



Passport No :

LABORATORY TEST REPORT



Patient Information	Sample Information	Client/Location Information
Name : Ms. Jagrutiben Shah	Lab Id : 082664300768	Client Name :
Sex/Age : Female / 70 Y	Registration on : 14-Aug-2026 08:27	Location : Laboratory
Ref. Id :	Collected at :	Approved on : 14-Aug-2026 15:32 Status : Revised
Ref. By : Dr. Self	Collected on : 14-Aug-2026 14:12	Printed On : 14-Aug-2026 18:09
	Sample Type : Fluoride plasma	Process At : 643. GL SAWPL Lab Gujarat Ahmedabad Maninagar

Cl. Biochemistry

Test	Result	Unit	Biological Ref. Interval
Postprandial Blood Glucose <i>Glucose Oxidase, Hydrogen Peroxidase</i>	H 225.4	mg/dL	70-140

	Fasting Blood Glucose*	Postprandial Blood Glucose #	Random Blood Glucose
Normal	< 100 mg/dL	< 140 mg/dL	< 140 mg/dL
Prediabetic	100 – 125 mg/dL	140 – 199 mg/dL	140 – 199 mg/dL
Diabetic	>=126 mg/dL	>= 200 mg/dl	>= 200 mg/dl

* Fasting is defined as no caloric intake for more than 8 hours

The test should be performed as described by the WHO, using a glucose load containing the equivalent of 75 g anhydrous glucose dissolved in water.

Criteria for Diagnosis of Diabetes:

1. Fasting blood glucose (FPG) $\geq$ 126 mg/dL
2. Two-hour blood glucose (2-h OGTT) = 200 mg/dL
3. HbA1c values (A1c) $\geq$ 6.5%
4. Random plasma glucose $\geq$ 200 mg/dL

(With symptoms of hyperglycemia or hyperglycemic crisis)

In the absence of unequivocal hyperglycemia, diagnosis of DM using A1C, FPG or 2-h OGTT requires two abnormal test results from the same sample or in two separate samples.

References:

1. American diabetes association. Standards of medical care in diabetes 2024
2. National Library of Medicine – National Institute of Health (USA) – Diabetes Mellitus
3. World Health Organization – Factsheet on Diabetes – Prevention and treatment



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Ref. Id :	Collected at :	Approved on : 14-Aug-2026 18:08 Status : Revised
Ref. By : Dr. Self	Collected on : 14-Aug-2026 08:27	Printed On : 14-Aug-2026 18:09
	Sample Type : Urine	Process At : 640. GL SAWPL Lab Gujarat Ahmedabad Pa

Urine Albumin:Creatinine Ratio

Test	Result	Unit	Biological Ref. Interval
Microalbumin (per urine volume) <i>Immunoturbidometry</i>	3.00	mg/L	< 30
Creatinine, Urine <i>Creatinine Amidohydrolase</i>	63.4	mg/dL	<40 years : 24 - 392; >40 years : 22 - 328;
Albumin/Creatinine Ratio <i>Calculated</i>	4.73	mg/g	Normal: <30 Abnormal: 30-300 High Abnormal: >300

Albuminuria:

Albuminuria is increased excretion of urinary albumin and a marker of kidney damage. Normal individuals excrete very small amounts of protein in the urine. Albumin is the most common type of protein in the urine. All patients with CKD should be screened for albuminuria. Persistent increased protein in the urine (two positive tests over 3 or more months) is the principal marker of kidney damage, acting as an early and sensitive marker in many types of kidney disease.

Detecting Albuminuria:

A routine dipstick is not sensitive enough to detect small amounts of urine protein. Therefore, it is recommended that screening in adults with CKD or at risk for CKD be done by testing for albuminuria.

Albumin-to-creatinine ratio (ACR) is the first method of preference to detect elevated protein. The recommended method to evaluate albuminuria is to measure urinary ACR in a spot urine sample. ACR is calculated by dividing albumin concentration in milligrams by creatinine concentration in grams. Although the 24-hour collection has been the "gold standard," alternative methods for detecting protein excretion such as urinary albumin-to-creatinine ratio (ACR) correct for variations in urinary concentration due to hydration as well as provide more convenience than timed urine collections. The spot specimen correlates well with 24-hour collections in adults.

Definitions of Abnormalities in Albumin Excretion:

Moderately increased albuminuria, historically known as microalbuminuria, (ACR 30-300 mg/g) refers to albumin excretion above the normal range but below the level of detection by tests for total protein. Severely increased albuminuria, historically known as macroalbuminuria, (ACR >300) refers to a higher elevation of albumin associated with progressive decline in glomerular filtration rate. The following chart lists the albuminuria categories in CKD.

Reference: https://www.kidney.org/kidneydisease/siemens_hcp_acr

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Ref. By : Dr. Self	Collected on : 14-Aug-2026 08:27	Printed On : 14-Aug-2026 18:09
	Sample Type : Serum	Process At : 640. GL SAWPL Lab Gujarat Ahmedabad Pa

Immunoassay

Test	Result	Unit	Biological Ref. Interval
C-Peptide (Fasting) Chemiluminescence	H 6.44	ng/mL	1.1 - 4.4



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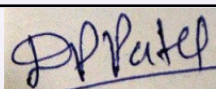
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Ref. By : Dr. Self	Collected on : 14-Aug-2026 08:27	Printed On : 14-Aug-2026 18:09
	Sample Type : EDTA blood	Process At : 643. GL SAWPL Lab Gujarat Ahmedabad Maninagar

Complete Blood Count

Test		Result	Unit	Biological Ref. Interval		
Hemoglobin	Colorimetric	L 11.4	g/dL	12.0 - 16.0		
RBC Count		4.61	million/cmm	3.8 - 4.8		
Hematocrit		L 35.0	%	36 - 48		
MCV		L 75.9	fL	83 - 101		
MCH		L 24.6	pg	26.4 - 33.2		
MCHC		32.4	g/dL	31.8 - 35.9		
RDW CV		H 14.70	%	11.6 - 14		
WBC count	Flowcytometry	9390	/cmm	4000 - 10000		
Neutrophils		58.3	%	40 - 80	5474 /cmm	1900 - 7900
Lymphocytes		36.0	%	20 - 40	3380 /cmm	1300 - 3600
Eosinophils		2.0	%	1 - 6	188 /cmm	00 - 400
Monocytes		3.7	%	2 - 10	347 /cmm	200 - 500
Basophils		0	%	0 - 2	0 /cmm	0 - 100
Platelet Count						
Platelet Count	Electric Impedance	280100	/cmm	150000 - 410000		
MPV		9.30	fL	7.5 - 10.3		
Peripheral Smear Examination						
RBC Morphology	Hypochromic(+), Microcytic(+), Anisocytosis(+)					
WBC Morphology	WBCs Series Shows Normal Morphology					
Platelets Morphology	Platelets are adequate on Smear					
Parasite	Malarial parasite is not detected.					
Erythrocytes Sedimentation Rate						
ESR	Capillary photometry	29	mm/1hr	0 - 23		



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Cl. Biochemistry

Test	Result	Unit	Biological Ref. Interval
Fasting Blood Glucose GOD-POD	107.9	mg/dL	74 - 110

	Fasting Blood Glucose*	Postprandial Blood Glucose #	Random Blood Glucose
Normal	< 100 mg/dL	< 140 mg/dL	< 140 mg/dL
Prediabetic	100 – 125 mg/dL	140 – 199 mg/dL	140 – 199 mg/dL
Diabetic	>=126 mg/dL	>= 200 mg/dl	>= 200 mg/dl

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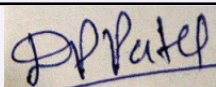
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Ref. By : Dr. Self	Collected on : 14-Aug-2026 08:27	Printed On : 14-Aug-2026 18:09
	Sample Type : Serum	Process At : 643. GL SAWPL Lab Gujarat Ahmedabad Maninagar

Renal Function Test

Test	Result	Unit	Biological Ref. Interval
Urea <i>Urease, Colorimetric</i>	39.0	mg/dL	10.0-50.0
Creatinine, serum <i>Kinetic Jaffe Reaction</i>	H 1.24	mg/dL	0.45 - 0.95
Sodium (Na+) <i>Direct- ISE</i>	L 134.8	mmol/L	136 - 145
Potassium (K+) <i>Direct- ISE</i>	4.75	mmol/L	3.5 - 5.1
Chloride (Cl-) <i>Direct- ISE</i>	105.7	mmol/L	98 - 107



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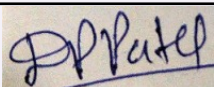
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	Sample Type : Serum	Process At : 643. GL SAWPL Lab Gujarat Ahmedabad Maninagar

Liver Function Test

Test	Result	Unit	Biological Ref. Interval
ALT (SGPT) <i>IFCC Method</i>	10.0	U/L	0 - 35
AST (SGOT) <i>IFCC Method</i>	12.8	U/L	0 - 35
GGT (Gamma Glutamyl Transferase)	17.8	U/L	5 - 32
Alkaline Phosphatase	80.1	U/L	35 - 104
Total Bilirubin	0.92	mg/dL	0.0 - 1.2
Conjugated Bilirubin <i>Cationic Mordant Binding</i>	0.22	mg/dL	0.0 - 0.3
Unconjugated Bilirubin <i>Cationic Mordant Binding</i>	0.70	mg/dL	0.0 - 1.1
Total Protein <i>Biuret</i>	7.07	g/dL	6.0 - 8.0
Albumin <i>Bromocresol Green Method</i>	4.10	g/dL	3.4 - 4.8
Globulin <i>Calculated</i>	2.97	g/dL	2.3 - 3.5
A/G Ratio <i>Calculated</i>	1.38		1.3 - 1.7



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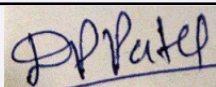


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Lipid Profile

Test	Result	Unit	Biological Ref. Interval
Cholesterol	201.2	mg/dL	150 - 220
Triglyceride <i>GPo-POD</i>	139.4	mg/dL	Normal : < 150 Borderline : 150-199 High : 200-499 Very High : > 500
HDL Cholesterol <i>PTA/MgCl2</i>	47.6	mg/dL	Low: < 40.0 High: >= 60.0
LDL Cholesterol <i>Modified Friedewald formula</i>	124.3	mg/dL	Optimal : < 100 Near / above optimal : 100-129 Borderline High : 130-159 High : 160-189 Very High : >190
VLDL <i>Calculated</i>	27.88	mg/dL	15 - 35
CHOL/HDL Ratio <i>Calculated</i>	4.2		Up to 5.0
Calculated LDL/HDL Ratio <i>Calculated</i>	2.6		Upto 3.5

Reference intervals are as per NCEP ATP-III criteria.



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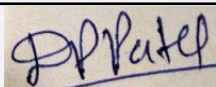
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Cl. Biochemistry

Test	Result	Unit	Biological Ref. Interval
Uric Acid	5.29	mg/dL	2.6-6.0
Calcium <i>Arsenazo III</i>	9.01	mg/dL	8.8 - 10.6
Phosphorus (PO4) <i>Phosphomolybdate Reduction</i>	3.04	mg/dL	2.5 - 4.5



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Ref. By : Dr. Self	Collected on : 14-Aug-2026 08:27	Printed On : 14-Aug-2026 18:09
	Sample Type : Serum	Process At : 640. GL SAWPL Lab Gujarat Ahmedabad Pa

Iron Studies

Test	Result	Unit	Biological Ref. Interval
Iron <i>Pyridyl azo Dye</i>	58.00	µg/dl	37 - 145
Total Iron Binding Capacity (TIBC) <i>Calculated</i>	366.000	µg/dl	120 - 480
Transferrin Saturation <i>Calculated</i>	15.85	%	Children : >16 Adult : 20 - 50



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	Sample Type : EDTA blood	Process At : 643. GL SAWPL Lab Gujarat Ahmedabad Maninagar

HbA1c (Glycosylated Hemoglobin) by HPLC

Test	Result	Unit	Biological Ref. Interval
HbA1c	13.70		4.0 - 6. % in Nondiabetic 6.0 - 7.0 % in good diabetic 7.0 - 8.0 % in Fair Above 8.0 % in poor
Mean Blood Glucose	346.49	mg/dL	

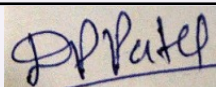
Description:

- Total haemoglobin A1 c is continuously synthesized in the red blood cell through its 120 days life span. The concentration of HBA1c in the cell reflects the average blood glucose concentration it encounters.
- The level of HBA1c increases proportionately in patients with uncontrolled diabetes. It reflects the average blood glucose concentration over an extended time period and remains unaffected by short-term fluctuations in blood glucose levels.
- The measurement of HbA1c can serve as a convenient test for evaluating the adequacy of diabetic control and in preventing various diabetic complications. Because the average half life of a red blood cell is sixty days, HbA1c has been accepted as a measurement which reflects the mean daily blood glucose concentration, better than fasting blood glucose determination, and the degree of carbohydrate imbalance over the preceding two months.
- It may also provide a better index of control of the diabetic patient without resorting to glucose loading procedures.

HbA1c assay Interferences:

Erroneous values might be obtained from samples with abnormally elevated quantities of other Haemoglobins as a result of either their simultaneous elution with HbA1c (HbF) or differences in their glycation from that of HbA (HbS).

Reference: American diabetes association. Standards of medical care in diabetes 2024



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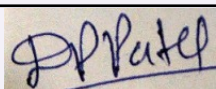
Thyroid Function Test

Test	Result	Unit	Biological Ref. Interval
T3, total (Triiodothyronine) ECLIA	1.24	ng/mL	0.8 - 2.00
T4, total (Thyroxine) ECLIA	13.81	µg/dl	5.10 - 14.10
TSH - Thyroid Stimulating Hormone Chemiluminescence	H 10.6500	µIU/mL	0.35 - 4.94

Levels of TSH in pregnancy (µIU/mL): First Trimester 0.1 - 2.5; Second Trimester 0.2 – 3.0; Third Trimester 0.3 – 3.0.

TSH	T3/FT3	T4/FT4	Suggested interpretation of Thyroid function tests pattern
Within range	Decreased	Within range	Isolated low T3 often seen in elderly & associated Non-Thyroid illness. In elderly the drop in T3 level can be up to 25%.
Raised	Within Range	Within Range	Isolated High TSH Especially in the range of 4.7 to 15 mIU/ml is commonly associated with physiological & Biological TSH Variability; Subclinical Autoimmune Hypothyroidism; Intermediate T4 therapy for hypothyroidism; Recovery phase after Non-Thyroidal illness.
Raised	Decreased	Decreased	Chronic Autoimmune Thyroiditis; Post thyroidectomy, post radioiodine; Hypothyroid phase of transient thyroiditis.
Raised or within range	Raised	Raised or within range	Interfering antibodies to thyroid hormones (anti-TPO antibodies); Intermediate T4 therapy of T4 overdose; Drug Interference-Amiodarone, Heparin, Beta blocker, steroids, anti-epileptics.
Decreased	Raised or within range	Raised or within range	Isolated Low TSH – Especially in the range of 0.1 to 0.4 often seen in elderly & associated with Non-Thyroidal illness; Subclinical Hyperthyroidism; Thyroxine ingestion.
Decreased	Decreased	Decreased	Central Hypothyroidism; Non-Thyroidal illness; Recent treatment for Hypothyroidism (TSH remains suppressed).
Decreased	Raised	Raised	Primary Hyperthyroidism (Graves' disease), Multinodular goitre Toxic nodule; Transient thyroiditis: postpartum, Silent (lymphocytic), Post viral (granulomatous, subacute, DeQuervain's) Gestational thyrotoxicosis hyperemesis gravidarum.
Decreased or within range	Raised	Within range	T3 toxicosis; Non-Thyroidal illness.

Reference: Wallach's Interpretation of Diagnostic by Mary Williamson, 10th edition, 2015.



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Passport No :

LABORATORY TEST REPORT



Patient Information	Sample Information	Client/Location Information
Name : Ms. Jagrutiben Shah	Lab Id : 082664300768	Client Name :
Sex/Age : Female / 70 Y	Registration on : 14-Aug-2026 08:27	Location : Laboratory
Ref. Id :	Collected at :	Approved on : 14-Aug-2026 12:49 Status : Revised
Ref. By : Dr. Self	Collected on : 14-Aug-2026 08:27	Printed On : 14-Aug-2026 18:09
	Sample Type : Serum	Process At : 643. GL SAWPL Lab Gujarat Ahmedabad Maninagar

Immunoassay

Test	Result	Unit	Biological Ref. Interval
Vitamin B12	695.40	pg/mL	197-771

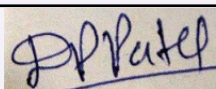
Vitamin B12 is essential in DNA synthesis, hematopoiesis, and CNS integrity.

Interpretation:

- Increased In:** Chronic granulocytic leukemia, COPD and Chronic renal failure, Leukocytosis, Liver cell damage (hepatitis, cirrhosis), Obesity and Severe CHF, Polycythemia vera, Protein malnutrition.
- Decreased In:** Abnormalities of cobalamin transport or metabolism, Bacterial overgrowth, Crohn disease, Dietary deficiency (e.g. in vegetarians), Diphylobothrium (fish tapeworm) infestation, Gastric or small intestine surgery, Hypochlorhydria, Inflammatory bowel diseases, Intestinal malabsorption and Intrinsic factor deficiency.

Limitations:

- Drugs such as chloral hydrate increase vitamin B12 levels. On the other hand, alcohol, aminosalicic acid, anticonvulsants, ascorbic acid, cholestyramine, cimetidine, colchicines, metformin, neomycin, oral contraceptives, ranitidine, and triamterene decrease vitamin B12 levels.
- The evaluation of macrocytic anemia requires measurements of both vitamin B12 and folate levels; ideally they should be measured simultaneously.
- Specimen collection soon after blood transfusion can falsely increase vitamin B12 levels.
- Patients taking vitamin B12 supplementation may have misleading results.
- A normal serum concentration of B12 does not rule out tissue deficiency of vitamin B12. The most sensitive test for B12 deficiency at the cellular level is the assay for MMA. If clinical symptoms suggest deficiency, measurement of MMA and homocysteine should be considered, even if serum B12 concentrations are normal.



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Sex/Age : Female / 70 Y	Registration on : 14-Aug-2026 08:27	Location : Laboratory
Ref. Id :	Collected at :	Approved on : 14-Aug-2026 15:32 Status : Revised
Ref. By : Dr. Self	Collected on : 14-Aug-2026 08:27	Printed On : 14-Aug-2026 18:09
	Sample Type : Serum	Process At : 643. GL SAWPL Lab Gujarat Ahmedabad Maninagar

Immunoassay

Test	Result	Unit	Biological Ref. Interval
25-OH Vitamin D Chemiluminescence	67.78	ng/mL	Deficiency: <10; Insufficiency: 10 - 30; Sufficiency: 30 - 100; Toxicity: >100

Vitamin D is a fat soluble vitamin and exists in two main forms as cholecalciferol(vitamin D3) which is synthesized in skin from 7-dehydrocholesterol in response to sunlight exposure & Ergocalciferol(vitamin D2) present mainly in dietary sources.Both cholecalciferol & Ergocalciferol are converted to 25(OH)vitamin D in liver.

Interpretation:

Increased In

- Vitamin D intoxication
- Excessive exposure to sunlight

Decreased In

- Malabsorption
- Steatorrhea
- Dietary osteomalacia, anticonvulsant osteomalacia
- Biliary and portal cirrhosis
- Thyrotoxicosis
- Pancreatic insufficiency
- Celiac disease
- Rickets
- Alzheimer disease

Limitations:

More recently, it has become clear that receptors for vitamin D are present in a wide variety of cells and that this hormone has biologic effects extending beyond the control of mineral metabolism. Vitamin D deficiency is not clear. Levels needed to prevent rickets and osteomalacia (15 ng/mL) are lower than those that dramatically suppress parathyroid hormone levels (20–30 ng/mL). In turn, those levels are lower than levels needed to optimize intestinal calcium absorption (34 ng/mL). Neuromuscular peak performance is associated with levels approximately 38 ng/mL. A recent study states that increasing mean baseline levels from 29 to 38 ng/mL was associated with a 50% lower risk for colon cancer and levels of 52 ng/mL with a 50% reduction in the incidence of breast cancer. It is recommended to have clinical correlation with serum 25(OH)vitamin D, serum calcium, serum PTH & serum alkaline phosphatase.



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Sex/Age : Female / 70 Y	Registration on : 14-Aug-2026 08:27	Location : Laboratory
Ref. Id :	Collected at :	Approved on : 14-Aug-2026 17:12 Status : Revised
Ref. By : Dr. Self	Collected on : 14-Aug-2026 08:27	Printed On : 14-Aug-2026 18:09
	Sample Type : Serum	Process At : 640. GL SAWPL Lab Gujarat Ahmedabad Pa

Immunoassay

Test	Result	Unit	Biological Ref. Interval
CA 125	16.60	U/mL	<35

Cancer antigen 125 (CA 125) is a glycoprotein antigen normally expressed in tissues derived from coelomic epithelia (ovary, fallopian tube, peritoneum, pleura, pericardium, colon, kidney, stomach). Serum CA 125 is elevated in approximately 80% of women with advanced epithelial ovarian cancer, but assay sensitivity is suboptimal in early disease stages. The average reported sensitivities are 50% for stage I and 90% for stage II or greater. Elevated serum CA 125 levels have been reported in individuals with a variety of nonovarian malignancies including cervical, liver, pancreatic, lung, colon, stomach, biliary tract, uterine, fallopian tube, breast, and endometrial carcinomas. Elevated serum CA 125 levels have been reported in individuals with a variety of benign conditions including: cirrhosis, hepatitis, endometriosis, first trimester pregnancy, ovarian cysts, and pelvic inflammatory disease. Elevated levels during the menstrual cycle also have been reported

Interpretation

1. In monitoring studies, elevations of cancer antigen 125 (CA 125) above the reference interval after debulking surgery and chemotherapy indicate that residual disease is likely (>95% accuracy). However, normal levels do not rule-out recurrence.
2. A persistently rising CA 125 value suggests progressive malignant disease and poor therapeutic response.
3. In patients with advanced disease who have undergone cytoreductive surgery and are on chemotherapy, a prolonged half-life (>20 days) may be associated with a shortened disease-free survival.

Limitation

1. Not useful as a screening assay for cancer detection in the normal population
2. Results cannot be interpreted as absolute evidence of the presence or absence of disease.
3. Serum markers are not specific for malignancy and values may vary by method. Values obtained with different assay methods cannot be used interchangeably.
4. Some individuals have antibodies to mouse protein (HAMA), which can cause interference in immunoassays that employ mouse antibodies. In particular, it has been reported that serum specimens from patients who have undergone therapeutic or diagnostic procedures that include infusion of mouse monoclonal antibodies may produce erroneous results in such assays. Rerunning the specimen in question after additional blocking treatment may resolve the issue.



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Ref. Id :	Collected at :	Approved on : 14-Aug-2026 15:17 Status : Revised
Ref. By : Dr. Self	Collected on : 14-Aug-2026 08:27	Printed On : 14-Aug-2026 18:09
	Sample Type : Serum	Process At : 640. GL SAWPL Lab Gujarat Ahmedabad Pa

Immunoassay

Test	Result	Unit	Biological Ref. Interval
Homocysteine	14.69	μmol/L	5 - 15

Summary and Uses:

- Total Hcy is a thiol-containing amino acid, produced by the intracellular demethylation of methionine to cysteine.
- Elevated levels of t Hcy may be used to exclude or confirm deficiencies of vitamin B12 or folate.
- It is recommended to test in patients using medications that interfere with folate status (methotrexate, antiepileptics), vegetarians without B12 supplementations, unexplained anemia, peripheral neuropathy or myelopathy, recurrent spontaneous abortions or infertility.
- Testing also recommended for patients 40 years of age with coronary artery disease to exclude homocystinuria.
- Elevations in tHcy levels have also been used as an independent risk factor of coronary or cerebral vascular disease. Treatment of moderate hyperhomocystinemia with folic acid supplementation for primary and secondary cardiovascular protection has met with inconsistent results and at present cannot be routinely recommended.

Limitations:

- The plasma must be separated immediately on collection to avoid continuous synthesis of Hcy by red cells.
- Samples must be immediately stored on ice and serum centrifuged immediately before a complete clot is formed.
- Certain drugs, such as anticonvulsants, methotrexate, or nitrous oxide, may interfere with the assay.
- Cigarette smoking and coffee consumption increase tHcy levels.
- Intraindividual variability is approximately 8%; it can be as much as 25% in patients with hyperhomocystinemia.
- Generally, a single measurement of tHcy is considered adequate.



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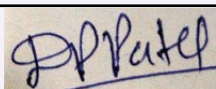


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Ref. By : Dr. Self	Collected on : 14-Aug-2026 08:27	Printed On : 14-Aug-2026 18:09
	Sample Type : Urine	Process At : 643. GL SAWPL Lab Gujarat Ahmedabad Maninagar

Urine Routine Examination

Test	Result	Unit	Biological Ref. Interval
Physical & Chemical (Dip strip) examination			
Volume	20	ml	
Colour	Pale Yellow		Pale Yellow
Clarity	Clear		Clear
pH <i>Double indicator</i>	6.5		4.6 - 8.0
Specific Gravity <i>Polyelectrolyte based reaction</i>	1.020		1.005 - 1.030
Glucose <i>GOD-POD</i>	Present (+)		Absent
Protein <i>Protein error of indicators</i>	Absent		Absent
Blood <i>Peroxidase like reaction</i>	Absent		Absent
Bilirubin <i>Diazo reaction</i>	Absent		Absent
Urobilinogen <i>Modified Ehrlich reaction</i>	Absent		Absent
Ketone <i>Nitroprusside</i>	Absent		Absent
Nitrite <i>p-arsanilic acid to diazonium compound</i>	Negative		Absent
Microscopic Examination			
Pus Cells	2-3	/hpf	0 - 5
Erythrocytes (RBCs)	Nil	/hpf	0 - 2
Epithelial Cells	1-2	/hpf	
Casts	Absent		Absent
Crystals	Absent		Absent
Amorphous Material	Absent		Absent
Bacteria	Absent		Absent

----- End Of Report -----



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