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CEO & Consultant Pathologist

NAME : Mr. H.K BANSAL  
AGE/ GENDER : 88 YRS/MALE  
COLLECTED BY : SURJESH  
REFERRED BY :  
BARCODE NO. : 01521136  
CLIENT CODE. : KOS DIAGNOSTIC LAB  
CLIENT ADDRESS : 6349/1, NICHOLSON ROAD, AMBALA CANTT

PATIENT ID : 1676917  
REG. NO./LAB NO. : 012411200024  
REGISTRATION DATE : 20/Nov/2024 10:41 AM  
COLLECTION DATE : 20/Nov/2024 10:46AM  
REPORTING DATE : 20/Nov/2024 12:34PM

Test Name	Value	Unit	Biological Reference interval
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CLINICAL CHEMISTRY/BIOCHEMISTRY

GLUCOSE FASTING (F)

GLUCOSE FASTING (F): PLASMA by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)	102.62 <sup>H</sup>	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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UREA			
UREA: SERUM by UREASE - GLUTAMATE DEHYDROGENASE (GLDH)	67.35 <sup>H</sup>	mg/dL	10.00 - 50.00
RECHECKED			



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**CREATININE**

CREATININE: SERUM by ENZYMATIC, SPECTROPHOTOMETRY RECHECKED	<b>1.69<sup>H</sup></b>	mg/dL	0.40 - 1.40
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### URIC ACID

URIC ACID: SERUM	6.39	mg/dL	3.60 - 7.70
by URICASE - OXIDASE PEROXIDASE			

#### INTERPRETATION:-

1. GOUT occurs when high levels of Uric Acid in the blood cause crystals to form & accumulate around a joint.  
 2. Uric Acid is the end product of purine metabolism . Uric acid is excreted to a large degree by the kidneys and to a smaller degree in the intestinal tract by microbial degradation.

#### INCREASED:-

##### (A).DUE TO INCREASED PRODUCTION:-

1. Idiopathic primary gout.
2. Excessive dietary purines (organ meats, legumes, anchovies, etc).
3. Cytolytic treatment of malignancies especially leukemias & lymphomas.
4. Polycythemia vera & myeloid metaplasia.
5. Psoriasis.
6. Sickle cell anaemia etc.

##### (B).DUE TO DECREASED EXCRETION (BY KIDNEYS)

1. Alcohol ingestion.
2. Thiazide diuretics.
3. Lactic acidosis.
4. Aspirin ingestion (less than 2 grams per day ).
5. Diabetic ketoacidosis or starvation.
6. Renal failure due to any cause etc.

#### DECREASED:-

##### (A).DUE TO DIETARY DEFICIENCY

1. Dietary deficiency of Zinc, Iron and molybdenum.
2. Fanconi syndrome & Wilsons disease.
3. Multiple sclerosis .
4. Syndrome of inappropriate antidiuretic hormone (SIADH) secretion & low purine diet etc.

##### (B).DUE TO INCREASED EXCRETION

1. Drugs:- Probenecid , sulphinpyrazone, aspirin doses (more than 4 grams per day), corticosteroids and ACTH, anti-coagulants and estrogens etc.



  
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### ELECTROLYTES COMPLETE PROFILE

SODIUM: SERUM <i>by ISE (ION SELECTIVE ELECTRODE)</i>	136.2	mmol/L	135.0 - 150.0
POTASSIUM: SERUM <i>by ISE (ION SELECTIVE ELECTRODE)</i>	5.53 <sup>H</sup>	mmol/L	3.50 - 5.00
CHLORIDE: SERUM <i>by ISE (ION SELECTIVE ELECTRODE)</i>	102.15	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 losing 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

\*\*\* End Of Report \*\*\*



  
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