NAME	**: Mrs. ASMITA BANSAL**		
AGE/ GENDER	: 48 YRS/FEMALE	**PATIENT ID**	: 1556008
COLLECTED BY	: SURJESH	**REG. NO./LAB NO.**	**: 012407210020**
REFERRED BY	:	**REGISTRATION DATE**	: 21/Jul/2024 08:50 AM
BARCODE NO.	: 01513541	**COLLECTION DATE**	: 21/Jul/2024 09:27AM
CLIENT CODE.	: KOS DIAGNOSTIC LAB	**REPORTING DATE**	: 21/Jul/2024 09:47AM
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

HAEMATOLOGY

COMPLETE BLOOD COUNT (CBC)

Test Name	Value	Unit	Biological Reference interval
RED BLOOD CELLS (RBCS) COUNT AND INDICES			
HAEMOGLOBIN (HB) *by CALORIMETRIC*	**10.7[L]**	**gm/dL**	**12.0 - 16.0**
RED BLOOD CELL (RBC) COUNT *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	4.63	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	**35[L]**	**%**	**37.0 - 50.0**
MEAN CORPUSCULAR VOLUME (MCV) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	**75.6[L]**	**fL**	**80.0 - 100.0**
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	**23.1[L]**	**pg**	**27.0 - 34.0**
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	**30.5[L]**	**g/dL**	**32.0 - 36.0**
RED CELL DISTRIBUTION WIDTH (RDW-CV) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	**30.6[H]**	**%**	**11.00 - 16.00**
RED CELL DISTRIBUTION WIDTH (RDW-SD) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	**87.1[H]**	**fL**	**35.0 - 56.0**
MENTZERS INDEX *by CALCULATED*	16.33	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX *by CALCULATED*	49.94	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*	6400	/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)			

DR.VINAY CHOPRA
CONSULTANT PATHOLOGIST
MBBS, MD (PATHOLOGY & MICROBIOLOGY)

DR.YUGAM CHOPRA
CONSULTANT PATHOLOGIST
MBBS , MD (PATHOLOGY)

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

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

NAME	**: Mrs. ASMITA BANSAL**		
AGE/ GENDER	: 48 YRS/FEMALE	**PATIENT ID**	: 1556008
COLLECTED BY	: SURJESH	**REG. NO./LAB NO.**	**: 012407210020**
REFERRED BY	:	**REGISTRATION DATE**	: 21/Jul/2024 08:50 AM
BARCODE NO.	: 01513541	**COLLECTION DATE**	: 21/Jul/2024 09:27AM
CLIENT CODE.	: KOS DIAGNOSTIC LAB	**REPORTING DATE**	: 21/Jul/2024 09:47AM
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
NEUTROPHILS *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	66	%	50 - 70
LYMPHOCYTES *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	25	%	20 - 40
EOSINOPHILS *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	3	%	1 - 6
MONOCYTES *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	6	%	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*	4224	/cmm	2000 - 7500
ABSOLUTE LYMPHOCYTE COUNT *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	1600	/cmm	800 - 4900
ABSOLUTE EOSINOPHIL COUNT *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	192	/cmm	40 - 440
ABSOLUTE MONOCYTE COUNT *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	384	/cmm	80 - 880
ABSOLUTE BASOPHIL COUNT *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	0	/cmm	0 - 110
PLATELETS AND OTHER PLATELET PREDICTIVE MARKERS.			
PLATELET COUNT (PLT) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	329000	/cmm	150000 - 450000
PLATELETCRIT (PCT) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	0.31	%	0.10 - 0.36
MEAN PLATELET VOLUME (MPV) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	9	fL	6.50 - 12.0
PLATELET LARGE CELL COUNT (P-LCC) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	74000	/cmm	30000 - 90000
PLATELET LARGE CELL RATIO (P-LCR) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	22.4	%	11.0 - 45.0
PLATELET DISTRIBUTION WIDTH (PDW) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	15.4	%	15.0 - 17.0

NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD

DR.VINAY CHOPRA
CONSULTANT PATHOLOGIST
MBBS, MD (PATHOLOGY & MICROBIOLOGY)

DR.YUGAM CHOPRA
CONSULTANT PATHOLOGIST
MBBS , MD (PATHOLOGY)

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

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

NAME	**: Mrs. ASMITA BANSAL**		
AGE/ GENDER	: 48 YRS/FEMALE	**PATIENT ID**	: 1556008
COLLECTED BY	: SURJESH	**REG. NO./LAB NO.**	**: 012407210020**
REFERRED BY	:	**REGISTRATION DATE**	: 21/Jul/2024 08:50 AM
BARCODE NO.	: 01513541	**COLLECTION DATE**	: 21/Jul/2024 09:27AM
CLIENT CODE.	: KOS DIAGNOSTIC LAB	**REPORTING DATE**	: 21/Jul/2024 10:45AM
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval

CLINICAL CHEMISTRY/BIOCHEMISTRY

URIC ACID

URIC ACID: SERUM	3.32	mg/dL	2.50 - 6.80

by URICASE - OXIDASE PEROXIDASE

INTERPRETATION:-

1.GOUT occurs when high levels of Uric Acid in the blood cause crystals to form & accumulate around a joint.
2.Uric Acid is the end product of purine metabolism . Uric acid is excreted to a large degree by the kidneys and to a smaller degree in the intestinal tract by microbial degradation.

INCREASED:-

(A).DUE TO INCREASED PRODUCTION:-

1.Idiopathic primary gout.
2.Excessive dietary purines (organ meats,legumes,anchovies, etc).
3.Cytolytic treatment of malignancies especially leukemais & lymphomas.
4.Polycythemai vera & myeloid metaplasia.
5.Psoriasis.
6.Sickle cell anaemia etc.

(B).DUE TO DECREASED EXCREATION (BY KIDNEYS)

1.Alcohol ingestion.
2.Thiazide diuretics.
3.Lactic acidosis.
4.Aspirin ingestion (less than 2 grams per day).
5.Diabetic ketoacidosis or starvation.
6.Renal failure due to any cause etc.

DECREASED:-

(A).DUE TO DIETARY DEFICIENCY

1.Dietary deficiency of Zinc, Iron and molybdenum.
2.Fanconi syndrome & Wilsons disease.
3.Multiple sclerosis .
4.Syndrome of inappropriate antidiuretic hormone (SIADH) secretion & low purine diet etc.

(B).DUE TO INCREASED EXCREATION

1.Drugs:-Probenecid , sulphinpyrazone, aspirin doses (more than 4 grams per day), corticosterroids and ACTH, anti-coagulants and estrogens etc.

DR.VINAY CHOPRA
CONSULTANT PATHOLOGIST
MBBS, MD (PATHOLOGY & MICROBIOLOGY)

DR.YUGAM CHOPRA
CONSULTANT PATHOLOGIST
MBBS , MD (PATHOLOGY)

NAME	**: Mrs. ASMITA BANSAL**		
AGE/ GENDER	: 48 YRS/FEMALE	**PATIENT ID**	: 1556008
COLLECTED BY	: SURJESH	**REG. NO./LAB NO.**	**: 012407210020**
REFERRED BY	:	**REGISTRATION DATE**	: 21/Jul/2024 08:50 AM
BARCODE NO.	: 01513541	**COLLECTION DATE**	: 21/Jul/2024 09:27AM
CLIENT CODE.	: KOS DIAGNOSTIC LAB	**REPORTING DATE**	: 21/Jul/2024 11:21AM
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval

ENDOCRINOLOGY

PROLACTIN

PROLACTIN: SERUM	10.511	ng/mL	3 - 25

by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)

INTERPRETATION:

1.Prolactin is secreted by the anterior pituitary gland and controlled by the hypothalamus.
2.The major chemical controlling prolactin secretion is dopamine, which inhibits prolactin secretion from the pituitary.
3.Physiological function of prolactin is the stimulation of milk production. In normal individuals, the prolactin level rises in response to physiologic stimuli such as sleep, exercise, nipple stimulation, sexual intercourse, hypoglycemia, postpartum period, and also is elevated in the newborn infant.

INCREASED (HYPERPROLACTEMIA):

1.Prolactin-secreting pituitary adenoma (prolactinoma, which is 5 times more frequent in females than males).
2.Functional and organic disease of the hypothalamus.
3.Primary hypothyroidism.
4.Section compression of the pituitary stalk.
5.Chest wall lesions and renal failure.
6.Ectopic tumors.
7.DRUGS:- Anti-Dopaminergic drugs like antipsychotic drugs, antinausea/antiemetic drugs, Drugs that affect CNS serotonin metabolism, serotonin receptors, or serotonin reuptake (anti-depressants of all classes, ergot derivatives, some illegal drugs such as cannabis), Antihypertensive drugs ,Opiates, High doses of estrogen or progesterone,anticonvulsants (valporic acid), anti-tuberculous medications (Isoniazid).

SIGNIFICANCE:

1.In loss of libido, galactorrhea, oligomHyperprolactinemia often results enorrhea or amenorrhea, and infertility in premenopausal females.
2.Loss of libido, impotence, infertility, and hypogonadism in males. Postmenopausal and premenopausal women, as well as men, can also suffer from decreased muscle mass and osteoporosis.
3. In males, prolactin levels >13 ng/mL are indicative of hyperprolactinemia.
4. In women, prolactin levels >27 ng/mL in the absence of pregnancy and postpartum lactation are indicative of hyperprolactinemia.
5.Clear symptoms and signs of hyperprolactinemia are often absent in patients with serum prolactin levels <100 ng/mL.
4. Mild to moderately increased levels of serum prolactin are not a reliable guide for determining whether a prolactin-producing pituitary adenoma is present, 5.Whereas levels >250 ng/mL are usually associated with a prolactin-secreting tumor.

CAUTION:

Prolactin values that exceed the reference values may be due to macroprolactin (prolactin bound to immunoglobulin). Macroprolactin should be evaluated if signs and symptoms of hyperprolactinemia are absent, or pituitary imaging studies are not informative.

*** End Of Report ***

DR.VINAY CHOPRA
CONSULTANT PATHOLOGIST
MBBS, MD (PATHOLOGY & MICROBIOLOGY)

DR.YUGAM CHOPRA
CONSULTANT PATHOLOGIST
MBBS , MD (PATHOLOGY)