

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

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

NAME : Mr. GURDEEP SINGH  
AGE/ GENDER : 72 YRS/MALE  
COLLECTED BY :  
REFERRED BY :  
BARCODE NO. : 01514911  
CLIENT CODE. : KOS DIAGNOSTIC LAB  
CLIENT ADDRESS : 6349/1, NICHOLSON ROAD, AMBALA CANTT

PATIENT ID : 1577903  
REG. NO./LAB NO. : 012408120005  
REGISTRATION DATE : 12/Aug/2024 07:45 AM  
COLLECTION DATE : 12/Aug/2024 07:46AM  
REPORTING DATE : 12/Aug/2024 12:05PM

Test Name	Value	Unit	Biological Reference interval
-----------	-------	------	-------------------------------

## CLINICAL CHEMISTRY/BIOCHEMISTRY

### KIDNEY FUNCTION TEST (COMPLETE)

UREA: SERUM by UREASE - GLUTAMATE DEHYDROGENASE (GLDH)	122.97 <sup>H</sup>	mg/dL	10.00 - 50.00
CREATININE: SERUM by ENZYMATIC, SPECTROPHOTOMETRY	3.52 <sup>H</sup>	mg/dL	0.40 - 1.40
BLOOD UREA NITROGEN (BUN): SERUM by CALCULATED, SPECTROPHOTOMETRY	57.46 <sup>H</sup>	mg/dL	7.0 - 25.0
BLOOD UREA NITROGEN (BUN)/CREATININE RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	16.32	RATIO	10.0 - 20.0
UREA/CREATININE RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	34.93	RATIO	
URIC ACID: SERUM by URICASE - OXIDASE PEROXIDASE	7.63	mg/dL	3.60 - 7.70
CALCIUM: SERUM by ARSENAZO III, SPECTROPHOTOMETRY	9.85	mg/dL	8.50 - 10.60

### ELECTROLYTES

SODIUM: SERUM by ISE (ION SELECTIVE ELECTRODE)	140.3	mmol/L	135.0 - 150.0
POTASSIUM: SERUM by ISE (ION SELECTIVE ELECTRODE)	3.73	mmol/L	3.50 - 5.00
CHLORIDE: SERUM by ISE (ION SELECTIVE ELECTRODE)	105.23	mmol/L	90.0 - 110.0

### ESTIMATED GLOMERULAR FILTRATION RATE

ESTIMATED GLOMERULAR FILTRATION RATE (eGFR): SERUM by CALCULATED	17.7
--	------

### INTERPRETATION:

To differentiate between pre- and post renal azotemia.

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

- Prerenal azotemia (BUN rises without increase in creatinine) e.g. heart failure, salt depletion, dehydration, blood loss) due to decreased glomerular filtration rate.
- Catabolic states with increased tissue breakdown.



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

<b>NAME</b>	: Mr. GURDEEP SINGH	<b>PATIENT ID</b>	: 1577903
<b>AGE/ GENDER</b>	: 72 YRS/MALE	<b>REG. NO./LAB NO.</b>	: 012408120005
<b>COLLECTED BY</b>	:	<b>REGISTRATION DATE</b>	: 12/Aug/2024 07:45 AM
<b>REFERRED BY</b>	:	<b>COLLECTION DATE</b>	: 12/Aug/2024 07:46AM
<b>BARCODE NO.</b>	: 01514911	<b>REPORTING DATE</b>	: 12/Aug/2024 12:05PM
<b>CLIENT CODE.</b>	: KOS DIAGNOSTIC LAB		
<b>CLIENT ADDRESS</b>	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
-----------	-------	------	-------------------------------

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 <sup>2</sup> )	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	



  
 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

<b>NAME</b>	: Mr. GURDEEP SINGH	<b>PATIENT ID</b>	: 1577903
<b>AGE/ GENDER</b>	: 72 YRS/MALE	<b>REG. NO./LAB NO.</b>	: 012408120005
<b>COLLECTED BY</b>	:	<b>REGISTRATION DATE</b>	: 12/Aug/2024 07:45 AM
<b>REFERRED BY</b>	:	<b>COLLECTION DATE</b>	: 12/Aug/2024 07:46AM
<b>BARCODE NO.</b>	: 01514911	<b>REPORTING DATE</b>	: 12/Aug/2024 12:05PM
<b>CLIENT CODE.</b>	: KOS DIAGNOSTIC LAB		
<b>CLIENT ADDRESS</b>	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
-----------	-------	------	-------------------------------

**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 \*\*\*



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

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

