

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

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

NAME : Mrs. ALKA GUPTA
AGE/ GENDER : 53 YRS/FEMALE
COLLECTED BY : SURJESH
REFERRED BY : CENTRAL PHOENIX CLUB (AMBALA CANTT)
BARCODE NO. : 01520733
CLIENT CODE. : KOS DIAGNOSTIC LAB
CLIENT ADDRESS : 6349/1, NICHOLSON ROAD, AMBALA CANTT

PATIENT ID : 1670700
REG. NO./LAB NO. : 012411130041
REGISTRATION DATE : 13/Nov/2024 12:31 PM
COLLECTION DATE : 13/Nov/2024 12:44PM
REPORTING DATE : 13/Nov/2024 01:03PM

Test Name	Value	Unit	Biological Reference interval
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FEVER PANEL
COMPLETE BLOOD COUNT (CBC)

RED BLOOD CELLS (RBCS) COUNT AND INDICES

HAEMOGLOBIN (HB) by CALORIMETRIC	12.3	gm/dL	12.0 - 16.0
RED BLOOD CELL (RBC) COUNT by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	4.95	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	39.5	%	37.0 - 50.0
MEAN CORPUSCULAR VOLUME (MCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	79.9 ^L	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	24.8 ^L	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	31.1 ^L	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	16	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	47.9	fL	35.0 - 56.0
MENTZERS INDEX by CALCULATED	16.14	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX by CALCULATED	25.78	RATIO	BETA THALASSEMIA TRAIT:<= 65.0 IRON DEFICIENCY ANEMIA: > 65.0

WHITE BLOOD CELLS (WBCS)

TOTAL LEUCOCYTE COUNT (TLC) by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	5250	/cmm	4000 - 11000
NUCLEATED RED BLOOD CELLS (nRBCS) by AUTOMATED 6 PART HEMATOLOGY ANALYZER	NIL		0.00 - 20.00
NUCLEATED RED BLOOD CELLS (nRBCS) % by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	NIL	%	< 10 %



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<u>DIFFERENTIAL LEUCOCYTE COUNT (DLC)</u>			
NEUTROPHILS <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	84 ^H	%	50 - 70
LYMPHOCYTES <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	8 ^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>	8	%	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>	4410	/cmm	2000 - 7500
ABSOLUTE LYMPHOCYTE COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	420 ^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>	420	/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>	281000	/cmm	150000 - 450000
PLATELETCRIT (PCT) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	0.28	%	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>	76000	/cmm	30000 - 90000
PLATELET LARGE CELL RATIO (P-LCR) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	27	%	11.0 - 45.0
PLATELET DISTRIBUTION WIDTH (PDW) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	16	%	15.0 - 17.0

NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD




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CLINICAL CHEMISTRY/BIOCHEMISTRY
LIVER FUNCTION TEST (COMPLETE)

BILIRUBIN TOTAL: SERUM <i>by DIAZOTIZATION, SPECTROPHOTOMETRY</i>	0.49	mg/dL	INFANT: 0.20 - 8.00 ADULT: 0.00 - 1.20
BILIRUBIN DIRECT (CONJUGATED): SERUM <i>by DIAZO MODIFIED, SPECTROPHOTOMETRY</i>	0.17	mg/dL	0.00 - 0.40
BILIRUBIN INDIRECT (UNCONJUGATED): SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	0.32	mg/dL	0.10 - 1.00
SGOT/AST: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	32.4	U/L	7.00 - 45.00
SGPT/ALT: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	50.9 ^H	U/L	0.00 - 49.00
AST/ALT RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	0.64	RATIO	0.00 - 46.00
ALKALINE PHOSPHATASE: SERUM <i>by PARA NITROPHENYL PHOSPHATASE BY AMINO METHYL PROPANOL</i>	89.32	U/L	40.0 - 130.0
GAMMA GLUTAMYL TRANSFERASE (GGT): SERUM <i>by SZASZ, SPECTROPHOTOMETRY</i>	45.49	U/L	0.00 - 55.0
TOTAL PROTEINS: SERUM <i>by BIURET, SPECTROPHOTOMETRY</i>	7.33	gm/dL	6.20 - 8.00
ALBUMIN: SERUM <i>by BROMOCRESOL GREEN</i>	3.67	gm/dL	3.50 - 5.50
GLOBULIN: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	3.66 ^H	gm/dL	2.30 - 3.50
A : G RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	1	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 CHOLESTATIS	> 1.5




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HEPATOCELLULAR CARCINOMA & CHRONIC HEPATITIS	> 1.3 (Slightly Increased)		
DECREASED:			
1. Acute Hepatitis due to virus, drugs, toxins (with AST increased 3 to 10 times upper limit of normal)			
2. Extra Hepatic cholestatis: 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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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 typhi*. 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
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CHIKUNGUNYA ANTIBODY IgM SCREENING

CHIKUNGUNYA ANTIBODY IgM QUANTITATIVE SERUM <i>by ELISA (ENZYME LINKED IMMUNOASSAY)</i>	0.12	INDEX VALUE	< 1.00
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INTERPRETATION:

- 1.Chikungunya is an insect borne viral disease belonging to genus ALPHAVIRIDAE transmitted to humans by infected Aedes mosquito.
- 2.It causes fever and severe joint pain. Other symptoms include muscle pain, headache, nausea, fatigue and rash.
- 3.Joint pain is often debilitating and can vary in duration.
- 4.The disease shares some clinical signs with dengue, and can be misdiagnosed in areas where dengue is common.
- 5.There is no cure for the disease. Treatment is focused on relieving the symptoms.

ROUTE OF TRANSMISSION:

- 1.The virus is transmitted from human to human by the bites of infected female mosquitoes.
- 2.Most commonly, the mosquitoes involved are Aedes aegypti and Aedes albopictus, two species which can also transmit other mosquito-borne viruses, including dengue.
- 3.These mosquitoes can be found biting throughout daylight hours, though there may be peaks of activity in the early morning and late afternoon.
- 4.Both species are found biting outdoors, but Ae. aegypti will also readily feed indoors.
- 5.After the bite of an infected mosquito, onset of illness occurs usually between 4 and 8 days but can range from 2 to 12 days.

NOTE:

This is a solid phase immunochromatographic assay for the detection of the Chikungunya specific IgM antibodies in the human serum. The test has a sensitivity of 97.5 % and a specificity of 99.1 %.




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Test Name	Value	Unit	Biological Reference interval
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C-REACTIVE PROTEIN (CRP)

C-REACTIVE PROTEIN (CRP) QUANTITATIVE: SERUM by NEPHLOMETRY	14.97^H	mg/L	0.0 - 6.0
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INTERPRETATION:

1. C-reactive protein (CRP) is one of the most sensitive acute-phase reactants for inflammation.
2. CRP levels can increase dramatically (100-fold or more) after severe trauma, bacterial infection, inflammation, surgery, or neoplastic proliferation.
3. CRP levels (Quantitative) has been used to assess activity of inflammatory disease, to detect infections after surgery, to detect transplant rejection, and to monitor these inflammatory processes.
4. As compared to ESR, CRP shows an earlier rise in inflammatory disorders which begins in 4-6 hrs, the intensity of the rise being higher than ESR and the recovery being earlier than ESR. Unlike ESR, CRP levels are not influenced by hematologic conditions like Anemia, Polycythemia etc.,
5. Elevated values are consistent with an acute inflammatory process.

- NOTE:**
1. Elevated C-reactive protein (CRP) values are nonspecific and should not be interpreted without a complete clinical history.
 2. Oral contraceptives may increase CRP levels.




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DENGUE FEVER COMBO SCREENING - (NS1 ANTIGEN, IgG AND IgM)

DENGUE NS1 ANTIGEN - SCREENING by ICT (IMMUNOCHROMATOGRAPHY)	POSITIVE (+ve)	NEGATIVE (-ve)
DENGUE ANTIBODY IgG - SCREENING by ICT (IMMUNOCHROMATOGRAPHY)	NEGATIVE (-ve)	NEGATIVE (-ve)
DENGUE ANTIBODY IgM - SCREENING by ICT (IMMUNOCHROMATOGRAPHY)	NEGATIVE (-ve)	NEGATIVE (-ve)

INTERPRETATION:-

- 1.This is a solid phase immunochromatographic ELISA test for the qualitative detection of the specific IgG and IgM antibodies against the Dengue virus.
- 2.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.
- 3.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.
- 4.The Dengue NS-1 antigen test is most suited for early diagnosis (within the first week of exposure).

NOTE--ADV. ELISA METHOD FOR FURTHER CONFIRMATION & BE REF. TO CIVIL HOSPITAL.




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MALARIA - P.FALCIPARUM AND P.VIVAX ANTIGEN DETECTION

PLASMODIUM FALCIPARUM ANTIGEN <i>by ICT (IMMUNOCHROMATOGRAPHY)</i>	NEGATIVE (-ve)	NEGATIVE (-ve)
PLASMODIUM VIVAX ANTIGEN <i>by ICT (IMMUNOCHROMATOGRAPHY)</i>	NEGATIVE (-ve)	NEGATIVE (-ve)




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COLLECTED BY	: SURJESH	REGISTRATION DATE	: 13/Nov/2024 12:31 PM
REFERRED BY	: CENTRAL PHOENIX CLUB (AMBALA CANTT)	COLLECTION DATE	: 13/Nov/2024 12:44PM
BARCODE NO.	: 01520733	REPORTING DATE	: 13/Nov/2024 04:29PM
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 RECEIVED	10	ml	
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
COLOUR	Pale yellow		PALE YELLOW
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
TRANSPARANCY	CLEAR		CLEAR
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
SPECIFIC GRAVITY	1.01		1.002 - 1.030
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			

CHEMICAL EXAMINATION

REACTION	Acidic		
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
PROTEIN	Trace		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
SUGAR	2+		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
pH	5.5		5.0 - 7.5
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
BILIRUBIN	Negative		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
NITRITE	Negative		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
UROBILINOGEN	Normal	EU/dL	0.2 - 1.0
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
KETONE BODIES	Negative		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
BLOOD	Negative		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
ASCORBIC ACID	NEGATIVE (-ve)		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			

MICROSCOPIC EXAMINATION

RED BLOOD CELLS (RBCs)	NEGATIVE (-ve)	/HPF	0 - 3
by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT			




 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

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Test Name	Value	Unit	Biological Reference interval
PUS CELLS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	2-4	/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>	NEGATIVE (-ve)		NEGATIVE (-ve)
TRICHOMONAS VAGINALIS (PROTOZOA) <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	ABSENT		ABSENT




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REFERRED BY	: CENTRAL PHOENIX CLUB (AMBALA CANTT)	COLLECTION DATE	: 13/Nov/2024 12:44PM
BARCODE NO.	: 01520733	REPORTING DATE	: 15/Nov/2024 03:01PM
CLIENT CODE.	: KOS DIAGNOSTIC LAB		
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
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MICROBIOLOGY

CULTURE AEROBIC BACTERIA AND ANTIBIOTIC SENSITIVITY: URINE

CULTURE AND SUSCEPTIBILITY: URINE

DATE OF SAMPLE	13-11-2024
SPECIMEN SOURCE	URINE
INCUBATION PERIOD	48 HOURS
by AUTOMATED BROTH CULTURE	
CULTURE	STERILE
by AUTOMATED BROTH CULTURE	
ORGANISM	NO AEROBIC PYOGENIC ORGANISM GROWN AFTER 48 HOURS OF
by AUTOMATED BROTH CULTURE	INCUBATION AT 37°C

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.





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 CONSULTANT PATHOLOGIST
 MBBS, MD (PATHOLOGY & MICROBIOLOGY)



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 CONSULTANT PATHOLOGIST
 MBBS, MD (PATHOLOGY)



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REFERRED BY	: CENTRAL PHOENIX CLUB (AMBALA CANTT)	COLLECTION DATE	: 13/Nov/2024 12:44PM
BARCODE NO.	: 01520733	REPORTING DATE	: 18/Nov/2024 09:57AM
CLIENT CODE.	: KOS DIAGNOSTIC LAB		
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
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CULTURE AEROBIC BACTERIA AND ANTIBIOTIC SENSITIVITY (CONVENTIONAL): BLOOD

BLOOD CULTURE AND SUSCEPTIBILITY

DATE OF SAMPLE	13-11-2024
SPECIMEN SOURCE	BLOOD
INCUBATION PERIOD	5 DAYS
CULTURE	STERILE

by AUTOMATED BROTH CULTURE

ORGANISM
 by AUTOMATED BROTH CULTURE
 NO AEROBIC PYOGENIC ORGANISM GROWN AFTER 5 DAYS OF INCUBATION AT 37°C

AEROBIC SUSCEPTIBILITY BLOOD

INTERPRETATION 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 ***




 DR.VINAY CHOPRA

CONSULTANT PATHOLOGIST
 MBBS, MD (PATHOLOGY & MICROBIOLOGY)


 DR.YUGAM CHOPRA

CONSULTANT PATHOLOGIST
 MBBS, MD (PATHOLOGY)

