

Dr. Vinay Chopra
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CEO & Consultant Pathologist

NAME : Mr. NAVTEJSETHI
AGE/ GENDER : 60 YRS/MALE
COLLECTED BY :
REFERRED BY :
BARCODE NO. : 01519505
CLIENT CODE. : KOS DIAGNOSTIC LAB
CLIENT ADDRESS : 6349/1, NICHOLSON ROAD, AMBALA CANTT

PATIENT ID : 1652878
REG. NO./LAB NO. : 012410250004
REGISTRATION DATE : 25/Oct/2024 07:50 AM
COLLECTION DATE : 25/Oct/2024 10:31AM
REPORTING DATE : 25/Oct/2024 08:52AM

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) <i>by CALORIMETRIC</i>	12.8	gm/dL	12.0 - 17.0
RED BLOOD CELL (RBC) COUNT <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	5.19 ^H	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	40.1	%	40.0 - 54.0
MEAN CORPUSCULAR VOLUME (MCV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	77.3 ^L	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	24.7 ^L	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	32	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	14	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	40.4	fL	35.0 - 56.0
MENTZERS INDEX <i>by CALCULATED</i>	14.89	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX <i>by CALCULATED</i>	20.88	RATIO	BETA THALASSEMIA TRAIT:<= 65.0 IRON DEFICIENCY ANEMIA: > 65.0

WHITE BLOOD CELLS (WBCS)

TOTAL LEUCOCYTE COUNT (TLC) <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	6290	/cmm	4000 - 11000
NUCLEATED RED BLOOD CELLS (nRBCS) <i>by AUTOMATED 6 PART HEMATOLOGY ANALYZER</i>	NIL		0.00 - 20.00
NUCLEATED RED BLOOD CELLS (nRBCS) % <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	NIL	%	< 10 %



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<u>DIFFERENTIAL LEUCOCYTE COUNT (DLC)</u>			
NEUTROPHILS <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	52	%	50 - 70
LYMPHOCYTES <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	33	%	20 - 40
EOSINOPHILS <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	9 ^H	%	1 - 6
MONOCYTES <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	6	%	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>	3271	/cmm	2000 - 7500
ABSOLUTE LYMPHOCYTE COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	2076	/cmm	800 - 4900
ABSOLUTE EOSINOPHIL COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	566 ^H	/cmm	40 - 440
ABSOLUTE MONOCYTE COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	377	/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>	294000	/cmm	150000 - 450000
PLATELETCRIT (PCT) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	0.33	%	0.10 - 0.36
MEAN PLATELET VOLUME (MPV) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	11	fL	6.50 - 12.0
PLATELET LARGE CELL COUNT (P-LCC) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	99000 ^H	/cmm	30000 - 90000
PLATELET LARGE CELL RATIO (P-LCR) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	33.7	%	11.0 - 45.0
PLATELET DISTRIBUTION WIDTH (PDW) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	16.6	%	15.0 - 17.0

NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD



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PROTHROMBIN TIME STUDIES (PT/INR)

PT TEST (PATIENT) <i>by PHOTO OPTICAL CLOT DETECTION</i>	12.4	SECS	11.5 - 14.5
PT (CONTROL) <i>by PHOTO OPTICAL CLOT DETECTION</i>	12	SECS	
ISI <i>by PHOTO OPTICAL CLOT DETECTION</i>	1.1		
INTERNATIONAL NORMALISED RATIO (INR) <i>by PHOTO OPTICAL CLOT DETECTION</i>	1.04		0.80 - 1.20
PT INDEX <i>by PHOTO OPTICAL CLOT DETECTION</i>	96.77	%	

INTERPRETATION:-


1. INR is the parameter of choice in monitoring adequacy of oral anti-coagulant therapy. Appropriate therapeutic range varies with the disease and treatment intensity.
2. Prolonged INR suggests potential bleeding disorder /bleeding complications
3. Results should be clinically correlated.
4. Test conducted on Citrated Plasma


RECOMMENDED THERAPEUTIC RANGE FOR ORAL ANTI-COAGULANT THERAPY (INR)

INDICATION	INTERNATIONAL NORMALIZED RATIO (INR)
Treatment of venous thrombosis	2.0 - 3.0
Treatment of pulmonary embolism	
Prevention of systemic embolism in tissue heart valves	
Valvular heart disease	
Acute myocardial infarction	
Atrial fibrillation	
Bileaflet mechanical valve in aortic position	2.5 - 3.5
Recurrent embolism	
Mechanical heart valve	
Antiphospholipid antibodies ⁺	

COMMENTS:




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The prothrombin time (PT) and its derived measures of prothrombin ratio (PR) and international normalized ratio (INR) are measures of the efficacy of the extrinsic pathway of coagulation. PT test reflects the adequacy of factors I (fibrinogen), II (prothrombin), V, VII, and X. It is used in conjunction with the activated partial thromboplastin time (aPTT) which measures the intrinsic pathway.

The common causes of prolonged prothrombin time are :

- 1.Oral Anticoagulant therapy.
- 2.Liver disease.
- 3.Vit K. deficiency.
- 4.Disseminated intra vascular coagulation.
- 5.Factor 5, 7 , 10 or Prothrombin deficiency




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CLINICAL CHEMISTRY/BIOCHEMISTRY

GLUCOSE FASTING (F)

GLUCOSE FASTING (F): PLASMA by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)	126.06^H	mg/dL	NORMAL: < 100.0 PREDIABETIC: 100.0 - 125.0 DIABETIC: > OR = 126.0
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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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Test Name	Value	Unit	Biological Reference interval
KIDNEY FUNCTION TEST (BASIC)			
UREA: SERUM <i>by UREASE - GLUTAMATE DEHYDROGENASE (GLDH)</i>	18.24	mg/dL	10.00 - 50.00
CREATININE: SERUM <i>by ENZYMATIC, SPECTROPHOTOMETRY</i>	0.93	mg/dL	0.40 - 1.40
BLOOD UREA NITROGEN (BUN): SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	8.52	mg/dL	7.0 - 25.0
BLOOD UREA NITROGEN (BUN)/CREATININE RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	9.16^L	RATIO	10.0 - 20.0
UREA/CREATININE RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	19.61	RATIO	
URIC ACID: SERUM <i>by URICASE - OXIDASE PEROXIDASE</i>	5.15	mg/dL	3.60 - 7.70




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INTERPRETATION:

Normal range for a healthy person on normal diet: 12 - 20

To Differentiate between pre- and postrenal 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.
3. GI hemorrhage.
4. High protein intake.
5. Impaired renal function plus .
6. Excess protein intake or production or tissue breakdown (e.g. infection, GI bleeding, thyrotoxicosis, Cushings syndrome, high protein diet, burns, surgery, cachexia, high fever).
7. Urine reabsorption (e.g. ureterocolostomy)
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 inappropriate antidiuretic hormone) 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.

INAPPROPRIATE 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).





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IMMUNOPATHOLOGY/SEROLOGY

HEPATITIS C VIRUS (HCV) ANTIBODIES SCREENING

HEPATITIS C ANTIBODY (HCV) TOTAL
 RESULT NON - REACTIVE
 by IMMUNOCHROMATOGRAPHY


INTERPRETATION:

1. Anti HCV total antibody assay identifies presence IgG antibodies in the serum . It is a useful screening test with a specificity of nearly 99%.
 2. It becomes positive approximately 24 weeks after exposure. The test can not isolate an active ongoing HCV infection from an old infection that has been cleared. All positive results must be confirmed for active disease by an HCV PCR test .

FALSE NEGATIVE RESULTS SEEN IN:

1. Window period
2. Immunocompromised states.




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ANTI HUMAN IMMUNODEFICIENCY VIRUS (HIV) ANTIBODIES HIV (1 & 2) SCREENING

HIV 1/2 AND P24 ANTIGEN RESULT NON - REACTIVE
 by IMMUNOCHROMATOGRAPHY

INTERPRETATION:-

- 1.AIDS is caused by at least 2 known types of HIV viruses, HIV-1 and HIV HIV-2.
- 2.This NACO approved immuno-chromatographic solid phase ELISA assay detects antibodies against both HIV-1 and HIV-2 viruses.
- 3.The test is used for routine serologic screening of patients at risk for HIV-1 or HIV-2 infection.
- 4.All screening ELISA assays for HIV antibody detection have high sensitivity but have low specificity.
- 5.At this laboratory, all positive samples are cross checked for positivity with two alternate assays prior to reporting.

NOTE:-

- 1.Confirmatory testing by Western blot is recommended for patients who are reactive for HIV by this assay.
- 2.Antibodies against HIV-1 and HIV-2 are usually not detectable until 6 to 12 weeks following exposure (window period) and are almost always detectable by 12 months.
- 3.The test is not recommended for children born to HIV infected mothers till the child turns two years old (as HIV antibodies may be transmitted passively to the child trans-placentally).

FALSE NEGATIVE RESULT SEEN IN:

- 1.Window period
- 2.Severe immuno-suppression including advanced AIDS.





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HEPATITIS B SURFACE ANTIGEN (HBsAg) SCREENING

HEPATITIS B SURFACE ANTIGEN (HBsAg) NON REACTIVE

by IMMUNOCHROMATOGRAPHY

INTERPRETATION:-

1.HBsAG is the first serological marker of HBV infection to appear in the blood (approximately 30-60 days after infection and prior to the onset of clinical disease). It is also the last viral protein to disappear from blood and usually disappears by three months after infection in self limiting acute Hepatitis B viral infection.

2.Persistence of HBsAg in blood for more than six months implies chronic infection. It is the most common marker used for diagnosis of an acute Hepatitis B infection but has very limited role in assessing patients suffering from chronic hepatitis.

FALSE NEGATIVE RESULT SEEN IN:

- 1.Window period.
- 2.Infection with HBsAg mutant strains
- 3.Hepatitis B Surface antigen (HBsAg) is the earliest indicator of HBV infection. Usually it appears in 27 - 41 days (as early as 14 days).
- 4.Appears 7 - 26 days before biochemical abnormalities. Peaks as ALT rises. Persists during the acute illness. Usually disappears 12- 20 weeks after the onset of symptoms / laboratory abnormalities in 90% of cases.
- 5.Is the most reliable serologic marker of HBV infection. Persistence > 6 months defines carrier state. May also be found in chronic infection.Hepatitis B vaccination does not cause a positive HBsAg. Titers are not of clinical value.

NOTE:-

- 1.All reactive HBsAG Should be reconfirmed with neutralization test(HBsAg confirmatory test).
- 2.Anti - HAV IgM appears at the same time as symptoms in > 99% of cases, peaks within the first month, becomes nondetectable in 12 months (usually 6 months). Presence confirms diagnosis of recent acute infection.





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VDRL

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 tonegative VDRL within 2 years.
- Rising titer (4X) indicates relapse, reinfection, or treatment failure and need for retreatment.
- May benonreactive in early primary, late latent, and late syphilis (approx. 25% ofcases).
- Reactive and weakly reactive tests should always be confirmedwith FTA-ABS (fluorescent treponemal antibody absorptiontest).**

SHORTTERM FALSE POSITIVE TEST RESULTS (<6 MONTHS DURATION) MAY OCCURIN:

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

LONGTERM 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 thanage 70 years.
- Patients taking some anti-hypertensive drugs.





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NAME	: Mr. NAVTEJSETHI	PATIENT ID	: 1652878
AGE/ GENDER	: 60 YRS/MALE	REG. NO./LAB NO.	: 012410250004
COLLECTED BY	:	REGISTRATION DATE	: 25/Oct/2024 08:13 AM
REFERRED BY	:	COLLECTION DATE	: 25/Oct/2024 10:31AM
BARCODE NO.	: 01519505	REPORTING DATE	: 25/Oct/2024 10:31AM
CLIENT CODE.	: KOS DIAGNOSTIC LAB		
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
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CLINICAL PATHOLOGY

URINE ROUTINE & MICROSCOPIC EXAMINATION

PHYSICAL EXAMINATION

QUANTITY RECIEVED <i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>	10	ml	
COLOUR <i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>	AMBER YELLOW		PALE YELLOW
TRANSPARANCY <i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>	CLEAR		CLEAR
SPECIFIC GRAVITY <i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>	1.01		1.002 - 1.030

CHEMICAL EXAMINATION


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

MICROSCOPIC EXAMINATION

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

*** End Of Report ***




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