

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

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

NAME : Mr. OM PRAKASH
AGE/ GENDER : 76 YRS/MALE
COLLECTED BY : SURJESH
REFERRED BY :
BARCODE NO. : 01519680
CLIENT CODE. : KOS DIAGNOSTIC LAB
CLIENT ADDRESS : 6349/1, NICHOLSON ROAD, AMBALA CANTT

PATIENT ID : 1655058
REG. NO./LAB NO. : 012410280017
REGISTRATION DATE : 28/Oct/2024 09:31 AM
COLLECTION DATE : 28/Oct/2024 09:39AM
REPORTING DATE : 28/Oct/2024 11:26AM

Test Name	Value	Unit	Biological Reference interval
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CLINICAL CHEMISTRY/BIOCHEMISTRY

UREA

UREA: SERUM by UREASE - GLUTAMATE DEHYDROGENASE (GLDH)	110.79 ^H	mg/dL	10.00 - 50.00
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CREATININE

CREATININE: SERUM by ENZYMATIC, SPECTROPHOTOMETRY	7.1 ^H	mg/dL	0.40 - 1.40
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ELECTROLYTES COMPLETE PROFILE

SODIUM: SERUM <i>by ISE (ION SELECTIVE ELECTRODE)</i>	132.9 ^L	mmol/L	135.0 - 150.0
POTASSIUM: SERUM <i>by ISE (ION SELECTIVE ELECTRODE)</i>	4.48	mmol/L	3.50 - 5.00
CHLORIDE: SERUM <i>by ISE (ION SELECTIVE ELECTRODE)</i>	99.68	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. Cushing's 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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4.Hemolysis of blood




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ENDOCRINOLOGY

TESTOSTERONE: TOTAL

TESTOSTERONE - TOTAL: SERUM	1.1^L	ng/mL	1.26 - 10.20
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by CMA (CHEMILUMINESCENT PARTICLE IMMUNOASSAY)

INTERPRETATION:

1. Testosterone is secreted in females by the ovary and formed indirectly from androstenedione in adrenal glands.
2. In males it is secreted by the testes. It circulates in blood bound largely to sex hormone binding globulin (SHBG). Less than 1% of the total testosterone is in the free form.
3. The bioavailable fraction includes the free form and that "weakly bound" to albumin (40% of the total in men and 20% of the total in women) and bound to cortisol binding globulin (CBG). It is the most potent circulating androgenic hormone.
4. The total testosterone bound to SHBG fluctuates since SHBG levels are affected by medication, disease, sex steroids and insulin.

CLINIC USE:

1. Assessment of testicular functions in males
2. Management of hirsutism and virilization in females


INCREASED LEVELS:


1. Precocious puberty (Males)
2. Androgen resistance
3. Testotoxicosis
4. Congenital Adrenal Hyperplasia
5. Polycystic ovarian disease
7. Ovarian tumors

DECREASED LEVELS:

1. Delayed puberty (Males)
2. Gonadotropin deficiency
3. Testicular defects
4. Systemic diseases




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TUMOUR MARKER

PROSTATE SPECIFIC ANTIGEN (PSA) - TOTAL

PROSTATE SPECIFIC ANTIGEN (PSA) - TOTAL: **17.28^H** ng/mL 0.0 - 4.0

SERUM

by CLIA (CHEMILUMINESCENCE IMMUNOASSAY)

INTERPRETATION:

NOTE:

1. This is a recommended test for detection of prostate cancer along with Digital Rectal Examination (DRE) in males above 50 years of age.
2. False negative / positive results are observed in patients receiving mouse monoclonal antibodies for diagnosis or therapy
3. PSA levels may appear consistently elevated / depressed due to the interference by heterophilic antibodies & nonspecific protein binding
4. Immediate PSA testing following digital rectal examination, ejaculation, prostatic massage, indwelling catheterization, ultrasonography and needle biopsy of prostate is not recommended as they falsely elevate levels
5. PSA values regardless of levels should not be interpreted as absolute evidence of the presence or absence of disease. All values should be correlated with clinical findings and results of other investigations
6. Sites of Non-prostatic PSA production are breast epithelium, salivary glands, peri-urethral & anal glands, cells of male urethra & breast milk
7. Physiological decrease in PSA level by 18% has been observed in hospitalized / sedentary patients either due to supine position or suspended sexual activity
8. The concentration of PSA in a given specimen, determined with assays from different manufacturers, may not be comparable due to differences in assay methods, calibration, and reagent specificity.

RECOMMENDED TESTING INTERVALS

1. Preoperatively (Baseline)
2. 2-4 Days Post operatively
3. Prior to discharge from hospital
4. Monthly Follow Up if levels are high and showing a rising trend

POST SURGERY	FREQUENCY OF TESTING
1st Year	Every 3 Months
2 nd Year	Every 4 Months
3 rd Year Onwards	Every 6 Months

CLINICAL USE:

1. An aid in the early detection of Prostate cancer when used in conjunction with Digital rectal examination in males more than 50 years of age and in those with two or more affected first degree relatives.
2. Followup and management of Prostate cancer patients.
3. Detect metastatic or persistent disease in patients following surgical or medical treatment of Prostate cancer

INCREASED LEVEL:

1. Prostate cancer
2. Benign Prostatic Hyperplasia
3. Prostatitis
4. Genitourinary infections




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*** End Of Report ***




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