

**Dr. Vinay Chopra**  
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 Chairman & Consultant Pathologist

**Dr. Yugam Chopra**  
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<b>NAME</b>	: Mrs. SHWETA	<b>PATIENT ID</b>	: 1577300
<b>AGE/ GENDER</b>	: 38 YRS/FEMALE	<b>REG. NO./LAB NO.</b>	: 012408100060
<b>COLLECTED BY</b>	:	<b>REGISTRATION DATE</b>	: 10/Aug/2024 06:57 PM
<b>REFERRED BY</b>	:	<b>COLLECTION DATE</b>	: 10/Aug/2024 06:58PM
<b>BARCODE NO.</b>	: 01514857	<b>REPORTING DATE</b>	: 11/Aug/2024 10:22AM
<b>CLIENT CODE.</b>	: KOS DIAGNOSTIC LAB		
<b>CLIENT ADDRESS</b>	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
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**FEVER PANEL**  
**COMPLETE BLOOD COUNT (CBC)**

**RED BLOOD CELLS (RBCS) COUNT AND INDICES**


<b>HAEMOGLOBIN (HB)</b> <i>by CALORIMETRIC</i>	11.7 <sup>L</sup>	gm/dL	12.0 - 16.0
RED BLOOD CELL (RBC) COUNT <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDEANCE</i>	4.24	Millions/cmm	3.50 - 5.00
<b>PACKED CELL VOLUME (PCV)</b> <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	35.9 <sup>L</sup>	%	37.0 - 50.0
MEAN CORPUSCULAR VOLUME (MCV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	84.6	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	27.6	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	32.7	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	13.4	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	42.5	fL	35.0 - 56.0
MENTZERS INDEX <i>by CALCULATED</i>	19.95	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX <i>by CALCULATED</i>	26.74	RATIO	BETA THALASSEMIA TRAIT: < = 65.0 IRON DEFICIENCY ANEMIA: > 65.0


**WHITE BLOOD CELLS (WBCS)**

<b>TOTAL LEUCOCYTE COUNT (TLC)</b> <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	3060 <sup>L</sup>	/cmm	4000 - 11000
NUCLEATED RED BLOOD CELLS (nRBCS) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER &amp; MICROSCOPY</i>	NIL		0.00 - 20.00
NUCLEATED RED BLOOD CELLS (nRBCS) % <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER &amp; MICROSCOPY</i>	NIL	%	< 10 %

**DIFFERENTIAL LEUCOCYTE COUNT (DLC)**



  
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<b>NEUTROPHILS</b> <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	23 <sup>L</sup>	%	50 - 70
<b>LYMPHOCYTES</b> <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	60 <sup>H</sup>	%	20 - 40
<b>EOSINOPHILS</b> <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	8 <sup>H</sup>	%	1 - 6
<b>MONOCYTES</b> <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	9	%	2 - 12
<b>BASOPHILS</b> <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	0	%	0 - 1
<b>IMMATURE GRANULOCTE (IG) %</b> <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	0	%	0 - 5.0
<b><u>ABSOLUTE LEUKOCYTES (WBC) COUNT</u></b>			
<b>ABSOLUTE NEUTROPHIL COUNT</b> <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	704 <sup>L</sup>	/cmm	2000 - 7500
<b>ABSOLUTE LYMPHOCYTE COUNT</b> <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	1836	/cmm	800 - 4900
<b>ABSOLUTE EOSINOPHIL COUNT</b> <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	245	/cmm	40 - 440
<b>ABSOLUTE MONOCYTE COUNT</b> <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	275	/cmm	80 - 880
<b>ABSOLUTE BASOPHIL COUNT</b> <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	0	/cmm	0 - 110
<b>ABSOLUTE IMMATURE GRANULOCYTE COUNT</b> <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	0	/cmm	0.0 - 999.0
<b><u>PLATELETS AND OTHER PLATELET PREDICTIVE MARKERS.</u></b>			
<b>PLATELET COUNT (PLT)</b> <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	315000	/cmm	150000 - 450000
<b>PLATELETCRIT (PCT)</b> <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	0.3	%	0.10 - 0.36
<b>MEAN PLATELET VOLUME (MPV)</b> <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	10	fL	6.50 - 12.0
<b>PLATELET LARGE CELL COUNT (P-LCC)</b> <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	70000	/cmm	30000 - 90000
<b>PLATELET LARGE CELL RATIO (P-LCR)</b> <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	22.2	%	11.0 - 45.0



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PLATELET DISTRIBUTION WIDTH (PDW)	16	%	15.0 - 17.0
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*by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*

**ADVICE** **KINDLY CORRELATE CLINICALLY**

NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD

RECHECKED.



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**CLINICAL CHEMISTRY/BIOCHEMISTRY**

**LIVER FUNCTION TEST (COMPLETE)**

BILIRUBIN TOTAL: SERUM <i>by DIAZOTIZATION, SPECTROPHOTOMETRY</i>	0.35	mg/dL	INFANT: 0.20 - 8.00 ADULT: 0.00 - 1.20
BILIRUBIN DIRECT (CONJUGATED): SERUM <i>by DIAZO MODIFIED, SPECTROPHOTOMETRY</i>	0.12	mg/dL	0.00 - 0.40
BILIRUBIN INDIRECT (UNCONJUGATED): SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	0.23	mg/dL	0.10 - 1.00
SGOT/AST: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	26.51	U/L	7.00 - 45.00
SGPT/ALT: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	44.72	U/L	0.00 - 49.00
AST/ALT RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	0.59	RATIO	0.00 - 46.00
ALKALINE PHOSPHATASE: SERUM <i>by PARA NITROPHENYL PHOSPHATASE BY AMINO METHYL PROPANOL</i>	128.49	U/L	40.0 - 130.0
GAMMA GLUTAMYL TRANSFERASE (GGT): SERUM <i>by SZASZ, SPECTROPHOTOMETRY</i>	51.35	U/L	0.00 - 55.0
TOTAL PROTEINS: SERUM <i>by BIURET, SPECTROPHOTOMETRY</i>	7.07	gm/dL	6.20 - 8.00
ALBUMIN: SERUM <i>by BROMOCRESOL GREEN</i>	3.71	gm/dL	3.50 - 5.50
GLOBULIN: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	3.36	gm/dL	2.30 - 3.50
A : G RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	1.1	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



  
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Test Name	Value	Unit	Biological Reference interval
INTRAHEPATIC CHOLESTATIS	> 1.5		
HEPATOCELLULAR CARCINOMA & CHRONIC HEPATITIS	> 1.3 (Slightly Increased)		

**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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**IMMUNOPATHOLOGY/SEROLOGY**

**TYPHOID COMBO SCREEN (TYPHOID ANTIGEN, IgG AND IgM): SERUM**

TYPHOID ANTIGEN - SERUM <i>by ICT (IMMUNOCHROMATOGRAPHY)</i>	NEGATIVE (-ve)	NEGATIVE (-ve)
TYPHI DOT ANTIBODY IgG <i>by ICT (IMMUNOCHROMATOGRAPHY)</i>	NEGATIVE (-ve)	NEGATIVE (-ve)
TYPHI DOT ANTIBODY IgM <i>by ICT (IMMUNOCHROMATOGRAPHY)</i>	NEGATIVE (-ve)	NEGATIVE (-ve)

**INTERPRETATION:**

Typhoid fever is a life threatening illness caused by the bacterium Salmonella typhus. The infection is acquired typically by ingestion. On reaching the gut, the bacilli attach themselves to the epithelial cells of the intestinal villi and penetrate the lamina and submucosa. They are then phagocytosed there by polymorphs and mesenteric lymph nodes, where they multiply and, via the thoracic duct, enter the blood stream. A transient bacteremia follows, during which the bacilli are seeded in the liver, gall bladder, spleen, bone marrow, lymph nodes, and kidneys, where further multiplication takes place. Towards the end of the incubation period, there occurs a massive bacteremia from these sites, heralding the onset of the clinical symptoms.

The diagnosis of typhoid consists of isolation of the bacilli and the demonstration of antibodies. The isolation of the bacilli is very time consuming and antibody detection is not very specific. Other tests include the Widal reaction. The advantage of this test is that it takes only 10-20 minutes and requires only a small amount of stool/serum/plasma to perform. It is the easiest and most specific method for detecting S. typhi infection.

**RELATIVE SENSITIVITY OF TYPHOID ANTIGEN DETECTION: 98.7%**

**RELATIVE SPECIFICITY OF TYPHOID ANTIGEN DETECTION: 97.4%**

**DETECTABLE IgM RESPONSE:**

ONSET OF FEVER	PERCENT POSITIVE
4 - 6 DAYS	43.5
6 - 9 DAYS	92.9
> 9 DAYS	99.5

1. This is a solid phase, immunochromatographic ELISA assay that detects specific IgM and IgG Antibodies against the OUTER MEMBRAN PROTEIN(OMP) of the Salmonella species. IgM antibodies appear in the serum 2-3 days post infection and are indicative of a recent infection while the IgG antibodies appear later and are useful for presumptive diagnosis of Enteric fever if the patient presents more than a week after onset of symptoms.

2. This is a useful screening assay for the early detection of Enteric fever and has a high sensitivity. However the test has moderate specificity and false positive results may be obtained in the following situations:

- Antibodies against Salmonella may cross react with other antibodies.



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Unrelated infections may lead to production of specific Salmonella antibodies if the patient has previously been exposed to Salmonella infection (**ANAMNESTIC RESPONSE**).

**NOTE:-**Rapid blood culture performed during 1<sup>st</sup> week of infection is highly recommended for confirmation of all IgM positive results. In case the patient has presented after the first week of infection, a thorough clinical correlation and confirmatory Widal test must be performed to establish the diagnosis.



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**CHIKUNGUNYA ANTIBODY IgM SCREENING**

CHIKUNGUNYA ANTIBODY IgM QUANTITATIVE SERUM <i>by ELISA (ENZYME LINKED IMMUNOASSAY)</i>	0.45	INDEX VALUE	< 1.00
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**INTERPRETATION:**

- 1.Chikungunya is an insect borne viral disease belonging to genus ALPHAVIRIDAE transmitted to humans by infected Aedes mosquito
- 2.It causes fever and severe joint pain. Other symptoms include muscle pain, headache, nausea, fatigue and rash.
- 3.Joint pain is often debilitating and can vary in duration.
- 4.The disease shares some clinical signs with dengue, and can be misdiagnosed in areas where dengue is common.
- 5.There is no cure for the disease. Treatment is focused on relieving the symptoms.


**ROUTE OF TRANSMISSION:**


- 1.The virus is transmitted from human to human by the bites of infected female mosquitoes.
- 2.Most commonly, the mosquitoes involved are Aedes aegypti and Aedes albopictus, two species which can also transmit other mosquito-borne viruses, including dengue.
- 3.These mosquitoes can be found biting throughout daylight hours, though there may be peaks of activity in the early morning and late afternoon.
- 4.Both species are found biting outdoors, but Ae. aegypti will also readily feed indoors.
- 5.After the bite of an infected mosquito, onset of illness occurs usually between 4 and 8 days but can range from 2 to 12 days.

**NOTE:**

This is a solid phase immunochromatographic assay for the detection of the Chikungunya specific IgM antibodies in the human serum. The test has a sensitivity of 97.5 % and a specificity of 99.1 %.



  
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**C-REACTIVE PROTEIN (CRP)**

<b>C-REACTIVE PROTEIN (CRP) QUANTITATIVE:</b>	<b>27.93<sup>H</sup></b>	<b>mg/L</b>	<b>0.0 - 6.0</b>
<b>SERUM</b>			
<i>by NEPHLOMETRY</i>			

**INTERPRETATION:**

1. C-reactive protein (CRP) is one of the most sensitive acute-phase reactants for inflammation.
2. CRP levels can increase dramatically (100-fold or more) after severe trauma, bacterial infection, inflammation, surgery, or neoplastic proliferation.
3. CRP levels (Quantitative) has been used to assess activity of inflammatory disease, to detect infections after surgery, to detect transplant rejection, and to monitor these inflammatory processes.
4. As compared to ESR, CRP shows an earlier rise in inflammatory disorders which begins in 4-6 hrs, the intensity of the rise being higher than ESR and the recovery being earlier than ESR. Unlike ESR, CRP levels are not influenced by hematologic conditions like Anemia, Polycythemia etc.,
5. Elevated values are consistent with an acute inflammatory process.

- NOTE:**
1. Elevated C-reactive protein (CRP) values are nonspecific and should not be interpreted without a complete clinical history.
  2. Oral contraceptives may increase CRP levels.



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<b>NAME</b>	: Mrs. SHWETA	<b>PATIENT ID</b>	: 1577300
<b>AGE/ GENDER</b>	: 38 YRS/FEMALE	<b>REG. NO./LAB NO.</b>	: 012408100060
<b>COLLECTED BY</b>	:	<b>REGISTRATION DATE</b>	: 10/Aug/2024 06:57 PM
<b>REFERRED BY</b>	:	<b>COLLECTION DATE</b>	: 10/Aug/2024 06:58PM
<b>BARCODE NO.</b>	: 01514857	<b>REPORTING DATE</b>	: 10/Aug/2024 08:06PM
<b>CLIENT CODE.</b>	: KOS DIAGNOSTIC LAB		
<b>CLIENT ADDRESS</b>	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		


Test Name	Value	Unit	Biological Reference interval
<b>DENGUE FEVER COMBO SCREENING - (NS1 ANTIGEN, IgG AND IgM)</b>			
DENGUE NS1 ANTIGEN - SCREENING <i>by ICT (IMMUNOCHROMATOGRAPHY)</i>	NEGATIVE (-ve)		NEGATIVE (-ve)
DENGUE ANTIBODY IgG - SCREENING <i>by ICT (IMMUNOCHROMATOGRAPHY)</i>	NEGATIVE (-ve)		NEGATIVE (-ve)
DENGUE ANTIBODY IgM - SCREENING <i>by ICT (IMMUNOCHROMATOGRAPHY)</i>	NEGATIVE (-ve)		NEGATIVE (-ve)

**INTERPRETATION:-**

- 1.This is a solid phase immunochromatographic ELISA test for the qualitative detection of the specific IgG and IgM antibodies against the Dengue virus.
- 2.The IgM antibodies take a minimum of 5-10 days in primary infection and 4-5 days in secondary infections to test positive and hence are suitable for the diagnosis of dengue fever only when the fever is approximately one week old.
- 3.The IgG antibodies develop at least two weeks after exposure to primary infection and subsequently remain positive for the rest of the life. A positive result is incapable of differentiating a current infection from a past infection.
- 4.The Dengue NS-1 antigen test is most suited for early diagnosis (within the first week of exposure).



  
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<b>BARCODE NO.</b>	: 01514857	<b>REPORTING DATE</b>	: 10/Aug/2024 08:05PM
<b>CLIENT CODE.</b>	: KOS DIAGNOSTIC LAB		
<b>CLIENT ADDRESS</b>	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
<b>MALARIA - P.FALCIPARUM AND P.VIVAX ANTIGEN DETECTION</b>			
PLASMODIUM FALCIPARUM ANTIGEN <i>by ICT (IMMUNOCHROMATOGRAPHY)</i>	NEGATIVE (-ve)		NEGATIVE (-ve)
PLASMODIUM VIVAX ANTIGEN <i>by ICT (IMMUNOCHROMATOGRAPHY)</i>	NEGATIVE (-ve)		NEGATIVE (-ve)



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<b>BARCODE NO.</b>	: 01514857	<b>REPORTING DATE</b>	: 13/Aug/2024 09:47AM
<b>CLIENT CODE.</b>	: KOS DIAGNOSTIC LAB		
<b>CLIENT ADDRESS</b>	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
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**CLINICAL PATHOLOGY**

**URINE ROUTINE & MICROSCOPIC EXAMINATION**

**PHYSICAL EXAMINATION**

QUANTITY RECEIVED	10	ml	
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
COLOUR	PALE YELLOW		PALE YELLOW
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
TRANSPARANCY	CLEAR		CLEAR
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
SPECIFIC GRAVITY	1.02		1.002 - 1.030
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			

**CHEMICAL EXAMINATION**

REACTION	ACIDIC		
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
PROTEIN	Negative		NEGATIVE (-ve)
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
SUGAR	Negative		NEGATIVE (-ve)
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
pH	6		5.0 - 7.5
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
BILIRUBIN	Negative		NEGATIVE (-ve)
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
NITRITE	Negative		NEGATIVE (-ve)
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY.</i>			
UROBILINOGEN	Normal	EU/dL	0.2 - 1.0
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
KETONE BODIES	Negative		NEGATIVE (-ve)
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
BLOOD	Negative		NEGATIVE (-ve)
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
ASCORBIC ACID	NEGATIVE (-ve)		NEGATIVE (-ve)
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			

**MICROSCOPIC EXAMINATION**



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<b>CLIENT CODE.</b>	: KOS DIAGNOSTIC LAB		
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Test Name	Value	Unit	Biological Reference interval
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>	1-2	/HPF	0 - 5
EPITHELIAL CELLS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	4-6	/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



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<b>BARCODE NO.</b>	: 01514857	<b>REPORTING DATE</b>	: 15/Aug/2024 04:31PM
<b>CLIENT CODE.</b>	: KOS DIAGNOSTIC LAB		
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Test Name	Value	Unit	Biological Reference interval
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**MICROBIOLOGY**

**CULTURE AEROBIC BACTERIA AND ANTIBIOTIC SENSITIVITY: URINE**

**CULTURE AND SUSCEPTIBILITY: URINE**

DATE OF SAMPLE	13-08-2024
SPECIMEN SOURCE	URINE
INCUBATION PERIOD	48 HOURS
<i>by AUTOMATED BROTH CULTURE</i>	
CULTURE	STERILE
<i>by AUTOMATED BROTH CULTURE</i>	
ORGANISM	NO AEROBIC PYOGENIC ORGANISM GROWN AFTER 48 HOURS OF INCUBATION AT 37°C
<i>by AUTOMATED BROTH CULTURE</i>	

**AEROBIC SUSCEPTIBILITY: URINE**

**INTERPRETATION:**

1. In urine culture and sensitivity, presence of more than 100,000 organism per mL in midstream sample of urine is considered clinically significant. However in symptomatic patients , a smaller number of bacteria (100 to 10000/mL) may signify infection.
2. Colony count of 100 to 10000/ mL indicate infection, if isolate from specimen obtained by suprapubic aspiration or "in-and-out" catheterization or from patients with indwelling catheters.

**SUSCEPTIBILITY:**

1. A test interpreted as **SENSITIVE** implies that infection due to isolate may be appropriately treated with the dosage of an antimicrobial agent recommended for that type of infection and infecting species, unless otherwise indicated..
2. A test interpreted as **INTERMEDIATE** implies that the "infection due to the isolate may be appropriately treated in body sites where the drugs are physiologically concentrated or when a high dosage of drug can be used".
3. A test interpreted as **RESISTANT** implies that the "isolates are not inhibited by the usually achievable concentration of the agents with normal dosage, schedule and/or fall in the range where specific microbial resistance mechanism are likely (e.g. beta-lactamases), and clinical efficacy has not been reliable in treatment studies.

**CAUTION:**

Conditions which can cause a false Negative culture:

1. Patient is on antibiotics. Please repeat culture post therapy.
2. Anaerobic bacterial infection.
3. Fastidious aerobic bacteria which are not able to grow on routine culture media.
4. Besides all these factors, at least in 25-40 % of cases there is no direct correlation between in vivo clinical picture.
5. Renal tuberculosis to be confirmed by AFB studies.



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<b>CLIENT CODE.</b>	: KOS DIAGNOSTIC LAB		
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Test Name	Value	Unit	Biological Reference interval
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**CULTURE AEROBIC BACTERIA AND ANTIBIOTIC SENSITIVITY (CONVENTIONAL): BLOOD**

**BLOOD CULTURE AND SUSCEPTIBILITY**

DATE OF SAMPLE	10-08-2024
SPECIMEN SOURCE	BLOOD
INCUBATION PERIOD	72 HOURS (3 SUBCULTURES)
CULTURE	STERILE
<i>by AUTOMATED BROTH CULTURE</i>	
ORGANISM	NO AEROBIC PYOGENIC ORGANISM GROWN AFTER 72 HOURS OF INCUBATION AT 37°C
<i>by AUTOMATED BROTH CULTURE</i>	

**AEROBIC SUSCEPTIBILITY BLOOD**

**INTERPRETATION**  
**SUSCEPTIBILITY:**

1. A test interpreted as **SENSITIVE** implies that infection due to isolate may be appropriately treated with the dosage of an antimicrobial agent recommended for that type of infection and infecting species, unless otherwise indicated.
2. A test interpreted as **INTERMEDIATE** implies that the "infection due to the isolate may be appropriately treated in body sites where the drugs are physiologically concentrated or when a high dosage of drug can be used".
3. A test interpreted as **RESISTANT** implies that the "isolates are not inhibited by the usually achievable concentration of the agents with normal dosage, schedule and/or fall in the range where specific microbial resistance mechanism are likely (e.g. beta-lactamases), and clinical efficacy has not been reliable in treatment studies.

**CAUTION:**

- Conditions which can cause a false Negative culture:
1. Patient is on antibiotics. Please repeat culture post therapy.
  2. Anaerobic bacterial infection.
  3. Fastidious aerobic bacteria which are not able to grow on routine culture media.
  4. Besides all these factors, at least in 25-40 % of cases there is no direct correlation between in vivo clinical picture.
  5. Renal tuberculosis to be confirmed by AFB studies.

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



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