

Dr. Vinay Chopra
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Chairman & Consultant Pathologist

Dr. Yugam Chopra
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CEO & Consultant Pathologist

NAME : Miss. ALISHA BABEJA
AGE/ GENDER : 31 YRS/FEMALE
COLLECTED BY : SURJESH
REFERRED BY :
BARCODE NO. : 01516814
CLIENT CODE. : KOS DIAGNOSTIC LAB
CLIENT ADDRESS : 6349/1, NICHOLSON ROAD, AMBALA CANTT

PATIENT ID : 1610510
REG. NO./LAB NO. : 012409120024
REGISTRATION DATE : 12/Sep/2024 09:18 AM
COLLECTION DATE : 12/Sep/2024 09:27AM
REPORTING DATE : 12/Sep/2024 10:08AM

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	13.4	gm/dL	12.0 - 16.0
RED BLOOD CELL (RBC) COUNT by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	4.38	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	41.6	%	37.0 - 50.0
MEAN CORPUSCULAR VOLUME (MCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	95	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	30.5	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	32.1	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	12.6	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	45.1	fL	35.0 - 56.0
MENTZERS INDEX by CALCULATED	21.69	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX by CALCULATED	27.25	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	2910 ^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	64	%	50 - 70
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LYMPHOCYTES <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	26	%	20 - 40
EOSINOPHILS <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	1	%	1 - 6
MONOCYTES <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	9	%	2 - 12
BASOPHILS <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	0	%	0 - 1
<u>ABSOLUTE LEUKOCYTES (WBC) COUNT</u>			
ABSOLUTE NEUTROPHIL COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	1862 ^L	/cmm	2000 - 7500
ABSOLUTE LYMPHOCYTE COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	757 ^L	/cmm	800 - 4900
ABSOLUTE EOSINOPHIL COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	29 ^L	/cmm	40 - 440
ABSOLUTE MONOCYTE COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	262	/cmm	80 - 880
ABSOLUTE BASOPHIL COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	0	/cmm	0 - 110
<u>PLATELETS AND OTHER PLATELET PREDICTIVE MARKERS.</u>			
PLATELET COUNT (PLT) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	305000	/cmm	150000 - 450000
PLATELET CRIT (PCT) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	0.33	%	0.10 - 0.36
MEAN PLATELET VOLUME (MPV) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	11	fL	6.50 - 12.0
PLATELET LARGE CELL COUNT (P-LCC) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	98000 ^H	/cmm	30000 - 90000
PLATELET LARGE CELL RATIO (P-LCR) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	32.1	%	11.0 - 45.0
PLATELET DISTRIBUTION WIDTH (PDW) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	16.6	%	15.0 - 17.0
NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD			

RECHECKED




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IMMUNOPATHOLOGY/SEROLOGY

TYPHOID COMBO SCREEN (TYPHOID ANTIGEN, IgG AND IgM): SERUM

TYPHOID ANTIGEN - SERUM by ICT (IMMUNOCHROMATOGRAPHY)	NEGATIVE (-ve)	NEGATIVE (-ve)
TYPHI DOT ANTIBODY IgG by ICT (IMMUNOCHROMATOGRAPHY)	NEGATIVE (-ve)	NEGATIVE (-ve)
TYPHI DOT ANTIBODY IgM by ICT (IMMUNOCHROMATOGRAPHY)	NEGATIVE (-ve)	NEGATIVE (-ve)

INTERPRETATION:

Typhoid fever is a life threatening illness caused by the bacterium *Salmonella typhus*. The infection is acquired typically by ingestion. On reaching the gut, the bacilli attach themselves to the epithelial cells of the intestinal villi and penetrate the lamina and submucosa. They are then phagocytosed there by polymorphs and mesenteric lymph nodes, where they multiply and, via the thoracic duct, enter the blood stream. A transient bacteremia follows, during which the bacilli are seeded in the liver, gall bladder, spleen, bone marrow, lymph nodes, and kidneys, where further multiplication takes place. Towards the end of the incubation period, there occurs a massive bacteremia from these sites, heralding the onset of the clinical symptoms.

The diagnosis of typhoid consists of isolation of the bacilli and the demonstration of antibodies. The isolation of the bacilli is very time consuming and antibody detection is not very specific. Other tests include the Widal reaction. The advantage of this test is that it takes only 10-20 minutes and requires only a small amount of stool/serum/plasma to perform. It is the easiest and most specific method for detecting *S. typhi* infection.

RELATIVE SENSITIVITY OF TYPHOID ANTIGEN DETECTION: 98.7%

RELATIVE SPECIFICITY OF TYPHOID ANTIGEN DETECTION: 97.4%

DETECTABLE IgM RESPONSE:

ONSET OF FEVER	PERCENT POSITIVE
4 - 6 DAYS	43.5
6 - 9 DAYS	92.9
> 9 DAYS	99.5


1. This is a solid phase, immunochromatographic ELISA assay that detects specific IgM and IgG Antibodies against the OUTER MEMBRANE PROTEIN (OMP) of the *Salmonella* species. IgM antibodies appear in the serum 2-3 days post infection and are indicative of a recent infection while the IgG antibodies appear later and are useful for presumptive diagnosis of Enteric fever if the patient presents more than a week after onset of symptoms.

2. This is a useful screening assay for the early detection of Enteric fever and has a high sensitivity. However the test has moderate specificity and false positive results may be obtained in the following situations:

- Antibodies against *Salmonella* may cross react with other antibodies.




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. Unrelated infections may lead to production of specific Salmonella antibodies if the patient has previously been exposed to Salmonella infection (ANAMNESTIC RESPONSE).

NOTE:- Rapid blood culture performed during 1st week of infection is highly recommended for confirmation of all IgM positive results. In case the patient has presented after the first week of infection, a thorough clinical correlation and confirmatory Widal test must be performed to establish the diagnosis.




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Test Name	Value	Unit	Biological Reference interval
DENGUE FEVER COMBO SCREENING - (NS1 ANTIGEN, IgG AND IgM)			
DENGUE NS1 ANTIGEN - SCREENING <i>by ICT (IMMUNOCHROMATOGRAPHY)</i>	NEGATIVE (-ve)		NEGATIVE (-ve)
DENGUE ANTIBODY IgG - SCREENING <i>by ICT (IMMUNOCHROMATOGRAPHY)</i>	NEGATIVE (-ve)		NEGATIVE (-ve)
DENGUE ANTIBODY IgM - SCREENING <i>by ICT (IMMUNOCHROMATOGRAPHY)</i>	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).




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MALARIA - P.FALCIPARUM AND P.VIVAX ANTIGEN DETECTION

PLASMODIUM FALCIPARUM ANTIGEN <i>by ICT (IMMUNOCHROMATOGRAPHY)</i>	NEGATIVE (-ve)	NEGATIVE (-ve)
PLASMODIUM VIVAX ANTIGEN <i>by ICT (IMMUNOCHROMATOGRAPHY)</i>	NEGATIVE (-ve)	NEGATIVE (-ve)

*** End Of Report ***




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