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NAME	**: Mrs. AMAR SHARDA**		
AGE/ GENDER	: 81 YRS/FEMALE	**PATIENT ID**	: 1580127
COLLECTED BY	: SURJESH	**REG. NO./LAB NO.**	**: 012408140012**
REFERRED BY	: CENTRAL PHOENIX CLUB (AMBALA CANTT)	**REGISTRATION DATE**	: 14/Aug/2024 09:39 AM
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HAEMATOLOGY

COMPLETE BLOOD COUNT (CBC)

Test Name	Value	Unit	Biological Reference interval
RED BLOOD CELLS (RBCS) COUNT AND INDICES			
HAEMOGLOBIN (HB) *by CALORIMETRIC*	**10^{L}**	**gm/dL**	**12.0 - 16.0**
RED BLOOD CELL (RBC) COUNT *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	**3.14^{L}**	**Millions/cmm**	**3.50 - 5.00**
PACKED CELL VOLUME (PCV) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	**29.9^{L}**	**%**	**37.0 - 50.0**
MEAN CORPUSCULAR VOLUME (MCV) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	95.1	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	31	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	32.6	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	15.6	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	55.1	fL	35.0 - 56.0
MENTZERS INDEX *by CALCULATED*	30.29	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX *by CALCULATED*	45.99	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*	**23270^{H}**	**/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)			

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Test Name	Value	Unit	Biological Reference interval
NEUTROPHILS	**92^{H}**	**%**	**50 - 70**
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
LYMPHOCYTES	**6^{L}**	**%**	**20 - 40**
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
EOSINOPHILS	**0^{L}**	**%**	**1 - 6**
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
MONOCYTES	2	%	2 - 12
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
BASOPHILS	0	%	0 - 1
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
ABSOLUTE LEUKOCYTES (WBC) COUNT			
ABSOLUTE NEUTROPHIL COUNT	**21408^{H}**	**/cmm**	**2000 - 7500**
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
ABSOLUTE LYMPHOCYTE COUNT	1396	/cmm	800 - 4900
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
ABSOLUTE EOSINOPHIL COUNT	**0^{L}**	**/cmm**	**40 - 440**
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
ABSOLUTE MONOCYTE COUNT	465	/cmm	80 - 880
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
PLATELETS AND OTHER PLATELET PREDICTIVE MARKERS.			
PLATELET COUNT (PLT)	167000	/cmm	150000 - 450000
by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE			
PLATELETCRIT (PCT)	0.18	%	0.10 - 0.36
by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE			
MEAN PLATELET VOLUME (MPV)	11	fL	6.50 - 12.0
by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE			
PLATELET LARGE CELL COUNT (P-LCC)	52000	/cmm	30000 - 90000
by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE			
PLATELET LARGE CELL RATIO (P-LCR)	30.9	%	11.0 - 45.0
by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE			
PLATELET DISTRIBUTION WIDTH (PDW)	**16.8^{H}**	%	15.0 - 17.0
by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE			
ADVICE	**KINDLY CORRELATE CLINICALLY**		

NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD

RECHECKED.

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Test Name	Value	Unit	Biological Reference interval

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Test Name	Value	Unit	Biological Reference interval

CLINICAL CHEMISTRY/BIOCHEMISTRY

CREATININE

CREATININE: SERUM *by ENZYMATIC, SPECTROPHOTOMETRY*	0.63	mg/dL	0.40 - 1.20

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Test Name	Value	Unit	Biological Reference interval

ELECTROLYTES COMPLETE PROFILE

SODIUM: SERUM *by ISE (ION SELECTIVE ELECTRODE)*	137.1	mmol/L	135.0 - 150.0
POTASSIUM: SERUM *by ISE (ION SELECTIVE ELECTRODE)*	3.67	mmol/L	3.50 - 5.00
CHLORIDE: SERUM *by ISE (ION SELECTIVE ELECTRODE)*	102.82	mmol/L	90.0 - 110.0

INTERPRETATION:-

SODIUM:-

Sodium is the major cation of extra-cellular fluid. Its primary function in the body is to chemically maintain osmotic pressure & acid base balance & to transmit nerve impulse.

HYPONATREMIA (LOW SODIUM LEVEL) CAUSES:-

1. Low sodium intake.
2. Sodium loss due to diarrhea & vomiting with adequate water and iadequate salt replacement.
3. Diuretics abuses.
4. Salt loosing nephropathy.
5. Metabolic acidosis.
6. Adrenocortical issuficiency .
7.Hepatic failure.

HYPERNATREMIA (INCREASED SODIUM LEVEL) CAUSES:-

1.Hyperapnea (Prolonged)
2.Diabetes insipidus
3.Diabetic acidosis
4.Cushings syndrome
5.Dehydration

POTASSIUM:-

Potassium is the major cation in the intracellular fluid. 90% of potassium is concentrated within the cells. When cells are damaged, potassium is released in the blood.

HYPOKALEMIA (LOW POTASSIUM LEVELS):-

1.Diarrhoea, vomiting & malabsorption.
2. Severe Burns.
3.Increased Secretions of Aldosterone

HYPERKALEMIA (INCREASED POTASSIUM LEVELS):-

1.Oliguria
2.Renal failure or Shock
3.Respiratory acidosis

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Test Name	Value	Unit	Biological Reference interval
4.Hemolysis of blood			

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Test Name	Value	Unit	Biological Reference interval

ENDOCRINOLOGY

PROCALCITONIN (PCT)

PROCALCITONIN (PCT): SERUM ***by ELFA (ENZYME LINKED FLOUROSCENCE ASSAY)***	**1.03^{H}**	**ng/mL**	**< 0.50**

INTERPRETATION:

Procalcitonin, the prohormone of calcitonin is below limit of detection 500 pg/ml in healthy individuals. It rises in response to an inflammatory stimulus especially of bacterial origin. It does not rise significantly with viral or non inflammations.

PROCALCITONIN (VALUE IN ng/mL)	INFERENCE
< 0.50 ng/mL	Minor local bacterial infection is possible. Severe systemic infection (Sepsis) is not likely
0.50- < 2.0 ng/mL	Systemic infection is possible, but various conditions are known to induce PCT as well (see below). Suggest repeat after 6-24 hours for a definitive diagnosis
2.0 - < 10.0 ng/mL	Systemic infection (Sepsis) is likely, unless other causes are known
>=10.0 ng/mL	Important systemic inflammatory response, almost exclusively due to severe bacterial sepsis or septic shock

PCT levels can be elevated in non infectious causes like:

1.The first days after a major trauma, major surgical intervention, burns, treatment with OKT3 antibodies and other drugs stimulating the release of pro-inflammatory cytokines, small cell lung cancer, medullary C-cell carcinoma of thyroid.
2.Patients with prolonged or severe cardiogenic shock, prolonged severe organ perfusion anomalies.
3.Neonates < 48 hrs of life.
4.Patients with PCT values 2000 pg/mL should be closely monitored both clinically and by reassessing PCT within 6-24 hrs.

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IMMUNOPATHOLOGY/SEROLOGY

C-REACTIVE PROTEIN (CRP)

C-REACTIVE PROTEIN (CRP) QUANTITATIVE: SERUM	**171.95^{H}**	**mg/L**	**0.0 - 6.0**

by NEPHLOMETRY

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.

*** End Of Report ***

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