



Freiburg Medical Laboratory Middle East (L.L.C)

P.O. Box: 3068, Dubai - UAE, Tel: 04 396 2227, Fax: 04 396 2228

E-mail: info@fml-dubai.com, Website: www.fml-dubai.com

Physician:

Dr. M. Jaksch
Freiburg Medical Lab

Laboratory Report Online Version

Report Date: 27.04.2016

Patient Name: sample report UAE risk profile

Gender: Female
Date of Birth: 01.01.1973
Nationality:
Your ID:

Test Request Code: 1276
Sample ID:
Patient IDNo: 380030

Sampling Date / Time: 27.04.2016 / 16:18
Receipt Date / Time: 27.04.2016 / 16:18

Remarks:

Insurance:

Analysis	Result	Flag	Units	Reference Range
Haematology				
CBC (EDTA blood)				
WBC	7.6		10 ³ /μl	4.0 - 10.0
RBC	5.42	high	10 ⁶ /μl	3.8 - 4.8
The constellation (MCV, MCH and RBC) could point to hemoglobinopathy (i.e. thalassemia trait). We recommend to perform Hb-HPLC.				
HGB	12.0		g/dl	12.0 - 15.0
HCT	38.8		%	36.0 - 46.0
MCV	71.6	low	fl	83.0 - 101.0
MCH	22.1	low	pg	27.0 - 32.0
MCHC	30.9	low	g/dl	31.5 - 36.0
PLT	272		10 ³ /μl	150 - 450
Differential Count (automatic)				
Neutrophils	50.4		%	50 - 70
Lymphocytes	42.4	high	%	20 - 40
Monocytes	5.2		%	4 - 12
Eosinophils	1.7		%	0 - 4
Basophils	0.3		%	0 - 2
Neutrophils absolute	3.8		10 ³ /μl	2.0 - 7.0
Lymphocytes absolute	3.2		10 ³ /μl	0.8 - 4.0
Monocytes absolute	0.4		10 ³ /μl	< 1.2
Eosinophils absolute	0.1		10 ³ /μl	< 0.4

Note:

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Daily internal Quality Control within the required range (according to ISO 15189).

External Quality Control available on request.

^ non-accredited parameter

* This investigation has been performed in a collaborating accredited laboratory (Germany).

Techn. Validation by
Amira Fahd
Chief Technician
(DHA-LS-241791)

Dr. Nehmat ElBanna
Specialist
Clinical Pathology (U/S)
(DHA-P-0084548)

PD Dr. med. habil. M. Jaksch
Associate Professor
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Differential Count (automatic), Continuation				
Basophils absolute	0.0		10 ³ /μl	0.0 - 0.1
Coagulation (Citratd Plasma)				
PT (COAG)	81		%	70 - 130
INR (CALC)	1.23	high	ratio	0.85 - 1.20
INRs are calculated using the international normalized ratio formula including the lot depending reagent factor ISI. In rare cases, INRs are flagged, however the values should be considered normal.				
Proteins/Metabolites (Serum)				
Lipid Studies in mg/dl (Recommendations for Adults from the American Heart Association)				
Cholesterol, total (PHO)	150		mg/dl	100 - 199
Normal: 100 - 199, Desirable: < 200, Borderline: 200 - 239, High Risk: >240				
Triglycerides (PHO)	54		mg/dl	< 150
Normal: < 150, Borderline: 150 - 199, High: 200 - 499, Very High: >500				
HDL Cholesterol, direct (PHO)	65.3		mg/dl	> 50
Increased Risk Men: < 40, Increased Risk Women: < 50, Normal: 50 - 60, Optimal: > 60				
LDL Chol., Friedewald (CALC)	74		mg/dl	< 100
Optimal: < 100, Near Optimal: 100 - 129, Borderline: 130 - 159, High: 160 - 189, Very High: > 190				
VLDL (CALC)	10.8		mg/dl	< 30.0
Cholesterol/HDL (CALC)	2.3		Ratio	2.0 - 4.4
Normal: 2.0 - 4.4, Desirable: < 4.5, Borderline: 4.5 - 6.0, Increased Risk: > 6.0				

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Proteins/Metabolites (Serum)				
Lipid Studies in mmol/l (Recommendations for Adults from the American Heart Association)				
Cholesterol, total (PHO)	3.9		mmol/l	2.6 - 5.1
Normal: 2.6 - 5.1, Desirable: < 5.2, Borderline: 5.2 - 6.2, High Risk: >6.2				
Triglycerides (PHO)	0.6		mmol/l	< 1.7
Normal: < 1.7, Borderline: 1.7 - 2.2, High: 2.2 - 5.6, Very High: >5.6				
HDL Cholesterol, direct (PHO)	1.7		mmol/l	>1.3
Increased Risk Men: < 1.0, Increased Risk Women: < 1.3, Normal: 1.3 - 1.6, Optimal: > 1.6				
LDL Chol., Friedewald (CALC)	1.9		mmol/l	< 2.6
Optimal: < 2.6, Near Optimal: 2.6 - 3.3, Borderline: 3.4 - 4.1, High: 4.2 - 4.9, Very High: > 4.9				
VLDL (CALC)	0.28		mmol/l	<0.77
Cholesterol/HDL (CALC)	2.3		Ratio	2.0 - 4.4
Normal: 2.0 - 4.4, Desirable: < 4.5, Borderline: 4.5 - 6.0, Increased Risk: > 6.0				
Proteins/Metabolites (EDTA-Plasma)				
Homocysteine (PHO)	8.7		umol/l	<12.0
Proteins/Metabolites (Serum)				
Albumin (PHO)	4.4		g/dl	3.5 - 5.0
Total Bilirubin (PHO)	0.6		mg/dl	0.2 - 1.1
Ferritin (TURB)	21.1		ng/ml	15.0 - 150.0
Lipoprotein (a) (TURB)	22.4		nmol/l	< 75.0

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Units

Reference Range

Elevated lipoprotein (a) increases the risk for CHD in combination with other CHD risk factors. A moderately strong association of Lp (a) with CHD has been established independently of the classical vascular risk factors.

The risk of angina pectoris is increased with high concentration of Lp (a) and it is more significant if accompanied by high LDL-C concentration.

Treatment with Niacin reduces Lp (a) levels by 30-40% and yields other potential beneficial effects by reducing LDL cholesterol, total cholesterol, triglycerides, remnant cholesterol and by raising HDL cholesterol.

Ref: Borge G. Nordestgaard, M. John Chapman, Kausik Ray et al. for the European Atherosclerosis Society Consensus Panel: Lipoprotein (a) as a cardiovascular risk factor: current status.

Source: European Heart Journal: 2010; 31:2844-2853

Total Protein (PHO)	7.4		g/dl	6.4 - 8.3
Uric Acid (PHO)	4.7		mg/dl	2.6 - 7.2

2012 American College of Rheumatology
Guidelines for Management of Gout

- Serum urate level should be lowered sufficiently to durably improve signs and symptoms of gout, with the target <6 mg/dl at a minimum, and often <5mg/dl
- The task force panel recommended that the goal of urate lowering therapy is to achieve a serum urate level target at a minimum of 6 mg/dl in all gout case scenarios (evidence A).
- Moreover, the task force panel recommended that the target serum urate level should be lowered sufficiently to durably improve signs and symptoms of gout, including palpable and visible tophi detected

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by physical examination, and this may involve therapeutic serum urate level lowering to below 5 mg/dl (evidence B).

Source: Kanna D et al, Arthritis Care & Research 2012, 64, 1431 - 1446

Proteins/Metabolites (EDTA blood)

HbA1c acc. to IFCC (TURB)	35		mmol/mol	29 - 42
HbA1c acc. DCCT/NGSP (TURB)	5.3		%	4.8 - 6.0
Estimated avg. Glucose (CALC)	107		mg/dl	92 - 127

The American Diabetes Association (ADA) suggests an HbA1c level of 7% DCCT (53mmol/mol IFCC) and below (reflecting an average glucose level of 154mg/dl) as the therapeutic target. However, more or less stringent glycemic goals may be appropriate for each individual (please refer to the ADA website: www.diabetes.org).

ADA defines the cut-off point for HbA1c in the diagnosis of diabetes at 6.5% DCCT (48 mmol/mol IFCC).

Please note that we have adjusted the unit according to the recommendation of the IFCC. Reference HbA1c (IFCC/NGSP). Source: www.ngsp.org/docs/IFCCstd.pdf

Enzymes (Serum)

ALT/GPT (PHO)	83	high	U/l	< 32
AST/GOT (PHO)	42	high	U/l	< 33
Alk. Phosphatase (PHO)	64		U/l	35 - 104
Cholinesterase (PHO)	7604		U/l	5320 - 12920
GGT (PHO)	20		IU/l	5 - 39
LDH (PHO)	143		U/l	135 - 214

Endocrinology (Serum)

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Endocrinology (Serum), Continuation

TSH (ECL)	4.85	high	mIU/l	0.30 - 4.20
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We recommend to test for FT3 and FT4.

Important note:

Revised TSH levels:

The American Association of Clinical Endocrinologists (AACE), www.aace.com and the American Thyroid Association (ATA), www.thyroid.org have released guidelines to lower the TSH reference range to 0.3 - 3.0 mIU/l in order to not miss any latent hypothyreosis. The discussion is still controversial, however Freiburg Medical Laboratory recommends to consider TSH levels from 3.0 - 4.2 mIU/l as greyzone (borderline increased TSH) and definitely elevated TSH levels >4.2 mIU/l.

TSH values in pregnancy:

First Trimester: 0.03 - 3.00 mIU/l

Second Trimester: 0.10 - 3.00 mIU/l

Third Trimester: 0.20 - 3.50 mIU/l

(2.5th - 97.5th percentiles)

Source:

Guidelines of the American Thyroid Association for the Diagnosis and Management of Thyroid Disease During Pregnancy and Postpartum.

A. Stagnaro-Green et al. (2011) Thyroid 21:10;1081-1125

Vitamins (Serum, light-protected)

Vitamin D (25 OH), total (ECL)	18.6	low	ng/ml	30.0 - 80.0
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Deficient: <20 Borderline: 20 - 30 Desirable >30

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Important note:

The two most important forms for detecting Vitamin D deficiency are 25-OH-Vitamin D3 and 25-OH-Vitamin D2. Vitamin D3 ("human or animal form", cholecalciferol) is mainly produced in the skin after sun exposure but can also be taken up through food; Vitamin D2 ("plant form", ergocalciferol) can be obtained only from fortified foods and supplements. Both forms are metabolized in the liver to the inactive form 25-OH-Vitamin D and stored until needed, at which point 25-OH-Vitamin D is converted in the kidney to the active 1.25-(OH)2-Vitamin D. Please note that this active form does not reflect Vitamin D deficiency as it is tightly regulated by PTH, Calcium and Phosphate. Therefore 1.25-(OH)2-Vitamin D testing is indicated in kidney disorders only (insufficiency, dialysis etc.).

The concentration of 25-OH-Vitamin D in serum reflects the stored supply of all Vitamin D (D3 and D2) and gives a good indication of the Vitamin D deficiency status of the patient. Normally, more than 95% of the measured 25-OH-Vitamin D is D3; Vitamin D2 can only be measured if Vitamin D2 supplements are being taken. Our newly evaluated test, compared with liquid chromatography/mass spectrometry (LCMS), measures the serum concentration of total 25-OH-Vitamin D (immunological method). Should you require a separate measurement of D3 and D2 levels, this can be done through our partners in Germany using LCMS.

Microbiology (Stool)

H. Pylori Ag in Stool (EIA)	positive	qualitative	negative
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Using monoclonal antibodies, this test is highly sensitive and specific.

Serology: Hepatitis B (Serum)

Hepatitis Bs Ag (ECL)	0.5	COI	< 0.9
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No sign of Hepatitis B infection.

Serology: Hepatitis C (Serum)

HCV Abs (ECL) **0.08** S/CO <1.00

No sign of Hepatitis C infection.

Autoimmune Diagnostics (Serum)

Thyroid Antibodies

TPO Abs (ECL) **9.3** IU/ml 0 - 34

Detection frequency of TPO Abs.:

Disease	TPO Abs. positive
Hashimoto Thyroiditis	60 - 90 %
Primary Myxoedema	40 - 70 %
Morbus Basedow	60 - 70 %
Postpartum Thyroiditis	50 - 70 %
Cytokine induced Thyroiditis	30 - 40 %
Subacute Thyroiditis de Quervain	< 5 %
Autonomy of the thyroid gland	approx. 5 %
Healthy Person	approx. 5 %

Thyreoglobulin Abs. (ECL) **12.9** IU/ml < 115

Detection frequency of TG Abs.:

Disease	TG Abs positive
Hashimoto Thyroiditis	30 - 40 %
Primary Myxoedema	20 - 30 %

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Postpartum Thyroiditis	20 - 40 %			
Cytokine induced Thyroiditis	10 - 20 %			
Subacute Thyroiditis de Quervain	0 - 20 %			
Autonomy of the thyroid gland	approx. 5 %			
Healthy Person	approx. 5 %			

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