

Dr. Vinay Chopra
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NAME : Mrs. GURPREET KAUR
AGE/ GENDER : 54 YRS/FEMALE
COLLECTED BY : SURJESH
REFERRED BY :
BARCODE NO. : 01515239
CLIENT CODE. : KOS DIAGNOSTIC LAB
CLIENT ADDRESS : 6349/1, NICHOLSON ROAD, AMBALA CANTT

PATIENT ID : 1584006
REG. NO./LAB NO. : 012408180027
REGISTRATION DATE : 18/Aug/2024 08:53 AM
COLLECTION DATE : 18/Aug/2024 09:23AM
REPORTING DATE : 18/Aug/2024 10:17AM

Test Name	Value	Unit	Biological Reference interval
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HAEMATOLOGY COMPLETE BLOOD COUNT (CBC)

RED BLOOD CELLS (RBCS) COUNT AND INDICES

HAEMOGLOBIN (HB) by CALORIMETRIC	11.7 ^L	gm/dL	12.0 - 16.0
RED BLOOD CELL (RBC) COUNT by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	4.1	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	36.4 ^L	%	37.0 - 50.0
MEAN CORPUSCULAR VOLUME (MCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	88.7	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	28.5	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	32.2	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	14.5	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	47.7	fL	35.0 - 56.0
MENTZERS INDEX by CALCULATED	21.63	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX by CALCULATED	31.33	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	5770	/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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NEUTROPHILS <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	60	%	50 - 70
LYMPHOCYTES <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	29	%	20 - 40
EOSINOPHILS <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	4	%	1 - 6
MONOCYTES <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	7	%	2 - 12
BASOPHILS <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	0	%	0 - 1
IMMATURE GRANULOCTE (IG) % <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	0	%	0 - 5.0
<u>ABSOLUTE LEUKOCYTES (WBC) COUNT</u>			
ABSOLUTE NEUTROPHIL COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	3462	/cmm	2000 - 7500
ABSOLUTE LYMPHOCYTE COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	1673	/cmm	800 - 4900
ABSOLUTE EOSINOPHIL COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	231	/cmm	40 - 440
ABSOLUTE MONOCYTE COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	404	/cmm	80 - 880
<u>PLATELETS AND OTHER PLATELET PREDICTIVE MARKERS.</u>			
PLATELET COUNT (PLT) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	243000	/cmm	150000 - 450000
PLATELETCRIT (PCT) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	0.3	%	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>	109000 ^H	/cmm	30000 - 90000
PLATELET LARGE CELL RATIO (P-LCR) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	44.7	%	11.0 - 45.0
PLATELET DISTRIBUTION WIDTH (PDW) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	16.3	%	15.0 - 17.0
NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD			




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ERYTHROCYTE SEDIMENTATION RATE (ESR)

ERYTHROCYTE SEDIMENTATION RATE (ESR)	14	mm/1st hr	0 - 20
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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 autoimmune 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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CLINICAL CHEMISTRY/BIOCHEMISTRY

URIC ACID

URIC ACID: SERUM	6.61	mg/dL	2.50 - 6.80
by URICASE - OXIDASE PEROXIDASE			

INTERPRETATION:-

1.GOUT occurs when high levels of Uric Acid in the blood cause crystals to form & accumulate around a joint.
 2.Uric Acid is the end product of purine metabolism . Uric acid is excreted to a large degree by the kidneys and to a smaller degree in the intestinal tract by microbial degradation.

INCREASED:-

(A).DUE TO INCREASED PRODUCTION:-

- 1.Idiopathic primary gout.
- 2.Excessive dietary purines (organ meats,legumes,anchovies, etc).
- 3.Cytolytic treatment of malignancies especially leukemias & lymphomas.
- 4.Polycythemia vera & myeloid metaplasia.
- 5.Psoriasis.
- 6.Sickle cell anaemia etc.

(B).DUE TO DECREASED EXCRETION (BY KIDNEYS)

- 1.Alcohol ingestion.
- 2.Thiazide diuretics.
- 3.Lactic acidosis.
- 4.Aspirin ingestion (less than 2 grams per day).
- 5.Diabetic ketoacidosis or starvation.
- 6.Renal failure due to any cause etc.

DECREASED:-

(A).DUE TO DIETARY DEFICIENCY

- 1.Dietary deficiency of Zinc, Iron and molybdenum.
- 2.Fanconi syndrome & Wilsons disease.
- 3.Multiple sclerosis .
- 4.Syndrome of inappropriate antidiuretic hormone (SIADH) secretion & low purine diet etc.

(B).DUE TO INCREASED EXCRETION

- 1.Drugs:-Probenecid , sulphinpyrazone, aspirin doses (more than 4 grams per day), corticosteroids and ACTH, anti-coagulants and estrogens etc.





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IMMUNOPATHOLOGY/SEROLOGY WIDAL SLIDE AGGLUTINATION TEST

SALMONELLA TYPHI O by SLIDE AGGLUTINATION	NIL	TITRE	1 : 80
SALMONELLA TYPHI H by SLIDE AGGLUTINATION	NIL	TITRE	1 : 160
SALMONELLA PARATYPHI AH by SLIDE AGGLUTINATION	NIL	TITRE	1 : 160
SALMONELLA PARATYPHI BH by SLIDE AGGLUTINATION	NIL	TITRE	1 : 160

INTERPRETATION:

1. Titres of 1:80 or more for "O" agglutinin is considered significant.
2. Titres of 1:160 or more for "H" agglutinin is considered significant.

LIMITATIONS:

1. Agglutinins usually appear by 5th to 6th day of illness of enteric fever, hence a negative result in early stage is inconclusive. The titre then rises till 3rd or 4th week, after which it declines gradually.
2. Lower titres may be found in normal individuals.
3. A single positive result has less significance than the rising agglutination titre, since demonstration of rising titre four or more in 1st and 3rd week is considered as a definite evidence of infection.
4. A simultaneous rise in H agglutinins is suggestive of paratyphoid infection.

NOTE:

1. Individuals with prior infection or immunization with TAB vaccine may develop an ANAMNESTIC RESPONSE (False-Positive) during an unrelated fever i.e High titres of antibodies to various antigens. This may be differentiated by repetition of the test after a week.
2. The anamnestic response shows only a transient rise, while in enteric fever rise is sustained.
3. H agglutinins tend to persist for many months after vaccination but O agglutinins tend to disappear sooner i.e within 6 months. Therefore rise in O agglutinins indicate recent infection.

*** End Of Report ***




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