Dr. Vinay Chopra
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Dr. Yugam Chopra
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NAME	**: Mr. NARESH SHARMA**		
AGE/ GENDER	: 67 YRS/MALE	**PATIENT ID**	: 1597326
COLLECTED BY	: SURJESH	**REG. NO./LAB NO.**	**: 012408310053**
REFERRED BY	:	**REGISTRATION DATE**	: 31/Aug/2024 12:25 PM
BARCODE NO.	: 01516049	**COLLECTION DATE**	: 31/Aug/2024 12:28PM
CLIENT CODE.	: KOS DIAGNOSTIC LAB	**REPORTING DATE**	: 31/Aug/2024 01:33PM
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
CLINICAL CHEMISTRY/BIOCHEMISTRY			
CREATININE			
CREATININE: SERUM *by ENZYMATIC, SPECTROPHOTOMETRY*	**1.89^{H}**	**mg/dL**	**0.40 - 1.40**

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Test Name	Value	Unit	Biological Reference interval

URIC ACID

URIC ACID: SERUM	5.11	mg/dL	3.60 - 7.70

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 leukemais & lymphomas.
4.Polycythemai vera & myeloid metaplasia.
5.Psoriasis.
6.Sickle cell anaemia etc.

(B).DUE TO DECREASED EXCREATION (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 EXCREATION

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

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CLIENT CODE.	: KOS DIAGNOSTIC LAB	**REPORTING DATE**	: 31/Aug/2024 04:58PM
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

CLINICAL PATHOLOGY

MICROALBUMIN/CREATININE RATIO - RANDOM URINE

Test Name	Value	Unit	Biological Reference interval
MICROALBUMIN: RANDOM URINE *by SPECTROPHOTOMETRY*	**27.39^{H}**	**mg/L**	**0 - 25**
CREATININE: RANDOM URINE *by SPECTROPHOTOMETRY*	93.99	mg/dL	20 - 320
MICROALBUMIN/CREATININE RATIO - RANDOM URINE *by SPECTROPHOTOMETRY*	29.14	mg/g	0 - 30

***INTERPRETATION*:-**

PHYSIOLOGICALLY NORMAL:	mg/L	0 - 30
MICROALBUMINURIA:	mg/L	30 - 300
GROSS PROTEINURIA:	mg/L	> 300

Long standing un-treated Diabetes and Hypertension can lead to renal dysfunction.
2. Diabetic nephropathy or kidney disease is the most common cause of end stage renal disease(ERSD) or kidney failure.
3. Presence of Microalbuminuria is an early indicator of onset of compromised renal function in these patients.
4.Microalbuminuria is the condition when urinary albumin excre tion is between 30-300 mg & above this it is called as macroalbuminuria, the presence of which indicates serious kidney disease.
5.Microalbuminuria is not only associated with kidney disease but of cardiovascular disease in patients with dibetes & hypertension.
6.Microalbuminuria reflects vascular damage & appear to be a marker of of early arterial disease & endothelial dysfunction.
NOTE:- *IF A PATIENT HAS = 1+ PROTEINURIA (30 mg/dl OR 300 mg/L) BY URINE DIPSTICK (URINEANALYSIS), OVERT PROTEINURIA IS PRESENT AND TESTING FOR MICROALBUMIN IS INAPPROPIATE. IN SUCH A CASE, URINE PROTEIN:CREATININE RATIO OR 24 HOURS TOTAL URINE MICROPROTEIN IS APPROPIATE.*

*** End Of Report ***

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