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CEO & Consultant Pathologist

NAME : Mr. PARDEEP AGGARWAL
AGE/ GENDER : 60 YRS/MALE
COLLECTED BY : SURJESH
REFERRED BY :
BARCODE NO. : 01515129
CLIENT CODE. : KOS DIAGNOSTIC LAB
CLIENT ADDRESS : 6349/1, NICHOLSON ROAD, AMBALA CANTT

PATIENT ID : 1581938
REG. NO./LAB NO. : 012408160010
REGISTRATION DATE : 16/Aug/2024 09:19 AM
COLLECTION DATE : 16/Aug/2024 09:42AM
REPORTING DATE : 16/Aug/2024 10:08AM

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

RED BLOOD CELLS (RBCS) COUNT AND INDICES

HAEMOGLOBIN (HB) by CALORIMETRIC	13	gm/dL	12.0 - 17.0
RED BLOOD CELL (RBC) COUNT by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	4.66	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	40.4	%	40.0 - 54.0
MEAN CORPUSCULAR VOLUME (MCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	86.8	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	27.9	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	32.1	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	46.3	fL	35.0 - 56.0
MENTZERS INDEX by CALCULATED	18.63	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX by CALCULATED	26.45	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	8180	/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>	43 ^L	%	50 - 70
LYMPHOCYTES <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	49 ^H	%	20 - 40
EOSINOPHILS <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	3	%	1 - 6
MONOCYTES <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	5	%	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>	3517	/cmm	2000 - 7500
ABSOLUTE LYMPHOCYTE COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	4008	/cmm	800 - 4900
ABSOLUTE EOSINOPHIL COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	245	/cmm	40 - 440
ABSOLUTE MONOCYTE COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	409	/cmm	80 - 880
PLATELETS AND OTHER PLATELET PREDICTIVE MARKERS.			
PLATELET COUNT (PLT) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	191000	/cmm	150000 - 450000
PLATELETCRIT (PCT) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	0.22	%	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>	70000	/cmm	30000 - 90000
PLATELET LARGE CELL RATIO (P-LCR) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	36.9	%	11.0 - 45.0
PLATELET DISTRIBUTION WIDTH (PDW) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	15.9	%	15.0 - 17.0
NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD			




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GLYCOSYLATED HAEMOGLOBIN (HbA1c)

GLYCOSYLATED HAEMOGLOBIN (HbA1c): WHOLE BLOOD by HPLC (HIGH PERFORMANCE LIQUID CHROMATOGRAPHY)	6.7 ^H	%	4.0 - 6.4
ESTIMATED AVERAGE PLASMA GLUCOSE by HPLC (HIGH PERFORMANCE LIQUID CHROMATOGRAPHY)	145.59 ^H	mg/dL	60.00 - 140.00

INTERPRETATION:

AS PER AMERICAN DIABETES ASSOCIATION (ADA):		
REFERENCE GROUP	GLYCOSYLATED HEMOGLOBIN (HBA1C) 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:

- Glycosylated hemoglobin (HbA1c) test is three monthly monitoring done to assess compliance with therapeutic regimen in diabetic patients.
- 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 HbA1c. Converse is true for a diabetic previously under good control but now poorly controlled.
- 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, targeting a goal of < 7.0% may not be appropriate.
- High HbA1c (>9.0 -9.5 %) is strongly associated with risk of development and rapid progression of microvascular and nerve complications
- Any condition that shorten RBC life span like acute blood loss, hemolytic anemia falsely lower HbA1c results.
- 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 glycemic control.
- Specimens from patients with polycythemia or post-splenectomy may exhibit increase in HbA1c values due to a somewhat longer life span of the red cells.




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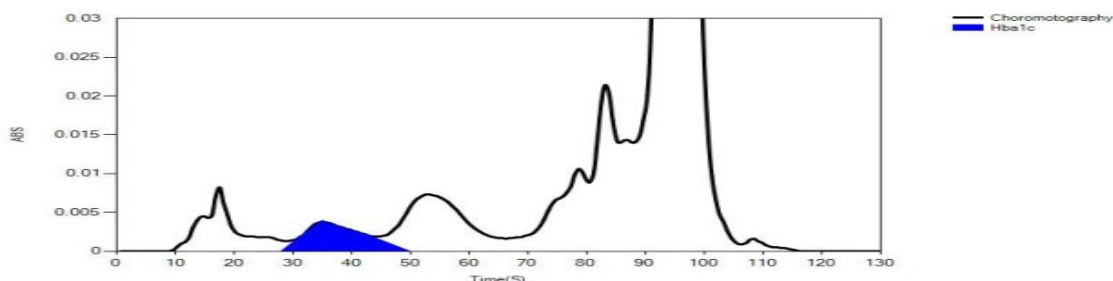
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LIFOTRONIC Graph Report

Name :	Case :	Patient Type :	Test Date : 16/08/2024 15:02:55
Age :	Department :	Sample Type : Whole Blood EDTA	Sample Id : 01515129
Gender :			Total Area : 14510

Peak Name	Retention Time(s)	Absorbance	Area	Result (Area %)
HbA0	70	2782	12775	85.8
HbA1c	39	73	1001	6.7
La1c	25	38	312	2.1
HbF	21	13	20	0.1
Hba1b	12	83	259	1.7
Hba1a	10	45	143	1.0




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ERYTHROCYTE SEDIMENTATION RATE (ESR)

ERYTHROCYTE SEDIMENTATION RATE (ESR) 4 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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BARCODE NO.	: 01515129	REPORTING DATE	: 16/Aug/2024 10:29AM
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CLINICAL CHEMISTRY/BIOCHEMISTRY

GLUCOSE FASTING (F)

GLUCOSE FASTING (F): PLASMA	87.91	mg/dL	NORMAL: < 100.0
by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)			PREDIABETIC: 100.0 - 125.0
			DIABETIC: > OR = 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
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GLUCOSE POST PRANDIAL (PP)

GLUCOSE POST PRANDIAL (PP): PLASMA <i>by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)</i>	151.39 ^H	mg/dL	NORMAL: < 140.00 PREDIABETIC: 140.0 - 200.0 DIABETIC: > OR = 200.0
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INTERPRETATION

IN ACCORDANCE WITH AMERICAN DIABETES ASSOCIATION GUIDELINES:

1. A post-prandial plasma glucose level below 140 mg/dl is considered normal.
2. A post-prandial glucose level between 140 - 200 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 post-prandial plasma glucose level of above 200 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 <i>by CHOLESTEROL OXIDASE PAP</i>	120.59	mg/dL	OPTIMAL: < 200.0 BORDERLINE HIGH: 200.0 - 239.0 HIGH CHOLESTEROL: > OR = 240.0
TRIGLYCERIDES: SERUM <i>by GLYCEROL PHOSPHATE OXIDASE (ENZYMATIC)</i>	183.73 ^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 <i>by SELECTIVE INHIBITION</i>	48.06	mg/dL	LOW HDL: < 30.0 BORDERLINE HIGH HDL: 30.0 - 60.0 HIGH HDL: > OR = 60.0
LDL CHOLESTEROL: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	35.78	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 <i>by CALCULATED, SPECTROPHOTOMETRY</i>	72.53	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 <i>by CALCULATED, SPECTROPHOTOMETRY</i>	36.75	mg/dL	0.00 - 45.00
TOTAL LIPIDS: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	424.91	mg/dL	350.00 - 700.00
CHOLESTEROL/HDL RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	2.51	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 <i>by CALCULATED, SPECTROPHOTOMETRY</i>	0.74	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	3.82	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>	0.33	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>	0.21	mg/dL	0.10 - 1.00
SGOT/AST: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	21.2	U/L	7.00 - 45.00
SGPT/ALT: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	29.9	U/L	0.00 - 49.00
AST/ALT RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	0.71	RATIO	0.00 - 46.00
ALKALINE PHOSPHATASE: SERUM <i>by PARA NITROPHENYL PHOSPHATASE BY AMINO METHYL PROPANOL</i>	47.57	U/L	40.0 - 130.0
GAMMA GLUTAMYL TRANSFERASE (GGT): SERUM <i>by SZASZ, SPECTROPHOTOMETRY</i>	17.07	U/L	0.00 - 55.0
TOTAL PROTEINS: SERUM <i>by BIURET, SPECTROPHOTOMETRY</i>	6.26	gm/dL	6.20 - 8.00
ALBUMIN: SERUM <i>by BROMOCRESOL GREEN</i>	4.33	gm/dL	3.50 - 5.50
GLOBALIN: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	1.93 ^L	gm/dL	2.30 - 3.50
A : G RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	2.24 ^H	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 CHOLESTATIS	> 1.5
HEPATOCELLULAR CARCINOMA & CHRONIC HEPATITIS	> 1.3 (Slightly Increased)




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NAME	: Mr. PARDEEP AGGARWAL	PATIENT ID	: 1581938
AGE/ GENDER	: 60 YRS/MALE	REG. NO./LAB NO.	: 012408160010
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Test Name	Value	Unit	Biological Reference interval
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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 by UREASE - GLUTAMATE DEHYDROGENASE (GLDH)	37.05	mg/dL	10.00 - 50.00
CREATININE: SERUM by ENZYMATIC, SPECTROPHOTOMETRY	0.91	mg/dL	0.40 - 1.40
BLOOD UREA NITROGEN (BUN): SERUM by CALCULATED, SPECTROPHOTOMETRY	17.31	mg/dL	7.0 - 25.0
BLOOD UREA NITROGEN (BUN)/CREATININE RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	19.02	RATIO	10.0 - 20.0
UREA/CREATININE RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	40.71	RATIO	
URIC ACID: SERUM by URICASE - OXIDASE PEROXIDASE	5.2	mg/dL	3.60 - 7.70
CALCIUM: SERUM by ARSENAZO III, SPECTROPHOTOMETRY	9.16	mg/dL	8.50 - 10.60
PHOSPHOROUS: SERUM by PHOSPHOMOLYBDATE, SPECTROPHOTOMETRY	3.72	mg/dL	2.30 - 4.70

ELECTROLYTES

SODIUM: SERUM by ISE (ION SELECTIVE ELECTRODE)	141.8	mmol/L	135.0 - 150.0
POTASSIUM: SERUM by ISE (ION SELECTIVE ELECTRODE)	4.24	mmol/L	3.50 - 5.00
CHLORIDE: SERUM by ISE (ION SELECTIVE ELECTRODE)	106.35	mmol/L	90.0 - 110.0

ESTIMATED GLOMERULAR FILTRATION RATE

ESTIMATED GLOMERULAR FILTRATION RATE (eGFR): SERUM by CALCULATED	96.5
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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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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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ENDOCRINOLOGY

THYROID STIMULATING HORMONE (TSH)

THYROID STIMULATING HORMONE (TSH): SERUM 4.473 μ IU/mL 0.35 - 5.50

by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)

3rd GENERATION, ULTRASENSITIVE

INTERPRETATION:

AGE	REFERENCE RANGE (μ IU/mL)
0 – 5 DAYS	0.70 – 15.20
6 Days – 2 Months	0.70 – 11.00
3 – 11 Months	0.70 – 8.40
1 – 5 Years	0.70 – 7.00
6 – 10 Years	0.60 – 5.50
11 - 15	0.50 – 5.50
> 20 Years (Adults)	0.27 – 5.50
PREGNANCY	
1st Trimester	0.10 - 3.00
2nd Trimester	0.20 - 3.00
3rd Trimester	0.30 - 4.10

NOTE:- TSH levels are subjected 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 concentration.

USE:- TSH controls biosynthesis and release of thyroid hormones T4 & T3. It is a sensitive measure of thyroid function, especially useful in early or subclinical hypothyroidism, before the patient develops any clinical findings or goitre or any other thyroid function abnormality.

INCREASED LEVELS:

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

DECREASED LEVELS:

- 1.Toxic multi-nodular goitre & Thyroiditis.
- 2.Over replacement of thyroid hormone in treatment of hypothyroidism.
- 3.Autonomously functioning Thyroid adenoma
- 4.Secondary pituitary or hypothalamic hypothyroidism
- 5.Acute psychiatric illness
- 6.Severe dehydration.





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7.DRUGS: Glucocorticoids, Dopamine, Levodopa, T4 replacement therapy, Anti-thyroid drugs for thyrotoxicosis.

8.Pregnancy: 1st and 2nd Trimester


LIMITATIONS:

- 1.TSH may be normal in central hypothyroidism, recent rapid correction of hyperthyroidism or hypothyroidism, pregnancy, phenytoin therapy.
- 2.Autoimmune disorders may produce spurious results.

*** End Of Report ***




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