACID (SERUM)	5.23		mg/dl	3.4-7	Enzymatic colorimetric test
BLOOD UREA NITROGEN (SERUM)	9.1		mg/dl	6-20	Calculation
BUN/CREATININE RATIO	8.92	L	mg/dl	10-30	Calculation

Interpretation Notes :

CLINICAL IMPLICATIONS:

1. A markedly increased BUN is conclusive of severe impaired glomerular function and in chronic renal disease BUN level correlates better with the symptoms of uremia than does the serum creatinine.
2. Uric acid levels is used most in the evaluation of renal failure, gout, and leukaemia. In gout the amount of increase is not directly related to the severity of the disease. Acute levels may occur following administration of cytotoxic drugs.
3. In chronic renal disease, BUN/creatinine ratio is a better indicator to evaluate the renal problem than evaluating either alone. For each 50% reduction in GFR serum creatinine doubles. In chronic renal disease the plasma levels of creatinine may be more sensitive to changes in glomerular function than creatinine clearance, which may be factitiously higher than the true value.

INTERFERING FACTORS:

1. A combination of low protein high carbohydrate diet, late pregnancy (PHYSIOLOGIC HYDREMIA), IV feedings may cause a low level of BUN. BUN is normally lower in children and women than adult. Elderly person can have an increased BUN level. Many drugs like steroids, tetracyclines, thyroxine, stress, strenuous exercise may alter the values of BUN levels.
2. Stress, strenuous exercise, purine rich diet(liver, kidney, sweet breads)increases uric acid levels. High levels of aspirin, low purine intake, coffee, tea intake may cause a decreased level of uric acid. Drugs like steroids, diuretics, acetaminophen may alter the uric acid levels.
3. High levels of ascorbic acid, cephalosporin, diet high in meat, ketoacidosis may increase serum creatinine substantially. Creatinine is falsely decreased by bilirubin, glucose, histamine, quinidine compounds. Drugs like cephalosporins may alter the values. Lipemic and homolyzed samples may cause false elevations.

REFERENCE:

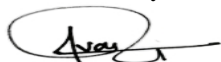
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Sample: Serum

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**Department of BIOCHEMISTRY
GENERAL WELLNESS CHECK-UP(PESHAWAR)**

GLYCATED HEMOGLOBIN (HbA1c)

<u>Investigation</u>	<u>Results</u>	<u>Flag</u>	<u>Units</u>	<u>Biological Reference Interval</u>	<u>Method</u>
Sample: EDTA Whole Blood GLYCATED HEMOGLOBIN (HbA1C) ^	5.8		%	<5.7 non-diabetic 5.7-6.4 Pre-Diabetic >6.4 Diabetic	HPLC
Average Blood Glucose	119.8		mg/dl	90-120 Good Control 121-150 Fair Control 151-180 Unsatisfactory Control >180 Poor Control	Calculated

Comments :

False elevated levels may be due to hypertriglyceridemia, iron deficiency anemia, B12 deficiency, vit C supplement usage, uremia, hemoglobinopathies. In such cases recommended to evaluate the value using alternative index like fructosamine, glycated albumin or continuous glucose monitoring

CLINICAL IMPLICATIONS:

- 1) Glycated hemoglobin reflects average blood sugar level for 2 to 3 month period and useful for evaluating diabetic medications and to track the control of blood glucose in milder cases.
- 2) Increase in Glycated hemoglobin occurs in non diabetic conditions like Iron deficiency anemia, splenectomy, alcohol toxicity. Decrease in Glycated Hemoglobin in hemolytic anemia, chronic blood loss, pregnancy and chronic renal failure.
- 3) Improvement in the glucose control occurring in the 4 weeks before drawing of the sample is not well reflected in the result since the formation of glycated haemoglobin is irreversible.

INTERFERING FACTORS:

- 1) Presence of HbF and HbH cause falsely elevated values.
- 2) Presence of Hb S, C, E, D, G and Lepore cause falsely decrease results.
- 3) If test results are not consistent with clinical finding check the patient for HbF which elevates HbA1c results.
- 4) Haemolytic blood samples may cause falsely low results because of increased erythrocyte turnover.

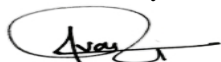
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Referral Client : CITICARE MEDICAL CENTER
Emirates ID / Passport No :

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Department of BIOCHEMISTRY
GENERAL WELLNESS CHECK-UP(PESHAWAR)
LIVER FUNCTION TEST

<u>Investigation</u>	<u>Results</u>	<u>Flag</u>	<u>Units</u>	<u>Biological Reference Interval</u>	<u>Method</u>
ALT / SGPT	25.2		U/L	10-50	IFCC with P5P
AST / SGOT	71	H	U/L	10-50	IFCC with P5P
ALP (ALKALINE PHOSPHATASE)	113		U/L	40-129	Colorimetric assay
GGT (GAMMA GLUTAMYL TRANSFERASE)	8		U/L	8-61	Enzymatic colorimetric assay
BILIRUBIN (TOTAL)	0.9		mg/dl	0.1-1.2	Diazo
BILIRUBIN (DIRECT)	0.02		mg/dl	0-0.3	Diazo
INDIRECT BILIRUBIN	0.88		mg/dl	0.00-1.1	Calculated Parameter
TOTAL PROTEIN	7.2		g/dl	6.6-8.7	Colorimetric assay
ALBUMIN (SERUM)	4.2		g/dl	3.97-4.94	Colorimetric assay
GLOBULIN	3.0		g/dl	2.35 - 3.5	Calculated Parameter
A/G RATIO	1.4			1.1-2.5	Calculated Parameter

Interpretation Notes :

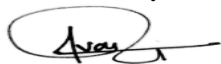
CLINICAL IMPLICATIONS:

- 1) Total Bilirubin elevation accompanied by jaundice is due to hepatic, obstructive, hemolytic and blood group compatibility.
- 2) Increase albumin is associated with dehydration and decrease is due to acute and chronic inflammation, burns and heart failure.
- 3) Although AST levels always increase in acute MI, ALT level doesn't always increase unless there also liver damage.
- 4) ALT is usually increased more than AST in acute extra hepatic biliary obstruction.
- 5) ALT is more specific than AST for liver disease but AST is more sensitive to liver disease.
- 6) Alkaline phosphatase normal values are higher in pediatric patient and in pregnancy. Values may increase up to 3 times in puberty.
- 7) GGT is used to confirm biliary abnormality and is elevated in hepatobiliary disease but not in uncomplicated bone disease.

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Department of BIOCHEMISTRY
GENERAL WELLNESS CHECK-UP(PESHAWAR)
LIVER FUNCTION TEST

Investigation **Results** **Flag** **Units** **Biological Reference Interval** **Method**

8) GGT values are higher in new born, first 3 to 6 month . Adult male have 25% higher values than female.

INTERFERING FACTORS:

- 1) Certain foods like carrots, yam, drugs, anorexia, prolonged fasting may falsely increase bilirubin level.
- 2) Albumin levels may reduce in pregnancy, over hydration, edema, drugs, obesity.
- 3) Young children, pregnant women, post-menopausal women have physiological high level of ALT. Alkaline phosphatase increase after fatty meal.
- 4) Slight reduce level of AST can be seen during pregnancy and false reduced level in severe liver disease.

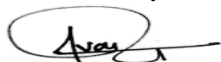
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Sample: Serum

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**Department of BIOCHEMISTRY
GENERAL WELLNESS CHECK-UP(PESHAWAR)**

GLUCOSE R/F

<u>Investigation</u>	<u>Results</u>	<u>Flag</u>	<u>Units</u>	<u>Biological Reference Interval</u>	<u>Method</u>
Sample: Fluoride Plasma GLUCOSE RANDOM	103		mg/dl	70-140	Hexokinase

Comments :

CLINICAL IMPLICATIONS:

ADA criteria for definitive test for diabetes:

- 1) Fasting blood glucose > 126 mg/dl (> 6.99 mmol/l) on at least two occasions.
- 2) Symptoms of diabetes plus random blood glucose > 200 mg/dl (> 11.1 mmol/l)
- 3) OGTT with 2 hrs. post load (75 gm glucose load) > 200 mg/dl (> 11.1 mmol/l) 4) HbA1c > 6.5%

INTERFERING FACTORS:

- 1) Steroids, diuretics, pregnancy, surgical procedures, anesthesia, obesity, smoking may cause elevated glucose levels.
- 2) Hematocrit > 55%, intense exercise, drug intake may cause lowered glucose level.
- 3) Dawn Phenomenon-Increase in blood glucose typically between 4.00am and 8.00 am due to counter-regulatory hormones.

RECOMMENDATION:

As mild borderline cases may present with normal fasting glucose levels, recommended repeat testing on a different day.

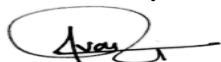
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DHA No. 87250933-002



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Dr. Dheepa Manoharan
Medical Director
Specialist Microbiologist
DHA No. 00231751-004

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Patient Name : Mr. MANDEEP KUMAR
Age / Gender : 28 Y / Male
Patient ID : QLD044583
Referred By : Dr.ENOMEN
Referral Client : CITICARE MEDICAL CENTER
Emirates ID / Passport No :

Sample UID No. : EB4044634
Sample Collected On : 09-01-2025 19:04
Registered On : 09-01-2025 21:36
Reported on : 10-01-2025 01:36
External Patient ID : 45486
Print Version : V.1

Department of HEMATOLOGY
GENERAL WELLNESS CHECK-UP(PESHAWAR)
ADVANCE COMPLETE BLOOD COUNT

Investigation	Results	Flag	Units	Biological Reference Interval	Method
HEMOGLOBIN	14.8		g/dl	13-17	photometric
WBC COUNT	10		10 ³ /uL	4-11	Electrical Impedance
RBC COUNT	4.72		10 ⁶ /uL	4.5-5.5	Electrical Impedance
HEMATOCRIT	44.1		%	42-52	Calculation
MCV	93.5		fL	78-100	Calculation
MCH	31.3	H	pg	27-31	Calculation
MCHC	33.4		g/dl	31-35	Calculation
RDW	15.6		%	9.3-16	Calculation
RDW-SD	50.3	H	fL	38.9-49	Calculation
MPV	8.7	L	fL	8.8-12.5	Calculation
PLATELET COUNT	433	H	10 ³ /uL	150-400	Electrical Impedance
Neutrophil	52.9		%	40-80	VCS-Method
Lymphocyte	40.6	H	%	20-40	VCS-Method
Monocyte	4.5		%	2-10	VCS-Method
Eosinophil	1.4		%	1-8	VCS-Method
Basophil	0.6		%	0-2	VCS-Method
ABSOLUTE NEUTROPHIL COUNT	5.3		10 ³ /uL	1.5-7	Calculation
ABSOLUTE LYMPHOCYTE COUNT	4.1	H	10 ³ /uL	1.5-4	Calculation
ABSOLUTE MONOCYTE COUNT	0.4		10 ³ /uL	0-0.8	Calculation
ABSOLUTE EOSINOPHIL COUNT	0.1		10 ³ /uL	0-0.6	Calculation
ABSOLUTE BASOPHIL COUNT	0.1		10 ³ /uL	0-0.2	Calculation

Interpretation Notes :

Interfering factors: Factors such as age, gender, pregnancy, drug intake, excessive fluid intake, dehydration, hyperlipidemia, stress, exercise, post-operative state, new born, clotted specimen may interfere with test results. Hence recommended fresh EDTA blood sample for confirmation.

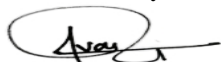
Reference :-Manual of Laboratory and Diagnostics -Frances Fischbach Marshall B. Dunning III [9th Edition

Sample: EDTA Whole Blood

- END OF REPORT -

"QLabs compliance with ISO 15189:2022 standards"

Verified By



Vaishnav Jayamohan
Lab Technologist

DHA No. 87250933-002



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Dr. Vidhya Mohan
Specialist Clinical Pathologist
Clinical Pathologist

DHA No. 23553203-004

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Referred By	: Dr.ENOMEN	Reported on	: 10-01-2025 06:55
Referral Client	: CITICARE MEDICAL CENTER	External Patient ID	: 45486
Emirates ID / Passport No	:	Print Version	: V.1

**Department of IMMUNOLOGY
GENERAL WELLNESS CHECK-UP(PESHAWAR)**

<u>Investigation</u>	<u>Results</u>	<u>Flag</u>	<u>Units</u>	<u>Biological Reference Interval</u>	<u>Method</u>
VITAMIN D, 25-OH (TOTAL)	14.1	L	ng/mL	Deficient : ≤ 20 insufficient: 21-29 Sufficient: ≥ 30 Toxicity : >80	ECLIA

Sample: Serum

Comments :

CLINICAL IMPLICATIONS:

1. Increased Vitamin D levels are seen in gastrointestinal symptoms like anorexia, nausea, vomiting, constipation, hypercalcemia, renal colic, supplements, normal growing children, pregnant and lactating females, tuberculosis, idiopathic hypercalciuria, sarcoidosis. Levels can increase to 200 -300pg/ml during treatment of osteoma Lacia with physiological doses of vitamin D.
2. Decreased levels are seen in Inadequate diet, Inadequate exposure to sunlight, liver disease, Malabsorption syndrome, osteoma Lacia, Anticonvulsants, rickets, chronic renal failure, pseudohypoparathyroidism, post-menopausal osteoporosis and adults with insulin requiring diabetes mellitus.
3. 25(OH) levels do not indicate clinical vitamin D status in patients with chronic renal failure or type 1 vitamin D dependent rickets or when calcitriol is used as a supplement.

INTERFERING FACTORS:

Age, season of the year, diarrhoea or vomiting, certain drugs, diseases, and long term hyperalimentation are the factors that may interfere with the vitamin levels.

RECOMMENDATION:

Recommended to evaluate alternate cause of impaired mineralization ,if the levels are not consistent with the suspected diagnosis.

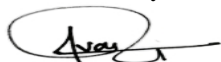
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**Department of IMMUNOLOGY
GENERAL WELLNESS CHECK-UP(PESHAWAR)**

<u>Investigation</u>	<u>Results</u>	<u>Flag</u>	<u>Units</u>	<u>Biological Reference Interval</u>	<u>Method</u>
VITAMIN B12	219		pg/mL	197-771	ECLIA

Sample: Serum

Comments :

CLINICAL IMPLICATIONS: 1. Levels of Vitamin B12 and folate are usually tested in conjunction with one another for the diagnosis of Macrocytic anaemia and measurement of unsaturated VB12 binding capacity is valuable in distinguishing between untreated polycythemia vera and other conditions in which there is an elevated HCT. 2. Serum levels can be low in the absence of either anaemia or macrocytosis(eg. in patients with myeloma, aplastic anaemia) and conversely elevated Transcobalamin II can cause a normal or increase Vitamin B12 levels despite deficient liverstores.

INTERFERING FACTORS: 1. Blood transfusion, pregnancy, elderly patients, high vitamin C and A, smoking, drugs like aminoglycosides, metformin may alter the vitamin B 12 levels. 2. Low serum vitamin B 12 levels often occur in folate deficiency, and B12 deficiency can be masked by folate therapy.

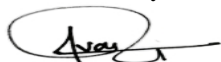
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Department of IMMUNOLOGY
GENERAL WELLNESS CHECK-UP(PESHAWAR)
THYROID FUNCTION TEST (T3,T4,TSH)

Investigation	Results	Flag	Units	Biological Reference Interval	Method
TRIIODOTHYRONINE, TOTAL (T3)	1.34		ng/mL	0.8-2	ECLIA
THYROXINE, TOTAL (T4)	9.2		ug/dL	5.1-14.1	ECLIA
THYROID STIMULATING HORMONE (TSH)	1.49		uIU/mL	0.27-4.2	ECLIA

Interpretation Notes :

Total T3 Clinical implication:

Total T3 level is a quantitative determination of the total T3 concentration in the blood and is the test of choice in the diagnosis of T3 thyrotoxicosis.

Total T4 Clinical Implications:

Total T4 is a good index of thyroid function when TB G (Thyroid Binding Globulin) is normal. The increase in TBG levels normally seen in pregnancy and with estrogen therapy increases total T4 levels. The decrease of TBG levels in person receiving anabolic steroids, in chronic liver disease and in nephrosis decrease the total T4 value..

TSH CLINICAL IMPLICATIONS:

TSH has diurnal rhythm, peaks at 2:00-4:00am and has low levels at 5:00-6:00pm with ultradian rhythm (shorter than circadian).

Moderately high TSH is often found in euthyroid patients during treatment for hyperthyroidism. In treated hyperthyroid patient, TSH may remain low for 4-6 week after euthyroid state is achieved. TSH surges with birth, peaking at 30min at 25-160mU/L, declining to cord blood levels by 3 days, and reaching adult values in the first week of life.

REFERENCE:

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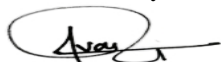
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Sample: Serum

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