

Dr. Vinay Chopra  
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Dr. Yugam Chopra  
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NAME : Mr. AMIT DHINGRA  
AGE/ GENDER : 29 YRS/MALE  
COLLECTED BY : SURJESH  
REFERRED BY :  
BARCODE NO. : 01515808  
CLIENT CODE. : KOS DIAGNOSTIC LAB  
CLIENT ADDRESS : 6349/1, NICHOLSON ROAD, AMBALA CANTT

PATIENT ID : 1592888  
REG. NO./LAB NO. : 012408270038  
REGISTRATION DATE : 27/Aug/2024 11:39 AM  
COLLECTION DATE : 27/Aug/2024 11:41AM  
REPORTING DATE : 27/Aug/2024 11:51AM

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

SWASTHYA WELLNESS PANEL: G  
COMPLETE BLOOD COUNT (CBC)

RED BLOOD CELLS (RBCS) COUNT AND INDICES

|  |                   |              |   |
|--|-------------------|--------------|---|
| HAEMOGLOBIN (HB)<br>by CALORIMETRIC  | 15.6              | gm/dL        | 12.0 - 17.0   |
| RED BLOOD CELL (RBC) COUNT<br>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE              | 5.35 <sup>H</sup> | Millions/cmm | 3.50 - 5.00   |
| PACKED CELL VOLUME (PCV)<br>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER                 | 48.1              | %            | 40.0 - 54.0   |
| MEAN CORPUSCULAR VOLUME (MCV)<br>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER            | 90.1              | fL           | 80.0 - 100.0  |
| MEAN CORPUSCULAR HAEMOGLOBIN (MCH)<br>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER       | 29.1              | pg           | 27.0 - 34.0   |
| MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC)<br>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER | 32.3              | g/dL         | 32.0 - 36.0   |
| RED CELL DISTRIBUTION WIDTH (RDW-CV)<br>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER     | 12.6              | %            | 11.00 - 16.00   |
| RED CELL DISTRIBUTION WIDTH (RDW-SD)<br>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER     | 42.3              | fL           | 35.0 - 56.0   |
| MENTZERS INDEX<br>by CALCULATED  | 16.84             | RATIO        | BETA THALASSEMIA TRAIT: < 13.0<br>IRON DEFICIENCY ANEMIA: >13.0   |
| GREEN & KING INDEX<br>by CALCULATED  | 21.18             | 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              | 7980 | /cmm | 4000 - 11000 |
| NUCLEATED RED BLOOD CELLS (nRBCS)<br>by AUTOMATED 6 PART HEMATOLOGY ANALYZER          | NIL  |      | 0.00 - 20.00 |
| NUCLEATED RED BLOOD CELLS (nRBCS) %<br>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER | NIL  | %    | < 10 %       |

DIFFERENTIAL LEUCOCYTE COUNT (DLC)

|  |    |   |         |
|--|----|---|---------|
| NEUTROPHILS<br>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY | 55 | % | 50 - 70 |
|--|----|---|---------|



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| <b>CLIENT ADDRESS</b> | : 6349/1, NICHOLSON ROAD, AMBALA CANTT |                          |                        |

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|---|---------------------|------|-------------------------------|
| LYMPHOCYTES<br><i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>                         | 34                  | %    | 20 - 40                       |
| EOSINOPHILS<br><i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>                         | 5                   | %    | 1 - 6                         |
| MONOCYTES<br><i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>                           | 6                   | %    | 2 - 12                        |
| BASOPHILS<br><i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>                           | 0                   | %    | 0 - 1                         |
| <b><u>ABSOLUTE LEUKOCYTES (WBC) COUNT</u></b>   |                     |      |                               |
| ABSOLUTE NEUTROPHIL COUNT<br><i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>           | 4389                | /cmm | 2000 - 7500                   |
| ABSOLUTE LYMPHOCYTE COUNT<br><i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>           | 2713                | /cmm | 800 - 4900                    |
| ABSOLUTE EOSINOPHIL COUNT<br><i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>           | 399                 | /cmm | 40 - 440                      |
| ABSOLUTE MONOCYTE COUNT<br><i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>             | 479                 | /cmm | 80 - 880                      |
| ABSOLUTE BASOPHIL COUNT<br><i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>             | 0                   | /cmm | 0 - 110                       |
| <b><u>PLATELETS AND OTHER PLATELET PREDICTIVE MARKERS.</u></b>                              |                     |      |                               |
| PLATELET COUNT (PLT)<br><i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>              | 143000 <sup>L</sup> | /cmm | 150000 - 450000               |
| PLATELET CRIT (PCT)<br><i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>               | 0.2                 | %    | 0.10 - 0.36                   |
| MEAN PLATELET VOLUME (MPV)<br><i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>        | 14 <sup>H</sup>     | fL   | 6.50 - 12.0                   |
| PLATELET LARGE CELL COUNT (P-LCC)<br><i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i> | 73000               | /cmm | 30000 - 90000                 |
| PLATELET LARGE CELL RATIO (P-LCR)<br><i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i> | 50.8 <sup>H</sup>   | %    | 11.0 - 45.0                   |
| PLATELET DISTRIBUTION WIDTH (PDW)<br><i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i> | 16.6                | %    | 15.0 - 17.0                   |
| NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD  |                     |      |                               |



  
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| <b>BARCODE NO.</b>    | : 01515808                             | <b>REPORTING DATE</b>    | : 27/Aug/2024 03:08PM  |
| <b>CLIENT CODE.</b>   | : KOS DIAGNOSTIC LAB                   |                          |                        |
| <b>CLIENT ADDRESS</b> | : 6349/1, NICHOLSON ROAD, AMBALA CANTT |                          |                        |

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**GLYCOSYLATED HAEMOGLOBIN (HbA1c)**

|  |                    |       |                |
|--|--------------------|-------|----------------|
| GLYCOSYLATED HAEMOGLOBIN (HbA1c):                | 12 <sup>H</sup>    | %     | 4.0 - 6.4      |
| WHOLE BLOOD                                      |                    |       |                |
| by HPLC (HIGH PERFORMANCE LIQUID CHROMATOGRAPHY) |                    |       |                |
| ESTIMATED AVERAGE PLASMA GLUCOSE                 | 297.7 <sup>H</sup> | mg/dL | 60.00 - 140.00 |
| by HPLC (HIGH PERFORMANCE LIQUID CHROMATOGRAPHY) |                    |       |                |

**INTERPRETATION:**

| AS PER AMERICAN DIABETES ASSOCIATION (ADA): |                                      |       |
|---|--------------------------------------|-------|
| REFERENCE GROUP                             | GLYCOSYLATED HEMOGLOBIG (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:**

- 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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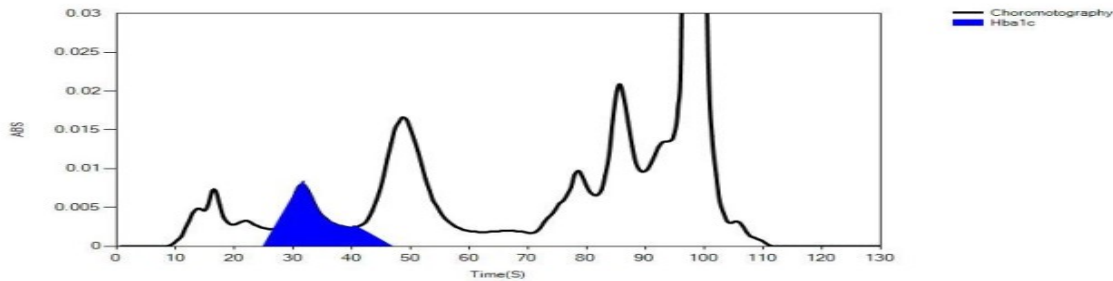
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|-----------|-------|------|-------------------------------|


LIFOTRONIC Graph Report

|          |              |                                |                                 |
|----------|--------------|--------------------------------|---------------------------------|
| Name :   | Case :       | Patient Type :                 | Test Date : 27/08/2024 14:52:24 |
| Age :    | Department : | Sample Type : Whole Blood EDTA | Sample Id : 01515808            |
| Gender : |              |                                | Total Area : 12451              |

| Peak Name | Retention Time(s) | Absorbance | Area  | Result (Area %) |
|-----------|-------------------|------------|-------|-----------------|
| HbA0      | 72                | 7443       | 10464 | 80.8            |
| HbA1c     | 36                | 166        | 1551  | 12.0            |
| La1c      | 28                | 24         | 188   | 1.4             |
| HbF       | 23                | 79         | 85    | 0.6             |
| Hba1b     | 15                | 30         | 38    | 0.3             |
| Hba1a     | 10                | 49         | 125   | 1.0             |



  
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| <b>BARCODE NO.</b>    | : 01515808                             | <b>REPORTING DATE</b>    | : 27/Aug/2024 12:10PM  |
| <b>CLIENT CODE.</b>   | : KOS DIAGNOSTIC LAB                   |                          |                        |
| <b>CLIENT ADDRESS</b> | : 6349/1, NICHOLSON ROAD, AMBALA CANTT |                          |                        |

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

### ERYTHROCYTE SEDIMENTATION RATE (ESR)

ERYTHROCYTE SEDIMENTATION RATE (ESR) 14 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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COLLECTION DATE : 27/Aug/2024 12:35PM  
REPORTING DATE : 27/Aug/2024 12:37PM

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|-----------|-------|------|-------------------------------|

PERIPHERAL BLOOD SMEAR FOR MALARIA

PERIPHERAL BLOOD SMEAR  
FOR MALARIAL PARASITE (MP)  
by MICROSCOPY

NO MALARIA PARASITE (MP) SEEN IN SMEAR EXAMINED



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### CLINICAL CHEMISTRY/BIOCHEMISTRY

#### GLUCOSE FASTING (F)

|  |                     |       |   |
|--|---------------------|-------|---|
| GLUCOSE FASTING (F): PLASMA<br>by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD) | 162.02 <sup>H</sup> | mg/dL | NORMAL: < 100.0<br>PREDIABETIC: 100.0 - 125.0<br>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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| <b>LIPID PROFILE : BASIC</b>  |                     |       |  |
| <b>CHOLESTEROL TOTAL: SERUM</b><br><i>by CHOLESTEROL OXIDASE PAP</i>            | 243.84 <sup>H</sup> | mg/dL | OPTIMAL: < 200.0<br>BORDERLINE HIGH: 200.0 - 239.0<br>HIGH CHOLESTEROL: > OR = 240.0   |
| <b>TRIGLYCERIDES: SERUM</b><br><i>by GLYCEROL PHOSPHATE OXIDASE (ENZYMATIC)</i> | 273.12 <sup>H</sup> | mg/dL | OPTIMAL: < 150.0<br>BORDERLINE HIGH: 150.0 - 199.0<br>HIGH: 200.0 - 499.0<br>VERY HIGH: > OR = 500.0                                 |
| <b>HDL CHOLESTEROL (DIRECT): SERUM</b><br><i>by SELECTIVE INHIBITION</i>        | 53.54               | mg/dL | LOW HDL: < 30.0<br>BORDERLINE HIGH HDL: 30.0 - 60.0<br>HIGH HDL: > OR = 60.0   |
| <b>LDL CHOLESTEROL: SERUM</b><br><i>by CALCULATED, SPECTROPHOTOMETRY</i>        | 135.68 <sup>H</sup> | 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 |
| <b>NON HDL CHOLESTEROL: SERUM</b><br><i>by CALCULATED, SPECTROPHOTOMETRY</i>    | 190.3 <sup>H</sup>  | 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 |
| <b>VLDL CHOLESTEROL: SERUM</b><br><i>by CALCULATED, SPECTROPHOTOMETRY</i>       | 54.62 <sup>H</sup>  | mg/dL | 0.00 - 45.00   |
| <b>TOTAL LIPIDS: SERUM</b><br><i>by CALCULATED, SPECTROPHOTOMETRY</i>           | 760.8 <sup>H</sup>  | mg/dL | 350.00 - 700.00  |
| <b>CHOLESTEROL/HDL RATIO: SERUM</b><br><i>by CALCULATED, SPECTROPHOTOMETRY</i>  | 4.55 <sup>H</sup>   | 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                                 |
| <b>LDL/HDL RATIO: SERUM</b><br><i>by CALCULATED, SPECTROPHOTOMETRY</i>          | 2.53                | RATIO | LOW RISK: 0.50 - 3.0<br>MODERATE RISK: 3.10 - 6.0<br>HIGH RISK: > 6.0  |



  
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| <b>AGE/ GENDER</b>    | : 29 YRS/MALE                          | <b>REG. NO./LAB NO.</b>  | : 012408270038         |
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| <b>CLIENT CODE.</b>   | : KOS DIAGNOSTIC LAB                   |                          |                        |
| <b>CLIENT ADDRESS</b> | : 6349/1, NICHOLSON ROAD, AMBALA CANTT |                          |                        |

| Test Name  | Value            | Unit  | Biological Reference interval |
|--|------------------|-------|-------------------------------|
| TRIGLYCERIDES/HDL RATIO: SERUM<br>by CALCULATED, SPECTROPHOTOMETRY | 5.1 <sup>H</sup> | 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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| Test Name | Value | Unit | Biological Reference interval |
|-----------|-------|------|-------------------------------|
|-----------|-------|------|-------------------------------|

#### LIVER FUNCTION TEST (COMPLETE)

|  |                     |       |   |
|--|---------------------|-------|---|
| BILIRUBIN TOTAL: SERUM<br><i>by DIAZOTIZATION, SPECTROPHOTOMETRY</i>                           | 0.93                | mg/dL | INFANT: 0.20 - 8.00<br>ADULT: 0.00 - 1.20 |
| BILIRUBIN DIRECT (CONJUGATED): SERUM<br><i>by DIAZO MODIFIED, SPECTROPHOTOMETRY</i>            | 0.27                | mg/dL | 0.00 - 0.40                               |
| BILIRUBIN INDIRECT (UNCONJUGATED): SERUM<br><i>by CALCULATED, SPECTROPHOTOMETRY</i>            | 0.66                | mg/dL | 0.10 - 1.00                               |
| SGOT/AST: SERUM<br><i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>                                 | 94.51 <sup>H</sup>  | U/L   | 7.00 - 45.00                              |
| SGPT/ALT: SERUM<br><i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>                                 | 147.7 <sup>H</sup>  | U/L   | 0.00 - 49.00                              |
| AST/ALT RATIO: SERUM<br><i>by CALCULATED, SPECTROPHOTOMETRY</i>                                | 0.64                | RATIO | 0.00 - 46.00                              |
| ALKALINE PHOSPHATASE: SERUM<br><i>by PARA NITROPHENYL PHOSPHATASE BY AMINO METHYL PROPANOL</i> | 94.67               | U/L   | 40.0 - 130.0                              |
| GAMMA GLUTAMYL TRANSFERASE (GGT): SERUM<br><i>by SZASZ, SPECTROPHOTOMETRY</i>                  | 195.41 <sup>H</sup> | U/L   | 0.00 - 55.0                               |
| TOTAL PROTEINS: SERUM<br><i>by BIURET, SPECTROPHOTOMETRY</i>                                   | 7.02                | gm/dL | 6.20 - 8.00                               |
| ALBUMIN: SERUM<br><i>by BROMOCRESOL GREEN</i>  | 3.87                | gm/dL | 3.50 - 5.50                               |
| GLOBULIN: SERUM<br><i>by CALCULATED, SPECTROPHOTOMETRY</i>                                     | 3.15                | gm/dL | 2.30 - 3.50                               |
| A : G RATIO: SERUM<br><i>by CALCULATED, SPECTROPHOTOMETRY</i>                                  | 1.23                | 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 CHOLESTASIS                     | > 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 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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| Test Name | Value | Unit | Biological Reference interval |
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|-----------|-------|------|-------------------------------|

### KIDNEY FUNCTION TEST (COMPLETE)

|   |       |       |               |
|---|-------|-------|---------------|
| UREA: SERUM<br><i>by UREASE - GLUTAMATE DEHYDROGENASE (GLDH)</i>                                | 20.96 | mg/dL | 10.00 - 50.00 |
| CREATININE: SERUM<br><i>by ENZYMATIC, SPECTROPHOTOMETRY</i>                                     | 0.87  | mg/dL | 0.40 - 1.40   |
| BLOOD UREA NITROGEN (BUN): SERUM<br><i>by CALCULATED, SPECTROPHOTOMETRY</i>                     | 9.79  | mg/dL | 7.0 - 25.0    |
| BLOOD UREA NITROGEN (BUN)/CREATININE<br>RATIO: SERUM<br><i>by CALCULATED, SPECTROPHOTOMETRY</i> | 11.25 | RATIO | 10.0 - 20.0   |
| UREA/CREATININE RATIO: SERUM<br><i>by CALCULATED, SPECTROPHOTOMETRY</i>                         | 24.09 | RATIO |               |
| URIC ACID: SERUM<br><i>by URICASE - OXIDASE PEROXIDASE</i>                                      | 7.01  | mg/dL | 3.60 - 7.70   |
| CALCIUM: SERUM<br><i>by ARSENAZO III, SPECTROPHOTOMETRY</i>                                     | 9.89  | mg/dL | 8.50 - 10.60  |
| PHOSPHOROUS: SERUM<br><i>by PHOSPHOMOLYBDATE, SPECTROPHOTOMETRY</i>                             | 4.64  | mg/dL | 2.30 - 4.70   |

### ELECTROLYTES

|   |        |        |               |
|---|--------|--------|---------------|
| SODIUM: SERUM<br><i>by ISE (ION SELECTIVE ELECTRODE)</i>    | 138.9  | mmol/L | 135.0 - 150.0 |
| POTASSIUM: SERUM<br><i>by ISE (ION SELECTIVE ELECTRODE)</i> | 3.75   | mmol/L | 3.50 - 5.00   |
| CHLORIDE: SERUM<br><i>by ISE (ION SELECTIVE ELECTRODE)</i>  | 104.18 | mmol/L | 90.0 - 110.0  |

### ESTIMATED GLOMERULAR FILTRATION RATE

|   |       |
|---|-------|
| ESTIMATED GLOMERULAR FILTRATION RATE<br>(eGFR): SERUM<br><i>by CALCULATED</i> | 119.8 |
|---|-------|

### 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 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 <sup>2</sup> ) | 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 m<sup>2</sup> (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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### IMMUNOPATHOLOGY/SEROLOGY

#### DENGUE FEVER COMBO SCREENING - (NS1 ANTIGEN, IgG AND IgM)

|  |                |                |
|--|----------------|----------------|
| DENGUE NS1 ANTIGEN - SCREENING<br>by ICT (IMMUNOCHROMATOGRAPHY)  | NEGATIVE (-ve) | NEGATIVE (-ve) |
| DENGUE ANTIBODY IgG - SCREENING<br>by ICT (IMMUNOCHROMATOGRAPHY) | NEGATIVE (-ve) | NEGATIVE (-ve) |
| DENGUE ANTIBODY IgM - SCREENING<br>by ICT (IMMUNOCHROMATOGRAPHY) | NEGATIVE (-ve) | NEGATIVE (-ve) |

#### INTERPRETATION:-

- 1.This is a solid phase immunochromatographic ELISA test for the qualitative detection of the specific IgG and IgM antibodies against the Dengue virus.
- 2.The IgM antibodies take a minimum of 5-10 days in primary infection and 4-5 days in secondary infections to test positive and hence are suitable for the diagnosis of dengue fever only when the fever is approximately one week old.
- 3.The IgG antibodies develop at least two weeks after exposure to primary infection and subsequently remain positive for the rest of the life. A positive result is incapable of differentiating a current infection from a past infection.
- 4.The Dengue NS-1 antigen test is most suited for early diagnosis (within the first week of exposure).

\*\*\* End Of Report \*\*\*



  
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