

(A Unit of KOS Healthcare)



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

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

NAME : Mrs. RENU

AGE/ GENDER : 35 YRS/FEMALE PATIENT ID : 1703570

COLLECTED BY : REG. NO./LAB NO. : 012412190039

 REFERRED BY
 : 19/Dec/2024 03:35 PM

 BARCODE NO.
 : 01522689
 COLLECTION DATE
 : 19/Dec/2024 03:38 PM

 CLIENT CODE.
 : KOS DIAGNOSTIC LAB
 REPORTING DATE
 : 19/Dec/2024 04:08 PM

CLIENT ADDRESS : 6349/1, NICHOLSON ROAD, AMBALA CANTT

Test Name Value Unit Biological Reference interval

## HAEMATOLOGY HAEMOGLOBIN (HB)

HAEMOGLOBIN (HB) 11.8<sup>L</sup> gm/dL 12.0 - 16.0

by CALORIMETRIC

<u>INTERPRETATION:-</u>
Hemoglobin is the protein molecule in red blood cells that carries oxygen from the lungs to the bodys tissues and returns carbon dioxide from the tissues back to the lungs.

A low hemoglobin level is referred to as ANEMIA or low red blood count.

ANEMIA (DECRESED HAEMOGLOBIN):

1) Loss of blood (traumatic injury, surgery, bleeding, colon cancer or stomach ulcer)

2) Nutritional deficiency (iron, vitamin B12, folate)

3) Bone marrow problems (replacement of bone marrow by cancer)

4) Suppression by red blood cell synthesis by chemotherapy drugs

5) Kidney failure

6) Abnormal hemoglobin structure (sickle cell anemia or thalassemia).

## POLYCYTHEMIA (INCREASED HAEMOGLOBIN):

- 1) People in higher altitudes (Physiological)
- 2) Smoking (Secondary Polycythemia)
- 3) Dehydration produces a falsely rise in hemoglobin due to increased haemoconcentration
- 4) Advanced lung disease (for example, emphysema)
- 5) Certain tumors
- 6) A disorder of the bone marrow known as polycythemia rubra vera,
- 7) Abuse of the drug erythropoetin (Epogen) by athletes for blood doping purposes (increasing the amount of oxygen available to the body by chemically raising the production of red blood cells).

NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD



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CONSULTANT PATHOLOGIST
MBBS, MD (PATHOLOGY & MICROBIOLOGY)





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PLATELET COUNT (P/C)

PLATELET COUNT (PLT)

230000 /cmm 150000 - 450000 by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE &

MICROSCOPY

NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD



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## **BLOOD GROUP (ABO) AND RH FACTOR TYPING**

ABO GROUP by SLIDE AGGLUTINATION RH FACTOR TYPE by SLIDE AGGLUTINATION

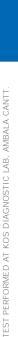
Α

**POSITIVE** 



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**BLEEDING TIME (BT)** 

**BLEEDING TIME (BT)** 2 MIN.25 SEC. MINS by DUKE METHOD

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**CLOTTING TIME (CT)** 

CLOTTING TIME (CT) 6 MIN.40 SEC. MINS by CAPILLARY TUBE METHOD



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## **CLINICAL CHEMISTRY/BIOCHEMISTRY GLUCOSE RANDOM (R)**

100.57 GLUCOSE RANDOM (R): PLASMA NORMAL: < 140.00 mg/dL

by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD) PREDIABETIC: 140.0 - 200.0 DIABETIC: > 0R = 200.0

IN ACCORDANCE WITH AMERICAN DIABETES ASSOCIATION GUIDELINES:

1. A random plasma glucose level below 140 mg/dl is considered normal.

2. A random glucose level between 140 - 200 mg/dl is considered as glucose intolerant or prediabetic. A fasting and post-prnadial blood test (after consumption of 75 gms of glucose) is recommended for all such patients.

3. A random glucose level of above 200 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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## **LIVER FUNCTION TEST (COMPLETE)**

BILIRUBIN TOTAL: SERUM by DIAZOTIZATION, SPECTROPHOTOMETRY	0.36	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	0.25	mg/dL	0.10 - 1.00
SGOT/AST: SERUM by IFCC, WITHOUT PYRIDOXAL PHOSPHATE	21.3	U/L	7.00 - 45.00
SGPT/ALT: SERUM by IFCC, WITHOUT PYRIDOXAL PHOSPHATE	17.4	U/L	0.00 - 49.00
AST/ALT RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	1.22	RATIO	0.00 - 46.00
ALKALINE PHOSPHATASE: SERUM by PARA NITROPHENYL PHOSPHATASE BY AMINO METHYL PROPANOL	53.79	U/L	40.0 - 130.0
GAMMA GLUTAMYL TRANSFERASE (GGT): SERUM by SZASZ, SPECTROPHTOMETRY	13.17	U/L	0.00 - 55.0
TOTAL PROTEINS: SERUM by BIURET, SPECTROPHOTOMETRY	7.46	gm/dL	6.20 - 8.00
ALBUMIN: SERUM by BROMOCRESOL GREEN	4.35	gm/dL	3.50 - 5.50
GLOBULIN: SERUM by CALCULATED, SPECTROPHOTOMETRY	3.11	gm/dL	2.30 - 3.50
A: G RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	1.4	RATIO	1.00 - 2.00

### INTERPRETATION

NOTE:- To be correlated in individuals having SGOT and SGPT values higher than Normal Referance 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
HEPATOCELLULAR CARCINOMA & CHRONIC HEPATITIS	> 1.3 (Slightly Increased)



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#### **DECREASED:**

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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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# ENDOCRINOLOGY THYROID STIMULATING HORMONE (TSH)

THYROID STIMULATING HORMONE (TSH): SERUM 0.617 μIU/mL 0.35 - 5.50

by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)

3rd GENERATION, ULTRASENSITIVE

#### **INTERPRETATION:**

AGE	REFFERENCE RANGE (μIU/mL)		
0 – 5 DAYS	0.70 - 15.20		
6 Days – 2 Months	0.70 - 11.00		
3 – 11 Months	0.70 - 8.40		
1 – 5 Years	0.70 - 7.00		
6 – 10 Years	0.60 - 5.50 0.50 - 5.50		
11 - 15			
> 20 Years (Adults)	0.27 - 5.50		
	PREGNANCY		
1st Trimester	0.10 - 3.00		
2nd Trimester	0.20 - 3.00		
3rd Trimester	0.30 - 4.10		

NOTE:-TSH levels are subjected to circardian variation, reaching peak levels between 2-4 a.m and at a minimum between 6-10 pm. The variation is of the order of 50 %. Hence time of the day has influence on the measured serum TSH concentration.

**USE**:- TSH controls biosynthesis and release of thyroid harmones T4 & T3. It is a sensitive measure of thyroid function, especially useful in early or subclinical hypothyroidism, before the patient develops any clinical findings or goitre or any other thyroid function abnormality.

## **INCREASED LEVELS:**

- 1. Primary or untreated hypothyroidism, may vary from 3 times to more than 100 times normal depending on degree of hypofunction.
- 2. Hypothyroid patients receiving insufficient thyroid replacement therapy.
- 3. Hashimotos thyroiditis.
- 4.DRUGS: Amphetamines, Iodine containing agents and dopamine antagonist.
- 5. Neonatal period, increase in 1st 2-3 days of life due to post-natal surge.

## **DECREASED LEVELS:**

- 1. Toxic multi-nodular goitre & Thyroiditis.
- 2. Over replacement of thyroid harmone in treatment of hypothyroidism.
- 3. Autonomously functioning Thyroid adenoma
- ${\it 4. Secondary\ pituatary\ or\ hypothalmic\ hypothyroidism}$
- 5. Acute psychiatric illness
- 6. Severe dehydration.
- 7.DRUGS: Glucocorticoids, Dopamine, Levodopa, T4 replacement therapy, Anti-thyroid drugs for thyrotoxicosis.



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8. Pregnancy: 1st and 2nd Trimester

## LIMITATIONS:

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1.TSH may be normal in central hypothyroidism, recent rapid correction of hyperthyroidism or hypothyroidism, pregnancy, phenytoin therapy.

2. Autoimmune disorders may produce spurious results.



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## IMMUNOPATHOLOGY/SEROLOGY HEPATITIS C VIRUS (HCV) ANTIBODIES SCREENING

HEPATITIS C ANTIBODY (HCV) TOTAL

NON - REACTIVE

**RESULT** 

by IMMUNOCHROMATOGRAPHY

#### **INTERPRETATION:**

1.Anti HCV total antibody assay identifies presence IgG antibodies in the serum . It is a useful screening test with a specificity of nearly 99%. 2.It becomes positive approximately 24 weeks after exposure. The test can not isolate an active ongoing HCV infection from an old infection that has been cleared. All positive results must be confirmed for active disease by an HCV PCR test .

## **FALSE NEGATIVE RESULTS SEEN IN:**

1. Window period

2.Immunocompromised states.



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## ANTI HUMAN IMMUNODEFICIENCY VIRUS (HIV) ANTIBODIES HIV (1 & 2) SCREENING

HIV 1/2 AND P24 ANTIGEN RESULT

NON - REACTIVE

by IMMUNOCHROMATOGRAPHY

## **INTERPRETATION:-**

1.AIDS is caused by at least 2 known types of HIV viruses, HIV-1 and HIV HIV-2.

- 2. This NACO approved immuno-chromatographic solid phase ELISA assay detects antibodies against both HIV-1 and HIV-2 viruses.
- 3. The test is used for routine serologic screening of patients at risk for HIV-1 or HIV-2 infection.
- 4.All screening ELISA assays for HIV antibody detection have high sensitivity but have low specificity.
- 5.At this laboratory, all positive samples are cross checked for positivity with two alternate assays prior to reporting.

#### NOTE:-

- 1. Confirmatory testing by Western blot is recommended for patients who are reactive for HIV by this assay.
- 2.Antibodies against HIV-1 and HIV-2 are usually not detectable until 6 to 12 weeks following exposure (window period) and are almost always detectable by 12 months.
- 3. The test is not recommended for children born to HIV infected mothers till the child turns two years old (as HIV antibodies may be transmitted passively to the child trans-placentally).

## **FALSE NÉGATIVE RESULT SEEN IN:**

- 1. Window period
- 2. Severe immuno-suppression including advanced AIDS.



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## HEPATITIS B SURFACE ANTIGEN (HBsAg) SCREENING

HEPATITIS B SURFACE ANTIGEN (HBsAg)

NON REACTIVE

RESULT

by IMMUNOCHROMATOGRAPHY

## **INTERPRETATION:-**

1.HBsAG is the first serological marker of HBV infection to appear in the blood (approximately 30-60 days after infection and prior to the onset of clinical disease). It is also the last viral protein to disappear from blood and usually disappears by three months after infection in self limiting acute Hepatitis B viral infection.

2.Persistence of HBsAg in blood for more than six months implies chronic infection. It is the most common marker used for diagnosis of an acute Hepatitis B infection but has very limited role in assessing patients suffering from chronic hepatitis.

### **FALSE NEGATIVE RESULT SEEN IN:**

- 1. Window period.
- 2.Infection with HBsAg mutant strains
- 3. Hepatitis B Surface antigen (HBsAg) is the earliest indicator of HBV infection. Usually it appears in 27 41 days (as early as 14 days).
- 4.Appears 7 26 days before biochemical abnormalities. Peaks as ALT rises. Persists during the acute illness. Usually disappears 12- 20 weeks after the onset of symptoms / laboratory abnormalities in 90% of cases.

5.ls the most reliable serologic marker of HBV infection. Persistence > 6 months defines carrier state. May also be found in chronic infection. Hepatitis B vaccination does not cause a positive HBsAg. Titers are not of clinical value.

## NOTE:-

1.All reactive HBsAG Should be reconfirmed with neutralization test(HBsAg confirmatory test).

2.Anti - HAV IgM appears at the same time as symptoms in > 99% of cases, peaks within the first month, becomes nondetectable in 12 months (usually 6 months). Presence confirms diagnosis of recent acute infection.



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**VDRL** 

VDRL NON REACTIVE NON REACTIVE

by IMMUNOCHROMATOGRAPHY

## **INTERPRETATION:**

1. Does not become positive until 7 - 10 days after appearance of chancre.

- 2. High titer (>1:16) active disease.
- 3.Low titer (<1:8) biological falsepositive test in 90% cases or due to late or late latent syphillis.
- 4.Treatment of primary syphillis causes progressive decline tonegative VDRL within 2 years.
- 5. Rising titer (4X) indicates relapse, reinfection, or treatment failure and need for retreatment.
- 6. May benonreactive in early primary, late latent, and late syphillis (approx. 25% ofcases).
- 7. Reactive and weakly reactive tests should always be confirmed with FTA-ABS (fluorescent treponemal antibody absorption test).

#### SHORTTERM FALSE POSITIVE TEST RESULTS (<6 MONTHS DURATION) MAY OCCURIN:

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

## LONGTERM FALSE POSITIVE TEST RESULTS (>6 MONTHS DURATION) MAY OCCUR IN:

- 1. Serious underlying disease e.g., collagen vascular diseases, leprosy, malignancy.
- 2.Intravenous drug users.
- 3. Rheumatoid arthritis, thyroiditis, AIDS, Sjogren's syndrome.
- 4.<10 % of patients older thanage 70 years.
- 5. Patients taking some anti-hypertensive drugs.



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**CLIENT ADDRESS** : 6349/1, NICHOLSON ROAD, AMBALA CANTT

**Value** Unit **Biological Reference interval Test Name** 

## **CLINICAL PATHOLOGY URINE ROUTINE & MICROSCOPIC EXAMINATION**

## PHYSICAL EXAMINATION

QUANTITY RECIEVED 10 ml by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY

PALE YELLOW COLOUR AMBER YELLOW

by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY

TRANSPARANCY HAZY **CLEAR** 

by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY

SPECIFIC GRAVITY 1.01 1.002 - 1.030by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY

**CHEMICAL EXAMINATION** 

ALKALINE REACTION by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY

Negative NEGATIVE (-ve) by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY

**SUGAR** 

Negative NEGATIVE (-ve) by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY

рН 7.5 5.0 - 7.5

by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY

BILIRUBIN NEGATIVE (-ve) Negative by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY

**NITRITE** Negative **NEGATIVE** (-ve)

by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY. EU/dL UROBILINOGEN Normal 0.2 - 1.0

by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY

NEGATIVE (-ve) KETONE BODIES Negative by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY

NEGATIVE (-ve) BLOOD Negative

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

CONSULTANT PATHOLOGIST MBBS, MD (PATHOLOGY & MICROBIOLOGY) DR.YUGAM CHOPRA CONSULTANT PATHOLOGIST





(A Unit of KOS Healthcare)



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

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

NAME : Mrs. RENU

**AGE/ GENDER** : 35 YRS/FEMALE **PATIENT ID** : 1703570

COLLECTED BY : REG. NO./LAB NO. : 012412190039

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Test Name	Value	Unit	Biological Reference interval
by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT			
PUS CELLS by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT	12-15	/HPF	0 - 5
EPITHELIAL CELLS by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT	6-8	/HPF	ABSENT
CRYSTALS by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT	NEGATIVE (-ve)		NEGATIVE (-ve)
CASTS by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT	NEGATIVE (-ve)		NEGATIVE (-ve)
BACTERIA by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT	NEGATIVE (-ve)		NEGATIVE (-ve)
OTHERS  by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT	NEGATIVE (-ve)		NEGATIVE (-ve)
TRICHOMONAS VAGINALIS (PROTOZOA) by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT	ABSENT		ABSENT

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



DR.VINAY CHOPRA
CONSULTANT PATHOLOGIST
MBBS, MD (PATHOLOGY & MICROBIOLOGY)

DR.YUGAM CHOPRA CONSULTANT PATHOLOGIST MBBS , MD (PATHOLOGY)



KOS Central Lab: 6349/1, Nicholson Road, Ambala Cantt -133 001, Haryana
KOS Molecular Lab: IInd Floor, Parry Hotel, Staff Road, Opp. GPO, Ambala Cantt -133 001, Haryana
0171-2643898, +91 99910 43898 | care@koshealthcare.com | www.koshealthcare.com