

Dr. Vinay Chopra  
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Chairman & Consultant Pathologist

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

NAME : Mrs. VEENA  
AGE/ GENDER : 64 YRS/FEMALE  
COLLECTED BY :  
REFERRED BY : LOOMBA HOSPITAL (AMBALA CANTT)  
BARCODE NO. : 01516949  
CLIENT CODE. : KOS DIAGNOSTIC LAB  
CLIENT ADDRESS : 6349/1, NICHOLSON ROAD, AMBALA CANTT  
PATIENT ID : 1612810  
REG. NO./LAB NO. : 012409140036  
REGISTRATION DATE : 14/Sep/2024 12:13 PM  
COLLECTION DATE : 14/Sep/2024 12:32PM  
REPORTING DATE : 14/Sep/2024 12:41PM

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	11.6 <sup>L</sup>	gm/dL	12.0 - 16.0
RED BLOOD CELL (RBC) COUNT by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	4.04	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	35.8 <sup>L</sup>	%	37.0 - 50.0
MEAN CORPUSCULAR VOLUME (MCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	88.6	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	28.6	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	32.3	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	14	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	46.2	fL	35.0 - 56.0
MENTZERS INDEX by CALCULATED	21.93	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX by CALCULATED	30.58	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	7150	/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	59	%	50 - 70
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LYMPHOCYTES by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	33	%	20 - 40
EOSINOPHILS by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	2	%	1 - 6
MONOCYTES by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	6	%	2 - 12
BASOPHILS by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	0	%	0 - 1
<b><u>ABSOLUTE LEUKOCYTES (WBC) COUNT</u></b>			
ABSOLUTE NEUTROPHIL COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	4219	/cmm	2000 - 7500
ABSOLUTE LYMPHOCYTE COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	2360	/cmm	800 - 4900
ABSOLUTE EOSINOPHIL COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	143	/cmm	40 - 440
ABSOLUTE MONOCYTE COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	429	/cmm	80 - 880
ABSOLUTE BASOPHIL COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	0	/cmm	0 - 110
<b><u>PLATELETS AND OTHER PLATELET PREDICTIVE MARKERS.</u></b>			
PLATELET COUNT (PLT) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	188000	/cmm	150000 - 450000
PLATELETCRIT (PCT) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	0.26	%	0.10 - 0.36
MEAN PLATELET VOLUME (MPV) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	14 <sup>H</sup>	fL	6.50 - 12.0
PLATELET LARGE CELL COUNT (P-LCC) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	96000 <sup>H</sup>	/cmm	30000 - 90000
PLATELET LARGE CELL RATIO (P-LCR) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	50.9 <sup>H</sup>	%	11.0 - 45.0
PLATELET DISTRIBUTION WIDTH (PDW) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	16.4	%	15.0 - 17.0
NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD			



  
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**BLEEDING TIME (BT)**

BLEEDING TIME (BT) by DUKE METHOD	2 MIN.5 SEC.	MINS	1 - 5
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**CLOTTING TIME (CT)**

CLOTTING TIME (CT)	6 MIN. 25 SEC.	MINS	4 - 9
by CAPILLARY TUBE METHOD			



  
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### CLINICAL CHEMISTRY/BIOCHEMISTRY

#### GLUCOSE RANDOM (R)


GLUCOSE RANDOM (R): PLASMA by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)	156.64 <sup>H</sup>	mg/dL	NORMAL: < 140.00 PREDIABETIC: 140.0 - 200.0 DIABETIC: > OR = 200.0
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#### INTERPRETATION

##### IN ACCORDANCE WITH AMERICAN DIABETES ASSOCIATION GUIDELINES:

1. A random plasma glucose level below 140 mg/dl is considered normal.
2. A random glucose level between 140 - 200 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 random glucose level of above 200 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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**UREA**

UREA: SERUM	28.12	mg/dL	10.00 - 50.00
by UREASE - GLUTAMATE DEHYDROGENASE (GLDH)			



  
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CREATININE

CREATININE: SERUM by ENZYMATIC, SPECTROPHOTOMETRY	0.57	mg/dL	0.40 - 1.20
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### IMMUNOPATHOLOGY/SEROLOGY

#### HEPATITIS C VIRUS (HCV) ANTIBODY: TOTAL

HEPATITIS C ANTIBODY (HCV) TOTAL: SERUM	0.11	S/CO	NEGATIVE: < 1.00
by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)			POSITIVE: > 1.00
HEPATITIS C ANTIBODY (HCV) TOTAL	Non reactive		
RESULT			
by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)			

#### INTERPRETATION:-

RESULT (INDEX)	REMARKS
< 1.00	NON - REACTIVE/NOT - DETECTED
> =1.00	REACTIVE/ASYMPTOMATIC/INFECTIVE STATE/CARRIER STATE.

Hepatitis C (HCV) is an RNA virus of Favivirus group transmitted via blood transfusions, transplantation, injection drug abusers, accidental needle punctures in healthcare workers, dialysis patients and rarely from mother to infant. 10 % of new cases show sexual transmission. As compared to HAV & HBV , chronic infection with HCV occurs in 85 % of infected individuals. In high risk population, the predictive value of Anti HCV for HCV infection is > 99% whereas in low risk populations it is only 25 %.


#### USES:


- Indicator of past or present infection, but does not differentiate between Acute/ Chronic/Resolved Infection.
- Routine screening of low and high prevalence population including blood donors.

#### NOTE:

- False positive results are seen in Auto-immune disease, Rheumatoid Factor, HYpergammaglobulinemia, Paraproteinemia, Passive antibody transfer, Anti-idiotypes and Anti-superoxide dismutase.
- False negative results are seen in early Acute infection, Immunosuppression and Immuno— incompetence.
- HCV-RNA PCR recommended in all reactive results to differentiate between past and present infection.



  
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**ANTI HUMAN IMMUNODEFICIENCY VIRUS (HIV) DUO ULTRA WITH (P-24 ANTIGEN DETECTION)**

HIV 1/2 AND P24 ANTIGEN: SERUM	0.21	S/CO	NEGATIVE: < 1.00 POSITIVE: > 1.00
by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)			
HIV 1/2 AND P24 ANTIGEN RESULT	Non reactive		
by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)			

**INTERPRETATION:-**

RESULT (INDEX)	REMARKS
< 1.00	NON - REACTIVE
> = 1.00	PROVISIONALLY REACTIVE

Non-Reactive result implies that antibodies to HIV 1/ 2 have not been detected in the sample . This means that patient has either not been exposed to HIV 1/ 2 infection or the sample has been tested during the "window phase" i.e. before the development of detectable levels of antibodies. Hence a Non Reactive result does not exclude the possibility of exposure or infection with HIV 1/ 2.

**RECOMMENDATIONS:**

1. Results to be clinically correlated
2. Rarely falsenegativity/positivity may occur.



  
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### HEPATITIS B SURFACE ANTIGEN (HBsAg) ULTRA

HEPATITIS B SURFACE ANTIGEN (HBsAg): 0.22 S/CO  
 SERUM  
 NEGATIVE: < 1.0  
 POSITIVE: > 1.0

by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)

HEPATITIS B SURFACE ANTIGEN (HBsAg) NON REACTIVE  
 RESULT


by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)


#### INTERPRETATION:

RESULT IN INDEX VALUE	REMARKS
< 1.30	NEGATIVE (-ve)
>=1.30	POSITIVE (+ve)

Hepatitis B Virus (HBV) is a member of the Hepadna virus family causing infection of the liver with extremely variable clinical features. Hepatitis B is transmitted primarily by body fluids especially serum and also spread effectively sexually and from mother to baby. In most individuals HBV hepatitis is self limiting, but 1-2 % normal adolescent and adults develop Chronic Hepatitis. Frequency of chronic HBV infection is 5-10% in immunocompromised patients and 80 % neonates. The initial serological marker of acute infection is HBsAg which typically appears 2-3 months after infection and disappears 12-20 weeks after onset of symptoms. Persistence of HBsAg for more than 6 months indicates carrier state or Chronic Liver disease.



  
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VDRL by IMMUNOCHROMATOGRAPHY	NON REACTIVE		NON REACTIVE
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**INTERPRETATION:**

- Does not become positive until 7 - 10 days after appearance of chancre.
- High titer (>1:16) - active disease.**
- Low titer (<1:8) - biological falsepositive test in 90% cases or due to late or late latent syphilis.**
- Treatment of primary syphilis causes progressive decline to negative VDRL within 2 years.
- Rising titer (4X) indicates relapse, reinfection, or treatment failure and need for retreatment.
- May be nonreactive in early primary, late latent, and late syphilis (approx. 25% of cases).
- Reactive and weakly reactive tests should always be confirmed with FTA-ABS (fluorescent treponemal antibody absorption test).**

**SHORT TERM FALSE POSITIVE TEST RESULTS (<6 MONTHS DURATION) MAY OCCUR IN:**


- Acute viral illnesses (e.g., hepatitis, measles, infectious mononucleosis)
- M. pneumoniae; Chlamydia; Malaria infection.
- Some immunizations
- Pregnancy (rare)


**LONG TERM FALSE POSITIVE TEST RESULTS (>6 MONTHS DURATION) MAY OCCUR IN:**

- Serious underlying disease e.g., collagen vascular diseases, leprosy, malignancy.
- Intravenous drug users.
- Rheumatoid arthritis, thyroiditis, AIDS, Sjogren's syndrome.
- <10 % of patients older than age 70 years.
- Patients taking some anti-hypertensive drugs.

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



  
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