

Dr. Vinay Chopra
MD (Pathology & Microbiology)
Chairman & Consultant Pathologist

Dr. Yugam Chopra
MD (Pathology)
CEO & Consultant Pathologist

NAME : Mrs. USHA
AGE/ GENDER : 30 YRS/FEMALE
COLLECTED BY : SHYAM
REFERRED BY : LOOMBA HOSPITAL (AMBALA CANTT)
BARCODE NO. : 01512989
CLIENT CODE. : KOS DIAGNOSTIC LAB
CLIENT ADDRESS : 6349/1, NICHOLSON ROAD, AMBALA CANTT
PATIENT ID : 1546567
REG. NO./LAB NO. : 012407120041
REGISTRATION DATE : 12/Jul/2024 12:22 PM
COLLECTION DATE : 12/Jul/2024 12:32 PM
REPORTING DATE : 12/Jul/2024 12:55 PM

Test Name	Value	Unit	Biological Reference interval
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HAEMATOLOGY

COMPLETE BLOOD COUNT (CBC)

RED BLOOD CELLS (RBCS) COUNT AND INDICES

HAEMOGLOBIN (HB) by CALORIMETRIC	6.7 ^L	gm/dL	12.0 - 16.0
RED BLOOD CELL (RBC) COUNT by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	3.48 ^L	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	22.9 ^L	%	37.0 - 50.0
MEAN CORPUSCULAR VOLUME (MCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	65.7 ^L	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	18.6 ^L	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	28.3 ^L	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	19.9 ^H	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	48.5	fL	35.0 - 56.0
MENTZERS INDEX by CALCULATED	18.88	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX by CALCULATED	36.3	RATIO	BETA THALASSEMIA TRAIT: < = 65.0 IRON DEFICIENCY ANEMIA: > 65.0


WHITE BLOOD CELLS (WBCS)

TOTAL LEUCOCYTE COUNT (TLC) by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	6220	/cmm	4000 - 11000
NUCLEATED RED BLOOD CELLS (nRBCS) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER & MICROSCOPY	NIL		0.00 - 20.00
NUCLEATED RED BLOOD CELLS (nRBCS) % by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER & MICROSCOPY	NIL	%	< 10 %

DIFFERENTIAL LEUCOCYTE COUNT (DLC)




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NEUTROPHILS by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	68	%	50 - 70
LYMPHOCYTES by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	27	%	20 - 40
EOSINOPHILS by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	1 ^L	%	1 - 6
MONOCYTES by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	4	%	2 - 12
BASOPHILS by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	0	%	0 - 1
<u>ABSOLUTE LEUKOCYTES (WBC) COUNT</u>			
ABSOLUTE NEUTROPHIL COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	4230	/cmm	2000 - 7500
ABSOLUTE LYMPHOCYTE COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	1679	/cmm	800 - 4900
ABSOLUTE EOSINOPHIL COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	62	/cmm	40 - 440
ABSOLUTE MONOCYTE COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	249	/cmm	80 - 880
ABSOLUTE BASOPHIL COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	0	/cmm	0 - 110
<u>PLATELETS AND OTHER PLATELET PREDICTIVE MARKERS.</u>			
PLATELET COUNT (PLT) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	246000	/cmm	150000 - 450000
PLATELETCRIT (PCT) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	0.23	%	0.10 - 0.36
MEAN PLATELET VOLUME (MPV) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	11	fL	6.50 - 12.0
PLATELET LARGE CELL COUNT (P-LCC) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	75000	/cmm	30000 - 90000
PLATELET LARGE CELL RATIO (P-LCR) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	35	%	11.0 - 45.0
PLATELET DISTRIBUTION WIDTH (PDW) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	15.5	%	15.0 - 17.0
ADVICE	KINDLY CORRELATE CLINICALLY		
NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD			




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RECHECKED




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BLEEDING TIME (BT)

BLEEDING TIME (BT) by DUKE METHOD	1 MIN. 25 SEC.	MINS	1 - 5
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CLOTTING TIME (CT)

CLOTTING TIME (CT)	5 MIN. 45 SEC.	MINS	4 - 9
by CAPILLARY TUBE METHOD			




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CLINICAL CHEMISTRY/BIOCHEMISTRY

GLUCOSE RANDOM (R)

GLUCOSE RANDOM (R): PLASMA by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)	116.58	mg/dL	NORMAL: < 140.00 PREDIABETIC: 140.0 - 200.0 DIABETIC: > OR = 200.0
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INTERPRETATION

IN ACCORDANCE WITH AMERICAN DIABETES ASSOCIATION GUIDELINES:

1. A random plasma glucose level below 140 mg/dl is considered normal.
2. A random glucose level between 140 - 200 mg/dl is considered as glucose intolerant or prediabetic. A fasting and post-prandial blood test (after consumption of 75 gms of glucose) is recommended for all such patients.
3. A random glucose level of above 200 mg/dl is highly suggestive of diabetic state. A repeat post-prandial is strongly recommended for all such patients. A fasting plasma glucose level in excess of 125 mg/dl on both occasions is confirmatory for diabetic state.




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ENDOCRINOLOGY

THYROID STIMULATING HORMONE (TSH)

THYROID STIMULATING HORMONE (TSH): SERUM 0.731 μ IU/mL 0.35 - 5.50

by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)

3rd GENERATION, ULTRASENSITIVE

INTERPRETATION:

AGE	REFERENCE RANGE (μ IU/mL)
0 – 5 DAYS	0.70 – 15.20
6 Days – 2 Months	0.70 – 11.00
3 – 11 Months	0.70 – 8.40
1 – 5 Years	0.70 – 7.00
6 – 10 Years	0.60 – 5.50
11 - 15	0.50 – 5.50
> 20 Years (Adults)	0.27 – 5.50
PREGNANCY	
1st Trimester	0.10 - 3.00
2nd Trimester	0.20 - 3.00
3rd Trimester	0.30 - 4.10

NOTE:- TSH levels are subjected to circadian variation, reaching peak levels between 2-4 a.m and at a minimum between 6-10 pm. The variation is of the order of 50 %. Hence time of the day has influence on the measured serum TSH concentration.

USE:- TSH controls biosynthesis and release of thyroid hormones T4 & T3. It is a sensitive measure of thyroid function, especially useful in early or subclinical hypothyroidism, before the patient develops any clinical findings or goitre or any other thyroid function abnormality.

INCREASED LEVELS:

- 1.Primary or untreated hypothyroidism, may vary from 3 times to more than 100 times normal depending on degree of hypofunction.
- 2.Hypothyroid patients receiving insufficient thyroid replacement therapy.
- 3.Hashimotos thyroiditis.
- 4.DRUGS: Amphetamines, Iodine containing agents and dopamine antagonist.
- 5.Neonatal period, increase in 1st 2-3 days of life due to post-natal surge.

DECREASED LEVELS:

- 1.Toxic multi-nodular goitre & Thyroiditis.
- 2.Over replacement of thyroid hormone in treatment of hypothyroidism.
- 3.Autonomously functioning Thyroid adenoma
- 4.Secondary pituitary or hypothalamic hypothyroidism
- 5.Acute psychiatric illness
- 6.Severe dehydration.





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7.DRUGS: Glucocorticoids, Dopamine, Levodopa, T4 replacement therapy, Anti-thyroid drugs for thyrotoxicosis.

8.Pregnancy: 1st and 2nd Trimester

LIMITATIONS:

- 1.TSH may be normal in central hypothyroidism, recent rapid correction of hyperthyroidism or hypothyroidism, pregnancy, phenytoin therapy.
- 2.Autoimmune disorders may produce spurious results.

*** End Of Report ***




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