

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

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

<b>NAME</b>	: Mr. RUPU	<b>PATIENT ID</b>	: 1567239
<b>AGE/ GENDER</b>	: 39 YRS/MALE	<b>REG. NO./LAB NO.</b>	: <b>012408220006</b>
<b>COLLECTED BY</b>	:	<b>REGISTRATION DATE</b>	: 22/Aug/2024 07:32 AM
<b>REFERRED BY</b>	:	<b>COLLECTION DATE</b>	: 22/Aug/2024 07:43AM
<b>BARCODE NO.</b>	: 01515453	<b>REPORTING DATE</b>	: 22/Aug/2024 08:48AM
<b>CLIENT CODE.</b>	: KOS DIAGNOSTIC LAB		
<b>CLIENT ADDRESS</b>	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

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) <i>by CALORIMETRIC</i>	13.9	gm/dL	12.0 - 17.0
<b>RED BLOOD CELL (RBC) COUNT</b> <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	<b>5.25<sup>H</sup></b>	<b>Millions/cmm</b>	<b>3.50 - 5.00</b>
PACKED CELL VOLUME (PCV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	42.8	%	40.0 - 54.0
MEAN CORPUSCULAR VOLUME (MCV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	81.5	fL	80.0 - 100.0
<b>MEAN CORPUSCULAR HAEMOGLOBIN (MCH)</b> <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	<b>26.4<sup>L</sup></b>	<b>pg</b>	<b>27.0 - 34.0</b>
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	<b>32.4<sup>L</sup></b>	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	14.2	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	43.4	fL	35.0 - 56.0
MENTZERS INDEX <i>by CALCULATED</i>	15.52	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX <i>by CALCULATED</i>	21.98	RATIO	BETA THALASSEMIA TRAIT: <= 65.0 IRON DEFICIENCY ANEMIA: > 65.0

**WHITE BLOOD CELLS (WBCS)**

TOTAL LEUCOCYTE COUNT (TLC) <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	4390	/cmm	4000 - 11000
NUCLEATED RED BLOOD CELLS (nRBCS) <i>by AUTOMATED 6 PART HEMATOLOGY ANALYZER</i>	NIL		0.00 - 20.00
NUCLEATED RED BLOOD CELLS (nRBCS) % <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	NIL	%	< 10 %

**DIFFERENTIAL LEUCOCYTE COUNT (DLC)**

<b>NEUTROPHILS</b> <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	<b>77<sup>H</sup></b>	%	<b>50 - 70</b>
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TEST PERFORMED AT KOS DIAGNOSTIC LAB, AMBALA CANTT.

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<b>LYMPHOCYTES</b> <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	14 <sup>L</sup>	%	20 - 40
<b>EOSINOPHILS</b> <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	4	%	1 - 6
<b>MONOCYTES</b> <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	5	%	2 - 12
<b>BASOPHILS</b> <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	0	%	0 - 1
<b><u>ABSOLUTE LEUKOCYTES (WBC) COUNT</u></b>			
<b>ABSOLUTE NEUTROPHIL COUNT</b> <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	3380	/cmm	2000 - 7500
<b>ABSOLUTE LYMPHOCYTE COUNT</b> <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	615 <sup>L</sup>	/cmm	800 - 4900
<b>ABSOLUTE EOSINOPHIL COUNT</b> <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	176	/cmm	40 - 440
<b>ABSOLUTE MONOCYTE COUNT</b> <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	220	/cmm	80 - 880
<b>ABSOLUTE BASOPHIL COUNT</b> <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	0	/cmm	0 - 110
<b><u>PLATELETS AND OTHER PLATELET PREDICTIVE MARKERS.</u></b>			
<b>PLATELET COUNT (PLT)</b> <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	120000 <sup>L</sup>	/cmm	150000 - 450000
<b>PLATELETCRIT (PCT)</b> <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	0.16	%	0.10 - 0.36
<b>MEAN PLATELET VOLUME (MPV)</b> <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	13 <sup>H</sup>	fL	6.50 - 12.0
<b>PLATELET LARGE CELL COUNT (P-LCC)</b> <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	57000	/cmm	30000 - 90000
<b>PLATELET LARGE CELL RATIO (P-LCR)</b> <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	47.3 <sup>H</sup>	%	11.0 - 45.0
<b>PLATELET DISTRIBUTION WIDTH (PDW)</b> <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	16.3	%	15.0 - 17.0

**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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**CLINICAL CHEMISTRY/BIOCHEMISTRY**

**GLUCOSE FASTING (F)**


GLUCOSE FASTING (F): PLASMA <i>by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)</i>	91.29	mg/dL	NORMAL: < 100.0 PREDIABETIC: 100.0 - 125.0 DIABETIC: > OR = 126.0
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**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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**SGOT/ASPARTATE AMINOTRANSFERASE (AST)**

SGOT/AST: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	43.3	U/L	7.00 - 45.00
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**SGPT/ALANINE AMINOTRANSFERASE (ALT)**

SGPT/ALT: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	50.1 <sup>H</sup>	U/L	0.00 - 49.00
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**AMYLASE**


AMYLASE - SERUM <i>by CNPG 3, SPECTROPHOTOMETRY</i>	46.37	IU/L	0 - 90
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**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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**LIPASE**

LIPASE - SERUM	24.02	U/L	0 - 60
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*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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**IMMUNOPATHOLOGY/SEROLOGY**

**C-REACTIVE PROTEIN (CRP)**

C-REACTIVE PROTEIN (CRP) QUANTITATIVE: SERUM	2.82	mg/L	0.0 - 6.0
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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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