LB-MED-305

| | | | | | |
|---|---|---|---|---|---|
| **Patient Name** | : | Mr. AHSAN AZHAR AZHAR ALI | **Sample UID No.** | : | 4063590 |
| **Age / Gender** | : | 30 Y / Male | **Sample Collected On** | : | 17-03-2025 14:53 |
| **Patient ID** | : | QLD063475 | **Registered On** | : | 17-03-2025 14:58 |
| **Referred By** | : | PESHAWAR | **Reported on** | : | 17-03-2025 23:39 |
| **Referral Client** | : | CITICARE MEDICAL CENTER | **External Patient ID** | : | 46189 |
| **Emirates ID / Passport No** | : | | **Print Version** | : | V.1 |

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

| Investigation | Results | Flag | Units | Biological Reference Interval | Method |
|---|---|---|---|---|---|
| **IRON** | 93 | | 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. Homolysis 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.

**REFERENCE:**

1) Manual of Laboratory and Diagnostics -Frances Fischbach Marshall B. Dunning III [9th Edition]

2) Tietz clinical guide to Laboratory tests(Fourth edition) ALAN H.B.WU

**- END OF REPORT -**

"QLabs compliance with ISO 15189:2022 standards"

**Verified By**

**Ebin C Lorance**
**Lab Technologist**

**DHA No. 57146854-002**

**Authorised By**

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



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LB-MED-305

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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) | 226 | H | mg/dl | Desirable: < 200<br>Borderline High: 200-239<br>High: > 240 | Enzymatic colorimteric assay |
| TRIGLYCERIDES | 135 | | mg/dl | Normal Up to 150<br>Borderline-High 150-199<br>High 200-499<br>Very High > 500 | Enzymatic colorimetric test |
| HDL CHOLESTEROL | 36 | | mg/dl | High risk up to 40<br>Low risk > 60 | Homogeneous Enzymatic Colorimetric |
| LDL CHOLESTEROL DIRECT | 164 | H | mg/dl | Optimal up to < 100<br>Near Optimal: 100-129<br>Borderline : 130-159<br>High: 160-189<br>Very High: > 190 | Enzymatic, colorimetric method |
| VLDL CHOLESTEROL | 27 | | mg/dl | 10-35 | Calculation |
| NON-HDL CHOLESTEROL | 190 | H | mg/dl | Desirable < 130<br>Borderline 130 – 159<br>High >159 | Calculation |
| TOTAL CHOLESTEROL / HDL RATIO | 6.3 | H | -- | < 4.5 | Calculation |
| LDL / HDL RATIO | 4.6 | | -- | Low Risk < 3.0<br>Borderline 3.1-6.0<br>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.

**- END OF REPORT -**

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**DHA No. 57146854-002**

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

| Investigation | Results | Flag | Units | Biological Reference Interval | Method |
|---|---|---|---|---|---|

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

**REFERENCE:** 1) Manual of Laboratory and Diagnostics -Frances Fischbach Marshall B. Dunning III [9th Edition]
2) Tietz clinical guide to Laboratory tests(Fourth edition) ALAN H.B.WU

Sample: Serum

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LB-MED-305

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

| Investigation | Results | Flag | Units | Biological Reference Interval | Method |
|---|---|---|---|---|---|
| UREA (SERUM) | 37.5 | | mg/dl | 16.6-48.5 | Kinetic test,Urease |
| CREATININE (SERUM) | 0.92 | | mg/dl | 0.7 - 1.2 | Alkaline picrate |
| URIC ACID (SERUM) | 6.19 | | mg/dl | 3.4-7 | Enzymatic colorimetric test |
| BLOOD UREA NITROGEN (SERUM) | 17.5 | | mg/dl | 6-20 | Calculation |
| BUN/CREATININE RATIO | 19.02 | | 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:**

1) Manual of Laboratory and Diagnostics -Frances Fischbach Marshall B. Dunning III [9th Edition]
2) Tietz clinical guide to Laboratory tests(Fourth edition) ALAN H.B.WU

Sample: Serum

**- END OF REPORT -**

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

### GLYCATED HEMOGLOBIN (Hba1c)

| Investigation | Results | Flag | Units | Biological Reference Interval | Method |
|---|---|---|---|---|---|
| Sample: EDTA Whole Blood | | | | | |
| **GLYCATED HEMOGLOBIN (HbA1C) ^** | 5.5 | | % | <5.7 non-diabetic<br>5.7-6.4 Pre-Diabetic<br>>6.4 Diabetic | HPLC |
| **Average Blood Glucose** | 111.2 | | mg/dl | 90-120 Good Control<br>121-150 Fair Control<br>151-180 Unsatisfactory Control<br>>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.

**REFERENCE:**

1) Manual of Laboratory and Diagnostics -Frances Fischbach Marshall B. Dunning III [9th Edition]
2) Tietz clinical guide to Laboratory tests(Fourth edition) ALAN H.B.WU

**- END OF REPORT -**

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

| Investigation | Results | Flag | Units | Biological Reference Interval | Method |
|---|---|---|---|---|---|
| ALT / SGPT | 40.3 | | U/L | 10-50 | IFCC with P5P |
| AST / SGOT | 28 | | U/L | 10-50 | IFCC with P5P |
| ALP (ALKALINE PHOSPHATASE) | 78 | | U/L | 40-129 | Colorimetric assay |
| GGT (GAMMA GLUTAMYL TRANSFERASE) | 49 | | U/L | 8-61 | Enzymatic colorimetric assay |
| BILIRUBIN (TOTAL) | 0.4 | | mg/dl | 0.1-1.2 | Diazo |
| BILIRUBIN (DIRECT) | 0.22 | | mg/dl | 0-0.3 | Diazo |
| INDIRECT BILIRUBIN | 0.18 | | mg/dl | 0.00-1.1 | Calculated Parameter |
| TOTAL PROTEIN | 7.3 | | g/dl | 6.6-8.7 | Colorimetric assay |
| ALBUMIN (SERUM) | 4.4 | | g/dl | 3.97-4.94 | Colorimetric assay |
| GLOBULIN | 2.9 | | g/dl | 2.35 - 3.5 | Calculated Parameter |
| A/G RATIO | 1.5 | | | 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.

**- END OF REPORT -**

"QLabs compliance with ISO 15189:2022 standards"

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**DHA No. 57146854-002**

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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.

**REFERENCE:** 1) Manual of Laboratory and Diagnostics -Frances Fischbach Marshall B. Dunning III [9th Edition]
2) Tietz clinical guide to Laboratory tests(Fourth edition) ALAN H.B.WU

Sample: Serum

**- END OF REPORT -**

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

### GLUCOSE R/F

| Investigation | Results | Flag | Units | Biological Reference Interval | Method |
|---|---|---|---|---|---|
| Sample: Fluoride Plasma | | | | | |
| GLUCOSE FASTING | 91 | | mg/dl | 74-109 | 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.

**REFERENCE:**
1) Manual of Laboratory and Diagnostics -Frances Fischbach Marshall B. Dunning III [9th Edition]
2) Tietz clinical guide to Laboratory tests(Fourth edition) ALAN H.B.WU

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

| Investigation | Results | Flag | Units | Biological Reference Interval | Method |
|---|---|---|---|---|---|
| HEMOGLOBIN | 16.8 | | g/dl | 13-17 | photometric |
| WBC COUNT | 11.7 | H | 10^3/uL | 4-11 | Electrical Impedance |
| RBC COUNT | 5.62 | H | 10^6/uL | 4.5-5.5 | Electrical Impedance |
| HEMATOCRIT | 47.9 | | % | 42-52 | Calculation |
| MCV | 85.2 | | fL | 78-100 | Calculation |
| MCH | 29.9 | | pg | 27-31 | Calculation |
| MCHC | 35.1 | H | g/dl | 31-35 | Calculation |
| RDW | 12.9 | | % | 9.3-16 | Calculation |
| RDW-SD | 38.5 | L | fL | 38.9-49 | Calculation |
| MPV | 8.7 | L | fL | 8.8-12.5 | Calculation |
| PLATELET COUNT | 317 | | 10^3/uL | 150-400 | Electrical Impedance |
| * Neutrophil | 65.1 | | % | 40-80 | VCS-Method |
| * Lymphocyte | 24.2 | | % | 20-40 | VCS-Method |
| * Monocyte | 5.1 | | % | 2-10 | VCS-Method |
| * Eosinophil | 4.9 | | % | 1-8 | VCS-Method |
| * Basophil | 0.7 | | % | 0-2 | VCS-Method |
| * ABSOLUTE NEUTROPHIL COUNT | 7.6 | H | 10^3/uL | 1.5-7 | Calculation |
| * ABSOLUTE LYMPHOCYTE COUNT | 2.8 | | 10^3/uL | 1.5-4 | Calculation |
| * ABSOLUTE MONOCYTE COUNT | 0.6 | | 10^3/uL | 0-0.8 | Calculation |
| * ABSOLUTE EOSINOPHIL COUNT | 0.6 | | 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 -**

**Note:** "The analytes with asterix (*) symbol are non-accredited parameters.".
"QLabs compliance with ISO 15189:2022 standards"

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| **Referred By** | : | PESHAWAR | **Reported on** | : | 17-03-2025 23:39 |
| **Referral Client** | : | CITICARE MEDICAL CENTER | **External Patient ID** | : | 46189 |
| **Emirates ID / Passport No** | : | | **Print Version** | : | V.1 |

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

| Investigation | Results | Flag | Units | Biological Reference Interval | Method |
|---|---|---|---|---|---|
| VITAMIN D, 25-OH (TOTAL) | 11.7 | L | ng/mL | Deficient : ≤ 20<br>insufficient: 21-29<br>Sufficient: ≥ 30<br>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.

**REFERENCE:**

1) Manual of Laboratory and Diagnostics -Frances Fischbach Marshall B. Dunning III [9th Edition]

2) Tietz clinical guide to Laboratory tests(Fourth edition) ALAN H.B.WU

3) Clinical microbiology procedures 4th edition AMY L LEBER

**- END OF REPORT -**

"QLabs compliance with ISO 15189:2022 standards"

**Verified By**

**Ebin C Lorance**
**Lab Technologist**

**DHA No. 57146854-002**

**Authorised By**

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

LB-MED-305

| | | | | | |
|---|---|---|---|---|---|
| **Patient Name** | : | Mr. AHSAN AZHAR AZHAR ALI | **Sample UID No.** | : | 4063590 |
| **Age / Gender** | : | 30 Y / Male | **Sample Collected On** | : | 17-03-2025 14:53 |
| **Patient ID** | : | QLD063475 | **Registered On** | : | 17-03-2025 14:58 |
| **Referred By** | : | PESHAWAR | **Reported on** | : | 17-03-2025 23:39 |
| **Referral Client** | : | CITICARE MEDICAL CENTER | **External Patient ID** | : | 46189 |
| **Emirates ID / Passport No** | : | | **Print Version** | : | V.1 |

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

| Investigation | Results | Flag | Units | Biological Reference Interval | Method |
|---|---|---|---|---|---|
| VITAMIN B12 | 195 | L | 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.

**REFERENCE:**

1) Manual of Laboratory and Diagnostics -Frances Fischbach Marshall B. Dunning III [9th Edition]

2) Tietz clinical guide to Laboratory tests(Fourth edition) ALAN H.B.WU

3) Clinical microbiology procedures 4th edition AMY L LEBER

**- END OF REPORT -**

"QLabs compliance with ISO 15189:2022 standards"

**Verified By**

**Ebin C Lorance**
**Lab Technologist**

**DHA No. 57146854-002**

**Authorised By**

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



QLABS Clinical Laboratory Off No 304, Carrera Building, Karama +971 4 578 2223 info@qlabsonline.com

LB-MED-305

| | | | | | |
|---|---|---|---|---|---|
| **Patient Name** | : Mr. AHSAN AZHAR AZHAR ALI | | **Sample UID No.** | : | 4063590 |
| **Age / Gender** | : 30 Y / Male | | **Sample Collected On** | : | 17-03-2025 14:53 |
| **Patient ID** | : QLD063475 | | **Registered On** | : | 17-03-2025 14:58 |
| **Referred By** | : PESHAWAR | | **Reported on** | : | 17-03-2025 23:39 |
| **Referral Client** | : CITICARE MEDICAL CENTER | | **External Patient ID** | : | 46189 |
| **Emirates ID / Passport No** | : | | **Print Version** | : | V.1 |

## 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) | 1.14 | | ng/mL | 0.8-2 | ECLIA |
| THYROXINE, TOTAL (T4) | 7.1 | | ug/dL | 5.1-14.1 | ECLIA |
| THYROID STIMULATING HORMONE (TSH) | 3.58 | | 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:**

Manual of Laboratory and Diagnostics -Frances Fischbach Marshall B. Dunning III [9th Edition].
Tietz clinical guide to Laboratory tests(Fourth edition) ALAN H.B.WU

Sample: Serum

**- END OF REPORT -**

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**Lab Technologist**

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