

Dr. Vinay Chopra
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Chairman & Consultant Pathologist

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

NAME : Master. HARMAN
AGE/ GENDER : 3 YRS/MALE
COLLECTED BY :
REFERRED BY : DR SUPREET NAGPAL
BARCODE NO. : 01521083
CLIENT CODE. : KOS DIAGNOSTIC LAB
CLIENT ADDRESS : 6349/1, NICHOLSON ROAD, AMBALA CANTT

PATIENT ID : 1675917
REG. NO./LAB NO. : 012411190031
REGISTRATION DATE : 19/Nov/2024 11:31 AM
COLLECTION DATE : 19/Nov/2024 11:38AM
REPORTING DATE : 19/Nov/2024 01:06PM

Test Name	Value	Unit	Biological Reference interval
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CLINICAL CHEMISTRY/BIOCHEMISTRY
LIVER FUNCTION TEST (COMPLETE)

BILIRUBIN TOTAL: SERUM by DIAZOTIZATION, SPECTROPHOTOMETRY	0.33	mg/dL	INFANT: 0.20 - 8.00 ADULT: 0.00 - 1.20
BILIRUBIN DIRECT (CONJUGATED): SERUM by DIAZO MODIFIED, SPECTROPHOTOMETRY	0.11	mg/dL	0.00 - 0.40
BILIRUBIN INDIRECT (UNCONJUGATED): SERUM by CALCULATED, SPECTROPHOTOMETRY	0.22	mg/dL	0.10 - 1.00
SGOT/AST: SERUM by IFCC, WITHOUT PYRIDOXAL PHOSPHATE	71 ^H	U/L	7.00 - 45.00
SGPT/ALT: SERUM by IFCC, WITHOUT PYRIDOXAL PHOSPHATE	28.7	U/L	0.00 - 49.00
AST/ALT RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	2.47	RATIO	0.00 - 46.00
ALKALINE PHOSPHATASE: SERUM by PARA NITROPHENYL PHOSPHATASE BY AMINO METHYL PROPANOL	103.51	U/L	50.00 - 370.00
GAMMA GLUTAMYL TRANSFERASE (GGT): SERUM by SZASZ, SPECTROPHOTOMETRY	42.1	U/L	0.00 - 55.0
TOTAL PROTEINS: SERUM by BIURET, SPECTROPHOTOMETRY	4.12 ^L	gm/dL	6.20 - 8.00
ALBUMIN: SERUM by BROMOCRESOL GREEN	2.74 ^L	gm/dL	3.50 - 5.50
GLOBULIN: SERUM by CALCULATED, SPECTROPHOTOMETRY	1.38 ^L	gm/dL	2.30 - 3.50
A : G RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	1.99	RATIO	1.00 - 2.00

NOTE 2 RESULT RECHECKED TWICE
ADVICE KINDLY CORRELATE CLINICALLY

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
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ALCOHOLIC HEPATITIS		> 2 (Highly Suggestive)	
CIRRHOSIS		1.4 - 2.0	
INTRAHEPATIC CHOLESTATIS		> 1.5	
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 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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Test Name	Value	Unit	Biological Reference interval
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IMMUNOPATHOLOGY/SEROLOGY

ANTI TISSUE TRANSGLUTAMINASE (tTG) ANTIBODY IgA

ANTI TISSUE TRANSGLUTAMINASE ANTIBODY IgA	>200 ^H	IU/mL	NEGATIVE: < 20.0 POSITIVE: > 20.0
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by ELISA (ENZYME LINKED IMMUNOASSAY)

INTERPRETATION:

1. Anti-transglutaminase antibodies (ATA) are autoantibodies against the transglutaminase protein.
2. Antibodies to tissue transglutaminase are found in patients with several conditions, including coeliac disease, juvenile diabetes, inflammatory bowel disease, and various forms of arthritis.
3. In coeliac disease, ATA are involved in the destruction of the villous extracellular matrix and target the destruction of intestinal villous epithelial cells by killer cells.
4. Deposits of anti-tTG in the intestinal epithelium predict coeliac disease.
5. Celiac disease (gluten-sensitive enteropathy, celiac sprue) results from an immune-mediated inflammatory process following ingestion of wheat, rye, or barley proteins that occurs in genetically susceptible individuals. The inflammation in celiac disease occurs primarily in the mucosa of the small intestine, which leads to villous atrophy.

CLINICAL MANIFESTATIONS RELATED TO GASTROINTESTINAL TRACT:

1. Abdominal pain
2. Malabsorption
3. Diarrhea and Constipation.

CLINICAL MANIFESTATION OF CELIAC DISEASE NOT RESTRICTED TO GIT:

1. Failure to grow (delayed puberty and short stature)
2. Iron deficiency anemia
3. Recurrent fetal loss
4. Osteoporosis and chronic fatigue
5. Recurrent aphthous stomatitis (canker sores)
6. Dental enamel hypoplasia, and dermatitis herpetiformis.
7. Patients with celiac disease may also present with neuropsychiatric manifestations including ataxia and peripheral neuropathy, and are at increased risk for development of non-Hodgkin lymphoma.
8. The disease is also associated with other clinical disorders including thyroiditis, type I diabetes mellitus, Down syndrome, and IgA deficiency.

NOTE:

1. The finding of tissue transglutaminase (tTG)-IgA antibodies is specific for celiac disease and possibly for dermatitis herpetiformis. For individuals with moderately to strongly positive results, a diagnosis of celiac disease is likely and the patient should undergo biopsy to confirm the diagnosis.
2. If patients strictly adhere to a gluten-free diet, the unit value of IgA-anti-tTG should begin to decrease within 6 to 12 months of onset of dietary therapy.

CAUTION:

1. This test should not be solely relied upon to establish a diagnosis of celiac disease. It should be used to identify patients who have an increased probability of having celiac disease and in whom a small intestinal biopsy is recommended.





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2. Affected individuals who have been on a gluten-free diet prior to testing may have a negative result.
3. For individuals who test negative, IgA deficiency should be considered. If total IgA is normal and tissue transglutaminase (tTG)-IgA is negative, there is a low probability of the patient having celiac disease and a biopsy may not be necessary.
4. If serology is negative or there is substantial clinical doubt remaining, then further investigation should be performed with endoscopy and bowel biopsy. This is especially important in patients with frank malabsorptive symptoms since many syndromes can mimic celiac disease. For the patient with frank malabsorptive symptoms, bowel biopsy should be performed regardless of serologic test results.
5. The antibody pattern in dermatitis herpetiformis may be more variable than in celiac disease; therefore, both endomysial and tTG antibody determinations are recommended to maximize the sensitivity of the serologic tests.

*** End Of Report ***




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