

Dr. Vinay Chopra
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 Chairman & Consultant Pathologist

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 CEO & Consultant Pathologist

NAME	: Mr. DINESH RASTOGI	PATIENT ID	: 1664057
AGE/ GENDER	: 75 YRS/MALE	REG. NO./LAB NO.	: 012411070032
COLLECTED BY	: SURJESH	REGISTRATION DATE	: 07/Nov/2024 10:55 AM
REFERRED BY	:	COLLECTION DATE	: 07/Nov/2024 11:14AM
BARCODE NO.	: 01520289	REPORTING DATE	: 07/Nov/2024 11:27AM
CLIENT CODE.	: KOS DIAGNOSTIC LAB		
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
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SWASTHYA WELLNESS PANEL: 1.0
COMPLETE BLOOD COUNT (CBC)


RED BLOOD CELLS (RBCS) COUNT AND INDICES


HAEMOGLOBIN (HB) <i>by CALORIMETRIC</i>	10.6^L	gm/dL	12.0 - 17.0
RED BLOOD CELL (RBC) COUNT <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDEANCE</i>	4.14	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	33.1^L	%	40.0 - 54.0
MEAN CORPUSCULAR VOLUME (MCV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	79.8^L	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	25.6^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>	15.1	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	44.7	fL	35.0 - 56.0
MENTZERS INDEX <i>by CALCULATED</i>	19.28	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX <i>by CALCULATED</i>	29.1	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>	11200^H	/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>	90^H	%	50 - 70
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>	3	%	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>	10080^H	/cmm	2000 - 7500
ABSOLUTE LYMPHOCYTE COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	784^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>	336	/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>	304000	/cmm	150000 - 450000
PLATELETCRIT (PCT) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	0.31	%	0.10 - 0.36
MEAN PLATELET VOLUME (MPV) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	10	fL	6.50 - 12.0
PLATELET LARGE CELL COUNT (P-LCC) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	85000	/cmm	30000 - 90000
PLATELET LARGE CELL RATIO (P-LCR) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	28	%	11.0 - 45.0
PLATELET DISTRIBUTION WIDTH (PDW) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	15.8	%	15.0 - 17.0

NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD



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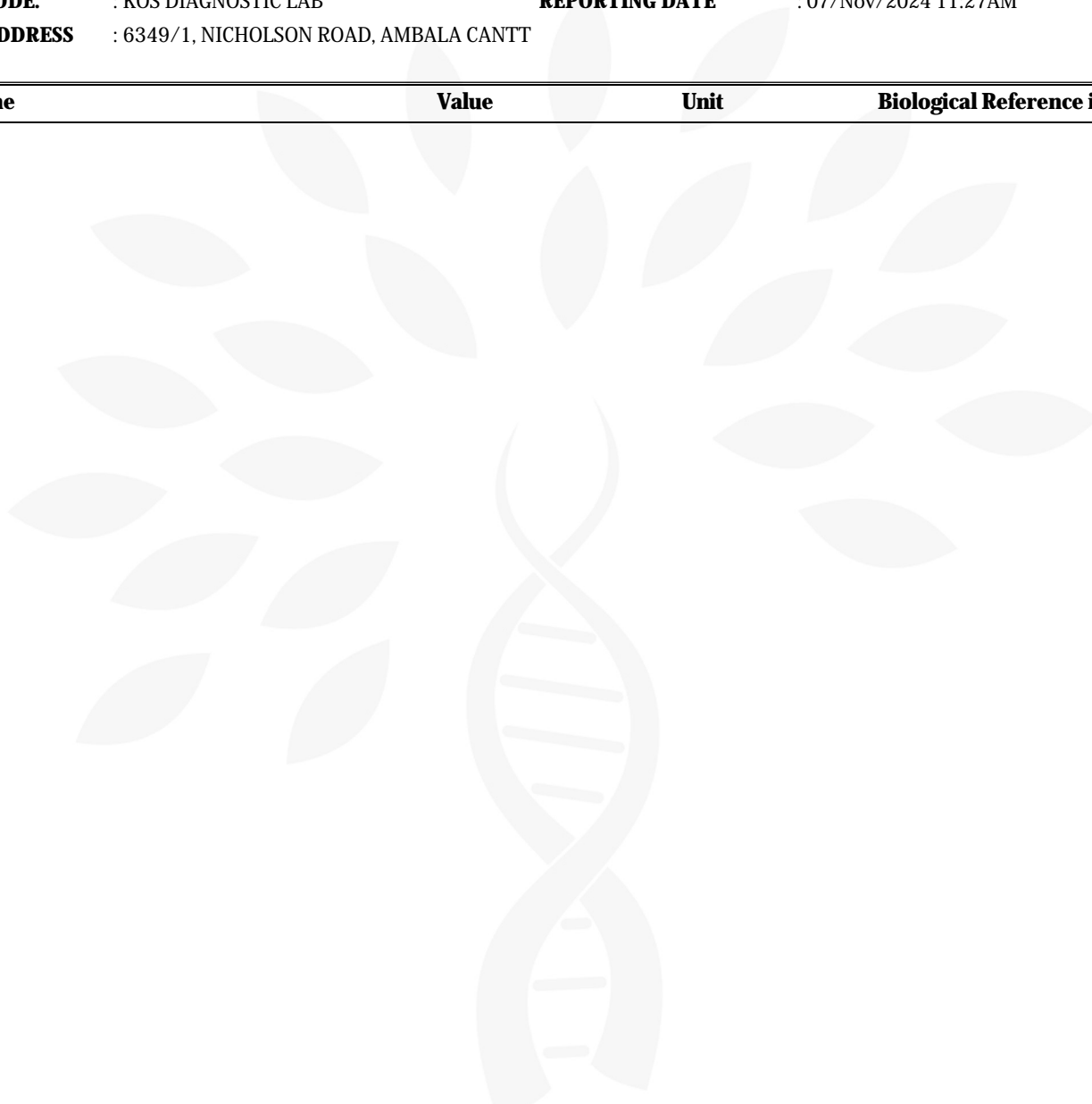
KOS Diagnostic Lab
(A Unit of KOS Healthcare)



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ERYTHROCYTE SEDIMENTATION RATE (ESR)

ERYTHROCYTE SEDIMENTATION RATE (ESR) <i>by RED CELL AGGREGATION BY CAPILLARY PHOTOMETRY</i>	58^H	mm/1st hr	0 - 20
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INTERPRETATION:

1. ESR is a non-specific test because an elevated result often indicates the presence of inflammation associated with infection, cancer and autoimmune disease, but does not tell the health practitioner exactly where the inflammation is in the body or what is causing it.
2. An ESR can be affected by other conditions besides inflammation. For this reason, the ESR is typically used in conjunction with other test such as C-reactive protein
3. This test may also be used to monitor disease activity and response to therapy in both of the above diseases as well as some others, such as systemic lupus erythematosus

CONDITION WITH LOW ESR

A low ESR can be seen with conditions that inhibit the normal sedimentation of red blood cells, such as a high red blood cell count (polycythaemia), significantly high white blood cell count (leucocytosis), and some protein abnormalities. Some changes in red cell shape (such as sickle cells in sickle cell anaemia) also lower the ESR.

NOTE:

1. ESR and C - reactive protein (C-RP) are both markers of inflammation.
2. Generally, ESR does not change as rapidly as does CRP, either at the start of inflammation or as it resolves.
3. **CRP is not affected by as many other factors as is ESR, making it a better marker of inflammation.**
4. If the ESR is elevated, it is typically a result of two types of proteins, globulins or fibrinogen.
5. Women tend to have a higher ESR, and menstruation and pregnancy can cause temporary elevations.
6. Drugs such as dextran, methyldopa, oral contraceptives, penicillamine procainamide, theophylline, and vitamin A can increase ESR, while aspirin, cortisone, and quinine may decrease it




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CLINICAL CHEMISTRY/BIOCHEMISTRY

GLUCOSE FASTING (F)


GLUCOSE FASTING (F): PLASMA <i>by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)</i>	167.25^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
LIPID PROFILE : BASIC			
CHOLESTEROL TOTAL: SERUM <i>by CHOLESTEROL OXIDASE PAP</i>	87.23	mg/dL	OPTIMAL: < 200.0 BORDERLINE HIGH: 200.0 - 239.0 HIGH CHOLESTEROL: > OR = 240.0
TRIGLYCERIDES: SERUM <i>by GLYCEROL PHOSPHATE OXIDASE (ENZYMATIC)</i>	127.77	mg/dL	OPTIMAL: < 150.0 BORDERLINE HIGH: 150.0 - 199.0 HIGH: 200.0 - 499.0 VERY HIGH: > OR = 500.0
HDL CHOLESTEROL (DIRECT): SERUM <i>by SELECTIVE INHIBITION</i>	15.92^L	mg/dL	LOW HDL: < 30.0 BORDERLINE HIGH HDL: 30.0 - 60.0 HIGH HDL: > OR = 60.0
LDL CHOLESTEROL: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	45.76	mg/dL	OPTIMAL: < 100.0 ABOVE OPTIMAL: 100.0 - 129.0 BORDERLINE HIGH: 130.0 - 159.0 HIGH: 160.0 - 189.0 VERY HIGH: > OR = 190.0
NON HDL CHOLESTEROL: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	71.31	mg/dL	OPTIMAL: < 130.0 ABOVE OPTIMAL: 130.0 - 159.0 BORDERLINE HIGH: 160.0 - 189.0 HIGH: 190.0 - 219.0 VERY HIGH: > OR = 220.0
VLDL CHOLESTEROL: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	25.55	mg/dL	0.00 - 45.00
TOTAL LIPIDS: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	302.23^L	mg/dL	350.00 - 700.00
CHOLESTEROL/HDL RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	5.48^H	RATIO	LOW RISK: 3.30 - 4.40 AVERAGE RISK: 4.50 - 7.0 MODERATE RISK: 7.10 - 11.0 HIGH RISK: > 11.0



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LDL/HDL RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	2.87	RATIO	LOW RISK: 0.50 - 3.0 MODERATE RISK: 3.10 - 6.0 HIGH RISK: > 6.0
TRIGLYCERIDES/HDL RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	8.03^H	RATIO	3.00 - 5.00

INTERPRETATION:

1. Measurements in the same patient can show physiological & analytical variations. Three serial samples 1 week apart are recommended for Total Cholesterol, Triglycerides, HDL & LDL Cholesterol.
2. As per NLA-2014 guidelines, all adults above the age of 20 years should be screened for lipid status. Selective screening of children above the age of 2 years with a family history of premature cardiovascular disease or those with at least one parent with high total cholesterol is recommended.
3. Low HDL levels are associated with increased risk for Atherosclerotic Cardiovascular disease (ASCVD) due to insufficient HDL being available to participate in reverse cholesterol transport, the process by which cholesterol is eliminated from peripheral tissues.
4. NLA-2014 identifies Non HDL Cholesterol (an indicator of all atherogenic lipoproteins such as LDL, VLDL, IDL, Lp(a), Chylomicron remnants) along with LDL-cholesterol as co-primary target for cholesterol lowering therapy. Note that major risk factors can modify treatment goals for LDL & Non HDL.
5. Additional testing for Apolipoprotein B, hsCRP, Lp(a) & LP-PLA2 should be considered among patients with moderate risk for ASCVD for risk refinement

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LIVER FUNCTION TEST (COMPLETE)

BILIRUBIN TOTAL: SERUM <i>by DIAZOTIZATION, SPECTROPHOTOMETRY</i>	1.35^H	mg/dL	INFANT: 0.20 - 8.00 ADULT: 0.00 - 1.20
BILIRUBIN DIRECT (CONJUGATED): SERUM <i>by DIAZO MODIFIED, SPECTROPHOTOMETRY</i>	0.42^H	mg/dL	0.00 - 0.40
BILIRUBIN INDIRECT (UNCONJUGATED): SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	0.93	mg/dL	0.10 - 1.00
SGOT/AST: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	31.9	U/L	7.00 - 45.00
SGPT/ALT: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	13.2	U/L	0.00 - 49.00
AST/ALT RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	2.42	RATIO	0.00 - 46.00
ALKALINE PHOSPHATASE: SERUM <i>by PARA NITROPHENYL PHOSPHATASE BY AMINO METHYL PROPANOL</i>	107.41	U/L	40.0 - 130.0
GAMMA GLUTAMYL TRANSFERASE (GGT): SERUM <i>by SZASZ, SPECTROPHOTOMETRY</i>	9.79	U/L	0.00 - 55.0
TOTAL PROTEINS: SERUM <i>by BIURET, SPECTROPHOTOMETRY</i>	6.5	gm/dL	6.20 - 8.00
ALBUMIN: SERUM <i>by BROMOCRESOL GREEN</i>	3.82	gm/dL	3.50 - 5.50
GLOBULIN: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	2.68	gm/dL	2.30 - 3.50
A : G RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	1.43	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
INTRAHEPATIC CHOLESTASIS	> 1.5
HEPATOCELLULAR CARCINOMA & CHRONIC HEPATITIS	> 1.3 (Slightly Increased)



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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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KIDNEY FUNCTION TEST (COMPLETE)

UREA: SERUM <i>by UREASE - GLUTAMATE DEHYDROGENASE (GLDH)</i>	64.29^H	mg/dL	10.00 - 50.00
CREATININE: SERUM <i>by ENZYMATIC, SPECTROPHOTOMETRY</i>	1.65^H	mg/dL	0.40 - 1.40
BLOOD UREA NITROGEN (BUN): SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	30.04^H	mg/dL	7.0 - 25.0
BLOOD UREA NITROGEN (BUN)/CREATININE RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	18.21	RATIO	10.0 - 20.0
UREA/CREATININE RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	38.96	RATIO	
URIC ACID: SERUM <i>by URICASE - OXIDASE PEROXIDASE</i>	7.63	mg/dL	3.60 - 7.70
CALCIUM: SERUM <i>by ARSENAZO III, SPECTROPHOTOMETRY</i>	8.97	mg/dL	8.50 - 10.60
PHOSPHOROUS: SERUM <i>by PHOSPHOMOLYBDATE, SPECTROPHOTOMETRY</i>	2.35	mg/dL	2.30 - 4.70

ELECTROLYTES

SODIUM: SERUM <i>by ISE (ION SELECTIVE ELECTRODE)</i>	141.9	mmol/L	135.0 - 150.0
POTASSIUM: SERUM <i>by ISE (ION SELECTIVE ELECTRODE)</i>	3.47^L	mmol/L	3.50 - 5.00
CHLORIDE: SERUM <i>by ISE (ION SELECTIVE ELECTRODE)</i>	106.43	mmol/L	90.0 - 110.0

ESTIMATED GLOMERULAR FILTRATION RATE

ESTIMATED GLOMERULAR FILTRATION RATE (eGFR): SERUM <i>by CALCULATED</i>	43		
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INTERPRETATION:


To differentiate between pre- and post renal 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 haemorrhage.




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NAME	: Mr. DINESH RASTOGI	PATIENT ID	: 1664057
AGE/ GENDER	: 75 YRS/MALE	REG. NO./LAB NO.	: 012411070032
COLLECTED BY	: SURJESH	REGISTRATION DATE	: 07/Nov/2024 10:55 AM
REFERRED BY	:	COLLECTION DATE	: 07/Nov/2024 11:14AM
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Test Name	Value	Unit	Biological Reference interval
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4. High protein intake.
 5. Impaired renal function plus
 6. Excess protein intake or production or tissue breakdown (e.g. infection, GI bleeding, thyrotoxicosis, Cushing's syndrome, high protein diet, burns, surgery, cachexia, high fever).
 7. Urine reabsorption (e.g. ureter colostomy)
 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).
- ESTIMATED GLOMERULAR FILTRATION RATE:**

CKD STAGE	DESCRIPTION	GFR (mL/min/1.73m2)	ASSOCIATED FINDINGS
G1	Normal kidney function	>90	No proteinuria
G2	Kidney damage with normal or high GFR	>90	Presence of Protein , Albumin or cast in urine
G3a	Mild decrease in GFR	60 -89	
G3b	Moderate decrease in GFR	30-59	
G4	Severe decrease in GFR	15-29	
G5	Kidney failure	<15	



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COMMENTS:

1. Estimated Glomerular filtration rate (eGFR) is the sum of filtration rates in all functioning nephrons and so an estimation of the GFR provides a measure of functioning nephrons of the kidney.
2. eGFR calculated using the 2009 CKD-EPI creatinine equation and GFR category reported as per KDIGO guideline 2012
3. In patients, with eGFR creatinine between 45-59 ml/min/1.73 m² (G3) and without any marker of Kidney damage, It is recommended to measure eGFR with Cystatin C for confirmation of CKD
4. eGFR category G1 OR G2 does not fulfill the criteria for CKD, in the absence of evidence of Kidney Damage
5. In a suspected case of Acute Kidney Injury (AKI), measurement of eGFR should be done after 48-96 hours of any Intervention or procedure
6. eGFR calculated by Serum Creatinine may be less accurate due to certain factors like Race, Muscle Mass, Diet, Certain Drugs. In such cases, eGFR should be calculated using Serum Cystatin C
7. **A decrease in eGFR implies either progressive renal disease, or a reversible process causing decreased nephron function (eg, severe dehydration).**

ADVICE:
KDIGO guideline, 2012 recommends Chronic Kidney Disease (CKD) should be classified based on cause, eGFR category and Albuminuria (ACR) category. GFR & ACR category combined together reflect risk of progression and helps Clinician to identify the individual who are progressing at more rapid rate than anticipated



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IMMUNOPATHOLOGY/SEROLOGY

TYPHOID COMBO SCREEN (TYPHOID ANTIGEN, IgG AND IgM): SERUM

TYPHOID ANTIGEN - SERUM <i>by ICT (IMMUNOCHROMATOGRAPHY)</i>	NEGATIVE (-ve)	NEGATIVE (-ve)
TYPHI DOT ANTIBODY IgG <i>by ICT (IMMUNOCHROMATOGRAPHY)</i>	NEGATIVE (-ve)	NEGATIVE (-ve)
TYPHI DOT ANTIBODY IgM <i>by ICT (IMMUNOCHROMATOGRAPHY)</i>	NEGATIVE (-ve)	NEGATIVE (-ve)

INTERPRETATION:

Typhoid fever is a life threatening illness caused by the bacterium Salmonella typhus. The infection is acquired typically by ingestion. On reaching the gut, the bacilli attach themselves to the epithelial cells of the intestinal villi and penetrate the lamina and submucosa. They are then phagocytosed there by polymorphs and mesenteric lymph nodes, where they multiply and, via the thoracic duct, enter the blood stream. A transient bacteremia follows, during which the bacilli are seeded in the liver, gall bladder, spleen, bone marrow, lymph nodes, and kidneys, where further multiplication takes place. Towards the end of the incubation period, there occurs a massive bacteremia from these sites, heralding the onset of the clinical symptoms.

The diagnosis of typhoid consists of isolation of the bacilli and the demonstration of antibodies. The isolation of the bacilli is very time consuming and antibody detection is not very specific. Other tests include the Widal reaction. The advantage of this test is that it takes only 10-20 minutes and requires only a small amount of stool/serum/plasma to perform. It is the easiest and most specific method for detecting S. typhi infection.

RELATIVE SENSITIVITY OF TYPHOID ANTIGEN DETECTION: 98.7%
RELATIVE SPECIFICITY OF TYPHOID ANTIGEN DETECTION: 97.4%

DETECTABLE IgM RESPONSE:

ONSET OF FEVER	PERCENT POSITIVE
4 - 6 DAYS	43.5
6 - 9 DAYS	92.9
> 9 DAYS	99.5

1. This is a solid phase, immunochromatographic ELISA assay that detects specific IgM and IgG Antibodies against the OUTER MEMBRAN PROTEIN(OMP) of the Salmonella species. IgM antibodies appear in the serum 2-3 days post infection and are indicative of a recent infection while the IgG antibodies appear later and are useful for presumptive diagnosis of Enteric fever if the patient presents more than a week after onset of symptoms.

2. This is a useful screening assay for the early detection of Enteric fever and has a high sensitivity. However the test has moderate specificity and false positive results may be obtained in the following situations:

- Antibodies against Salmonella may cross react with other antibodies.
- Unrelated infections may lead to production of specific Salmonella antibodies if the patient has previously been exposed to



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Salmonella infection (ANAMNESTIC RESPONSE).

NOTE:- Rapid blood culture performed during 1st week of infection is highly recommended for confirmation of all IgM positive results. In case the patient has presented after the first week of infection, a thorough clinical correlation and confirmatory Widal test must be performed to establish the diagnosis.



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Test Name	Value	Unit	Biological Reference interval
DENGUE FEVER COMBO SCREENING - (NS1 ANTIGEN, IgG AND IgM)			
DENGUE NS1 ANTIGEN - SCREENING <i>by ICT (IMMUNOCHROMATOGRAPHY)</i>	NEGATIVE (-ve)		NEGATIVE (-ve)
DENGUE ANTIBODY IgG - SCREENING <i>by ICT (IMMUNOCHROMATOGRAPHY)</i>	NEGATIVE (-ve)		NEGATIVE (-ve)
DENGUE ANTIBODY IgM - SCREENING <i>by ICT (IMMUNOCHROMATOGRAPHY)</i>	NEGATIVE (-ve)		NEGATIVE (-ve)

INTERPRETATION:-

- This is a solid phase immunochromatographic ELISA test for the qualitative detection of the specific IgG and IgM antibodies against the Dengue virus.
- The IgM antibodies take a minimum of 5-10 days in primary infection and 4-5 days in secondary infections to test positive and hence are suitable for the diagnosis of dengue fever only when the fever is approximately one week old.
- The IgG antibodies develop at least two weeks after exposure to primary infection and subsequently remain positive for the rest of the life. A positive result is incapable of differentiating a current infection from a past infection.
- The Dengue NS-1 antigen test is most suited for early diagnosis (within the first week of exposure).



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Test Name	Value	Unit	Biological Reference interval
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CLINICAL PATHOLOGY

URINE ROUTINE & MICROSCOPIC EXAMINATION

PHYSICAL EXAMINATION

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

CHEMICAL EXAMINATION

REACTION	ACIDIC		
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
PROTEIN	1+		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	TRACE		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	TRACE		NEGATIVE (-ve)
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
ASCORBIC ACID	NEGATIVE (-ve)		NEGATIVE (-ve)
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			

MICROSCOPIC EXAMINATION

RED BLOOD CELLS (RBCs)	2-4	/HPF	0 - 3
<i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>			



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Test Name	Value	Unit	Biological Reference interval
PUS CELLS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	1-3	/HPF	0 - 5
EPITHELIAL CELLS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	3-5	/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>	AMORPHOUS (+)		NEGATIVE (-ve)
TRICHOMONAS VAGINALIS (PROTOZOA) <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	ABSENT		ABSENT

*** End Of Report ***

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