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| | | | |
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| **NAME** | **: Mr. JAI PAL** | | |
| **AGE/ GENDER** | : 53 YRS/MALE | **PATIENT ID** | : 1577909 |
| **COLLECTED BY** | : | **REG. NO./LAB NO.** | **: 012408120011** |
| **REFERRED BY** | : | **REGISTRATION DATE** | : 12/Aug/2024 08:57 AM |
| **BARCODE NO.** | : 01514917 | **COLLECTION DATE** | : 12/Aug/2024 09:00AM |
| **CLIENT CODE.** | : KOS DIAGNOSTIC LAB | **REPORTING DATE** | : 12/Aug/2024 10:06AM |
| **CLIENT ADDRESS** | : 6349/1, NICHOLSON ROAD, AMBALA CANTT | | |

## SWASTHYA WELLNESS PANEL: GT

### COMPLETE BLOOD COUNT (CBC)

| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|
| **RED BLOOD CELLS (RBCS) COUNT AND INDICES** | | | |
| HAEMOGLOBIN (HB)<br>*by CALORIMETRIC* | 14.4 | gm/dL | 12.0 - 17.0 |
| **RED BLOOD CELL (RBC) COUNT**<br>***by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*** | **5.46$^{H}$** | **Millions/cmm** | **3.50 - 5.00** |
| PACKED CELL VOLUME (PCV)<br>*by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER* | 44.9 | % | 40.0 - 54.0 |
| MEAN CORPUSCULAR VOLUME (MCV)<br>*by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER* | 82.2 | fL | 80.0 - 100.0 |
| **MEAN CORPUSCULAR HAEMOGLOBIN (MCH)**<br>***by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*** | **26.4$^{L}$** | **pg** | **27.0 - 34.0** |
| MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC)<br>*by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER* | 32.2 | g/dL | 32.0 - 36.0 |
| RED CELL DISTRIBUTION WIDTH (RDW-CV)<br>*by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER* | 14.6 | % | 11.00 - 16.00 |
| RED CELL DISTRIBUTION WIDTH (RDW-SD)<br>*by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER* | 44.7 | fL | 35.0 - 56.0 |
| MENTZERS INDEX<br>*by CALCULATED* | 15.05 | RATIO | BETA THALASSEMIA TRAIT: < 13.0<br>IRON DEFICIENCY ANEMIA: >13.0 |
| GREEN & KING INDEX<br>*by CALCULATED* | 22 | RATIO | BETA THALASSEMIA TRAIT: < = 65.0<br>IRON DEFICIENCY ANEMIA: > 65.0 |
| **WHITE BLOOD CELLS (WBCS)** | | | |
| TOTAL LEUCOCYTE COUNT (TLC)<br>*by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY* | 7600 | /cmm | 4000 - 11000 |
| NUCLEATED RED BLOOD CELLS (nRBCS)<br>*by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER & MICROSCOPY* | NIL | | 0.00 - 20.00 |
| NUCLEATED RED BLOOD CELLS (nRBCS) %<br>*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<br>*by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY* | 55 | % | 50 - 70 |
| LYMPHOCYTES<br>*by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY* | 34 | % | 20 - 40 |
| EOSINOPHILS<br>*by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY* | 6 | % | 1 - 6 |
| MONOCYTES<br>*by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY* | 5 | % | 2 - 12 |
| BASOPHILS<br>*by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY* | 0 | % | 0 - 1 |
| **ABSOLUTE LEUKOCYTES (WBC) COUNT** | | | |
| ABSOLUTE NEUTROPHIL COUNT<br>*by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY* | 4180 | /cmm | 2000 - 7500 |
| ABSOLUTE LYMPHOCYTE COUNT<br>*by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY* | 2584 | /cmm | 800 - 4900 |
| **ABSOLUTE EOSINOPHIL COUNT**<br>***by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*** | **456$^{H}$** | **/cmm** | **40 - 440** |
| ABSOLUTE MONOCYTE COUNT<br>*by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY* | 380 | /cmm | 80 - 880 |
| ABSOLUTE BASOPHIL COUNT<br>*by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY* | 0 | /cmm | 0 - 110 |
| **PLATELETS AND OTHER PLATELET PREDICTIVE MARKERS.** | | | |
| PLATELET COUNT (PLT)<br>*by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE* | 183000 | /cmm | 150000 - 450000 |
| PLATELETCRIT (PCT)<br>*by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE* | 0.25 | % | 0.10 - 0.36 |
| **MEAN PLATELET VOLUME (MPV)**<br>***by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*** | **14$^{H}$** | **fL** | **6.50 - 12.0** |
| **PLATELET LARGE CELL COUNT (P-LCC)**<br>***by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*** | **96000$^{H}$** | **/cmm** | **30000 - 90000** |
| **PLATELET LARGE CELL RATIO (P-LCR)**<br>***by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*** | **52.3$^{H}$** | **%** | **11.0 - 45.0** |
| PLATELET DISTRIBUTION WIDTH (PDW)<br>*by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE* | 16.7 | % | 15.0 - 17.0 |

NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD

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| **CLIENT CODE.** | : KOS DIAGNOSTIC LAB | **REPORTING DATE** | : 12/Aug/2024 03:09PM |
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## GLYCOSYLATED HAEMOGLOBIN (HBA1C)

| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|
| **GLYCOSYLATED HAEMOGLOBIN (HbA1c): WHOLE BLOOD** *by HPLC (HIGH PERFORMANCE LIQUID CHROMATOGRAPHY)* | **12.6$^{H}$** | **%** | **4.0 - 6.4** |
| **ESTIMATED AVERAGE PLASMA GLUCOSE** *by HPLC (HIGH PERFORMANCE LIQUID CHROMATOGRAPHY)* | **314.92$^{H}$** | **mg/dL** | **60.00 - 140.00** |

***INTERPRETATION:***

| AS PER AMERICAN DIABETES ASSOCIATION (ADA): | | |
|---|---|---|
| **REFERENCE GROUP** | **GLYCOSYLATED HEMOGLOGIB (HBAIC) in %** | |
| Non diabetic Adults >= 18 years | <5.7 | |
| At Risk (Prediabetes) | 5.7 – 6.4 | |
| Diagnosing Diabetes | >= 6.5 | |
| Therapeutic goals for glycemic control | **Age > 19 Years** | |
| | Goals of Therapy: | < 7.0 |
| | Actions Suggested: | >8.0 |
| | **Age < 19 Years** | |
| | Goal of therapy: | <7.5 |

**COMMENTS:**

1.Glycosylated hemoglobin (HbA1c) test is three monthly monitoring done to assess compliace with therapeutic regimen in diabetic patients.

*2.Since Hb1c reflects long term fluctuations in blood glucose concentration, a diabetic patient who has recently under good control may still have high concentration of HbAIc. Converse is true for a diabetic previously under good control but now poorly controlled.*

*3.Target goals of < 7.0 % may be beneficial in patients with short duration of diabetes, long life expectancy and no significant cardiovascular disease. In patients with significant complications of diabetes, limited life expectancy or extensive co-morbid conditions, targetting a goal of < 7.0% may not be appropiate.*

*4.*High HbA1c (>9.0 -9.5 %) is strongly associated with risk of development and rapid progression of microvascular and nerve complications

5.Any condition that shorten RBC life span like acute blood loss, hemolytic anemia falsely lower HbA1c results.

6.HbA1c results from patients with HbSS,HbSC and HbD must be interpreted with caution , given the pathological processes including anemia,increased red cell turnover, and transfusion requirement that adversely impact HbA1c as a marker of long-term gycemic control.

7.Specimens from patients with polycythemia or post-splenctomy may exhibit increse in HbA1c values due to a somewhat longer life span of the red cells.

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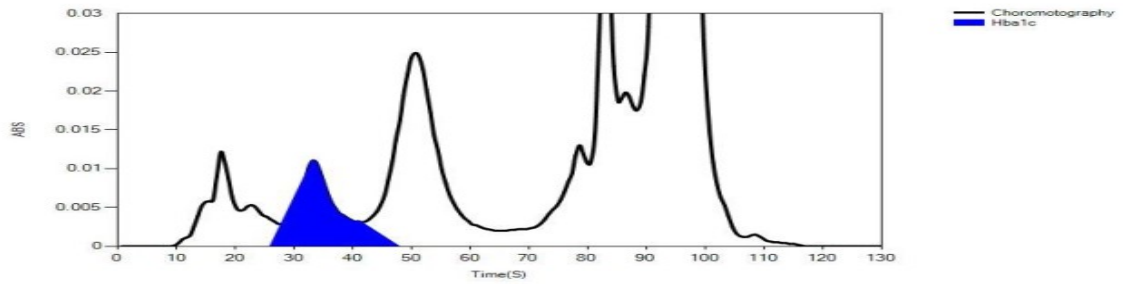
| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|

LIFOTRONIC Graph Report

| | | | | |
|---|---|---|---|---|
| Name : | Case : | Patient Type : | | Test Date : 12/08/2024 14:37:17 |
| Age : | Department : | Sample Type : Whole Blood EDTA | | Sample Id : 01514917 |
| Gender : | | | | Total Area : 18136 |

| Peak Name | Retention Time(s) | Absorbance | Area | Result (Area %) |
|---|---|---|---|---|
| HbA0 | 69 | 4695 | 14916 | 79.7 |
| HbA1c | 37 | 249 | 2364 | 12.6 |
| La1c | 24 | 110 | 417 | 2.2 |
| HbF | 21 | 32 | 19 | 0.1 |
| Hba1b | 13 | 122 | 282 | 1.5 |
| Hba1a | 11 | 58 | 138 | 0.7 |

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

## ERYTHROCYTE SEDIMENTATION RATE (ESR)

| | | | |
|---|---|---|---|
| ERYTHROCYTE SEDIMENTATION RATE (ESR) | 17 | mm/1st hr | 0 - 20 |

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

## CLINICAL CHEMISTRY/BIOCHEMISTRY

### GLUCOSE FASTING (F)

| | | | |
|---|---|---|---|
| **GLUCOSE FASTING (F): PLASMA**<br>*by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)* | **283.3$^{H}$** | **mg/dL** | **NORMAL: < 100.0**<br>**PREDIABETIC: 100.0 - 125.0**<br>**DIABETIC: > 0R = 126.0** |

***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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| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|
| | **LIPID PROFILE : BASIC** | | |
| CHOLESTEROL TOTAL: SERUM<br>*by CHOLESTEROL OXIDASE PAP* | 194.49 | mg/dL | OPTIMAL: < 200.0<br>BORDERLINE HIGH: 200.0 - 239.0<br>HIGH CHOLESTEROL: > OR = 240.0 |
| **TRIGLYCERIDES: SERUM**<br>***by GLYCEROL PHOSPHATE OXIDASE (ENZYMATIC)*** | **259.62$^{H}$** | **mg/dL** | **OPTIMAL: < 150.0**<br>**BORDERLINE HIGH: 150.0 - 199.0**<br>**HIGH: 200.0 - 499.0**<br>**VERY HIGH: > OR = 500.0** |
| HDL CHOLESTEROL (DIRECT): SERUM<br>*by SELECTIVE INHIBITION* | 34.14 | mg/dL | LOW HDL: < 30.0<br>BORDERLINE HIGH HDL: 30.0 - 60.0<br>HIGH HDL: > OR = 60.0 |
| LDL CHOLESTEROL: SERUM<br>*by CALCULATED, SPECTROPHOTOMETRY* | 108.43 | mg/dL | OPTIMAL: < 100.0<br>ABOVE OPTIMAL: 100.0 - 129.0<br>BORDERLINE HIGH: 130.0 - 159.0<br>HIGH: 160.0 - 189.0<br>VERY HIGH: > OR = 190.0 |
| **NON HDL CHOLESTEROL: SERUM**<br>***by CALCULATED, SPECTROPHOTOMETRY*** | **160.35$^{H}$** | **mg/dL** | **OPTIMAL: < 130.0**<br>**ABOVE OPTIMAL: 130.0 - 159.0**<br>**BORDERLINE HIGH: 160.0 - 189.0**<br>**HIGH: 190.0 - 219.0**<br>**VERY HIGH: > OR = 220.0** |
| **VLDL CHOLESTEROL: SERUM**<br>***by CALCULATED, SPECTROPHOTOMETRY*** | **51.92$^{H}$** | **mg/dL** | **0.00 - 45.00** |
| TOTAL LIPIDS: SERUM<br>*by CALCULATED, SPECTROPHOTOMETRY* | 648.6 | mg/dL | 350.00 - 700.00 |
| **CHOLESTEROL/HDL RATIO: SERUM**<br>***by CALCULATED, SPECTROPHOTOMETRY*** | **5.7$^{H}$** | **RATIO** | **LOW RISK: 3.30 - 4.40**<br>**AVERAGE RISK: 4.50 - 7.0**<br>**MODERATE RISK: 7.10 - 11.0**<br>**HIGH RISK: > 11.0** |
| **LDL/HDL RATIO: SERUM**<br>***by CALCULATED, SPECTROPHOTOMETRY*** | **3.18$^{H}$** | **RATIO** | **LOW RISK: 0.50 - 3.0**<br>**MODERATE RISK: 3.10 - 6.0**<br>**HIGH RISK: > 6.0** |

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| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|
| **TRIGLYCERIDES/HDL RATIO: SERUM**<br>*by CALCULATED, SPECTROPHOTOMETRY* | **7.6$^{H}$** | **RATIO** | **3.00 - 5.00** |

***INTERPRETATION:***

1.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.
2. 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.
3. 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.
4. NLA-2014 identifies Non HDL Cholesterol (an indicator of all atherogeniclipoproteins such as LDL , VLDL, IDL, Lpa, 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.
5. 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)

| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|
| BILIRUBIN TOTAL: SERUM<br>*by DIAZOTIZATION, SPECTROPHOTOMETRY* | 0.68 | mg/dL | INFANT: 0.20 - 8.00<br>ADULT: 0.00 - 1.20 |
| BILIRUBIN DIRECT (CONJUGATED): SERUM<br>*by DIAZO MODIFIED, SPECTROPHOTOMETRY* | 0.18 | mg/dL | 0.00 - 0.40 |
| BILIRUBIN INDIRECT (UNCONJUGATED): SERUM<br>*by CALCULATED, SPECTROPHOTOMETRY* | 0.5 | mg/dL | 0.10 - 1.00 |
| SGOT/AST: SERUM<br>*by IFCC, WITHOUT PYRIDOXAL PHOSPHATE* | 23.2 | U/L | 7.00 - 45.00 |
| SGPT/ALT: SERUM<br>*by IFCC, WITHOUT PYRIDOXAL PHOSPHATE* | 34.6 | U/L | 0.00 - 49.00 |
| AST/ALT RATIO: SERUM<br>*by CALCULATED, SPECTROPHOTOMETRY* | 0.67 | RATIO | 0.00 - 46.00 |
| ALKALINE PHOSPHATASE: SERUM<br>*by PARA NITROPHENYL PHOSPHATASE BY AMINO METHYL PROPANOL* | 111.52 | U/L | 40.0 - 130.0 |
| **GAMMA GLUTAMYL TRANSFERASE (GGT): SERUM**<br>***by SZASZ, SPECTROPHTOMETRY*** | **99.39$^{H}$** | **U/L** | **0.00 - 55.0** |
| TOTAL PROTEINS: SERUM<br>*by BIURET, SPECTROPHOTOMETRY* | 6.95 | gm/dL | 6.20 - 8.00 |
| ALBUMIN: SERUM<br>*by BROMOCRESOL GREEN* | 3.88 | gm/dL | 3.50 - 5.50 |
| GLOBULIN: SERUM<br>*by CALCULATED, SPECTROPHOTOMETRY* | 3.07 | gm/dL | 2.30 - 3.50 |
| A : G RATIO: SERUM<br>*by CALCULATED, SPECTROPHOTOMETRY* | 1.26 | 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 |
|---|---|---|---|
| **KIDNEY FUNCTION TEST (COMPLETE)** | | | |
| UREA: SERUM<br>*by UREASE - GLUTAMATE DEHYDROGENASE (GLDH)* | 23.84 | mg/dL | 10.00 - 50.00 |
| CREATININE: SERUM<br>*by ENZYMATIC, SPECTROPHOTOMETERY* | 0.86 | mg/dL | 0.40 - 1.40 |
| BLOOD UREA NITROGEN (BUN): SERUM<br>*by CALCULATED, SPECTROPHOTOMETRY* | 11.14 | mg/dL | 7.0 - 25.0 |
| BLOOD UREA NITROGEN (BUN)/CREATININE RATIO: SERUM<br>*by CALCULATED, SPECTROPHOTOMETRY* | 12.95 | RATIO | 10.0 - 20.0 |
| UREA/CREATININE RATIO: SERUM<br>*by CALCULATED, SPECTROPHOTOMETRY* | 27.72 | RATIO | |
| URIC ACID: SERUM<br>*by URICASE - OXIDASE PEROXIDASE* | 7.23 | mg/dL | 3.60 - 7.70 |
| CALCIUM: SERUM<br>*by ARSENAZO III, SPECTROPHOTOMETRY* | 9.83 | mg/dL | 8.50 - 10.60 |
| PHOSPHOROUS: SERUM<br>*by PHOSPHOMOLYBDATE, SPECTROPHOTOMETRY* | 4.2 | mg/dL | 2.30 - 4.70 |
| **ELECTROLYTES** | | | |
| SODIUM: SERUM<br>*by ISE (ION SELECTIVE ELECTRODE)* | 139.5 | mmol/L | 135.0 - 150.0 |
| POTASSIUM: SERUM<br>*by ISE (ION SELECTIVE ELECTRODE)* | 4.2 | mmol/L | 3.50 - 5.00 |
| CHLORIDE: SERUM<br>*by ISE (ION SELECTIVE ELECTRODE)* | 104.63 | mmol/L | 90.0 - 110.0 |
| **ESTIMATED GLOMERULAR FILTERATION RATE** | | | |
| ESTIMATED GLOMERULAR FILTERATION RATE (eGFR): SERUM<br>*by CALCULATED* | 103.5 | | |

***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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| 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 inappropiate antidiuretic harmone) 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.

**INAPPROPIATE 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 FILTERATION RATE:**

| CKD STAGE | DESCRIPTION | GFR ( mL/min/1.73m2 ) | 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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| 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 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 fullfill 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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| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|

## AMYLASE

| | | | |
|---|---|---|---|
| AMYLASE - SERUM | 26.07 | 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 |
|---|---|---|---|

## LIPASE

| | | | |
|---|---|---|---|
| LIPASE - SERUM | 32.32 | U/L | 0 - 60 |

*by METHYL RESORUFIN, SPECTROPHOTOMETRY*

***INTERPRETATION***

1. Pancreas is the major and primary source of serum lipase though lipases are also present in liver, stomach, intestine, WBC, fat cells and milk.
2. In acute pancreatitis, serum lipase becomes elevated at the same time as amylase and remains high for 7-10 days.
3. Increased lipase activity rarely lasts longer than 14 days.
4. Prolonged increase suggests poor prognosis or presence of a cyst.
5. The combined use of serum lipase and serum amylase is effective in ruling out acute pancreatitis.

**INCREASED LEVEL:**

1. Acute & Chronic pancreatitis
2. Obstruction of pancreatic duct
3. Non pancreatic conditions like renal diseases, acute cholecystitis, intestinal obstruction, duodenal ulcer, alcoholism, diabetic ketoacidosis and following endoscopic retrograde cholangiopancreatography

**NOTE:**

1.Elevations 2 to 50 times the upper reference have been reported. The increase in serum lipase is not necessarily proportional to the severity of the attack. Normalization is not necessarily a sign of resolution.

**ADVICE:**

Concomitant testing of serum amylase and lipase is highly recommended to establish a diagnosis of pancreatic injury

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

## ENDOCRINOLOGY

### THYROID FUNCTION TEST: TOTAL

| | | | |
|---|---|---|---|
| TRIIODOTHYRONINE (T3): SERUM<br>*by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)* | 0.864 | ng/mL | 0.35 - 1.93 |
| THYROXINE (T4): SERUM<br>*by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)* | 10.07 | µgm/dL | 4.87 - 12.60 |
| THYROID STIMULATING HORMONE (TSH): SERUM<br>*by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)* | 3.982 | µIU/mL | 0.35 - 5.50 |

**3rd GENERATION, ULTRASENSITIVE**

***INTERPRETATION:***

*TSH levels are subject to circadian variation, reaching peak levels between 2-4 a.m and at a minimum between 6-10 pm. The variation is of the order of 50%.Hence time of the day has influence on the measured serum TSH concentrations.*TSH stimulates the production and secretion of the metabolically active hormones, thyroxine (T4)and trilodothyronine (T3).Failure at any level of regulation of the hypothalamic-pituitary-thyroid axis will result in either underproduction (hypothyroidism) or overproduction(hyperthyroidism) of T4 and/or T3.

| CLINICAL CONDITION | T3 | T4 | TSH |
|---|---|---|---|
| Primary Hypothyroidism: | Reduced | Reduced | Increased (Significantly) |
| Subclinical Hypothyroidism: | Normal or Low Normal | Normal or Low Normal | High |
| Primary Hyperthyroidism: | Increased | Increased | Reduced (at times undetectable) |
| Subclinical Hyperthyroidism: | Normal or High Normal | Normal or High Normal | Reduced |

**LIMITATIONS:-**

1. T3 and T4 circulates in reversibly bound form with Thyroid binding globulins (TBG),and to a lesser extent albumin and Thyroid binding Pre Albumin so conditions in which TBG and protein levels alter such as pregnancy, excess estrogens, androgens, anabolic steroids and glucocorticoids may falsely affect the T3 and T4 levels and may cause false thyroid values for thyroid function tests.
2. Normal levels of T4 can also be seen in Hyperthyroid patients with :T3 Thyrotoxicosis, Decreased binding capacity due to hypoproteinemia or ingestion of certain drugs (eg: phenytoin , salicylates).
3. Serum T4 levles in neonates and infants are higher than values in the normal adult , due to the increased concentration of TBG in neonate serum.
4. TSH may be normal in central hypothyroidism , recent rapid correction of hyperthyroidism or hypothroidism , pregnancy , phenytoin therapy.

| TRIIODOTHYRONINE (T3) | | THYROXINE (T4) | | THYROID STIMULATING HORMONE (TSH) | |
|---|---|---|---|---|---|
| **Age** | **Refferance Range (ng/mL)** | **Age** | **Refferance Range ( µg/dL)** | **Age** | **Reference Range ( µIU/mL)** |
| **0 - 7 Days** | **0.20 - 2.65** | **0 - 7 Days** | **5.90 – 18.58** | **0 - 7 Days** | **2.43 - 24.3** |
| **7 Days - 3 Months** | **0.36 - 2.59** | **7 Days - 3 Months** | **6.39 - 17.66** | **7 Days - 3 Months** | **0.58 - 11.00** |
| **3 - 6 Months** | **0.51 - 2.52** | **3 - 6 Months** | **6.75 – 17.04** | **3 Days – 6 Months** | **0.70 - 8.40** |

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| Test Name | | | Value | Unit | Biological Reference interval |
|---|---|---|---|---|---|
| 6 - 12 Months | 0.74 - 2.40 | 6 - 12 Months | 7.10 – 16.16 | 6 – 12 Months | 0.70 - 7.00 |
| 1 - 10 Years | 0.92 - 2.28 | 1 - 10 Years | 6.00 - 13.80 | 1 – 10 Years | 0.60 - 5.50 |
| 11- 19 Years | 0.35 - 1.93 | 11 - 19 Years | 4.87- 13.20 | 11 – 19 Years | 0.50 – 5.50 |
| > 20 years (Adults) | 0.35 - 1.93 | > 20 Years (Adults) | 4.87 - 12.60 | > 20 Years (Adults) | 0.35– 5.50 |
| RECOMMENDATIONS OF TSH LEVELS DURING PREGNANCY ( µIU/mL) | | | | | |
| 1st Trimester | | | 0.10 – 2.50 | | |
| 2nd Trimester | | | 0.20 – 3.00 | | |
| 3rd Trimester | | | 0.30 – 4.10 | | |

**INCREASED TSH LEVELS:**

1.Primary or untreated hypothyroidism may vary from 3 times to more than 100 times normal depending upon degree of hypofunction.
2.Hypothyroid patients receiving insufficient thyroid replacement therapy.
3.Hashimotos thyroiditis
4.DRUGS: Amphetamines, idonie containing agents & dopamine antagonist.
5.Neonatal period, increase in 1st 2-3 days of life due to post-natal surge

**DECREASED TSH LEVELS:**

1.Toxic multi-nodular goitre & Thyroiditis.
2.Over replacement of thyroid harmone in treatment of hypothyroidism.
3.Autonomously functioning Thyroid adenoma
4.Secondary pituatary or hypothalmic hypothyroidism
5.Acute psychiatric illness
6.Severe dehydration.
7.DRUGS: Glucocorticoids, Dopamine, Levodopa, T4 replacement therapy, Anti-thyroid drugs for thyrotoxicosis.
8.Pregnancy: 1st and 2nd Trimester

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

## IMMUNOPATHOLOGY/SEROLOGY

### RHEUMATOID FACTOR (RA): QUANTITATIVE - SERUM

| | | | |
|---|---|---|---|
| RHEUMATOID (RA) FACTOR QUANTITATIVE: SERUM<br>*by NEPHLOMETRY* | 3.12 | IU/mL | NEGATIVE: < 18.0<br>BORDERLINE: 18.0 - 25.0<br>POSITIVE: > 25.0 |

***INTERPRETATION:-***

**RHEUMATOID FACTOR (RA):**

1. Rheumatoid factors (RF) are antibodies that are directed against the Fc fragment of IgG altered in its tertiary structure.
2. Over 75% of patients with rheumatoid arthritis (RA) have an IgM antibody to IgG immunoglobulin. This autoantibody (RF) is diagnostically useful although it may not be etiologically related to RA.
3. Inflammatory Markers such as ESR & C-Reactive protein (CRP) are normal in about 60 % of patients with positive RA.
4. The titer of RF correlates poorly with disease activity, but those patients with high titers tend to have more severe disease course.
5. The test is useful for diagnosis and prognosis of rheumatoid arthritis.

**RHEUMATOID ARTHIRITIS:**

1. Rheumatoid Arthiritis is a systemic autoimmune disease that is multi-functional in origin and is characterized by chronic inflammation of the membrane lining (synovium) joints which ledas to progressive joint destruction and in most cases to disability and reduction of quality life.
2. The disease spredas from small to large joints, with greatest damage in early phase.
3. The diagnosis of RA is primarily based on clinical, radiological & immunological features.The most frequent serological test is the measurement of RA factor.

**CAUTION (FALSE POSTIVE):-**

*1. RA factor is not specific for Rheumatoid arthiritis, as it is often present in healthy individuals with other autoimmune diseases and chronic infections.*
*2. Non rheumatoid and rheumatoid arthritis (RA) populations are not clearly separate with regard to the presence of rheumatoid factor (RF) (15% of RA patients have a nonreactive titer and 8% of nonrheumatoid patients have a positive titer).*
*3. Patients with various nonrheumatoid diseases,characterized by chronic inflammation may have positive tests for RF. These diseases include systemic lupus erythematosus, polymyositis, tuberculosis, syphilis, viral hepatitis, infectious mononucleosis, and influenza.*
*4. Anti-CCP have been discovered in joints of patients with RA, but not in other form of joint disease.Anti-CCP2 is HIGHLY SENSITIVE (71%) & more specific (98%) than RA factor.*
*5. Upto 30 % of patients with Seronegative Rheumatoid arthiritis also show Anti-CCP antibodies.*
*6. The positive predictive value of Anti-CCP antibodies for Rheumatoid Arthiritis is far greater than Rheumatoid factor.*

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| | | | |
|---|---|---|---|
| **NAME** | **: Mr. JAI PAL** | | |
| **AGE/ GENDER** | : 53 YRS/MALE | **PATIENT ID** | : 1577909 |
| **COLLECTED BY** | : | **REG. NO./LAB NO.** | **: 012408120011** |
| **REFERRED BY** | : | **REGISTRATION DATE** | : 12/Aug/2024 08:57 AM |
| **BARCODE NO.** | : 01514917 | **COLLECTION DATE** | : 12/Aug/2024 09:00AM |
| **CLIENT CODE.** | : KOS DIAGNOSTIC LAB | **REPORTING DATE** | : 12/Aug/2024 11:02AM |
| **CLIENT ADDRESS** | : 6349/1, NICHOLSON ROAD, AMBALA CANTT | | |

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

## TUMOUR MARKER

### CARCINO EMBRYONIC ANTIGEN (CEA)

| | | | |
|---|---|---|---|
| CARCINO EMBRYONIC ANTIGEN (CEA): SERUM<br>*by CLIA (CHEMILUMINESCENCE IMMUNOASSAY)* | 3.98 | ng/mL | < 5.0 |

***INTERPRETATION:***

1. Carcinoembryonic antigen (CEA) is a glycoprotein normally found in embryonic entodermal epithelium.
2. Increased levels may be found in patients with primary colorectal cancer or other malignancies including medullary thyroid carcinoma and breast, gastrointestinal tract, liver, lung, ovarian, pancreatic, and prostatic cancers.
3. Serial monitoring of CEA should begin prior to initiation of cancer therapy to verify post therapy decrease in concentration and to establish a baseline for evaluating possible recurrence. Levels generally return to normal within 1 to 4 months after removal of cancerous tissue.

**CLINICAL SIGNIFICANCE:**

1. Monitoring colorectal cancer and selected other cancers such as medullary thyroid carcinoma
2. May be useful in assessing the effectiveness of chemotherapy or radiation treatment.

**NOTE:**

1. Carcinoembryonic antigen levels should not be used for screening of the general population for undetected cancers.
2. Grossly elevated carcino-embryonic antigen (CEA) concentrations (>20 ng/mL) in a patient with compatible symptoms are strongly suggestive of the presence of cancer and also suggest metastasis.
3. Most healthy subjects (97%) have values < or =3.0 ng/mL.
4. After removal of a colorectal tumor, the serum CEA concentration should return to normal by 6 weeks, unless there is residual tumor.
5. Increases in test values over time in a patient with a history of cancer suggest tumor recurrence.

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| **REFERRED BY** | : | **REGISTRATION DATE** | : 12/Aug/2024 08:57 AM |
| **BARCODE NO.** | : 01514917 | **COLLECTION DATE** | : 12/Aug/2024 09:00AM |
| **CLIENT CODE.** | : KOS DIAGNOSTIC LAB | **REPORTING DATE** | : 14/Aug/2024 04:23PM |
| **CLIENT ADDRESS** | : 6349/1, NICHOLSON ROAD, AMBALA CANTT | | |

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

## MICROBIOLOGY

### CULTURE AEROBIC BACTERIA AND ANTIBIOTIC SENSITIVITY: URINE

**CULTURE AND SUSCEPTIBILITY: URINE**

| | |
|---|---|
| DATE OF SAMPLE | 12-08-2024 |
| SPECIMEN SOURCE | URINE |
| INCUBATION PERIOD<br>*by AUTOMATED BROTH CULTURE* | 48 HOURS |
| CULTURE<br>*by AUTOMATED BROTH CULTURE* | STERILE |
| ORGANISM<br>*by AUTOMATED BROTH CULTURE* | NO AEROBIC PYOGENIC ORGANISM GROWN AFTER 48 HOURS OF INCUBATION AT 37*C |

**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 **SENSTITIVE** 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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