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NAME	**: Mr. S.C DHAWAN**		
AGE/ GENDER	: 95 YRS/MALE	**PATIENT ID**	: 1555062
COLLECTED BY	: SURJESH	**REG. NO./LAB NO.**	**: 012407200047**
REFERRED BY	: CENTRAL PHOENIX CLUB (AMBALA CANTT)	**REGISTRATION DATE**	: 20/Jul/2024 11:56 AM
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HAEMATOLOGY

COMPLETE BLOOD COUNT (CBC)

Test Name	Value	Unit	Biological Reference interval
RED BLOOD CELLS (RBCS) COUNT AND INDICES			
HAEMOGLOBIN (HB) *by CALORIMETRIC*	13.4	gm/dL	12.0 - 17.0
RED BLOOD CELL (RBC) COUNT ***by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE***	**7.79^{H}**	**Millions/cmm**	**3.50 - 5.00**
PACKED CELL VOLUME (PCV) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	46.3	%	40.0 - 54.0
MEAN CORPUSCULAR VOLUME (MCV) ***by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER***	**59.5^{L}**	**fL**	**80.0 - 100.0**
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) ***by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER***	**17.3^{L}**	**pg**	**27.0 - 34.0**
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) ***by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER***	**29^{L}**	**g/dL**	**32.0 - 36.0**
RED CELL DISTRIBUTION WIDTH (RDW-CV) ***by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER***	**23.4^{H}**	**%**	**11.00 - 16.00**
RED CELL DISTRIBUTION WIDTH (RDW-SD) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	51.7	fL	35.0 - 56.0
MENTZERS INDEX *by CALCULATED*	7.64	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX *by CALCULATED*	17.98	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*	6940	/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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Test Name	Value	Unit	Biological Reference interval
NEUTROPHILS *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	60	%	50 - 70
LYMPHOCYTES *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	20	%	20 - 40
EOSINOPHILS *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	4	%	1 - 6
MONOCYTES ***by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY***	**16^{H}**	**%**	**2 - 12**
BASOPHILS *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	0	%	0 - 1
ABSOLUTE LEUKOCYTES (WBC) COUNT			
ABSOLUTE NEUTROPHIL COUNT *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	4164	/cmm	2000 - 7500
ABSOLUTE LYMPHOCYTE COUNT *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	1388	/cmm	800 - 4900
ABSOLUTE EOSINOPHIL COUNT *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	278	/cmm	40 - 440
ABSOLUTE MONOCYTE COUNT ***by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY***	**1110^{H}**	**/cmm**	**80 - 880**
ABSOLUTE BASOPHIL COUNT *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	0	/cmm	0 - 110
ABSOLUTE IMMATURE GRANULOCYTE COUNT *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	0	/cmm	0.0 - 999.0
PLATELETS AND OTHER PLATELET PREDICTIVE MARKERS.			
PLATELET COUNT (PLT) ***by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE***	**102000^{L}**	**/cmm**	**150000 - 450000**
PLATELETCRIT (PCT) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	0.1	%	0.10 - 0.36
MEAN PLATELET VOLUME (MPV) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	10	fL	6.50 - 12.0
PLATELET LARGE CELL COUNT (P-LCC) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	35000	/cmm	30000 - 90000
PLATELET LARGE CELL RATIO (P-LCR) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	35.2	%	11.0 - 45.0
PLATELET DISTRIBUTION WIDTH (PDW) ***by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE***	**14.4^{L}**	**%**	**15.0 - 17.0**

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Test Name	Value	Unit	Biological Reference interval

NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD

RECHECKED.

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Test Name	Value	Unit	Biological Reference interval

D-DIMER (QUANTITATIVE)

D - DIMER (QUANTITATIVE)	**1724.8^{H}**	**ng/mL**	**0.00 - 500.00**

by EFIA (FLUORESCENT ENZYME IMMUNOASSAY)

INTERPRETATION:

During coagulation sequence of reactions occuring in the body in response to variety of external and/or internal stimuli. The enzymaticcascade reaction reaction terminates in the conversion of fibrinogen to fibrin by enzyme thrombin. The fibrin gel is then converted to a stable fibrin clot. The fibrin network is dissolved by enzyme plasmin to generate cross-linked FIBRIN DEGRADATON PRODUCTS. D-DIMER is the smallest plasmin resistant molecular unit present within FDP.

INCREASED D-DIMER IS SEEN IN FOLLOWING CONDITIONS:

1.Deep Vein Thrombosis (DVT)
2.Venous Thromboembolism
3.Recent Surgery
4.Trauma
5.Infection
6.Liver disease
7.Pregnancy
8.Eclampsia
9.Heart Disease
10.Some cancers
11.Elderly

NOTE:

1. A normal or low D-dimer helps to rule out clotting as cause of symtoms.

2. D- DIMER is approximately 6 hours in circulation of individuals with normal renal functions. Patients with stabilized clots and not going active fibrin deposition and plasmin activation may not give detectable D-Dimer elevation,anti-coagulant therapy.
3. In Pulmonary Embolism (PE), the larger the clot size, higher the expected level of of circulating D-Dimer. Conversely, theamount of D – DIMER release from very small clots may be diluted by circulation and may not give detectable increase.
4. Fibrionolysis is a highly regulated process and in dynamic delicate balance. In case of hereditary, acquired deficiency and dysfunction of fibrinogen, the rate of fibrinolysis will be altered thereby not giving detectable D-Dimer level.
5. False positive may be seen with high levels of rheumatoid factor, bilirubin, lipemic sera and haemolysed blood

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Test Name	Value	Unit	Biological Reference interval

CLINICAL CHEMISTRY/BIOCHEMISTRY

GLUCOSE RANDOM (R)

GLUCOSE RANDOM (R): PLASMA *by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)*	106.3	mg/dL	NORMAL: < 140.00 PREDIABETIC: 140.0 - 200.0 DIABETIC: > 0R = 200.0

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-prnadial 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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LIVER FUNCTION TEST (COMPLETE)

Test Name	Value	Unit	Biological Reference interval
BILIRUBIN TOTAL: SERUM *by DIAZOTIZATION, SPECTROPHOTOMETRY*	0.93	mg/dL	INFANT: 0.20 - 8.00 ADULT: 0.00 - 1.20
BILIRUBIN DIRECT (CONJUGATED): SERUM *by DIAZO MODIFIED, SPECTROPHOTOMETRY*	0.39	mg/dL	0.00 - 0.40
BILIRUBIN INDIRECT (UNCONJUGATED): SERUM *by CALCULATED, SPECTROPHOTOMETRY*	0.54	mg/dL	0.10 - 1.00
SGOT/AST: SERUM *by IFCC, WITHOUT PYRIDOXAL PHOSPHATE*	20.1	U/L	7.00 - 45.00
SGPT/ALT: SERUM *by IFCC, WITHOUT PYRIDOXAL PHOSPHATE*	16.8	U/L	0.00 - 49.00
AST/ALT RATIO: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	1.2	RATIO	0.00 - 46.00
ALKALINE PHOSPHATASE: SERUM *by PARA NITROPHENYL PHOSPHATASE BY AMINO METHYL PROPANOL*	65	U/L	40.0 - 150.0
GAMMA GLUTAMYL TRANSFERASE (GGT): SERUM *by SZASZ, SPECTROPHTOMETRY*	34	U/L	0.00 - 55.0
TOTAL PROTEINS: SERUM *by BIURET, SPECTROPHOTOMETRY*	6.57	gm/dL	6.20 - 8.00
ALBUMIN: SERUM ***by BROMOCRESOL GREEN***	**3.35**^{L}	**gm/dL**	**3.50 - 5.50**
GLOBULIN: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	3.22	gm/dL	2.30 - 3.50
A : G RATIO: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	1.04	RATIO	1.00 - 2.00

INTERPRETATION

NOTE:- **To be correlated in individuals having SGOT and SGPT values higher than Normal Referance Range.**
USE:- Differential diagnosis of diseases of hepatobiliary system and pancreas.

INCREASED:

DRUG HEPATOTOXICITY	> 2
ALCOHOLIC HEPATITIS	> 2 (Highly Suggestive)
CIRRHOSIS	1.4 - 2.0
INTRAHEPATIC CHOLESTATIS	> 1.5
HEPATOCELLULAR CARCINOMA & CHRONIC HEPATITIS	> 1.3 (Slightly Increased)

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Test Name	Value	Unit	Biological Reference interval

DECREASED:

1. Acute Hepatitis due to virus, drugs, toxins (with AST increased 3 to 10 times upper limit of normal)
2. Extra Hepatic cholestatis: 0.8 (normal or slightly decreased).

PROGNOSTIC SIGNIFICANCE:

NORMAL	< 0.65
GOOD PROGNOSTIC SIGN	0.3 - 0.6
POOR PROGNOSTIC SIGN	1.2 - 1.6

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Test Name	Value	Unit	Biological Reference interval
	UREA		
UREA: SERUM ***by UREASE - GLUTAMATE DEHYDROGENASE (GLDH)***	**56.06^{H}**	**mg/dL**	**10.00 - 50.00**

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Test Name	Value	Unit	Biological Reference interval
	CREATININE		
CREATININE: SERUM *by ENZYMATIC, SPECTROPHOTOMETRY*	**1.93^{H}**	**mg/dL**	**0.40 - 1.40**

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ELECTROLYTES COMPLETE PROFILE

Test Name	Value	Unit	Biological Reference interval
SODIUM: SERUM *by ISE (ION SELECTIVE ELECTRODE)*	**134.9L**	**mmol/L**	**135.0 - 150.0**
POTASSIUM: SERUM *by ISE (ION SELECTIVE ELECTRODE)*	4.54	mmol/L	3.50 - 5.00
CHLORIDE: SERUM *by ISE (ION SELECTIVE ELECTRODE)*	101.18	mmol/L	90.0 - 110.0

INTERPRETATION:-

SODIUM:-

Sodium is the major cation of extra-cellular fluid. Its primary function in the body is to chemically maintain osmotic pressure & acid base balance & to transmit nerve impulse.

HYPONATREMIA (LOW SODIUM LEVEL) CAUSES:-

1. Low sodium intake.
2. Sodium loss due to diarrhea & vomiting with adequate water and iadequate salt replacement.
3. Diuretics abuses.
4. Salt loosing nephropathy.
5. Metabolic acidosis.
6. Adrenocortical issuficiency .
7. Hepatic failure.

HYPERNATREMIA (INCREASED SODIUM LEVEL) CAUSES:-

1. Hyperapnea (Prolonged)
2. Diabetes insipidus
3. Diabetic acidosis
4. Cushings syndrome
5. Dehydration

POTASSIUM:-

Potassium is the major cation in the intracellular fluid. 90% of potassium is concentrated within the cells. When cells are damaged, potassium is released in the blood.

HYPOKALEMIA (LOW POTASSIUM LEVELS):-

1. Diarrhoea, vomiting & malabsorption.
2. Severe Burns.
3. Increased Secretions of Aldosterone

HYPERKALEMIA (INCREASED POTASSIUM LEVELS):-

1. Oliguria
2. Renal failure or Shock
3. Respiratory acidosis

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Test Name	Value	Unit	Biological Reference interval
4.Hemolysis of blood			

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Test Name	Value	Unit	Biological Reference interval

SPECIAL INVESTIGATIONS

B-TYPE NATRIURETIC PEPTIDE (BNP)

BRAIN-TYPE NATRIURETIC PEPTIDE (BNP) ***by ELFA (ENZYME LINKED FLUORESCENT IMMUNOASSAY)***	**2450^{H}**	**pg/mL**	**0 - 1800**

INTERPRETATION:

AGE GROUP IN YEARS	CUT OFF IN pg/mL
< 50	450
50 - 75	900
>75	1800
FOR ALL AGE GROUPS	*300*

BNP is stored mainly in the myocardium and has biologic effects similar to those of Atrial Natriuretic Peptide (ANP). Increased concentrations of BNP occur in patients with hypervolemic states like congestive heart failure & hypertension. The circulating levels of BNP directly correlate with the higher incidence of cardiac events and mortality in patients with heart failure.

INCREASED LEVEL (CARDIAC CAUSE):
1.Heart failure
2.Asymptomatic Left ventricular dysfunction
3.Arterial & Pulmonary hypertension
4.Cardiac hypertrophy
5.Valvular heart disease
6.Arrhythmia
7.Acute Coronary syndrome

NON CARDIAC CAUSE:
1.Acute & Chronic renal failure
2.Liver Cirrhosis
3.Hyperaldosteronism
4.Cushing's syndrome

CLINICAL USE:
1.To confirm heart failure in patients presenting with ambiguous clinical symptoms
2.To assist / improve diagnostic accuracy for heart failure.

*** End Of Report ***

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