

Dr. Vinay Chopra  
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CEO & Consultant Pathologist

NAME : Mr. SURESH  
AGE/ GENDER : 61 YRS/MALE  
COLLECTED BY :  
REFERRED BY :  
BARCODE NO. : 01513247  
CLIENT CODE. : KOS DIAGNOSTIC LAB  
CLIENT ADDRESS : 6349/1, NICHOLSON ROAD, AMBALA CANTT

PATIENT ID : 1550609  
REG. NO./LAB NO. : 012407160034  
REGISTRATION DATE : 16/Jul/2024 11:02 AM  
COLLECTION DATE : 16/Jul/2024 11:03AM  
REPORTING DATE : 16/Jul/2024 11:17AM

Test Name	Value	Unit	Biological Reference interval
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## HAEMATOLOGY

### HAEMOGLOBIN (HB)

HAEMOGLOBIN (HB)  
by CALORIMETRIC

7<sup>L</sup>

gm/dL

12.0 - 17.0

#### INTERPRETATION:-

Hemoglobin is the protein molecule in red blood cells that carries oxygen from the lungs to the bodys tissues and returns carbon dioxide from the tissues back to the lungs.

A low hemoglobin level is referred to as ANEMIA or low red blood count.

#### ANEMIA ( DECREASED HAEMOGLOBIN):

- 1) Loss of blood (traumatic injury, surgery, bleeding, colon cancer or stomach ulcer)
- 2) Nutritional deficiency (iron, vitamin B12, folate)
- 3) Bone marrow problems (replacement of bone marrow by cancer)
- 4) Suppression by red blood cell synthesis by chemotherapy drugs
- 5) Kidney failure
- 6) Abnormal hemoglobin structure (sickle cell anemia or thalassemia).

#### POLYCYTHEMIA (INCREASED HAEMOGLOBIN):

- 1) People in higher altitudes (Physiological)
- 2) Smoking (Secondary Polycythemia)
- 3) Dehydration produces a falsely rise in hemoglobin due to increased haemoconcentration
- 4) Advanced lung disease (for example, emphysema)
- 5) Certain tumors
- 6) A disorder of the bone marrow known as polycythemia rubra vera,
- 7) Abuse of the drug erythropoietin (Epogen) by athletes for blood doping purposes (increasing the amount of oxygen available to the body by chemically raising the production of red blood cells).

NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD

RECHECKED.



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CLINICAL CHEMISTRY/BIOCHEMISTRY  
KIDNEY FUNCTION TEST (COMPLETE)

UREA: SERUM by UREASE - GLUTAMATE DEHYDROGENASE (GLDH)	143.49 <sup>H</sup>	mg/dL	10.00 - 50.00
CREATININE: SERUM by ENZYMATIC, SPECTROPHOTOMETRY	8.75 <sup>H</sup>	mg/dL	0.40 - 1.40
BLOOD UREA NITROGEN (BUN): SERUM by CALCULATED, SPECTROPHOTOMETRY	67.05 <sup>H</sup>	mg/dL	7.0 - 25.0
BLOOD UREA NITROGEN (BUN)/CREATININE RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	7.66 <sup>L</sup>	RATIO	10.0 - 20.0
UREA/CREATININE RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	16.4	RATIO	
URIC ACID: SERUM by URICASE - OXIDASE PEROXIDASE	8.3 <sup>H</sup>	mg/dL	3.60 - 7.70
CALCIUM: SERUM by ARSENazo III, SPECTROPHOTOMETRY	7.7 <sup>L</sup>	mg/dL	8.50 - 10.60
PHOSPHOROUS: SERUM by PHOSPHOMOLYBDATE, SPECTROPHOTOMETRY	4.72 <sup>H</sup>	mg/dL	2.30 - 4.70
<b>ELECTROLYTES</b>			
SODIUM: SERUM by ISE (ION SELECTIVE ELECTRODE)	136.5	mmol/L	135.0 - 150.0
POTASSIUM: SERUM by ISE (ION SELECTIVE ELECTRODE)	5.3 <sup>H</sup>	mmol/L	3.50 - 5.00
CHLORIDE: SERUM by ISE (ION SELECTIVE ELECTRODE)	102.38	mmol/L	90.0 - 110.0

**ESTIMATED GLOMERULAR FILTRATION RATE**

ESTIMATED GLOMERULAR FILTRATION RATE (eGFR): SERUM by CALCULATED	6.3
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**NOTE 2**

**ADVICE**

**INTERPRETATION:**

To differentiate between pre- and post renal azotemia.

RESULT RECHECKED TWICE

KINDLY CORRELATE CLINICALLY



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**INCREASED RATIO (>20:1) WITH NORMAL CREATININE:**

1. Prerenal azotemia (BUN rises without increase in creatinine) e.g. heart failure, salt depletion, dehydration, blood loss) due to decreased glomerular filtration rate.
2. Catabolic states with increased tissue breakdown.
3. GI haemorrhage.
4. High protein intake.
5. Impaired renal function plus
6. Excess protein intake or production or tissue breakdown (e.g. infection, GI bleeding, thyrotoxicosis, Cushing's syndrome, high protein diet, burns, surgery, cachexia, high fever).
7. Urine reabsorption (e.g. ureter colostomy)
8. Reduced muscle mass (subnormal creatinine production)
9. Certain drugs (e.g. tetracycline, glucocorticoids)

**INCREASED RATIO (>20:1) WITH ELEVATED CREATININE LEVELS:**

1. Postrenal azotemia (BUN rises disproportionately more than creatinine) (e.g. obstructive uropathy).

2. Prerenal azotemia superimposed on renal disease.

**DECREASED RATIO (<10:1) WITH DECREASED BUN :**

1. Acute tubular necrosis.
2. Low protein diet and starvation.
3. Severe liver disease.
4. Other causes of decreased urea synthesis.
5. Repeated dialysis (urea rather than creatinine diffuses out of extracellular fluid).
6. Inherited hyperammonemias (urea is virtually absent in blood).
7. SIADH (syndrome of inappropriate antidiuretic hormone) due to tubular secretion of urea.
8. Pregnancy.

**DECREASED RATIO (<10:1) WITH INCREASED CREATININE:**

1. Phenacimide therapy (accelerates conversion of creatine to creatinine).
2. Rhabdomyolysis (releases muscle creatinine).
3. Muscular patients who develop renal failure.

**INAPPROPRIATE RATIO:**


1. Diabetic ketoacidosis (acetoacetate causes false increase in creatinine with certain methodologies, resulting in normal ratio when dehydration should produce an increased BUN/creatinine ratio).
2. Cephalosporin therapy (interferes with creatinine measurement).

**ESTIMATED GLOMERULAR FILTRATION RATE:**

CKD STAGE	DESCRIPTION	GFR ( mL/min/1.73m2 )	ASSOCIATED FINDINGS
G1	Normal kidney function	>90	No proteinuria
G2	Kidney damage with normal or high GFR	>90	Presence of Protein , Albumin or cast in urine
G3a	Mild decrease in GFR	60 -89	
G3b	Moderate decrease in GFR	30-59	



  
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G4	Severe decrease in GFR	15-29	
G5	Kidney failure	<15	

**COMMENTS:**

1. Estimated Glomerular filtration rate (eGFR) is the sum of filtration rates in all functioning nephrons and so an estimation of the GFR provides a measure of functioning nephrons of the kidney.
2. eGFR calculated using the 2009 CKD-EPI creatinine equation and GFR category reported as per KDIGO guideline 2012
3. In patients, with eGFR creatinine between 45-59 ml/min/1.73 m<sup>2</sup> (G3) and without any marker of Kidney damage, It is recommended to measure eGFR with Cystatin C for confirmation of CKD
4. eGFR category G1 OR G2 does not fulfill the criteria for CKD, in the absence of evidence of Kidney Damage
5. In a suspected case of Acute Kidney Injury (AKI), measurement of eGFR should be done after 48-96 hours of any Intervention or procedure
6. eGFR calculated by Serum Creatinine may be less accurate due to certain factors like Race, Muscle Mass, Diet, Certain Drugs. In such cases, eGFR should be calculated using Serum Cystatin C
7. **A decrease in eGFR implies either progressive renal disease, or a reversible process causing decreased nephron function (eg, severe dehydration).**

**ADVICE:**

KDIGO guideline, 2012 recommends Chronic Kidney Disease (CKD) should be classified based on cause, eGFR category and Albuminuria (ACR) category. GFR & ACR category combined together reflect risk of progression and helps Clinician to identify the individual who are progressing at more rapid rate than anticipated

\*\*\* End Of Report \*\*\*



  
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