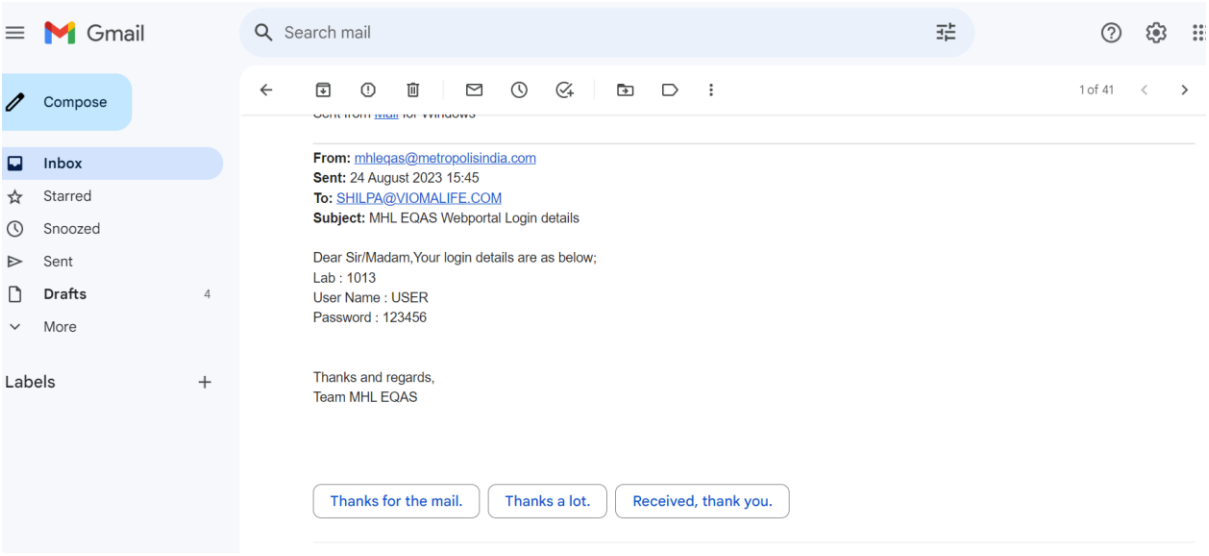
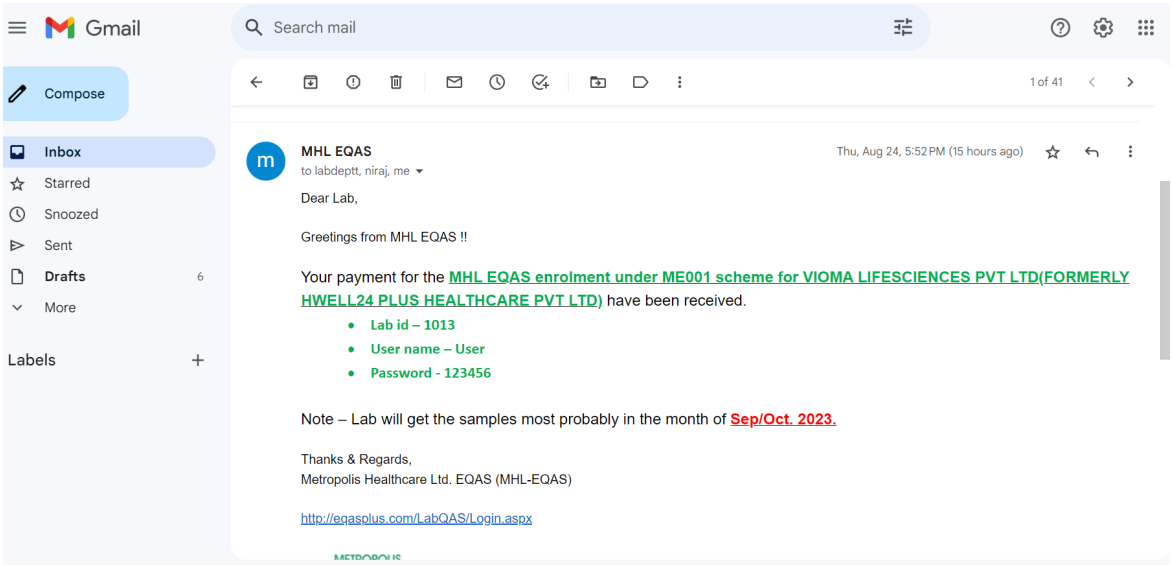
PT Participation - Enrollment from Metropolis, Mumbai





Register office: Off swami vivekanand road, Anand nagar, Sandoz Baugh, Thane MH 400607 India.
Website: www.viomalife.com CIN no: U74999MH2017PTC295120

Patient	: **JAIKEE MAURYA**	**Reg. No.**	: **00032**
Age	: **23 Years**	**Reg. Date**	: **17 Jul 2023 4:06 PM**
Sex	: **Male**	**Report Date**	: **17 Jul 2023 6:37 PM**
Ref. by	: **Self**	**Mobile No.**	: **8542046772**

Biochemistry

TEST	RESULT	UNIT	REFERENCE RANGE
Blood Glucose Fasting Method: GOD - POD METHOD	102.60	mg/dl	65.00 to 110.00
Urine Sugar Fasting	No Sample		
Urine Albumin Fasting	No Sample		
Urine Ketone Fasting	No Sample		

Instrument used: Fully Automated Random Access Biochemistry Analyzer
Note: Kindly Co-relate Clinically

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LIPID PROFILE

TEST	RESULT	UNIT	REFERENCE RANGE
Serum Appearance	Clear		
Serum Total Cholestrol Method: CHOD-PAP	136.6	mg/dl	130 Low Level 200 Desirable 200 - 239 Borderline High > 240 High
Serum Triglycerides Method: GPO-TOPS	**180.4**	mg/dl	160 Desirable 200 - 400 Borderline High 400 - 1000 High > 1000 Very High
HDL Cholesterol Method: Third Genration Direct Homogeneous	38.3	mg/dl	30 Low 70 High
LDL Cholestrol Method: Calculated	62.22	mg/dl	100 Optimal 100 -129 Near Optimal 130 -159 Borderline High 160 -189 High > 190 Very High
VLDL Cholesterol Method: Calculated	**36.08**	mg/dl	7.0 to 35.0
S.Cholesterol/HDL Ratio	3.57		5.0 dec risk of heart diseas
LDL Cholestrol/HDL Cholestrrol Method: Calculated	1.62		Desirable;Less than 3.60
S.Triglycerides/HDL Cholestrol Method: Calculated	**4.71**	-	Desirable: Less than 3.00

Interpretation:
Triglycerides are lipid compounds composed of glycerol esterified to 3 fatty acid chains of varying length and composition. These fatty acid chains can be saturated or unsaturated, and the chemical composition of each chain is different. Each chain consists of carbon and hydrogen atoms with varying single or double-bonded chains, depending on the degree of saturation or unsaturation. Triglycerides are formed of mixed chains, and the structural comparison between the chains is heterogeneous in nature.Serum triglyceride levels and classifications are as follows.
Less than 100 mg/dL - Optimal.101-150 mg/dL - Normal. 150-199 mg/dL - Borderline, 200-499 mg/dL - High. 500 mg/dL or higher - very high
Cholesterol : CHOD PAP; HDL Cholesterol: Direct; LDL: Direct Measurement; Triglycerides: GPO;

Note:
High Lipid / Tg values may be seen in Lipemic / Milky serum samples, Kindly repeat the test in 10-12 hrs fasting condition(ldl,vldl and {LDL VLDL AND RATIO ARE NOT APPLICABLE FOR HIGH TG VALUES}
Instrument used: Fully Automated Random Access Biochemistry Analyzer
Note: Kindly Co-relate Clinically

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HbA1C (Glycosylated Haemoglobin)

TEST	RESULT	UNIT	REFERENCE RANGE
HbA1C (IFA)	3.90	%	Normal 4.5 - 6.3 Good Control 6.4 - 7.5 Moderate Control 7.5 - 9.0 Poor Control 9.0 and Above.
Mean Blood Glucose Level	**65.15**	mg/dl	70.00 to 140.00
METHOD	IMMUNO FLUROSCENCE ASSAY ON ICHROMAII		

Note:
Glycosylated Haemoglobin is an accurate and true index of the " Mean Blood Glucose Level in the body for the previous 2-3 months.
HbA1c is an indicator of glycemic control. HbA1c represents average glycemia over the past six to eight weeks.
Glycation of hemoglobin occurs the entire 120 days life span of the red blood cell but within this 120 days.
Recent glycemia has the largest influence on the HbA1c value.
Clinical studies suggest that a patient in stable control will have 50% of their HbA1c formed in the mouth before sampling, 25% in the month before that, and the remaining 25% in months 2-4.
Note: Kindly Co-relate Clinically

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LIPASE

TEST	RESULT	UNIT	REFERENCE RANGE
LIPASE	50.7	U/L	0.0 to 64.0
Method	Enzymatic		

Interpretation:
Lipase is an enzyme produced mainly by the pancereas and secreted into the small intestine, where it breaks down fat into fatty acids and glycerol. Often lipase test is ordered along with serum Amylase, helps in diagnosis and monitoring of acute and chronic pancreatitis. It is also ordered in patient of Cystic fibrosis, Coeliac Disease and Crohns disease. In Acute pancreatitis, lipase level are frequently very high, often 5-10 times the highest reference value, lipase concentration typically rises within 24 to 48 hours of an actue pancreatic attack and remains elevated for about 5 to 7 days. Concentrations may also be increased with pancreatic duct obstruction, cholecystitis, duodenal ulcer, Gastroenteritis, Macrolipasemia, Pancreatic cancer and other pancreatic diseases. Drugs that may increase lipase level include codeine, indomethacin and morphine. Decreased lipase level may indicate permanent damage to lipase producing cells which occurs in chronic pancreatic disease such as Cystic fibrosis

Instrument used: Fully Automated Random Access Biochemistry Analyzer
Note: Kindly Co-relate Clinically

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AMYLASE, PANCREATIC ALPHA, SERUM

TEST	RESULT	UNIT	REFERENCE RANGE
Serum Amylase	48.9	IU/L	25.0 to 125.0

Interpretation:
Amylase is an enzyme that catalyzes the breakdown of starch into sugars. Amylase is present in human saliva. The pancreas also makes amylase to hydrolyze dietary starch into disaccharides & trisaccharides. The raised level is found in acute pancreatic inflammation [more specific along with Lipase], also in cholecystitis, perforated peptic ulcer, torsion of ovarian cyst, strangulation ileus, viral hepatitis, ruptured ectopic pregnancy macroamylasemia, mumps, lung, and pancreatic carcinoma. It is also measured in urine and peritoneal fluid. Hyperlipidemic patients with pancreatitis may show normal or near-normal amylase levels, as triglycerides cause suppression of amylase activity.

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MAGNESIUM

TEST	RESULT	UNIT	REFERENCE RANGE
S.MAGNESIUM	2.16	mg/dl	1.6 to 3.0

Instrument used: Fully Automated Random Access Biochemistry Analyzer
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ELECTROLYTES SERUM (Na, K, CL)

TEST	RESULT	UNIT	REFERENCE RANGE
Serum Sodium	144.2	mmol/L	135.0 to 155.0
Serum Potassium	4.1	mmol/L	3.5 to 5.6
Serum Chlorides	105.0	mmol/L	94.0 to 110.0

Instrument used: Fully Automated Random Access Biochemistry Analyzer
Note: Kindly Co-relate Clinically

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RENAL FUNCTON TEST

TEST	RESULT	UNIT	REFERENCE RANGE
Blood Urea	18.15	mg/dl	10.0 to 50.0
Blood Urea Nitrogen (BUN)	8.48	mg/dl	7.0 to 21.0
Serum Creatinine Method: Kinetic Method	0.90	mg/dl	0.50 to 1.50
Serum Uric Acid	5.58	mg/dl	3.5 to 7.0
Serum Phosphorous Method: Ammonium Molybdate.	**2.4**	mg/dl	2.5 to 5.0
Serum Calcium (Observed)	9.8	mg/dl	8.0 to 11.5
Serum Sodium	144.2	mmol/L	135.0 to 155.0
Serum Potassium	4.1	mmol/L	3.5 to 5.6
Serum Chlorides	105.0	mmol/L	94.0 to 110.0

Instrument used: Fully Automated Random Access Biochemistry Analyzer
Note: Kindly Co-relate Clinically

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LIVER FUNCTION TEST (LFT)

TEST	RESULT	UNIT	REFERENCE RANGE
Bilirubin - Total Method: Tab	0.92	mg/dl	0.10 to 1.20
Bilirubin - Direct Method: Daizo	0.28	mg/dl	0.00 to 0.40
Bilirubin - Indirect Method: Calculated	0.64	mg/dl	0.10 to 1.00
SGPT Method: IFCC	23.5	IU/L	0.0 to 45.0
SGOT Method: IFCC	26.5	IU/L	0.0 to 45.0
Alkaline Phosphatese Method: IFCC	71.7	IU/L	25.0 to 279.0
Total Proteins Method: Direct Biuret	7.62	gm/dl	6.70 to 8.70
Serum Albumin Method: Bromocresol green	5.01	gm/dl	3.70 to 5.30
Serum Globulin Method: Calculated	2.61	gm/dl	2.30 to 3.60
A/G Ratio Method: Calculated	1.92		

Instrument used: Fully Automated Random Access Biochemistry Analyzer
Note: Kindly Co-relate Clinically

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JAIKEE MAURYA

PID NO: P112301521722/
ILC SAMPLE
Age: 23.0 Year(s) Sex: Male

Reference:
Sample Collected At:
Hwell24 Plus Healthcare Pvt. Ltd
C-211 Eastern Business District, Lbs Road, Bhandup West - 400078.
Processing Location:- Metropolis Healthcare Ltd,Unit No409-416,4th Floor,Commercial Building-1,Kohinoor Mall,Mumbai-70

VID: 230011001517034
Registered On:
18/07/2023 04:18 PM
Collected On:
18/07/2023 4:22PM
Reported On:
19/07/2023 08:42 AM

Investigation	Observed Value	Unit	Biological Reference Interval
Magnesium (Serum,Colorimetry end point (Xylidyl blue))	2.23	mg/dL	1.6-2.6

Interpretation:
- High levels of magnesium may result from taking too many supplements/antacids/laxatives that contain magnesium, kidney disease, Addison disease, dehydration and diabetic ketoacidosis.
- Low levels of magnesium may be seen in chronic diarrhea, hemodialysis, gastrointestinal disorders, cirrhosis, hyperaldosteronism, hypoparathyroidism, severe burns, pancreatitis, preeclampsia, ulcerative colitis and uncontrolled diabetes.

Clinical Utility:
- Magnesium is a mineral that is important for immunity, muscle contraction, nerve function, strong bones and regulating blood pressure as well as blood sugar.
- Helps in monitoring patients with preeclampsia who are on magnesium sulfate supplements.

Note:
- Heavy periods and excessive sweating may affect the test results.
- Magnesium blood levels tend to be decreased in the second and third trimesters of pregnancy.
- It is suggested to stop taking magnesium supplements for a few days before the test

Caution:
- Drugs that can increase magnesium levels include lithium, aspirin, thyroid medication, few antibiotics and products that contain magnesium.
- Drugs that can decrease magnesium levels include digoxin, cyclosporine, diuretics, insulin, few antibiotics and phenytoin.

Associated Tests: Sodium (S0032), Calcium (C0017), Potassium (P0078), Chloride (C0101), Parathyroid hormone (P0114)

References:

- Kit Insert.
- Tietz Textbook of Clinical Chemistry. Chapter 49: Fourth edition.
- Henry's Clinical Diagnosis and Management by Laboratory Methods. 22nd ed. St Louis, MO: Elsevier; 2017.

Amylase level (Serum,Enzymatic colorimetric assay acc. to IFCC.)	46	U/L	28-100

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Investigation	Observed Value	Unit	Biological Reference Interval

Interpretation :

- Increased in RA, Chronic hepatitis, chronic viral infections, cirrhosis, Infectious mononucleosis, leishmaniasis, leprosy, malaria sarcoidosis Syphilis, TB etc.
- High levels are also seen in inflammatory rheumatic diseases and in various non rheumatic diseases.

Clinical Utility:

- The detection of rheumatoid factor (RF) is one of the criteria of the American Rheumatism Association (ARA) for the diagnosis of Rheumatoid Arthritis (RA) especially when clinical diagnosis is difficult.
- RFs play an important role in the differential diagnosis between RA and other rheumatic diseases. They also permit prognostic statements with regards to RA.

Note:

- Values of RA may increase with age. It should be interpreted along with overall clinical picture.
- Recent blood transfusion, multiple vaccinations or transfusions may affect results.
- Serum with cryoglobulin or high lipid levels may cause false-positive test results.

Associated Tests: Rheumatoid Arthritis Panel (R0022), Cyclic Citrullinated Peptide Antibody (CCP Antibody) Serum (C0047)

Reference:

- Package insert
- Wallach's interpretation of diagnostic tests, Ed11, 2020
- Henry's Clinical Diagnosis and Management by Laboratory Methods. 23rd ed; 2017.
- Tietz fundamentals of clinical chemistry 6th edition. Burtis CA, Ashwood ER, Bruns DE, 2008.

Glucose fasting (Plasma-F,UV Hexokinase)	91	mg/dL	Normal: 70-99 Impaired Fasting Glucose(IFG): 100-125 Diabetes mellitus: >= 126 (on more than one occassion) (American diabetes association guidelines 2022)

Note: An individual may show higher fasting glucose level in comparison to post prandial glucose level due to following reasons : The glycaemic index and response to food consumed, Changes in body composition, Increased insulin response and sensitivity, Alimentary hypoglycemia, Renal glycosuria, Effect of oral hypoglycaemics & Insulin treatment.

Associated Tests: HbA1c (H0018), Diabetes Profile – Maxi (D0021),HOMA Index (H0275), Insulin (I0275).

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Investigation	Observed Value	Unit	Biological Reference Interval
BUN-Blood Urea Nitrogen (Serum,Urease)	7.8	mg/dL	6-20

Remark: In blood, Urea is usually reported as BUN and expressed in mg/dl. BUN mass units can be converted to urea mass units by multiplying by 2.14.

Creatinine (Serum,Jaffes method(IDMS TRACEBLE))	0.94	mg/dL	0.90-1.30

Interpretation - Creatinine is a waste product formed in muscles from the high energy storage compound, creatine phosphate. The amount of creatinine produced is constant (unlike Urea) and is primarily a function of muscle mass.
Physiological factors affecting serum creatinine concentration includes age, gender, race, muscularity, exercise, Pregnancy, certain drugs, diet, dehydration and nutritional status.
Low serum Creatinine levels is seen in cases of low muscle mass like muscular atrophy, or aging.
High serum creatinine levels is seen in Acute and Chronic kidney disease, obstruction.
Since a rise in blood creatinine is observed only with marked damage of the nephrons, it is not suited to detect early stage kidney disease.

Uric Acid (Serum,Uricase)	4.9	mg/dL	3.4-7.0

Interpretation:

- Increased in Gout, asymptomatic hyperuricemia, leukemia, polycythemia, hemolytic anemia, sickle cell anemia, resolving pneumonia, toxemia of pregnancy, psoriasis, lymphoma, metabolic acidosis, chronic lead poisoning.
- Decreased in disorders of copper accumulation , kidney tubule disorder, Acromegaly, Celiac disease, Xanthine oxidase deficiency.
- Its used to monitor gout and also chemotherapeutic treatment of neoplasm to avoid renal urate deposition with possible renal failure (tumor lysis syndrome).

Note:

- A purine rich diet as well as sever exercise increases uric acid values.
- High protein-weight reduction diet and alcohol consumption can cause raised uric acid levels.

Reeference:

- Package insert
- Wallach's interpretation of diagnostic tests, Ed11, 2020.
- Henry's Clinical Diagnosis and Management by Laboratory Methods. 23rd ed; 2017.
- Tietz fundamentals of clinical chemistry 6th edition. Burtis CA, Ashwood ER, Bruns DE, 2008.

Calcium (Serum,NM-BAPTA)	9.9	mg/dL	8.6-10.0
Phosphorous (Serum,Molybdate UV)	**2.0**	mg/dL	2.5-4.5

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Investigation	Observed Value	Unit	Biological Reference Interval
Sodium (Serum,ISE Indirect)	**146**	mmol/L	136-145

Interpretation:
- Low levels are noted in prolonged vomiting or diarrhea, diminished reabsorption in the kidney and excessive fluid retention. High levels are seen in case of excessive fluid loss, high salt intake and increased kidney reabsorption

Potassium (Serum,ISE Indirect)	3.8	mmol/L	3.5-5.1

Interpretation:
- Low levels are noted in reduced intake of dietary potassium or excessive loss of potassium from the body due to diarrhea, prolonged vomiting or increased renal excretion. High levels may be caused by dehydration or shock, severe burns, hemolysis, diabetic ketoacidosis, and retention of potassium by the kidney

Chlorides (Serum,ISE Indirect)	104	mmol/L	98-107

Interpretation:
- **Low levels** are noted in reduced dietary intake, prolonged vomiting and reduced renal reabsorption as well as some forms of acidosis and alkalosis. High levels are found in dehydration, kidney failure, some forms of acidosis, high dietary or parenteral chloride intake, and salicylate poisoning.

BilirubinTotal, Direct, IndirectSerum
(Serum)

Bilirubin-Total (Diazo method)	0.33	mg/dL	0-1.2

Interpretation :

1. Total Bilirubin is the sum of the unconjugated and conjugated fractions. Total Bilirubin is elevated in hepatitis, cirrhosis, haemolytic disorders , several inherited enzyme deficiencies, and conditions causing hepatic obstruction.
2. Neonatal Bilirubin quantitation is used to monitor diseases causing jaundice in the new-born, chiefly erythroblastosis fetalis (also caused haemolytic disease of the newborn or HDN.)
3. Physiologic jaundice is seen at serum bilirubin concentrations from 7 to 17 mg/dl. Serum bilirubin concentrations greater than 17 mg/dl may be pathologic. The primary concern is the potential for bilirubin encephalopathy or kernicterus.

Bilirubin-Direct (Diazo method)	0.15	mg/dL	0.0-0.3

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Investigation	Observed Value	Unit	Biological Reference Interval

Note: Direct Bilirubin is elevated in conditions causing hepatic obstruction , hepatitis, cirrhosis, several inherited enzyme deficiencies, and inherited defects in canalicular excretion.

Bilirubin- Indirect (Calculated)	0.18	mg/dL	0.1-1.0
Proteins (Serum)			
Total Protein (Biuret)	7.45	g/dL	6.4-8.3
Albumin (Bromocresol green)	5.12	g/dL	3.5-5.2
Globulin	2.33	g/dL	1.8-3.6
A/G Ratio (Calculated)	2.2		1.1-2.2

Interpretation:

- Total Proteins are useful in the diagnosis and treatment of disease involving liver, kidney, bone marrow ,metabolic and nutritional disorders.
- The protein concentration of serum is an indicator of the hydration state of the body.
- Prolonged bed rest results in decreased total protein concentration.
- The A/G ratio measures the relative ratio of albumin to globulin
- Low A/G ratio may indicate viral infections, liver and kidney disease, or autoimmune disorders. These diseases increase globulin and decrease albumin thus lowering the A/G ratio.
- A high A/G ratio may indicate diseases that make the body produce less globulin, such as genetic disorders or may result from the use of immunosuppressive drugs.

Reference:

- Juraschek SP, Moliterno AR, Checkley W, Miller ER 3rd. The Gamma Gap and All-Cause Mortality. PLoS One. 2015 Dec 2;10(12):e0143494
- Busher JT. Serum Albumin and Globulin. In: Walker HK, Hall WD, Hurst JW, editors. Clinical Methods: The History, Physical, and Laboratory Examinations. 3rd edition. Boston: Butterworths; 1990. Chapter 101.
- Pack Insert

SGPT (ALT) (Serum,IFCC w/o pyridoxal phosphate activation)	20	U/L	0-41
SGOT (AST) (Serum,IFCC w/o pyridoxal phosphate activation)	24	U/L	0-40

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HbA1C- Glycated Haemoglobin, blood by HPLC method

(EDTA Whole Blood)

Investigation	Observed Value	Unit	Biological Reference Interval
HbA1C- Glycated Haemoglobin (HPLC)	5.2	%	Non-diabetic: <= 5.6 Pre-diabetic: 5.7-6.4 Diabetic: >= 6.5 Refer interpretation for monitoring ranges.
Estimated Average Glucose (eAG)	102.54	mg/dL	

Interpretation & Remark:

1. HbA1c is used for monitoring diabetic control. It reflects the estimated average glucose (eAG).
2. HbA1c has been endorsed by clinical groups & ADA (American Diabetes Association) guidelines 2017, for diagnosis of diabetes using a cut-off point of 6.5%.
3. Trends in HbA1c are a better indicator of diabetic control than a solitary test.
4. Low glycated haemoglobin(below 4%) in a non-diabetic individual are often associated with systemic inflammatory diseases, chronic anaemia(especially severe iron deficiency & haemolytic), chronic renal failure and liver diseases. Clinical correlation suggested.
5. To estimate the eAG from the HbA1C value, the following equation is used: eAG(mg/dl) = 28.7*A1c-46.7
6. Interference of Haemoglobinopathies in HbA1c estimation.
   A. For HbF > 25%, an alternate platform (Fructosamine) is recommended for testing of HbA1c.
   B. Homozygous hemoglobinopathy is detected, fructosamine is recommended for monitoring diabetic status
   C. Heterozygous state detected (D10/ Tosho G8 is corrected for HbS and HbC trait).
7. **In known diabetic patients, following values can be considered as a tool for monitoring the glycemic control.**
   Excellent Control - 6 to 7 %,
   Fair to Good Control - 7 to 8 %,
   Unsatisfactory Control - 8 to 10 %
   and Poor Control - More than 10 % .

Note : Hemoglobin electrophoresis (HPLC method) is recommended for detecting hemoglobinopathy.

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230011001517034

JAIKEE MAURYA

PID NO: P112301521722/
ILC SAMPLE

Age: 23.0 Year(s) Sex: Male

Reference:

Sample Collected At:
Hwell24 Plus Healthcare Pvt. Ltd C-211 Eastern Business District, Lbs Road, Bhandup West - 400078. Processing Location:- Metropolis Healthcare Ltd,Unit No409-416,4th Floor,Commercial Building-1,Kohinoor Mall,Mumbai-70

VID: 230011001517034

Registered On:
18/07/2023 04:18 PM

Collected On:
18/07/2023 4:22PM

Reported On:
19/07/2023 08:42 AM

Investigation	Observed Value	Unit	Biological Reference Interval
Lipid Profile-2 (Serum)			
Cholesterol-Total (Enzymatic)	135	mg/dL	Desirable: < 200 Borderline High: 200-240 High: >= 240
Triglycerides level (Enzymatic)	**199**	mg/dL	Normal: < 150 Borderline High: 150-199 High: 200-499 Very High: >= 500
HDL Cholesterol (Homogeneous enzymatic colorimetric assay)	**38**	mg/dL	Major risk factor for heart disease: < 40 Negative risk factor for heart disease: >= 60
Non HDL Cholesterol (Calculated)	97.0	mg/dL	Optimal: < 130 Desirable: 130-159 Borderline high: 159-189 High: 189-220 Very High: >= 220
LDL Cholesterol (Calculated)	57.2	mg/dL	Optimal: < 100 Near Optimal: 100-129 Borderline high: 130-159 High: 160-189 Very High: >= 190
VLDL Cholesterol (Calculated)	**39.8**	mg/dL	6-38
LDL/HDL RATIO (Calculated)	1.51		2.5-3.5
CHOL/HDL RATIO (Calculated)	3.55		3.5-5

Note: Reference Interval as per National Cholesterol Education Program (NCEP) Adult Treatment Panel III Report.

VLDL,CHOL/HDL RATIO,LDL/HDL RATIO,LDL Cholesterol,serum,Non HDL Colesterol are calculated parameters

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Reg No.2020/12/6991

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Investigation	Observed Value	Unit	Biological Reference Interval

Interpretation:

- High levels are seen in various pancreatic as well as salivary gland disorders, intestinal blockage, peptic ulcer, appendicitis, viral hepatitis, burns and acute alcohol poisoning.
- Low levels are seen in bone fracture, chronic heart failure, chronic pancreatitis, liver and kidney diseases.

Clinical Utility:

- Helps in diagnosing acute pancreatitis and other pancreatic diseases.
- In acute pancreatitis, high amylase levels are usually associated with high lipase concentrations, although lipase levels may take a while to rise than blood amylase levels and will remain elevated for a longer time period.

Note:

- Pregnancy and recent kidney transplant affects the test results.
- Usage of drugs like aspirin, diuretics, oral contraceptives, corticosteroids, indomethacin, ethyl alcohol and opiates also interfere in test results.
- Amylase levels may be increased in patients with Macroamylase. It can be confirmed by testing serum lipase and urinary amylase levels.

Associated Tests: Lipase Serum (L0068), Urinary amylase (A0433_24/ A0433_24H)

Reference:

- Kit Insert.
- Henry's Clinical Diagnosis and Management by Laboratory Methods. 24th ed. Philadelphia, PA: Elsevier; 2022:chap 23

Lipase (Serum,Enzymatiic colorimetric assay)	53	U/L	13-60
LDH-Lactate Dehydrogenase (Serum,Lactate-pyruvate(IFCC))	220	U/L	0-250

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