

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

NAME : Mr. SATVINDER BIR SINGH
AGE/ GENDER : 50 YRS/MALE
COLLECTED BY : SURJESH
REFERRED BY :
BARCODE NO. : 01517713
CLIENT CODE. : KOS DIAGNOSTIC LAB
CLIENT ADDRESS : 6349/1, NICHOLSON ROAD, AMBALA CANTT

PATIENT ID : 1625506
REG. NO./LAB NO. : 012409250065
REGISTRATION DATE : 25/Sep/2024 05:50 PM
COLLECTION DATE : 25/Sep/2024 06:52PM
REPORTING DATE : 25/Sep/2024 06:22PM

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	11.7 ^L	gm/dL	12.0 - 17.0
RED BLOOD CELL (RBC) COUNT by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	3.63	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	34.1 ^L	%	40.0 - 54.0
MEAN CORPUSCULAR VOLUME (MCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	94	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	31.4	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	33.4	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	12.4	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	43.4	fL	35.0 - 56.0
MENTZERS INDEX by CALCULATED	25.9	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX by CALCULATED	31.28	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	10830	/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	89 ^H	%	50 - 70
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LYMPHOCYTES <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	7 ^L	%	20 - 40
EOSINOPHILS <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	0 ^L	%	1 - 6
MONOCYTES <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	4	%	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>	9639 ^H	/cmm	2000 - 7500
ABSOLUTE LYMPHOCYTE COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	758 ^L	/cmm	800 - 4900
ABSOLUTE EOSINOPHIL COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	0 ^L	/cmm	40 - 440
ABSOLUTE MONOCYTE COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	433	/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>	164000	/cmm	150000 - 450000
PLATELETCRIT (PCT) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	0.18	%	0.10 - 0.36
MEAN PLATELET VOLUME (MPV) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	12	fL	6.50 - 12.0
PLATELET LARGE CELL COUNT (P-LCC) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	58000	/cmm	30000 - 90000
PLATELET LARGE CELL RATIO (P-LCR) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	36.1	%	11.0 - 45.0
PLATELET DISTRIBUTION WIDTH (PDW) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	15.9	%	15.0 - 17.0

NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD

RECHECKED.




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PERIPHERAL BLOOD SMEAR FOR MALARIA

PERIPHERAL BLOOD SMEAR
 FOR MALARIAL PARASITE (MP)
 by MICROSCOPY

NO MALARIA PARASITE (MP) SEEN IN SMEAR EXAMINED




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CLINICAL CHEMISTRY/BIOCHEMISTRY

LIVER FUNCTION TEST (COMPLETE)

BILIRUBIN TOTAL: SERUM <i>by DIAZOTIZATION, SPECTROPHOTOMETRY</i>	1.38 ^H	mg/dL	INFANT: 0.20 - 8.00 ADULT: 0.00 - 1.20
BILIRUBIN DIRECT (CONJUGATED): SERUM <i>by DIAZO MODIFIED, SPECTROPHOTOMETRY</i>	0.46 ^H	mg/dL	0.00 - 0.40
BILIRUBIN INDIRECT (UNCONJUGATED): SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	0.92	mg/dL	0.10 - 1.00
SGOT/AST: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	55 ^H	U/L	7.00 - 45.00
SGPT/ALT: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	59.2 ^H	U/L	0.00 - 49.00
AST/ALT RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	0.93	RATIO	0.00 - 46.00
ALKALINE PHOSPHATASE: SERUM <i>by PARA NITROPHENYL PHOSPHATASE BY AMINO METHYL PROPANOL</i>	139.95 ^H	U/L	40.0 - 130.0
GAMMA GLUTAMYL TRANSFERASE (GGT): SERUM <i>by SZASZ, SPECTROPHOTOMETRY</i>	388.58 ^H	U/L	0.00 - 55.0
TOTAL PROTEINS: SERUM <i>by BIURET, SPECTROPHOTOMETRY</i>	6.53	gm/dL	6.20 - 8.00
ALBUMIN: SERUM <i>by BROMOCRESOL GREEN</i>	3.96	gm/dL	3.50 - 5.50
GLOBULIN: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	2.57	gm/dL	2.30 - 3.50
A : G RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	1.54	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



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Test Name	Value	Unit	Biological Reference interval
INTRAHEPATIC CHOLESTATIS	> 1.5		
HEPATOCELLULAR CARCINOMA & CHRONIC HEPATITIS	> 1.3 (Slightly Increased)		

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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Test Name	Value	Unit	Biological Reference interval
UREA			
UREA: SERUM by UREASE - GLUTAMATE DEHYDROGENASE (GLDH)	63.79 ^H	mg/dL	10.00 - 50.00




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CREATININE

CREATININE: SERUM
 by ENZYMATIC, SPECTROPHOTOMETRY

1.84^H

mg/dL

0.40 - 1.40




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BARCODE NO.	: 01517713	REPORTING DATE	: 26/Sep/2024 06:27AM
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IMMUNOPATHOLOGY/SEROLOGY

DENGUE FEVER ANTIBODY IgM - ELISA (QUANTITATIVE)

DENGUE ANTIBODY IgM - QUANTITATIVE	0.19	ABSORBANCE	< 0.30
by ELISA (ENZYME LINKED IMMUNOSORBENT ASSAY)			

INTERPRETATION:

DENGUE IgM ELISA	
VALUE	RESULT
NEGATIVE	Less than 0.30 OD (Absorbance)
EQUIVOCAL	0.30 to 0.50 OD (Absorbance)
POSITIVE	More than 0.50 OD (Absorbance)
STRONGLY POSITIVE	More than 1.00 OD (Absorbance)

- 1.Treatment is often indicated prior to completion of serologic diagnosis, which requires at least two weeks.
- 2.Although dengue fever is usually not treated with antibiotics.
- 3.Diagnosis of dengue infection should not be made based on results of the IVD micro well Elisa dengue fever test alone, but in conjunction with other clinical signs and symptoms and other laboratory findings.
- 4.Epidemiologic factors, clinical findings, exposure to endemic regions, and other laboratory results should be considered when making a diagnosis.




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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)




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BARCODE NO.	: 01517713	REPORTING DATE	: 25/Sep/2024 06:29PM
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WIDAL SLIDE AGGLUTINATION TEST

SALMONELLA TYPHI O by SLIDE AGGLUTINATION	1 : 40	TITRE	1 : 80
SALMONELLA TYPHI H by SLIDE AGGLUTINATION	1 : 40	TITRE	1 : 160
SALMONELLA PARATYPHI AH by SLIDE AGGLUTINATION	NIL	TITRE	1 : 160
SALMONELLA PARATYPHI BH by SLIDE AGGLUTINATION	NIL	TITRE	1 : 160

INTERPRETATION:

1. Titres of 1:80 or more for "O" agglutinin is considered significant.
2. Titres of 1:160 or more for "H" agglutinin is considered significant.

LIMITATIONS:

1. Agglutinins usually appear by 5th to 6th day of illness of enteric fever, hence a negative result in early stage is inconclusive. The titre then rises till 3rd or 4th week, after which it declines gradually.
2. Lower titres may be found in normal individuals.
3. A single positive result has less significance than the rising agglutination titre, since demonstration of rising titre four or more in 1st and 3rd week is considered as a definite evidence of infection.
4. A simultaneous rise in H agglutinins is suggestive of paratyphoid infection.

NOTE:

1. Individuals with prior infection or immunization with TAB vaccine may develop an ANAMNESTIC RESPONSE (False-Positive) during an unrelated fever i.e High titres of antibodies to various antigens. This may be differentiated by repetition of the test after a week.
2. The anamnestic response shows only a transient rise, while in enteric fever rise is sustained.
3. H agglutinins tend to persist for many months after vaccination but O agglutinins tend to disappear sooner i.e within 6 months. Therefore rise in O agglutinins indicate recent infection.




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MICROBIOLOGY

CULTURE AEROBIC BACTERIA AND ANTIBIOTIC SENSITIVITY (CONVENTIONAL): BLOOD

BLOOD CULTURE AND SUSCEPTIBILITY

DATE OF SAMPLE	25-09-2024
SPECIMEN SOURCE	BLOOD
INCUBATION PERIOD	72 HOURS (3 SUBCULTURES)
CULTURE	STERILE
by AUTOMATED BROTH CULTURE	
ORGANISM	NO AEROBIC PYOGENIC ORGANISM GROWN AFTER 72 HOURS OF INCUBATION AT 37°C
by AUTOMATED BROTH CULTURE	

AEROBIC SUSCEPTIBILITY BLOOD

INTERPRETATION

SUSCEPTIBILITY:

1. A test interpreted as **SENSITIVE** implies that infection due to isolate may be appropriately treated with the dosage of an antimicrobial agent recommended for that type of infection and infecting species, unless otherwise indicated.
2. A test interpreted as **INTERMEDIATE** implies that the "Infection due to the isolate may be appropriately treated in body sites where the drugs are physiologically concentrated or when a high dosage of drug can be used".
3. A test interpreted as **RESISTANT** implies that the "isolates are not inhibited by the usually achievable concentration of the agents with normal dosage, schedule and/or fall in the range where specific microbial resistance mechanism are likely (e.g. beta-lactamases), and clinical efficacy has not been reliable in treatment studies.

CAUTION:

Conditions which can cause a false Negative culture:

1. Patient is on antibiotics. Please repeat culture post therapy.
2. Anaerobic bacterial infection.
3. Fastidious aerobic bacteria which are not able to grow on routine culture media.
4. Besides all these factors, at least in 25-40 % of cases there is no direct correlation between in vivo clinical picture.
5. Renal tuberculosis to be confirmed by AFB studies.

*** End Of Report ***




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