

Dr. Vinay Chopra
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 Chairman & Consultant Pathologist

Dr. Yugam Chopra
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 CEO & Consultant Pathologist

NAME	: Mrs. JANAK AGGARWAL	PATIENT ID	: 1642397
AGE/ GENDER	: 82 YRS/FEMALE	REG. NO./LAB NO.	: 012410140011
COLLECTED BY	: SURJESH	REGISTRATION DATE	: 14/Oct/2024 08:57 AM
REFERRED BY	:	COLLECTION DATE	: 14/Oct/2024 11:45AM
BARCODE NO.	: 01518854	REPORTING DATE	: 14/Oct/2024 04:11PM
CLIENT CODE.	: KOS DIAGNOSTIC LAB		
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
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HAEMATOLOGY

GLYCOSYLATED HAEMOGLOBIN (HBA1C)

GLYCOSYLATED HAEMOGLOBIN (HbA1c):	7.2 ^H	%	4.0 - 6.4
WHOLE BLOOD			
<i>by HPLC (HIGH PERFORMANCE LIQUID CHROMATOGRAPHY)</i>			
ESTIMATED AVERAGE PLASMA GLUCOSE	159.94 ^H	mg/dL	60.00 - 140.00
<i>by HPLC (HIGH PERFORMANCE LIQUID CHROMATOGRAPHY)</i>			
INTERPRETATION:			


AS PER AMERICAN DIABETES ASSOCIATION (ADA):


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

COMMENTS:

- Glycosylated hemoglobin (HbA1c) test is three monthly monitoring done to assess compliance with therapeutic regimen in diabetic patients.
- 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 HbA1c. Converse is true for a diabetic previously under good control but now poorly controlled.
- 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, targeting a goal of < 7.0% may not be appropriate.
- High
- HbA1c (>9.0 -9.5 %) is strongly associated with risk of development and rapid progression of microvascular and nerve complications
- Any condition that shorten RBC life span like acute blood loss, hemolytic anemia falsely lower HbA1c results.
- 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 glycemic control.
- Specimens from patients with polycythemia or post-splenectomy may exhibit increase in HbA1c values due to a somewhat longer life span of the red cells.




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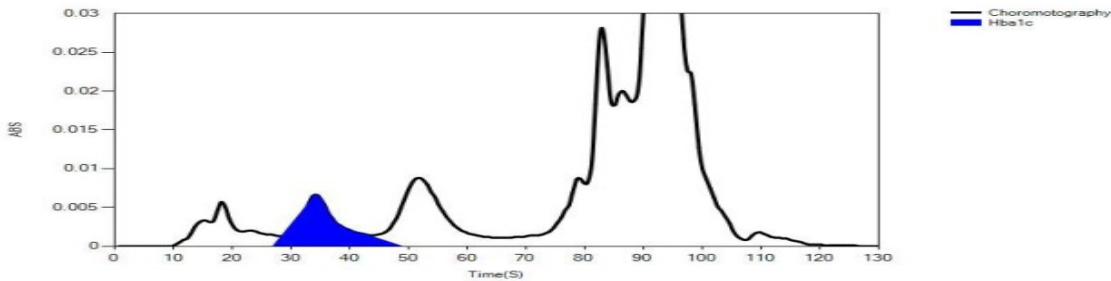
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LIFOTRONIC Graph Report

Name :	Case :	Patient Type :	Test Date : 14/10/2024 15:55:49
Age :	Department :	Sample Type : Whole Blood EDTA	Sample Id : 01518854
Gender :			Total Area : 12097

Peak Name	Retention Time(s)	Absorbance	Area	Result (Area %)
HbA0	68	3746	10551	82.8
HbA1c	38	89	746	7.2
La1c	25	66	429	3.4
HbF	17	20	99	0.8
Hba1b	13	57	173	1.4
Hba1a	11	33	99	0.8




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CLINICAL CHEMISTRY/BIOCHEMISTRY

GLUCOSE FASTING (F) AND POST PRANDIAL (PP)

GLUCOSE FASTING (F): PLASMA <i>by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)</i>	176.6 ^H	mg/dL	NORMAL: < 100.0 PREDIABETIC: 100.0 - 125.0 DIABETIC: > OR = 126.0
GLUCOSE POST PRANDIAL (PP): PLASMA <i>by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)</i>	245.89 ^H	mg/dL	NORMAL: < 140.00 PREDIABETIC: 140.0 - 200.0 DIABETIC: > OR = 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.



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Test Name	Value	Unit	Biological Reference interval
UREA			
UREA: SERUM <i>by UREASE - GLUTAMATE DEHYDROGENASE (GLDH)</i>	34.62	mg/dL	10.00 - 50.00



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Test Name	Value	Unit	Biological Reference interval
CREATININE			
CREATININE: SERUM <i>by ENZYMATIC, SPECTROPHOTOMETRY</i>	1.09	mg/dL	0.40 - 1.20



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ELECTROLYTES COMPLETE PROFILE

SODIUM: SERUM <i>by ISE (ION SELECTIVE ELECTRODE)</i>	141	mmol/L	135.0 - 150.0
POTASSIUM: SERUM <i>by ISE (ION SELECTIVE ELECTRODE)</i>	4.58	mmol/L	3.50 - 5.00
CHLORIDE: SERUM <i>by ISE (ION SELECTIVE ELECTRODE)</i>	105.75	mmol/L	90.0 - 110.0

INTERPRETATION:-

SODIUM:-

Sodium is the major cation of extra-cellular fluid. Its primary function in the body is to chemically maintain osmotic pressure & acid base balance & to transmit nerve impulse.

HYPONATREMIA (LOW SODIUM LEVEL) CAUSES:-

1. Low sodium intake.
2. Sodium loss due to diarrhea & vomiting with adequate water and inadequate salt replacement.
3. Diuretics abuses.
4. Salt loosing nephropathy.
5. Metabolic acidosis.
6. Adrenocortical insufficiency .
7. Hepatic failure.

HYPERNATREMIA (INCREASED SODIUM LEVEL) CAUSES:-

1. Hyperapnea (Prolonged)
2. Diabetes insipidus
3. Diabetic acidosis
4. Cushings syndrome
5. Dehydration

POTASSIUM:-

Potassium is the major cation in the intracellular fluid. 90% of potassium is concentrated within the cells. When cells are damaged, potassium is released in the blood.


HYPOKALEMIA (LOW POTASSIUM LEVELS):-


1. Diarrhoea, vomiting & malabsorption.
2. Severe Burns.
3. Increased Secretions of Aldosterone

HYPERKALEMIA (INCREASED POTASSIUM LEVELS):-

1. Oliguria
2. Renal failure or Shock
3. Respiratory acidosis




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KOS Diagnostic Lab
(A Unit of KOS Healthcare)



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4.Hemolysis of blood			
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CLINICAL PATHOLOGY

URINE ROUTINE & MICROSCOPIC EXAMINATION

PHYSICAL EXAMINATION

QUANTITY RECEIVED	10	ml	
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
COLOUR	AMBER YELLOW		PALE YELLOW
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
TRANSPARANCY	CLEAR		CLEAR
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
SPECIFIC GRAVITY	<=1.005		1.002 - 1.030
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			

CHEMICAL EXAMINATION

REACTION	ACIDIC		
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
PROTEIN	Negative		NEGATIVE (-ve)
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
SUGAR	Negative		NEGATIVE (-ve)
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
pH	<=5.0		5.0 - 7.5
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
BILIRUBIN	Negative		NEGATIVE (-ve)
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
NITRITE	Negative		NEGATIVE (-ve)
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY.</i>			
UROBILINOGEN	Normal	EU/dL	0.2 - 1.0
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
KETONE BODIES	Negative		NEGATIVE (-ve)
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
BLOOD	Negative		NEGATIVE (-ve)
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
ASCORBIC ACID	NEGATIVE (-ve)		NEGATIVE (-ve)
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			

MICROSCOPIC EXAMINATION



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

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Test Name	Value	Unit	Biological Reference interval
PROTEINS: 24 HOURS URINE			
URINE VOLUME: 24 HOUR <i>by SPECTROPHOTOMETRY</i>	1500	mL	
PROTEINS: 24 HOURS URINE <i>by BIURET, SPECTROPHOTOMETRY</i>	58.5	mg/ 24 HOURS	25 -160

INTERPRETATION:

TYPES OF PROTEINURIA	TOTAL PROTEINS IN mg/24 HOURS	CONDITIONS
MINIMAL PROTEINURIA:	150 - 500 mg/24 hours	Chronic pyelonephritis, Chronic Interstitial Nephritis, Renal Tubular disease, Postural
MODERATE PROTEINURIA:	500 - 1000 mg/24 hours	Nephrosclerosis, Multiple Myeloma, Toxic Nephropathy, Renal Calculi
HEAVY PROTEINURIA:	1000 - 3000 mg/24 hours	Nephrotic Syndrome, Acute Rapidly Progressive & Chronic Glomerulonephritis, Diabetes mellitus, Lupus erythematosus, Druga like Pencillamine, Heavy metals like Gold & Mercury.

NOTE:
1.Excretion of total protein in individuals is highly variable with or without kidney disease.
2.Conditions affecting protein excretion other than kidney disease are urinary tract infection, diet, menstruation & physical activity.

COMMENT:
1.Diagnosis of kidney disease and response to therapy is usually obtained by quatitatively analyzing the amount of protein excreted in urine over a 24 hour period.



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MICROBIOLOGY

CULTURE AEROBIC BACTERIA AND ANTIBIOTIC SENSITIVITY: URINE

CULTURE AND SUSCEPTIBILITY: URINE

DATE OF SAMPLE	14-10-2024
SPECIMEN SOURCE	URINE
INCUBATION PERIOD	48 HOURS
<i>by AUTOMATED BROTH CULTURE</i>	
CULTURE	STERILE
<i>by AUTOMATED BROTH CULTURE</i>	
ORGANISM	NO AEROBIC PYOGENIC ORGANISM GROWN AFTER 48 HOURS OF INCUBATION AT 37°C
<i>by AUTOMATED BROTH CULTURE</i>	

AEROBIC SUSCEPTIBILITY: URINE

INTERPRETATION:

1. In urine culture and sensitivity, presence of more than 100,000 organism per mL in midstream sample of urine is considered clinically significant. However in symptomatic patients , a smaller number of bacteria (100 to 10000/mL) may signify infection.
2. Colony count of 100 to 10000/ mL indicate infection, if isolate from specimen obtained by suprapubic aspiration or "in-and-out" catheterization or from patients with indwelling catheters.

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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