

Dr. Vinay Chopra
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Chairman & Consultant Pathologist

Dr. Yugam Chopra
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CEO & Consultant Pathologist

NAME : Mr. KABIR SOLAN
AGE/ GENDER : 2 YRS/MALE
COLLECTED BY :
REFERRED BY :
BARCODE NO. : 01522866
CLIENT CODE. : KOS DIAGNOSTIC LAB
CLIENT ADDRESS : 6349/1, NICHOLSON ROAD, AMBALA CANTT

PATIENT ID : 1706258
REG. NO./LAB NO. : 012412220072
REGISTRATION DATE : 22/Dec/2024 11:20 PM
COLLECTION DATE : 22/Dec/2024 11:29PM
REPORTING DATE : 22/Dec/2024 11:49PM

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	9.9 ^L	gm/dL	12.0 - 16.0
RED BLOOD CELL (RBC) COUNT by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	5.93 ^H	Millions/cmm	3.50 - 5.50
PACKED CELL VOLUME (PCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	34.1 ^L	%	35.0 - 49.0
MEAN CORPUSCULAR VOLUME (MCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	57.5 ^L	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	16.8 ^L	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	29 ^L	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	18.1 ^H	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	39.6	fL	35.0 - 56.0
MENTZERS INDEX by CALCULATED	9.7	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX by CALCULATED	17.66	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	17950 ^H	/cmm	5000 - 15000
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>	30 ^L	%	50 - 70
LYMPHOCYTES <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	60 ^H	%	20 - 45
EOSINOPHILS <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	5	%	1 - 6
MONOCYTES <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	5	%	3 - 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>	5385	/cmm	2000 - 7500
ABSOLUTE LYMPHOCYTE COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	10770 ^H	/cmm	800 - 4900
ABSOLUTE EOSINOPHIL COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	898 ^H	/cmm	40 - 440
ABSOLUTE MONOCYTE COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	898 ^H	/cmm	80 - 880
ABSOLUTE BASOPHIL COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	0 ^H	/cmm	0 - 110
<u>PLATELETS AND OTHER PLATELET PREDICTIVE MARKERS.</u>			
PLATELET COUNT (PLT) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	477000 ^H	/cmm	150000 - 450000
PLATELETCRIT (PCT) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	0.36 ^H	%	0.10 - 0.36
MEAN PLATELET VOLUME (MPV) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	8	fL	6.50 - 12.0
PLATELET LARGE CELL COUNT (P-LCC) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	46000	/cmm	30000 - 90000
PLATELET LARGE CELL RATIO (P-LCR) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	9.7 ^L	%	11.0 - 45.0
PLATELET DISTRIBUTION WIDTH (PDW) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	15	%	15.0 - 17.0
ADVICE	KINDLY CORRELATE CLINICALLY		





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NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD

RECHECKED




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PROTHROMBIN TIME STUDIES (PT/INR)

PT TEST (PATIENT) <i>by PHOTO OPTICAL CLOT DETECTION</i>	13	SECS	12.5 - 14.1
PT (CONTROL) <i>by PHOTO OPTICAL CLOT DETECTION</i>	12	SECS	
ISI <i>by PHOTO OPTICAL CLOT DETECTION</i>	1.1		
INTERNATIONAL NORMALISED RATIO (INR) <i>by PHOTO OPTICAL CLOT DETECTION</i>	1.09		0.92 - 1.14
PT INDEX <i>by PHOTO OPTICAL CLOT DETECTION</i>	92.31	%	

INTERPRETATION:-

1. INR is the parameter of choice in monitoring adequacy of oral anti-coagulant therapy. Appropriate therapeutic range varies with the disease and treatment intensity.
2. Prolonged INR suggests potential bleeding disorder /bleeding complications
3. Results should be clinically correlated.
4. Test conducted on Citrated Plasma

RECOMMENDED THERAPEUTIC RANGE FOR ORAL ANTI-COAGULANT THERAPY (INR)

INDICATION	INTERNATIONAL NORMALIZED RATIO (INR)
Treatment of venous thrombosis	2.0 - 3.0
Treatment of pulmonary embolism	
Prevention of systemic embolism in tissue heart valves	
Valvular heart disease	
Acute myocardial infarction	
Atrial fibrillation	
Bileaflet mechanical valve in aortic position	2.5 - 3.5
Recurrent embolism	
Mechanical heart valve	
Antiphospholipid antibodies ⁺	

COMMENTS:




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The prothrombin time (PT) and its derived measures of prothrombin ratio (PR) and international normalized ratio (INR) are measures of the efficacy of the extrinsic pathway of coagulation. PT test reflects the adequacy of factors I (fibrinogen), II (prothrombin), V, VII, and X. It is used in conjunction with the activated partial thromboplastin time (aPTT) which measures the intrinsic pathway.

The common causes of prolonged prothrombin time are :

- 1.Oral Anticoagulant therapy.
- 2.Liver disease.
- 3.Vit K. deficiency.
- 4.Disseminated intra vascular coagulation.
- 5.Factor 5, 7 , 10 or Prothrombin deficiency





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CLINICAL CHEMISTRY/BIOCHEMISTRY

LIVER FUNCTION TEST (COMPLETE)

BILIRUBIN TOTAL: SERUM <i>by DIAZOTIZATION, SPECTROPHOTOMETRY</i>	0.14	mg/dL	INFANT: 0.20 - 8.00 ADULT: 0.00 - 1.20
BILIRUBIN DIRECT (CONJUGATED): SERUM <i>by DIAZO MODIFIED, SPECTROPHOTOMETRY</i>	0.04	mg/dL	0.00 - 0.40
BILIRUBIN INDIRECT (UNCONJUGATED): SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	0.1	mg/dL	0.10 - 1.00
SGOT/AST: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	38.4	U/L	7.00 - 45.00
SGPT/ALT: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	13.9	U/L	0.00 - 49.00
AST/ALT RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	2.76	RATIO	0.00 - 46.00
ALKALINE PHOSPHATASE: SERUM <i>by PARA NITROPHENYL PHOSPHATASE BY AMINO METHYL PROPANOL</i>	292.92	U/L	50.00 - 370.00
GAMMA GLUTAMYL TRANSFERASE (GGT): SERUM <i>by SZASZ, SPECTROPHOTOMETRY</i>	5.7	U/L	0.00 - 55.0
TOTAL PROTEINS: SERUM <i>by BIURET, SPECTROPHOTOMETRY</i>	6.83	gm/dL	6.20 - 8.00
ALBUMIN: SERUM <i>by BROMOCRESOL GREEN</i>	4.28	gm/dL	3.50 - 5.50
GLOBULIN: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	2.55	gm/dL	2.30 - 3.50
A : G RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	1.68	RATIO	1.00 - 2.00

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
ALCOHOLIC HEPATITIS	> 2 (Highly Suggestive)
CIRRHOSIS	1.4 - 2.0
INTRAHEPATIC CHOLESTATIS	> 1.5




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Test Name	Value	Unit	Biological Reference interval
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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IMMUNOPATHOLOGY/SEROLOGY

HEPATITIS C VIRUS (HCV) ANTIBODIES SCREENING

HEPATITIS C ANTIBODY (HCV) TOTAL
 RESULT NON - REACTIVE
 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 NEGATIVE RESULT SEEN IN:

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




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C-REACTIVE PROTEIN (CRP)

C-REACTIVE PROTEIN (CRP) QUANTITATIVE: SERUM by NEPHLOMETRY	3.35	mg/L	0.0 - 6.0
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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.




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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.Is 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 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.

*** End Of Report ***




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