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

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

NAME	**: Mr. LOKESH**		
AGE/ GENDER	: 29 YRS/MALE	**PATIENT ID**	: 1635957
COLLECTED BY	:	**REG. NO./LAB NO.**	**: 012410060009**
REFERRED BY	:	**REGISTRATION DATE**	: 06/Oct/2024 08:51 AM
BARCODE NO.	: 01518390	**COLLECTION DATE**	: 06/Oct/2024 09:20AM
CLIENT CODE.	: KOS DIAGNOSTIC LAB	**REPORTING DATE**	: 06/Oct/2024 11:47AM
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval

HAEMATOLOGY

GLYCOSYLATED HAEMOGLOBIN (HBA1C)

GLYCOSYLATED HAEMOGLOBIN (HbA1c): WHOLE BLOOD *by HPLC (HIGH PERFORMANCE LIQUID CHROMATOGRAPHY)*	**7.7^{H}**	**%**	**4.0 - 6.4**
ESTIMATED AVERAGE PLASMA GLUCOSE *by HPLC (HIGH PERFORMANCE LIQUID CHROMATOGRAPHY)*	**174.29^{H}**	**mg/dL**	**60.00 - 140.00**

INTERPRETATION:

AS PER AMERICAN DIABETES ASSOCIATION (ADA):		
REFERENCE GROUP	**GLYCOSYLATED HEMOGLOGIB (HBAIC) in %**	
Non diabetic Adults >= 18 years	<5.7	
At Risk (Prediabetes)	5.7 – 6.4	
Diagnosing Diabetes	>= 6.5	
Therapeutic goals for glycemic control	**Age > 19 Years**	
	Goals of Therapy:	< 7.0
	Actions Suggested:	>8.0
	Age < 19 Years	
	Goal of therapy:	<7.5

COMMENTS:

1.Glycosylated hemoglobin (HbA1c) test is three monthly monitoring done to assess compliace with therapeutic regimen in diabetic patients.

2.Since Hb1c reflects long term fluctuations in blood glucose concentration, a diabetic patient who has recently under good control may still have high concentration of HbAIc. Converse is true for a diabetic previously under good control but now poorly controlled.

3.Target goals of < 7.0 % may be beneficial in patients with short duration of diabetes, long life expectancy and no significant cardiovascular disease. In patients with significant complications of diabetes, limited life expectancy or extensive co-morbid conditions, targetting a goal of < 7.0% may not be appropiate.

4.High HbA1c (>9.0 -9.5 %) is strongly associated with risk of development and rapid progression of microvascular and nerve complications

5.Any condition that shorten RBC life span like acute blood loss, hemolytic anemia falsely lower HbA1c results.

6.HbA1c results from patients with HbSS,HbSC and HbD must be interpreted with caution , given the pathological processes including anemia,increased red cell turnover, and transfusion requirement that adversely impact HbA1c as a marker of long-term gycemic control.

7.Specimens from patients with polycythemia or post-splenctomy may exhibit increse in HbA1c values due to a somewhat longer life span of the red cells.

DR.VINAY CHOPRA
CONSULTANT PATHOLOGIST
MBBS, MD (PATHOLOGY & MICROBIOLOGY)

DR.YUGAM CHOPRA
CONSULTANT PATHOLOGIST
MBBS , MD (PATHOLOGY)

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

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

NAME	**: Mr. LOKESH**		
AGE/ GENDER	: 29 YRS/MALE	**PATIENT ID**	: 1635957
COLLECTED BY	:	**REG. NO./LAB NO.**	**: 012410060009**
REFERRED BY	:	**REGISTRATION DATE**	: 06/Oct/2024 08:51 AM
BARCODE NO.	: 01518390	**COLLECTION DATE**	: 06/Oct/2024 09:20AM
CLIENT CODE.	: KOS DIAGNOSTIC LAB	**REPORTING DATE**	: 06/Oct/2024 01:06PM
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval

CLINICAL CHEMISTRY/BIOCHEMISTRY

GLUCOSE FASTING (F) AND POST PRANDIAL (PP)

GLUCOSE FASTING (F): PLASMA *by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)*	**151.26^{H}**	**mg/dL**	**NORMAL: < 100.0** **PREDIABETIC: 100.0 - 125.0** **DIABETIC: > 0R = 126.0**
GLUCOSE POST PRANDIAL (PP): PLASMA *by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)*	**200.06^{H}**	**mg/dL**	**NORMAL: < 140.00** **PREDIABETIC: 140.0 - 200.0** **DIABETIC: > 0R = 200.0**

INTERPRETATION:

IN ACCORDANCE WITH AMERICAN DIABETES ASSOCIATION GUIDELINES:

1. A fasting plasma glucose below 100 mg/dL and post-prandial plasma glucose level below 140 mg/dl is considered normal.
2. A fasting plasma glucose level between 100 - 125 mg/dl and post-prandial plasma glucose level between 140 – 200 mg/dL is considered as glucose intolerant or pre diabetic. 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 and post-prandial plasma glucose level 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.

DR.VINAY CHOPRA
CONSULTANT PATHOLOGIST
MBBS, MD (PATHOLOGY & MICROBIOLOGY)

DR.YUGAM CHOPRA
CONSULTANT PATHOLOGIST
MBBS , MD (PATHOLOGY)

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

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

NAME	**: Mr. LOKESH**		
AGE/ GENDER	: 29 YRS/MALE	**PATIENT ID**	: 1635957
COLLECTED BY	:	**REG. NO./LAB NO.**	**: 012410060009**
REFERRED BY	:	**REGISTRATION DATE**	: 06/Oct/2024 08:51 AM
BARCODE NO.	: 01518390	**COLLECTION DATE**	: 06/Oct/2024 09:20AM
CLIENT CODE.	: KOS DIAGNOSTIC LAB	**REPORTING DATE**	: 06/Oct/2024 10:25AM
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval

CLINICAL PATHOLOGY

STOOL ROUTINE AND MICROSCOPIC EXAMINATION

PHYSICAL EXAMINATION

COLOUR / APPEARANCE	YELLOWISH BROWN		YELLOWISH BROWN
CONSISTENCY	SOFT		SEMI- FORMED/FORMED
PUS	ABSENT		ABSENT
MUCOUS	ABSENT		ABSENT
BLOOD	Negative		NEGATIVE (-ve)
PARASITES	NOT SEEN		NOT SEEN

MICROSCOPIC EXAMINATION

PUS CELLS *by MICROSCOPY*	Negative	/HPF	0 - 5
RED BLOOD CELLS (RBCs) *by MICROSCOPY*	NEGATIVE (-ve)	/HPF	0 - 3
OVA *by MICROSCOPY*	NOT SEEN		NOT SEEN
CYSTS *by MICROSCOPY*	NOT SEEN		NOT SEEN
STOOL FOR VIBRIO CHOLERA *by MICROSCOPY*	NO DARTING MOTILITY SEEN		
STOOL FOR FAT GLOBULES *by MICROSCOPY*	NOT SEEN		NOT SEEN

DR.VINAY CHOPRA
CONSULTANT PATHOLOGIST
MBBS, MD (PATHOLOGY & MICROBIOLOGY)

DR.YUGAM CHOPRA
CONSULTANT PATHOLOGIST
MBBS , MD (PATHOLOGY)

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

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

NAME	**: Mr. LOKESH**		
AGE/ GENDER	: 29 YRS/MALE	**PATIENT ID**	: 1635957
COLLECTED BY	:	**REG. NO./LAB NO.**	**: 012410060009**
REFERRED BY	:	**REGISTRATION DATE**	: 06/Oct/2024 08:51 AM
BARCODE NO.	: 01518390	**COLLECTION DATE**	: 06/Oct/2024 09:20AM
CLIENT CODE.	: KOS DIAGNOSTIC LAB	**REPORTING DATE**	: 06/Oct/2024 12:05PM
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

MICROALBUMIN/CREATININE RATIO - RANDOM URINE

Test Name	Value	Unit	Biological Reference interval
MICROALBUMIN: RANDOM URINE *by SPECTROPHOTOMETRY*	**29.89^{H}**	**mg/L**	**0 - 25**
CREATININE: RANDOM URINE *by SPECTROPHOTOMETRY*	165.91	mg/dL	20 - 320
MICROALBUMIN/CREATININE RATIO - RANDOM URINE *by SPECTROPHOTOMETRY*	18.02	mg/g	0 - 30

***INTERPRETATION*:-**

PHYSIOLOGICALLY NORMAL:	mg/L	0 - 30
MICROALBUMINURIA:	mg/L	30 - 300
GROSS PROTEINURIA:	mg/L	> 300

Long standing un-treated Diabetes and Hypertension can lead to renal dysfunction.
2. Diabetic nephropathy or kidney disease is the most common cause of end stage renal disease(ERSD) or kidney failure.
3. Presence of Microalbuminuria is an early indicator of onset of compromised renal function in these patients.
4.Microalbuminuria is the condition when urinary albumin excre tion is between 30-300 mg & above this it is called as macroalbuminuria, the presence of which indicates serious kidney disease.
5.Microalbuminuria is not only associated with kidney disease but of cardiovascular disease in patients with dibetes & hypertension.
6.Microalbuminuria reflects vascular damage & appear to be a marker of of early arterial disease & endothelial disfunction.
NOTE:- *IF A PATIENT HAS = 1+ PROTEINURIA (30 mg/dl OR 300 mg/L) BY URINE DIPSTICK (URINEANALYSIS), OVERT PROTEINURIA IS PRESENT AND TESTING FOR MICROALBUMIN IS INAPPROPIATE. IN SUCH A CASE, URINE PROTEIN:CREATININE RATIO OR 24 HOURS TOTAL URINE MICROPROTEIN IS APPROPIATE.*

DR.VINAY CHOPRA
CONSULTANT PATHOLOGIST
MBBS, MD (PATHOLOGY & MICROBIOLOGY)

DR.YUGAM CHOPRA
CONSULTANT PATHOLOGIST
MBBS , MD (PATHOLOGY)

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

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

NAME	**: Mr. LOKESH**		
AGE/ GENDER	: 29 YRS/MALE	**PATIENT ID**	: 1635957
COLLECTED BY	:	**REG. NO./LAB NO.**	**: 012410060009**
REFERRED BY	:	**REGISTRATION DATE**	: 06/Oct/2024 08:51 AM
BARCODE NO.	: 01518390	**COLLECTION DATE**	: 06/Oct/2024 09:20AM
CLIENT CODE.	: KOS DIAGNOSTIC LAB	**REPORTING DATE**	: 09/Oct/2024 10:43AM
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval

SPECIAL INVESTIGATIONS

FECAL ELASTASE

FECAL ELASTASE *by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)*	523	µg/gm STOOL	200 - > 500: NORMAL 100 - 200: MILD TO MODERATE EXOCRINE PANCREATIC INSUFFICIENCY < 100.0: SEVERE EXOCRINE PANCREATIC INSUFFICIENCY

INTERPRETATION:

FECAL ELASTASE IN µg/gm STOOL	REMARKS
200.0 - > 500.0	Normal
100.0 – 200.0	Mild To Moderate exocrine pancreatic insufficiency
< 100.0	Severe exocrine pancreatic insufficiency

COMMENTS:

1. Pancreatic elastase-1 is a Pancreas specific protease in pancreatic juice.
2. It remains undegraded during intestinal transit and concentration in faeces is five to six fold as compared to pancreatic juice. Its measurement in faeces has high sensitivity for detection of moderate and severe chronic pancreatitis in adults.
3. It has high sensitivity and high negative predictive value for discriminating between diarrhoea of pancreatic and non pancreatic origin.
4. It is considered the most suitable test to confirm pancreatic insufficiency in screened Cystic Fibrosis infants older than 2 weeks. The test results remain unaffected by pancreatic enzyme supplements.

USAGE:

1. To diagnose or exclude pancreatic involvement in association with gastrointestinal symptoms e .g abdominal pain, failure to thrive, maldigestion, etc.
2. To diagnose or exclude exocrine pancreatic insufficiency caused by Chronic Pancreatitis, Diabetes Mellitus, Cholelithiasis, Cystic Fibrosis, Pancreatic Cancer, Celiac disease etc

NOTE:

1. False negative result may be observed in mild pancreatic insufficiency but has better sensitivity than other tests
2. False positive results may be observed in certain non pancreatic diseases such as Inflammatory bowel disease, Chronic diarrhoea, bacterial overgrowth or watery stool sample
3. The test is not specific for Chronic Pancreatitis and detects moderate to severe impairment of pancreatic function from any cause

*** End Of Report ***

DR.VINAY CHOPRA
CONSULTANT PATHOLOGIST
MBBS, MD (PATHOLOGY & MICROBIOLOGY)

DR.YUGAM CHOPRA
CONSULTANT PATHOLOGIST
MBBS , MD (PATHOLOGY)