

Dr. Vinay Chopra
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Dr. Yugam Chopra
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CEO & Consultant Pathologist

NAME : Mr. SATPAL
AGE/ GENDER : 83 YRS/MALE
COLLECTED BY : SURJESH
REFERRED BY :
BARCODE NO. : 01516606
CLIENT CODE. : KOS DIAGNOSTIC LAB
CLIENT ADDRESS : 6349/1, NICHOLSON ROAD, AMBALA CANTT

PATIENT ID : 1606512
REG. NO./LAB NO. : 012409090017
REGISTRATION DATE : 09/Sep/2024 08:21 AM
COLLECTION DATE : 09/Sep/2024 09:14AM
REPORTING DATE : 09/Sep/2024 10:18AM

Test Name	Value	Unit	Biological Reference interval
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SWASTHYA WELLNESS PANEL: 1.2
COMPLETE BLOOD COUNT (CBC)

RED BLOOD CELLS (RBCS) COUNT AND INDICES

HAEMOGLOBIN (HB) by CALORIMETRIC	4.6 ^L	gm/dL	12.0 - 17.0
RED BLOOD CELL (RBC) COUNT by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	1.84 ^L	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	15.1 ^L	%	40.0 - 54.0
MEAN CORPUSCULAR VOLUME (MCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	82	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	25.1 ^L	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	30.5 ^L	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	26.2 ^H	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	83.5 ^H	fL	35.0 - 56.0
MENTZERS INDEX by CALCULATED	44.57	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX by CALCULATED	117.23	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	2780 ^L	/cmm	4000 - 11000
NUCLEATED RED BLOOD CELLS (nRBCS) by AUTOMATED 6 PART HEMATOLOGY ANALYZER	NIL		0.00 - 20.00
NUCLEATED RED BLOOD CELLS (nRBCS) % by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	NIL	%	< 10 %

DIFFERENTIAL LEUCOCYTE COUNT (DLC)

NEUTROPHILS by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	65	%	50 - 70
LYMPHOCYTES	29	%	20 - 40



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by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
EOSINOPHILS	1 ^L	%	1 - 6
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
MONOCYTES	5	%	2 - 12
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
BASOPHILS	0	%	0 - 1
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
ABSOLUTE LEUKOCYTES (WBC) COUNT			
ABSOLUTE NEUTROPHIL COUNT	1807 ^L	/cmm	2000 - 7500
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
ABSOLUTE LYMPHOCYTE COUNT	806	/cmm	800 - 4900
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
ABSOLUTE EOSINOPHIL COUNT	28 ^L	/cmm	40 - 440
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
ABSOLUTE MONOCYTE COUNT	139	/cmm	80 - 880
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
ABSOLUTE BASOPHIL COUNT	0	/cmm	0 - 110
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
ABSOLUTE IMMATURE GRANULOCYTE COUNT	0	/cmm	0.0 - 999.0
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
PLATELETS AND OTHER PLATELET PREDICTIVE MARKERS.			
PLATELET COUNT (PLT)	168000	/cmm	150000 - 450000
by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE			
PLATELET CRIT (PCT)	0.18	%	0.10 - 0.36
by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE			
MEAN PLATELET VOLUME (MPV)	10	fL	6.50 - 12.0
by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE			
PLATELET LARGE CELL COUNT (P-LCC)	59000	/cmm	30000 - 90000
by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE			
PLATELET LARGE CELL RATIO (P-LCR)	35.1	%	11.0 - 45.0
by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE			
PLATELET DISTRIBUTION WIDTH (PDW)	16.7	%	15.0 - 17.0
by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE			

NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD




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ERYTHROCYTE SEDIMENTATION RATE (ESR)

ERYTHROCYTE SEDIMENTATION RATE (ESR)	22 ^H	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

GLUCOSE FASTING (F)

GLUCOSE FASTING (F): PLASMA by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)	100.18 ^H	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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Test Name	Value	Unit	Biological Reference interval
LIPID PROFILE : BASIC			
CHOLESTEROL TOTAL: SERUM <i>by CHOLESTEROL OXIDASE PAP</i>	72.26	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>	41.26	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>	22.97 ^L	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>	41.04	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>	49.29	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>	8.25	mg/dL	0.00 - 45.00
TOTAL LIPIDS: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	185.78^L	mg/dL	350.00 - 700.00
CHOLESTEROL/HDL RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	3.15	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>	1.79	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	1.8 ^L	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

RECHECKED.




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LIVER FUNCTION TEST (COMPLETE)

BILIRUBIN TOTAL: SERUM <i>by DIAZOTIZATION, SPECTROPHOTOMETRY</i>	1.49 ^H	mg/dL	INFANT: 0.20 - 8.00 ADULT: 0.00 - 1.20
BILIRUBIN DIRECT (CONJUGATED): SERUM <i>by DIAZO MODIFIED, SPECTROPHOTOMETRY</i>	0.43 ^H	mg/dL	0.00 - 0.40
BILIRUBIN INDIRECT (UNCONJUGATED): SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	1.06 ^H	mg/dL	0.10 - 1.00
SGOT/AST: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	17.2	U/L	7.00 - 45.00
SGPT/ALT: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	15.8	U/L	0.00 - 49.00
AST/ALT RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	1.09	RATIO	0.00 - 46.00
ALKALINE PHOSPHATASE: SERUM <i>by PARA NITROPHENYL PHOSPHATASE BY AMINO METHYL PROPANOL</i>	83.15	U/L	40.0 - 130.0
GAMMA GLUTAMYL TRANSFERASE (GGT): SERUM <i>by SZASZ, SPECTROPHOTOMETRY</i>	17.72	U/L	0.00 - 55.0
TOTAL PROTEINS: SERUM <i>by BIURET, SPECTROPHOTOMETRY</i>	6.13 ^L	gm/dL	6.20 - 8.00
ALBUMIN: SERUM <i>by BROMOCRESOL GREEN</i>	3.5	gm/dL	3.50 - 5.50
GLOBULIN: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	2.63	gm/dL	2.30 - 3.50
A : G RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	1.33	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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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 <i>by UREASE - GLUTAMATE DEHYDROGENASE (GLDH)</i>	59.92 ^H	mg/dL	10.00 - 50.00
CREATININE: SERUM <i>by ENZYMATIC, SPECTROPHOTOMETRY</i>	1.57 ^H	mg/dL	0.40 - 1.40
BLOOD UREA NITROGEN (BUN): SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	28 ^H	mg/dL	7.0 - 25.0
BLOOD UREA NITROGEN (BUN)/CREATININE RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	17.83	RATIO	10.0 - 20.0
UREA/CREATININE RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	38.17	RATIO	
URIC ACID: SERUM <i>by URICASE - OXIDASE PEROXIDASE</i>	10.51 ^H	mg/dL	3.60 - 7.70
CALCIUM: SERUM <i>by ARSENazo III, SPECTROPHOTOMETRY</i>	8.18 ^L	mg/dL	8.50 - 10.60
PHOSPHOROUS: SERUM <i>by PHOSPHOMOLYBDATE, SPECTROPHOTOMETRY</i>	2.69	mg/dL	2.30 - 4.70

ELECTROLYTES

SODIUM: SERUM <i>by ISE (ION SELECTIVE ELECTRODE)</i>	137.8	mmol/L	135.0 - 150.0
POTASSIUM: SERUM <i>by ISE (ION SELECTIVE ELECTRODE)</i>	4.35	mmol/L	3.50 - 5.00
CHLORIDE: SERUM <i>by ISE (ION SELECTIVE ELECTRODE)</i>	103.35	mmol/L	90.0 - 110.0

ESTIMATED GLOMERULAR FILTRATION RATE

ESTIMATED GLOMERULAR FILTRATION RATE (eGFR): SERUM <i>by CALCULATED</i>	43.5
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NOTE 2

ADVICE

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



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glomerular filtration rate.

2. Catabolic states with increased tissue breakdown.

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/1.73m2)	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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NAME	: Mr. SATPAL	PATIENT ID	: 1606512
AGE/ GENDER	: 83 YRS/MALE	REG. NO./LAB NO.	: 012409090017
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REFERRED BY	:	COLLECTION DATE	: 09/Sep/2024 09:14AM
BARCODE NO.	: 01516606	REPORTING DATE	: 09/Sep/2024 11:13AM
CLIENT CODE.	: KOS DIAGNOSTIC LAB		
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Test Name	Value	Unit	Biological Reference interval
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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 FUNCTION TEST: TOTAL

TRIiodOTHYRONINE (T3): SERUM	0.894	ng/mL	0.35 - 1.93
by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)			
THYroxINE (T4): SERUM	6.14	µgm/dL	4.87 - 12.60
by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)			
THYROID STIMULATING HORMONE (TSH): SERUM	4.152	µIU/mL	0.35 - 5.50
by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)			

3rd GENERATION, ULTRA SENSITIVE

INTERPRETATION:

TSH levels are subject 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 concentrations. TSH stimulates the production and secretion of the metabolically active hormones, thyroxine (T4) and triiodothyronine (T3). Failure at any level of regulation of the hypothalamic-pituitary-thyroid axis will result in either underproduction (hypothyroidism) or overproduction (hyperthyroidism) of T4 and/or T3.

CLINICAL CONDITION	T3	T4	TSH
Primary Hypothyroidism:	Reduced	Reduced	Increased (Significantly)
Subclinical Hypothyroidism:	Normal or Low Normal	Normal or Low Normal	High
Primary Hyperthyroidism:	Increased	Increased	Reduced (at times undetectable)
Subclinical Hyperthyroidism:	Normal or High Normal	Normal or High Normal	Reduced

LIMITATIONS:-

1. T3 and T4 circulates in reversibly bound form with Thyroid binding globulins (TBG), and to a lesser extent albumin and Thyroid binding Pre Albumin so conditions in which TBG and protein levels alter such as pregnancy, excess estrogens, androgens, anabolic steroids and glucocorticoids may falsely affect the T3 and T4 levels and may cause false thyroid values for thyroid function tests.
2. Normal levels of T4 can also be seen in Hyperthyroid patients with :T3 Thyrotoxicosis, Decreased binding capacity due to hypoproteinemia or ingestion of certain drugs (eg: phenytoin, salicylates).
3. Serum T4 levels in neonates and infants are higher than values in the normal adult, due to the increased concentration of TBG in neonate serum.
4. TSH may be normal in central hypothyroidism, recent rapid correction of hyperthyroidism or hypothyroidism, pregnancy, phenytoin therapy.

TRIiodOTHYRONINE (T3)		THYroxINE (T4)		THYROID STIMULATING HORMONE (TSH)	
Age	Refferance Range (ng/mL)	Age	Refferance Range (µg/dL)	Age	Reference Range (µIU/mL)
0 - 7 Days	0.20 - 2.65	0 - 7 Days	5.90 - 18.58	0 - 7 Days	2.43 - 24.3
7 Days - 3 Months	0.36 - 2.59	7 Days - 3 Months	6.39 - 17.66	7 Days - 3 Months	0.58 - 11.00
3 - 6 Months	0.51 - 2.52	3 - 6 Months	6.75 - 17.04	3 Days - 6 Months	0.70 - 8.40




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Test Name	Value	Unit	Biological Reference interval
6 - 12 Months	0.74 - 2.40	6 - 12 Months	7.10 - 16.16
1 - 10 Years	0.92 - 2.28	1 - 10 Years	6.00 - 13.80
11- 19 Years	0.35 - 1.93	11 - 19 Years	4.87- 13.20
> 20 years (Adults)	0.35 - 1.93	> 20 Years (Adults)	4.87 - 12.60
RECOMMENDATIONS OF TSH LEVELS DURING PREGNANCY (μ U/mL)			
1st Trimester			0.10 - 2.50
2nd Trimester			0.20 - 3.00
3rd Trimester			0.30 - 4.10

INCREASED TSH LEVELS:

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

DECREASED TSH 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.
- 7.DRUGS: Glucocorticoids, Dopamine, Levodopa, T4 replacement therapy, Anti-thyroid drugs for thyrotoxicosis.
- 8.Pregnancy: 1st and 2nd Trimester




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CLINICAL PATHOLOGY

URINE ROUTINE & MICROSCOPIC EXAMINATION

PHYSICAL EXAMINATION

QUANTITY RECIEVED	10	ml	
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
COLOUR	AMBER YELLOW		PALE YELLOW
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
TRANSPARANCY	CLEAR		CLEAR
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
SPECIFIC GRAVITY	1.01		1.002 - 1.030
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			

CHEMICAL EXAMINATION

REACTION	ACIDIC		
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
PROTEIN	Negative		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
SUGAR	Negative		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
pH	6.5		5.0 - 7.5
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
BILIRUBIN	Negative		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
NITRITE	Negative		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY.			
UROBILINOGEN	Normal	EU/dL	0.2 - 1.0
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
KETONE BODIES	Negative		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
BLOOD	Negative		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
ASCORBIC ACID	NEGATIVE (-ve)		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			

MICROSCOPIC EXAMINATION




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Test Name	Value	Unit	Biological Reference interval
RED BLOOD CELLS (RBCs) <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	NEGATIVE (-ve)	/HPF	0 - 3
PUS CELLS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	3-4	/HPF	0 - 5
EPITHELIAL CELLS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	1-3	/HPF	ABSENT
CRYSTALS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	NEGATIVE (-ve)		NEGATIVE (-ve)
CASTS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	NEGATIVE (-ve)		NEGATIVE (-ve)
BACTERIA <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	NEGATIVE (-ve)		NEGATIVE (-ve)
OTHERS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	NEGATIVE (-ve)		NEGATIVE (-ve)
TRICHOMONAS VAGINALIS (PROTOZOA) <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	ABSENT		ABSENT




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BARCODE NO.	: 01516606	REPORTING DATE	: 13/Sep/2024 09:20AM
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Test Name	Value	Unit	Biological Reference interval
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SPECIAL INVESTIGATIONS

PROTEIN ELECTROPHORESIS: SERUM

TOTAL PROTEINS: SERUM <i>by MIGRATION GEL ELECTROPHORESIS</i>	6.13 ^L	gm/dL	6.20 - 8.00
ALBUMIN: SERUM <i>by MIGRATION GEL ELECTROPHORESIS</i>	3 ^L	gm/dL	3.50 - 5.50
GLOBULIN: SERUM <i>by MIGRATION GEL ELECTROPHORESIS</i>	3.13	gm/dL	2.30 - 3.50
A : G RATIO: SERUM <i>by MIGRATION GEL ELECTROPHORESIS</i>	0.96 ^L	RATIO	1.00 - 2.00
ALPHA 1 GLOBULIN <i>by MIGRATION GEL ELECTROPHORESIS</i>	0.28	gm/dL	0.11 - 0.40
ALPHA 2 GLOBULIN <i>by MIGRATION GEL ELECTROPHORESIS</i>	0.63	gm/dL	0.43 - 1.03
BETA GLOBULIN <i>by MIGRATION GEL ELECTROPHORESIS</i>	0.54	mg/dL	0.53 - 1.40
GAMMA GLOBULIN <i>by MIGRATION GEL ELECTROPHORESIS</i>	1.68	gm/dL	0.75 - 1.80

INTERPRETATION

Serum protein electrophoresis shows Hypoalbuminemia.

ADVICE

KINDLY CORRELATE CLINICALLY

INTERPRETATION:

1. Serum protein electrophoresis is commonly used to identify patients with multiple myeloma and disorders of serum proteins.
2. Electrophoresis is a method of separating proteins based on their physical properties. the pattern of serum protein electrophoresis results depends on the frations of 2 types of protein : albumin and globulin (alpha 1 alpha2, beta and gamma.)
3. A homogeneous spike-like peak in a focal region of the gamma-globulin zone indicates a monoclonal gammopathy.
4. Monoclonal gammopathies are associated with a clonal process that is malignant or potentially malignant, including multiple myeloma, Waldenstrom macroglobulinemia, solitary plasmacytoma, smoldering multiple myeloma, monoclonal gammopathy of undetermined significance, plasma cell leukemia, heavy chain disease, and amyloidosis.
5. M-protein (in the gamma region) level greater than 3 g/dL should be interpreted along with other radiologic and haematological findings to arrive at a diagnosis of Multiple myeloma and must not be considered in isolation.
6. Occasionally M protein may appear as a narrow spike in the beta or alpha2 regions also.
7. Up to one fifth of patients with Myeloma may have an M-protein spike of less than 1 g /dL.
8. Hypogammaglobulinemia on serum protein electrophoresis occurs in about 10% of patients with multiple myeloma who do not have a serum M-protein spike.
9. Most of these patients have a large amount of Bence Jones protein (monoclonal free kappa or lambda chain) in their urine, wherein urine





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protein electrophoresis should be performed. Monoclonal gammopathy is present in up to 8 percent of healthy geriatric patients.

NOTE:

The following conditions require serum immunofixation to confirm monoclonality or to differentiate monoclonal and polyclonal disorders.

1.A well defined "M" band.

2.Faint band .

3.Chronic inflammatory pattern (decreased albumin, increased alpha, increased gamma fractions)

4.Isolated increase in any region with an otherwise normal pattern.

5.Shouldering of albumin peak along anodal or cathodal side may be seen with lipoproteins, drugs, bilirubin or radiological contrast.

*** End Of Report ***




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KOS Diagnostic Lab

(A Unit of KOS Healthcare)

PROTEIN ELECTROPHORESIS

NAME

SATPAL

AGE/SEX

83/m

BARCODE ID

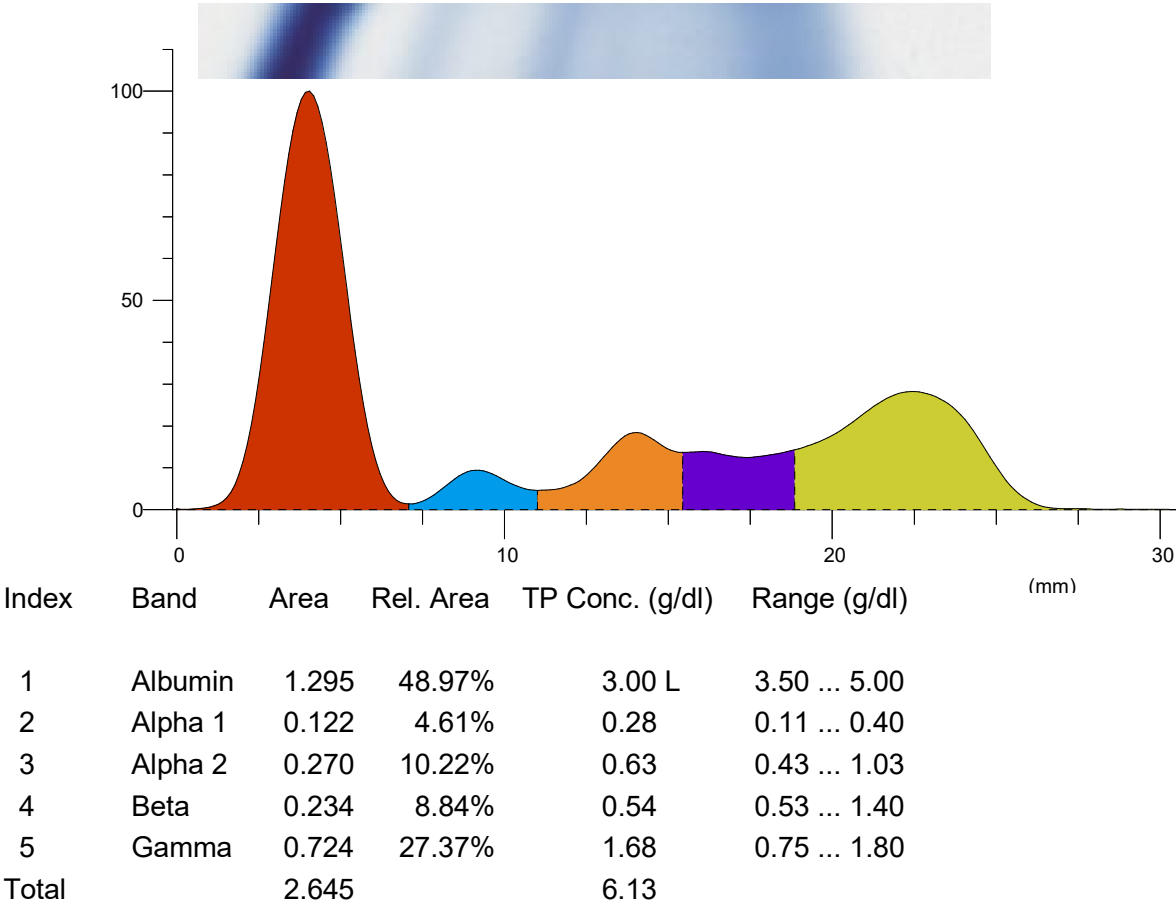
01516606

DATE

13/09/2024

Chemistry Results

TP 6.13(g/dl)



Ratio A/G 0.96

Comment:-
Serum protein electrophoresis shows Hypoalbuminemia. Kindly correlate clinically.