

(A Unit of KOS Healthcare)



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

NAME : Mr. NARESH AGGARWAL

AGE/ GENDER : 70 YRS/MALE PATIENT ID : 1619098

COLLECTED BY: SURJESH REG. NO./LAB NO. : 012409200018

 REFERRED BY
 : 20/Sep/2024 08:40 AM

 BARCODE NO.
 : 01517311
 COLLECTION DATE
 : 20/Sep/2024 08:49 AM

 CLIENT CODE.
 : KOS DIAGNOSTIC LAB
 REPORTING DATE
 : 20/Sep/2024 09:27 AM

**CLIENT ADDRESS**: 6349/1, NICHOLSON ROAD, AMBALA CANTT

Test Name Value Unit Biological Reference interval

# SWASTHYA WELLNESS PANEL: 1.0 COMPLETE BLOOD COUNT (CBC)

### RED BLOOD CELLS (RBCS) COUNT AND INDICES

HAEMOGLOBIN (HB) by CALORIMETRIC	14.8	gm/dL	12.0 - 17.0
RED BLOOD CELL (RBC) COUNT by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	5.13 <sup>H</sup>	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	45.9	%	40.0 - 54.0
MEAN CORPUSCULAR VOLUME (MCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	89.6	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH)  by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	28.9	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	32.2	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	14.1	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	47.3	fL	35.0 - 56.0
MENTZERS INDEX by CALCULATED	17.47	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX by CALCULATED	24.67	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	7830	/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	68	%	50 - 70



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YMPHOCYTES by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	20	%	20 - 40
OSINOPHILS by flow cytometry by sf cube & microscopy	4	%	1 - 6
MONOCYTES by flow cytometry by sf cube & microscopy	8	%	2 - 12
ASOPHILS by flow cytometry by sf cube & microscopy ABSOLUTE LEUKOCYTES (WBC) COUNT	0	%	0 - 1
BSOLUTE NEUTROPHIL COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	5324	/cmm	2000 - 7500
BSOLUTE LYMPHOCYTE COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	1566	/cmm	800 - 4900
BSOLUTE EOSINOPHIL COUNT by flow cytometry by Sf cube & microscopy	313	/cmm	40 - 440
BSOLUTE MONOCYTE COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	626	/cmm	80 - 880
BSOLUTE BASOPHIL COUNT  by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY  ATELETS AND OTHER DIATELET DREDICTIVE MARKET	0	/cmm	0 - 110
LATELETS AND OTHER PLATELET PREDICTIVE MARKER LATELET COUNT (PLT) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	206000	/cmm	150000 - 450000
LATELETCRIT (PCT) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	0.23	%	0.10 - 0.36
MEAN PLATELET VOLUME (MPV) by hydro dynamic focusing, electrical impedence	11	fL	6.50 - 12.0
LATELET LARGE CELL COUNT (P-LCC) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	68000	/cmm	30000 - 90000
LATELET LARGE CELL RATIO (P-LCR) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	32.8	%	11.0 - 45.0
LATELET DISTRIBUTION WIDTH (PDW) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE OTE: TEST CONDUCTED ON EDTA WHOLE BLOOD	16.3	%	15.0 - 17.0



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### ERYTHROCYTE SEDIMENTATION RATE (ESR)

**ERYTHROCYTE SEDIMENTATION RATE (ESR)** 

0 - 20

by RED CELL AGGREGATION BY CAPILLARY PHOTOMETRY

#### 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.

- ESR and C reactive protein (C-RP) are both markers of inflammation.
   Generally, ESR does not change as rapidly as does CRP, either at the start of inflammation or as it resolves.
   CRP is not affected by as many other factors as is ESR, making it a better marker of inflammation.
   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)**

99.92 GLUCOSE FASTING (F): PLASMA mg/dL NORMAL: < 100.0

by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD) PREDIABETIC: 100.0 - 125.0 DIABETIC: > 0R = 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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	LIPID PROFILE	: BASIC	
CHOLESTEROL TOTAL: SERUM by CHOLESTEROL OXIDASE PAP	169.95	mg/dL	OPTIMAL: < 200.0 BORDERLINE HIGH: 200.0 - 239.0 HIGH CHOLESTEROL: > OR = 240.0
TRIGLYCERIDES: SERUM by GLYCEROL PHOSPHATE OXIDASE (ENZYMATIC)	121.18	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 by SELECTIVE INHIBITION	41.63	mg/dL	LOW HDL: < 30.0  BORDERLINE HIGH HDL: 30.0 - 60.0  HIGH HDL: > OR = 60.0
LDL CHOLESTEROL: SERUM by CALCULATED, SPECTROPHOTOMETRY	104.08	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 by CALCULATED, SPECTROPHOTOMETRY	128.32	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 by CALCULATED, SPECTROPHOTOMETRY	24.24	mg/dL	0.00 - 45.00
TOTAL LIPIDS: SERUM  by CALCULATED, SPECTROPHOTOMETRY	461.08	mg/dL	350.00 - 700.00
CHOLESTEROL/HDL RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	4.08	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 by CALCULATED, SPECTROPHOTOMETRY	2.5	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 **RATIO** 3.00 - 5.002.91<sup>L</sup> by CALCULATED, SPECTROPHOTOMETRY

**INTERPRETATION:** 

CLIENT CODE.

1. 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.

2. 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.

3. 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.

4. NLA-2014 identifies Non HDL Cholesterol (an indicator of all atherogeniclipoproteins such as LDL, VLDL, IDL, Lpa, 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

5. 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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### LIVER FUNCTION TEST (COMPLETE)

BILIRUBIN TOTAL: SERUM by DIAZOTIZATION, SPECTROPHOTOMETRY	0.7	mg/dL	INFANT: 0.20 - 8.00 ADULT: 0.00 - 1.20
BILIRUBIN DIRECT (CONJUGATED): SERUM by DIAZO MODIFIED, SPECTROPHOTOMETRY	0.22	mg/dL	0.00 - 0.40
BILIRUBIN INDIRECT (UNCONJUGATED): SERUM by CALCULATED, SPECTROPHOTOMETRY	0.48	mg/dL	0.10 - 1.00
SGOT/AST: SERUM by IFCC, WITHOUT PYRIDOXAL PHOSPHATE	49.5 <sup>H</sup>	U/L	7.00 - 45.00
SGPT/ALT: SERUM by IFCC, WITHOUT PYRIDOXAL PHOSPHATE	77.5 <sup>H</sup>	U/L	0.00 - 49.00
AST/ALT RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	0.64	RATIO	0.00 - 46.00
ALKALINE PHOSPHATASE: SERUM  by Para Nitrophenyl Phosphatase by Amino Methy PROPANOL	76.4 L	U/L	40.0 - 130.0
GAMMA GLUTAMYL TRANSFERASE (GGT): SERUM by SZASZ, SPECTROPHTOMETRY	33.5	U/L	0.00 - 55.0
TOTAL PROTEINS: SERUM  by BIURET, SPECTROPHOTOMETRY	6.42	gm/dL	6.20 - 8.00
ALBUMIN: SERUM  by BROMOCRESOL GREEN	3.61	gm/dL	3.50 - 5.50
GLOBULIN: SERUM by CALCULATED, SPECTROPHOTOMETRY	2.81	gm/dL	2.30 - 3.50
A : G RATIO: SERUM	1.28	RATIO	1.00 - 2.00

#### **INTERPRETATION**

by CALCULATED, SPECTROPHOTOMETRY

NOTE: To be correlated in individuals having SGOT and SGPT values higher than Normal Referance 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 CHOLESTATIS	> 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 cholestatis: 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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mmol/L

135.0 - 150.0

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	KIDNEY FUNCTION TE	ST (COMPLETE)	
UREA: SERUM by UREASE - GLUTAMATE DEHYDROGENASE (GLDH)	30.83	mg/dL	10.00 - 50.00
CREATININE: SERUM by ENZYMATIC, SPECTROPHOTOMETERY	1.01	mg/dL	0.40 - 1.40
BLOOD UREA NITROGEN (BUN): SERUM by CALCULATED, SPECTROPHOTOMETRY	14.41	mg/dL	7.0 - 25.0
BLOOD UREA NITROGEN (BUN)/CREATININE RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	14.27	RATIO	10.0 - 20.0
UREA/CREATININE RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	30.52	RATIO	
URIC ACID: SERUM by URICASE - OXIDASE PEROXIDASE	6.49	mg/dL	3.60 - 7.70
CALCIUM: SERUM by ARSENAZO III, SPECTROPHOTOMETRY	9.21	mg/dL	8.50 - 10.60
PHOSPHOROUS: SERUM by PHOSPHOMOLYBDATE, SPECTROPHOTOMETRY	2.49	mg/dL	2.30 - 4.70

# **ELECTROLYTES**SODIUM: SERUM

 by ISE (ION SELECTIVE ELECTRODE)

 POTASSIUM: SERUM
 4.37
 mmol/L
 3.50 - 5.00

 by ISE (ION SELECTIVE ELECTRODE)

 CHLORIDE: SERUM
 104.85
 mmol/L
 90.0 - 110.0

139.8

by ISE (ION SELECTIVE ELECTRODE)
ESTIMATED GLOMERULAR FILTERATION RATE

ESTIMATED GLOMERULAR FILTERATION RATE 80

(eGFR): SERUM
by CALCULATED

**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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- 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 inappropiate antidiuretic harmone) 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.

#### **INAPPROPIATE 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 FILTERATION RATE:

ESTIMATED GEOMEROEAR TIETERATION RATE:				
CKD STAGE	DESCRIPTION	GFR ( mL/min/1.73m2 )	ASSOCIATED FINDINGS	
G1	Normal kidney function	>90	No proteinuria	
G2	Kidney damage with	>90	Presence of Protein,	
	normal or high GFR		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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(A Unit of KOS Healthcare)



Dr. Vinay Chopra MD (Pathology & Microbiology) Chairman & Consultant Pathologist

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

**NAME** : Mr. NARESH AGGARWAL

AGE/ GENDER : 70 YRS/MALE **PATIENT ID** : 1619098

:012409200018 COLLECTED BY : SURJESH REG. NO./LAB NO.

REFERRED BY **REGISTRATION DATE** : 20/Sep/2024 08:40 AM BARCODE NO. **COLLECTION DATE** : 20/Sep/2024 08:49AM :01517311

CLIENT CODE. : KOS DIAGNOSTIC LAB REPORTING DATE : 20/Sep/2024 12:28PM

**CLIENT ADDRESS** : 6349/1, NICHOLSON ROAD, AMBALA CANTT

Test Name Value Unit **Biological Reference interval** 

#### 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

4. eGFR category G1 OR G2 does not fullfill 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).

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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Test Name Value Unit Biological Reference interval

### 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

1.002 - 1.030

by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY

#### **CHEMICAL EXAMINATION**

REACTION NEUTRAL

by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY

by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY.

by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY

by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY

PROTEIN Negative NEGATIVE (-ve)

by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY

SUGAR Negative NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY

pH 5.0 - 7.5

by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY

BILIRUBIN Negative NEGATIVE (-ve)

by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY

NITRITE Negative NEGATIVE (-ve)

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)

ASCORBIC ACID NEGATIVE (-ve) NEGATIVE (-ve)

MICROSCOPIC EXAMINATION



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Test Name	Value	Unit	Biological Reference interval
RED BLOOD CELLS (RBCs) by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT	NEGATIVE (-ve)	/HPF	0 - 3
PUS CELLS by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT	2-4	/HPF	0 - 5
EPITHELIAL CELLS by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT	1-3	/HPF	ABSENT
CRYSTALS by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT	NEGATIVE (-ve)		NEGATIVE (-ve)
CASTS by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT	NEGATIVE (-ve)		NEGATIVE (-ve)
BACTERIA by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT	NEGATIVE (-ve)		NEGATIVE (-ve)
OTHERS by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT	NEGATIVE (-ve)		NEGATIVE (-ve)
TRICHOMONAS VAGINALIS (PROTOZOA) by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT	ABSENT		ABSENT

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



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