

Dr. Vinay Chopra
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Dr. Yugam Chopra
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CEO & Consultant Pathologist

NAME : Mr. OM PARKASH
AGE/ GENDER : 76 YRS/MALE
COLLECTED BY : SURJESH
REFERRED BY :
BARCODE NO. : 01521912
CLIENT CODE. : KOS DIAGNOSTIC LAB
CLIENT ADDRESS : 6349/1, NICHOLSON ROAD, AMBALA CANTT

PATIENT ID : 1689270
REG. NO./LAB NO. : 012412030041
REGISTRATION DATE : 03/Dec/2024 11:56 AM
COLLECTION DATE : 03/Dec/2024 12:19PM
REPORTING DATE : 03/Dec/2024 12:51PM

| Test Name | Value | Unit | Biological Reference interval |
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HAEMATOLOGY COMPLETE BLOOD COUNT (CBC)

RED BLOOD CELLS (RBCS) COUNT AND INDICES

| | | | |
|--|-------------------|--------------|--|
| HAEMOGLOBIN (HB) by CALORIMETRIC | 11.7 ^L | gm/dL | 12.0 - 17.0 |
| RED BLOOD CELL (RBC) COUNT by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE | 4.44 | Millions/cmm | 3.50 - 5.00 |
| PACKED CELL VOLUME (PCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER | 37.5 ^L | % | 40.0 - 54.0 |
| MEAN CORPUSCULAR VOLUME (MCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER | 84.3 | fL | 80.0 - 100.0 |
| MEAN CORPUSCULAR HAEMOGLOBIN (MCH) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER | 26.4 ^L | pg | 27.0 - 34.0 |
| MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER | 31.3 ^L | g/dL | 32.0 - 36.0 |
| RED CELL DISTRIBUTION WIDTH (RDW-CV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER | 17.5 ^H | % | 11.00 - 16.00 |
| RED CELL DISTRIBUTION WIDTH (RDW-SD) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER | 55 | fL | 35.0 - 56.0 |
| MENTZERS INDEX by CALCULATED | 18.99 | RATIO | BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0 |
| GREEN & KING INDEX by CALCULATED | 33.29 | 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 | 16540 ^H | /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> | 92 ^H | % | 50 - 70 |
| LYMPHOCYTES <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i> | 5 ^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> | 15217 ^H | /cmm | 2000 - 7500 |
| ABSOLUTE LYMPHOCYTE COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i> | 827 | /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> | 496 | /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> | 357000 | /cmm | 150000 - 450000 |
| PLATELETCRIT (PCT) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i> | 0.37 ^H | % | 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> | 105000 ^H | /cmm | 30000 - 90000 |
| PLATELET LARGE CELL RATIO (P-LCR) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i> | 29.4 | % | 11.0 - 45.0 |
| PLATELET DISTRIBUTION WIDTH (PDW) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i> | 16.6 | % | 15.0 - 17.0 |

NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD



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CLINICAL CHEMISTRY/BIOCHEMISTRY

UREA

| | | | |
|--|---------------------------|-------|---------------|
| UREA: SERUM | 226.52^H | mg/dL | 10.00 - 50.00 |
| by UREASE - GLUTAMATE DEHYDROGENASE (GLDH) | | | |
| Rechecked | | | |




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CREATININE

| | | | |
|---|-------------------------|-------|-------------|
| CREATININE: SERUM by ENZYMATIC, SPECTROPHOTOMETRY Rechecked | 6.37^H | mg/dL | 0.40 - 1.40 |
|---|-------------------------|-------|-------------|




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ELECTROLYTES COMPLETE PROFILE

| | | | |
|---|--------|--------|---------------|
| SODIUM: SERUM <i>by ISE (ION SELECTIVE ELECTRODE)</i> | 137 | mmol/L | 135.0 - 150.0 |
| POTASSIUM: SERUM <i>by ISE (ION SELECTIVE ELECTRODE)</i> | 3.72 | mmol/L | 3.50 - 5.00 |
| CHLORIDE: SERUM <i>by ISE (ION SELECTIVE ELECTRODE)</i> | 102.75 | 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 loosing 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




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IMMUNOPATHOLOGY/SEROLOGY C-REACTIVE PROTEIN (CRP)

C-REACTIVE PROTEIN (CRP) QUANTITATIVE: **39.59^H** mg/L 0.0 - 6.0
 SERUM
 by NEPHLOMETRY

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.

*** End Of Report ***




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