

Dr. Vinay Chopra
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CEO & Consultant Pathologist

NAME : Mr. RAKESH KUMAR
AGE/ GENDER : 45 YRS/MALE
COLLECTED BY :
REFERRED BY :
BARCODE NO. : 01521851
CLIENT CODE. : KOS DIAGNOSTIC LAB
CLIENT ADDRESS : 6349/1, NICHOLSON ROAD, AMBALA CANTT

PATIENT ID : 1687991
REG. NO./LAB NO. : 012412020034
REGISTRATION DATE : 02/Dec/2024 11:29 AM
COLLECTION DATE : 02/Dec/2024 11:45AM
REPORTING DATE : 02/Dec/2024 02:03PM

Test Name	Value	Unit	Biological Reference interval
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VIRAL MARKERS COMBO PANEL: 2.0

HEPATITIS C VIRUS (HCV) ANTIBODY: TOTAL

HEPATITIS C ANTIBODY (HCV) TOTAL: SERUM 0.13 S/CO NEGATIVE: < 1.00
by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY) POSITIVE: > 1.00

HEPATITIS C ANTIBODY (HCV) TOTAL NON - REACTIVE
RESULT
by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)

INTERPRETATION:-

RESULT (INDEX)	REMARKS
< 1.00	NON - REACTIVE/NOT - DETECTED
> =1.00	REACTIVE/ASYMPTOMATIC/INFECTIVE STATE/CARRIER STATE.

Hepatitis C (HCV) is an RNA virus of Favivirus group transmitted via blood transfusions, transplantation, injection drug abusers, accidental needle punctures in healthcare workers, dialysis patients and rarely from mother to infant. 10 % of new cases show sexual transmission. As compared to HAV & HBV , chronic infection with HCV occurs in 85 % of infected individuals. In high risk population, the predictive value of Anti HCV for HCV infection is > 99% whereas in low risk populations it is only 25 %.

USES:

- Indicator of past or present infection, but does not differentiate between Acute/ Chronic/Resolved Infection.
- Routine screening of low and high prevalence population including blood donors.

NOTE:

- False positive results are seen in Auto-immune disease, Rheumatoid Factor, HYpergammaglobulinemia, Paraproteinemia, Passive antibody transfer, Anti-idiotypes and Anti-superoxide dismutase.
- False negative results are seen in early Acute infection, Immunosuppression and Immuno—incompetence.
- HCV-RNA PCR recommended in all reactive results to differentiate between past and present infection.



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ANTI HUMAN IMMUNODEFICIENCY VIRUS (HIV) DUO ULTRA WITH (P-24 ANTIGEN DETECTION)

HIV 1/2 AND P24 ANTIGEN: SERUM 0.08 S/CO
 by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)

HIV 1/2 AND P24 ANTIGEN RESULT NON - REACTIVE
 by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)

INTERPRETATION:-

RESULT (INDEX)	REMARKS
< 1.00	NON - REACTIVE
> = 1.00	PROVISIONALLY REACTIVE

Non-Reactive result implies that antibodies to HIV 1/ 2 have not been detected in the sample . This means that patient has either not been exposed to HIV 1/ 2 infection or the sample has been tested during the "window phase" i.e. before the development of detectable levels of antibodies. Hence a Non Reactive result does not exclude the possibility of exposure or infection with HIV 1/ 2.

RECOMMENDATIONS:

1. Results to be clinically correlated
2. Rarely falsenegativity/positivity may occur.





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BARCODE NO.	: 01521851	REPORTING DATE	: 02/Dec/2024 01:34PM
CLIENT CODE.	: KOS DIAGNOSTIC LAB		
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Test Name	Value	Unit	Biological Reference interval
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HEPATITIS B SURFACE ANTIGEN (HBsAg) ULTRA

HEPATITIS B SURFACE ANTIGEN (HBsAg): 0.04 S/CO
 SERUM
 by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)


HEPATITIS B SURFACE ANTIGEN (HBsAg) NON REACTIVE
 RESULT
 by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)


INTERPRETATION:

RESULT IN INDEX VALUE	REMARKS
< 1.30	NEGATIVE (-ve)
>=1.30	POSITIVE (+ve)

Hepatitis B Virus (HBV) is a member of the Hepadna virus family causing infection of the liver with extremely variable clinical features. Hepatitis B is transmitted primarily by body fluids especially serum and also spread effectively sexually and from mother to baby. In most individuals HBV hepatitis is self limiting, but 1-2 % normal adolescent and adults develop Chronic Hepatitis. Frequency of chronic HBV infection is 5-10% in immunocompromised patients and 80 % neonates. The initial serological marker of acute infection is HBsAg which typically appears 2-3 months after infection and disappears 12-20 weeks after onset of symptoms. Persistence of HBsAg for more than 6 months indicates carrier state or Chronic Liver disease.




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BARCODE NO.	: 01521851	REPORTING DATE	: 02/Dec/2024 12:18PM
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Test Name	Value	Unit	Biological Reference interval
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TROPONIN I ULTRASENSITIVE (QUANTITATIVE)

TROPONIN I ULTRASENSITIVE (QUANTITATIVE) 0.18 ng/mL < 0.50

by ELFA (ENZYME LINKED FLUORESCENT IMMUNOASSAY), NEXT GENERATION, ULTRASENSITIVE

INTERPRETATION:

NOTE:
 1.False negative / positive results are observed in patients receiving mouse monoclonal antibodies for diagnosis or therapy.

COMMENTS

- 1.Troponin is a regulatory complex of 3 proteins that resides at regular intervals in the thin filament of striated muscle.
- 2.Cardiac Troponin is a cardiospecific, highly sensitive marker of myocardial damage and has never shown to be expressed in normal, regenerating or diseased skeletal muscle.
- 3.In cases of acute myocardial damage, Troponin I levels rise in serum about 3-4 hours after appearance of cardiac symptoms and remain elevated upto 10 days.
- 4.It is an independent prognostic marker which can predict near, mid and long term outcome in patients with Acute Coronary Syndrome (ACS).


INCREASED LEVELS


- 1.Congestive Heart Failure
- 2.Cardiomyopathy
- 3.Myocarditis
- 4.Heart contusion
- 5.Interventional therapy like cardiac surgery and drug induced cardiotoxicity

USES

- 1.To differentiate patients with Non ST elevation Myocardial Infarction (NSTMI) from Unstable angina-patients with ACS with elevated Troponin I and / or CK-MB are considered to have NSTMI whereas the diagnosis of Unstable angina is established if Troponin I and CK-MB are within the normal range.
- 2.Ideally Troponin I should be measured at presentation (0 hour) and repeated after 6-9 hours & 12-24 hours if earlier specimens are normal and the clinical suspicion is high.
3. Risk stratification of patients presenting with ACS and for cardiac risk in patients with Chronic Renal Failure. As it offers powerful risk assessment, in ACS, Troponin I monitoring should be included in practice guidelines.
4. For selection of more intensive therapy and intervention in patients with elevated Troponin I.




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VDRL

VDRL by IMMUNOCHROMATOGRAPHY	NON REACTIVE	NON REACTIVE
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INTERPRETATION:

- Does not become positive until 7 - 10 days after appearance of chancre.
- High titer (>1:16) - active disease.**
- Low titer (<1:8) - biological falsepositive test in 90% cases or due to late or late latent syphilis.**
- Treatment of primary syphilis causes progressive decline to negative VDRL within 2 years.
- Rising titer (4X) indicates relapse, reinfection, or treatment failure and need for retreatment.
- May be nonreactive in early primary, late latent, and late syphilis (approx. 25% of cases).
- Reactive and weakly reactive tests should always be confirmed with FTA-ABS (fluorescent treponemal antibody absorption test).**

SHORT TERM FALSE POSITIVE TEST RESULTS (<6 MONTHS DURATION) MAY OCCUR IN:

- Acute viral illnesses (e.g., hepatitis, measles, infectious mononucleosis)
- M. pneumoniae; Chlamydia; Malaria infection.
- Some immunizations
- Pregnancy (rare)

LONG TERM FALSE POSITIVE TEST RESULTS (>6 MONTHS DURATION) MAY OCCUR IN:

- Serious underlying disease e.g., collagen vascular diseases, leprosy, malignancy.
- Intravenous drug users.
- Rheumatoid arthritis, thyroiditis, AIDS, Sjogren's syndrome.
- <10 % of patients older than age 70 years.
- Patients taking some anti-hypertensive drugs.





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CLINICAL PATHOLOGY
DIGOXIN

DIGOXIN: SERUM	2.8^H	ng/mL	0.8 - 2.0
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*** End Of Report ***




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