

Dr. Vinay Chopra
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Dr. Yugam Chopra
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CEO & Consultant Pathologist

NAME : Mr. SATISH SEHGAL
AGE/ GENDER : 69 YRS/MALE
COLLECTED BY :
REFERRED BY :
BARCODE NO. : 01514489
CLIENT CODE. : KOS DIAGNOSTIC LAB
CLIENT ADDRESS : 6349/1, NICHOLSON ROAD, AMBALA CANTT

PATIENT ID : 1570688
REG. NO./LAB NO. : 012408050022
REGISTRATION DATE : 05/Aug/2024 08:56 AM
COLLECTION DATE : 05/Aug/2024 08:58AM
REPORTING DATE : 05/Aug/2024 10:01AM

Test Name	Value	Unit	Biological Reference interval
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SWASTHYA WELLNESS PANEL: 1.0
COMPLETE BLOOD COUNT (CBC)

RED BLOOD CELLS (RBCS) COUNT AND INDICES

HAEMOGLOBIN (HB) by CALORIMETRIC	14.4	gm/dL	12.0 - 17.0
RED BLOOD CELL (RBC) COUNT by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	5.31 ^H	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	43.7	%	40.0 - 54.0
MEAN CORPUSCULAR VOLUME (MCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	82.2	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	27.2	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	33	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	14.2	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	43.8	fL	35.0 - 56.0
MENTZERS INDEX by CALCULATED	15.48	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX by CALCULATED	22.05	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	9610	/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 %



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DIFFERENTIAL LEUCOCYTE COUNT (DLC)			
NEUTROPHILS <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	82 ^H	%	50 - 70
LYMPHOCYTES <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	12 ^L	%	20 - 40
EOSINOPHILS <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	2	%	1 - 6
MONOCYTES <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	4	%	2 - 12
BASOPHILS <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	0	%	0 - 1
ABSOLUTE LEUKOCYTES (WBC) COUNT			
ABSOLUTE NEUTROPHIL COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	7880 ^H	/cmm	2000 - 7500
ABSOLUTE LYMPHOCYTE COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	1153	/cmm	800 - 4900
ABSOLUTE EOSINOPHIL COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	192	/cmm	40 - 440
ABSOLUTE MONOCYTE COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	384	/cmm	80 - 880
ABSOLUTE BASOPHIL COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	0	/cmm	0 - 110
PLATELETS AND OTHER PLATELET PREDICTIVE MARKERS.			
PLATELET COUNT (PLT) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	419000	/cmm	150000 - 450000
PLATELET CRIT (PCT) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	0.49 ^H	%	0.10 - 0.36
MEAN PLATELET VOLUME (MPV) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	12	fL	6.50 - 12.0
PLATELET LARGE CELL COUNT (P-LCC) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	164000 ^H	/cmm	30000 - 90000
PLATELET LARGE CELL RATIO (P-LCR) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	39	%	11.0 - 45.0
PLATELET DISTRIBUTION WIDTH (PDW) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	16.5	%	15.0 - 17.0

NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD




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ERYTHROCYTE SEDIMENTATION RATE (ESR)

ERYTHROCYTE SEDIMENTATION RATE (ESR)	19	mm/1st hr	0 - 20
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by MODIFIED WESTERGREN AUTOMATED METHOD

INTERPRETATION:

1. ESR is a non-specific test because an elevated result often indicates the presence of inflammation associated with infection, cancer and auto-immune disease, but does not tell the health practitioner exactly where the inflammation is in the body or what is causing it.
2. An ESR can be affected by other conditions besides inflammation. For this reason, the ESR is typically used in conjunction with other test such as C-reactive protein
3. This test may also be used to monitor disease activity and response to therapy in both of the above diseases as well as some others, such as systemic lupus erythematosus

CONDITION WITH LOW ESR

A low ESR can be seen with conditions that inhibit the normal sedimentation of red blood cells, such as a high red blood cell count (polycythaemia), significantly high white blood cell count (leucocytosis), and some protein abnormalities. Some changes in red cell shape (such as sickle cells in sickle cell anaemia) also lower the ESR.

NOTE:

1. ESR and C - reactive protein (C-RP) are both markers of inflammation.
2. Generally, ESR does not change as rapidly as does CRP, either at the start of inflammation or as it resolves.
3. **CRP is not affected by as many other factors as is ESR, making it a better marker of inflammation.**
4. If the ESR is elevated, it is typically a result of two types of proteins, globulins or fibrinogen.
5. Women tend to have a higher ESR, and menstruation and pregnancy can cause temporary elevations.
6. Drugs such as dextran, methyldopa, oral contraceptives, penicillamine procainamide, theophylline, and vitamin A can increase ESR, while aspirin, cortisone, and quinine may decrease it




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CLINICAL CHEMISTRY/BIOCHEMISTRY

GLUCOSE FASTING (F)

GLUCOSE FASTING (F): PLASMA by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)	394.33 ^H	mg/dL	NORMAL: < 100.0 PREDIABETIC: 100.0 - 125.0 DIABETIC: > OR = 126.0
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INTERPRETATION

IN ACCORDANCE WITH AMERICAN DIABETES ASSOCIATION GUIDELINES:

1. A fasting plasma glucose level below 100 mg/dl is considered normal.
2. A fasting plasma glucose level between 100 - 125 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 fasting plasma glucose level of above 125 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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LIPID PROFILE : BASIC			
CHOLESTEROL TOTAL: SERUM by CHOLESTEROL OXIDASE PAP	149.24	mg/dL	OPTIMAL: < 200.0 BORDERLINE HIGH: 200.0 - 239.0 HIGH CHOLESTEROL: > OR = 240.0
TRIGLYCERIDES: SERUM by GLYCEROL PHOSPHATE OXIDASE (ENZYMATIC)	201.62 ^H	mg/dL	OPTIMAL: < 150.0 BORDERLINE HIGH: 150.0 - 199.0 HIGH: 200.0 - 499.0 VERY HIGH: > OR = 500.0
HDL CHOLESTEROL (DIRECT): SERUM by SELECTIVE INHIBITION	33.6	mg/dL	LOW HDL: < 30.0 BORDERLINE HIGH HDL: 30.0 - 60.0 HIGH HDL: > OR = 60.0
LDL CHOLESTEROL: SERUM by CALCULATED, SPECTROPHOTOMETRY	75.32	mg/dL	OPTIMAL: < 100.0 ABOVE OPTIMAL: 100.0 - 129.0 BORDERLINE HIGH: 130.0 - 159.0 HIGH: 160.0 - 189.0 VERY HIGH: > OR = 190.0
NON HDL CHOLESTEROL: SERUM by CALCULATED, SPECTROPHOTOMETRY	115.64	mg/dL	OPTIMAL: < 130.0 ABOVE OPTIMAL: 130.0 - 159.0 BORDERLINE HIGH: 160.0 - 189.0 HIGH: 190.0 - 219.0 VERY HIGH: > OR = 220.0
VLDL CHOLESTEROL: SERUM by CALCULATED, SPECTROPHOTOMETRY	40.32	mg/dL	0.00 - 45.00
TOTAL LIPIDS: SERUM by CALCULATED, SPECTROPHOTOMETRY	500.1	mg/dL	350.00 - 700.00
CHOLESTEROL/HDL RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	4.44 ^H	RATIO	LOW RISK: 3.30 - 4.40 AVERAGE RISK: 4.50 - 7.0 MODERATE RISK: 7.10 - 11.0 HIGH RISK: > 11.0
LDL/HDL RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	2.24	RATIO	LOW RISK: 0.50 - 3.0 MODERATE RISK: 3.10 - 6.0 HIGH RISK: > 6.0



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TRIGLYCERIDES/HDL RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	6 ^H	RATIO	3.00 - 5.00

INTERPRETATION:

- Measurements in the same patient can show physiological & analytical variations. Three serial samples 1 week apart are recommended for Total Cholesterol, Triglycerides, HDL & LDL Cholesterol.
- As per NLA-2014 guidelines, all adults above the age of 20 years should be screened for lipid status. Selective screening of children above the age of 2 years with a family history of premature cardiovascular disease or those with at least one parent with high total cholesterol is recommended.
- Low HDL levels are associated with increased risk for Atherosclerotic Cardiovascular disease (ASCVD) due to insufficient HDL being available to participate in reverse cholesterol transport, the process by which cholesterol is eliminated from peripheral tissues.
- NLA-2014 identifies Non HDL Cholesterol (an indicator of all atherogenic lipoproteins such as LDL, VLDL, IDL, Lp(a), Chylomicron remnants) along with LDL-cholesterol as co-primary target for cholesterol lowering therapy. Note that major risk factors can modify treatment goals for LDL & Non HDL.
- Additional testing for Apolipoprotein B, hsCRP, Lp(a) & LP-PLA2 should be considered among patients with moderate risk for ASCVD for risk refinement




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LIVER FUNCTION TEST (COMPLETE)

BILIRUBIN TOTAL: SERUM <i>by DIAZOTIZATION, SPECTROPHOTOMETRY</i>	1.55 ^H	mg/dL	INFANT: 0.20 - 8.00 ADULT: 0.00 - 1.20
BILIRUBIN DIRECT (CONJUGATED): SERUM <i>by DIAZO MODIFIED, SPECTROPHOTOMETRY</i>	0.47 ^H	mg/dL	0.00 - 0.40
BILIRUBIN INDIRECT (UNCONJUGATED): SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	1.08 ^H	mg/dL	0.10 - 1.00
SGOT/AST: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	39.2	U/L	7.00 - 45.00
SGPT/ALT: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	38.5	U/L	0.00 - 49.00
AST/ALT RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	1.02	RATIO	0.00 - 46.00
ALKALINE PHOSPHATASE: SERUM <i>by PARA NITROPHENYL PHOSPHATASE BY AMINO METHYL PROPANOL</i>	127.58	U/L	40.0 - 130.0
GAMMA GLUTAMYL TRANSFERASE (GGT): SERUM <i>by SZASZ, SPECTROPHOTOMETRY</i>	112.14 ^H	U/L	0.00 - 55.0
TOTAL PROTEINS: SERUM <i>by BIURET, SPECTROPHOTOMETRY</i>	6.6	gm/dL	6.20 - 8.00
ALBUMIN: SERUM <i>by BROMOCRESOL GREEN</i>	3.86	gm/dL	3.50 - 5.50
GLOBULIN: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	2.74	gm/dL	2.30 - 3.50
A : G RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	1.41	RATIO	1.00 - 2.00

INTERPRETATION

NOTE:- To be correlated in individuals having SGOT and SGPT values higher than Normal Reference 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 CHOLESTASIS	> 1.5
HEPATOCELLULAR CARCINOMA & CHRONIC HEPATITIS	> 1.3 (Slightly Increased)




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DECREASED:

1. Acute Hepatitis due to virus, drugs, toxins (with AST increased 3 to 10 times upper limit of normal)
2. Extra Hepatic cholestasis: 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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KIDNEY FUNCTION TEST (COMPLETE)

UREA: SERUM	29.8	mg/dL	10.00 - 50.00
by UREASE - GLUTAMATE DEHYDROGENASE (GLDH)			
CREATININE: SERUM	1.05	mg/dL	0.40 - 1.40
by ENZYMATIC, SPECTROPHOTOMETRY			
BLOOD UREA NITROGEN (BUN): SERUM	13.93	mg/dL	7.0 - 25.0
by CALCULATED, SPECTROPHOTOMETRY			
BLOOD UREA NITROGEN (BUN)/CREATININE RATIO: SERUM	13.27	RATIO	10.0 - 20.0
by CALCULATED, SPECTROPHOTOMETRY			
UREA/CREATININE RATIO: SERUM	28.38	RATIO	
by CALCULATED, SPECTROPHOTOMETRY			
URIC ACID: SERUM	5.67	mg/dL	3.60 - 7.70
by URICASE - OXIDASE PEROXIDASE			
CALCIUM: SERUM	10.04	mg/dL	8.50 - 10.60
by ARSENAZO III, SPECTROPHOTOMETRY			
PHOSPHOROUS: SERUM	2.88	mg/dL	2.30 - 4.70
by PHOSPHOMOLYBDATE, SPECTROPHOTOMETRY			

ELECTROLYTES

SODIUM: SERUM	141.2	mmol/L	135.0 - 150.0
by ISE (ION SELECTIVE ELECTRODE)			
POTASSIUM: SERUM	4.52	mmol/L	3.50 - 5.00
by ISE (ION SELECTIVE ELECTRODE)			
CHLORIDE: SERUM	105.9	mmol/L	90.0 - 110.0
by ISE (ION SELECTIVE ELECTRODE)			

ESTIMATED GLOMERULAR FILTRATION RATE

ESTIMATED GLOMERULAR FILTRATION RATE (eGFR): SERUM	76.8
by CALCULATED	

INTERPRETATION:

To differentiate between pre- and post renal azotemia.

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.





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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/1.73m ²)	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	
G4	Severe decrease in GFR	15-29	
G5	Kidney failure	<15	




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NAME	: Mr. SATISH SEHGAL	PATIENT ID	: 1570688
AGE/ GENDER	: 69 YRS/MALE	REG. NO./LAB NO.	: 012408050022
COLLECTED BY	:	REGISTRATION DATE	: 05/Aug/2024 08:56 AM
REFERRED BY	:	COLLECTION DATE	: 05/Aug/2024 08:58AM
BARCODE NO.	: 01514489	REPORTING DATE	: 05/Aug/2024 10:21AM
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Test Name	Value	Unit	Biological Reference interval
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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 m² (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




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AMYLASE

AMYLASE - SERUM	23.48	IU/L	0 - 90
by CNPG 3 , SPECTROPHOTOMETRY			

INTERPRETATION COMMENTS

- 1.Amylase is produced in the Pancreas and most of the elevation in serum is due to increased rate of Amylase entry into the blood stream / decreased rate of clearance or both.
- 2.Serum Amylase rises within 6 to 48 hours of onset of Acute pancreatitis in 80% of patients, but is not proportional to the severity of the disease.
- 3.Activity usually returns to normal in 3-5 days in patients with milder edematous form of the disease.
- 4.Values persisting longer than this period suggest continuing necrosis of pancreas or Pseudocyst formation.
- 5.Approximately 20% of patients with Pancreatitis have normal or near normal activity.
- 6.Hyperlipemic patients with Pancreatitis also show spuriously normal Amylase levels due to suppression of Amylase activity by triglyceride.
- 7.Low Amylase levels are seen in Chronic Pancreatitis, Congestive Heart failure, 2nd & 3rd trimesters of pregnancy, Gastrointestinal cancer & bone fractures.




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Test Name	Value	Unit	Biological Reference interval
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TUMOUR MARKER

PROSTATE SPECIFIC ANTIGEN (PSA) - TOTAL

PROSTATE SPECIFIC ANTIGEN (PSA) - TOTAL: 0.45 ng/mL 0.0 - 4.0

SERUM

by CLIA (CHEMILUMINESCENCE IMMUNOASSAY)

INTERPRETATION:-

Expected Values for the PSA

Smokers	< 4 ng/ml
Non-smokers	< 4 ng/ml

- 1.Prostate-specific antigen (PSA) is a glycoprotein that is produced by the prostate gland, the lining of the urethra, and the bulbourethral gland.
- 2.Normally, very little PSA is secreted in the blood.


INCREASED :-


- 1.Increased in glandular size and tissue damage caused by benign prostatic hypertrophy.
- 2.Prostatitis.
- 3.Prostate cancer may increase circulating PSA levels.
- 4.In patients with previously diagnosed prostate cancer, PSA testing is advocated as an early indicator of tumor recurrence and as an indicator of response to therapy.

The test is also useful for initial screening for prostate cancer:-

- 1.Total PSA levels < 2 ng/ml almost rule out the possibility of prostatic malignancy.
- 2.Total PSA levels between 2 and 10 ng/ml lie in the grey zone. Such values may be obtained in prostatitis, benign hyperplasia and malignancy. Further testing including a free PSA/PSA ratio and prostate biopsy is recommended for these patients for confirmation of the diagnosis.
- 3.Total PSA values >10 ng/ml are highly suspicious for prostate cancer but further testing, such as prostate biopsy, is needed to diagnose the exact pathology.




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CLINICAL PATHOLOGY

URINE ROUTINE & MICROSCOPIC EXAMINATION

PHYSICAL EXAMINATION

QUANTITY RECIEVED	10	ml	
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
COLOUR	AMBER YELLOW		PALE YELLOW
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
TRANSPARANCY	HAZY		CLEAR
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
SPECIFIC GRAVITY	1.01		1.002 - 1.030
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			

CHEMICAL EXAMINATION

REACTION	ACIDIC		
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
PROTEIN	NEGATIVE (-ve)		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
SUGAR	2+		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
pH	<=5.0		5.0 - 7.5
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
BILIRUBIN	NEGATIVE (-ve)		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
NITRITE	NEGATIVE (-ve)		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY.			
UROBILINOGEN	NOT DETECTED	EU/dL	0.2 - 1.0
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
KETONE BODIES	TRACE		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
BLOOD	NEGATIVE (-ve)		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
ASCORBIC ACID	NEGATIVE (-ve)		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			

MICROSCOPIC EXAMINATION




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RED BLOOD CELLS (RBCs) <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	NEGATIVE (-ve)	/HPF	0 - 3
PUS CELLS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	3-4	/HPF	0 - 5
EPITHELIAL CELLS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	1-3	/HPF	ABSENT
CRYSTALS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	NEGATIVE (-ve)		NEGATIVE (-ve)
CASTS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	NEGATIVE (-ve)		NEGATIVE (-ve)
BACTERIA <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	NEGATIVE (-ve)		NEGATIVE (-ve)
OTHERS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	NEGATIVE (-ve)		NEGATIVE (-ve)
TRICHOMONAS VAGINALIS (PROTOZOA) <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	ABSENT		ABSENT

*** End Of Report ***




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