

(A Unit of KOS Healthcare)



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

NAME : Mrs. GEETA KHANNA

AGE/ GENDER : 91 YRS/FEMALE **PATIENT ID** : 1708235

COLLECTED BY: SURJESH REG. NO./LAB NO. : 012412250025

 REFERRED BY
 : 25/Dec/2024 10:24 AM

 BARCODE NO.
 : 01522974
 COLLECTION DATE
 : 25/Dec/2024 10:25 AM

 CLIENT CODE.
 : KOS DIAGNOSTIC LAB
 REPORTING DATE
 : 25/Dec/2024 10:58 AM

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

Test Name Value Unit Biological Reference interval

HAEMATOLOGY COMPLETE BLOOD COUNT (CBC)

RED BLOOD CELLS (RBCS) COUNT AND INDICES

HAEMOGLOBIN (HB) by CALORIMETRIC	8.7 ^L	gm/dL	12.0 - 16.0
RED BLOOD CELL (RBC) COUNT by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	3.18 ^L	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	27.7 ^L	%	37.0 - 50.0
MEAN CORPUSCULAR VOLUME (MCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	87.1	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	27.3 ^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	17.6 ^H	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	55.6 ^H	fL	35.0 - 56.0
MENTZERS INDEX by CALCULATED	27.39	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX by CALCULATED	48.1	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	7960	/cmm	4000 - 11000
NUCLEATED RED BLOOD CELLS (nRBCS) by automated 6 part hematology analyzer	NIL		0.00 - 20.00

NIL



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< 10 %

NUCLEATED RED BLOOD CELLS (nRBCS) %

by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER



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Test Name	Value	Unit	Biological Reference interval
DIFFERENTIAL LEUCOCYTE COUNT (DLC)			
NEUTROPHILS by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	60	%	50 - 70
LYMPHOCYTES by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	32	%	20 - 40
EOSINOPHILS by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	2	%	1 - 6
MONOCYTES by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	6	%	2 - 12
BASOPHILS by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	0	%	0 - 1
ABSOLUTE LEUKOCYTES (WBC) COUNT			
ABSOLUTE NEUTROPHIL COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	4776	/cmm	2000 - 7500
ABSOLUTE LYMPHOCYTE COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	2547	/cmm	800 - 4900
ABSOLUTE EOSINOPHIL COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	159	/cmm	40 - 440
ABSOLUTE MONOCYTE COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	478	/cmm	80 - 880
ABSOLUTE BASOPHIL COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	0	/cmm	0 - 110
PLATELETS AND OTHER PLATELET PREDICTIVE	MARKERS.		
PLATELET COUNT (PLT) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	63000^{L}	/cmm	150000 - 450000
PLATELETCRIT (PCT) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	0.06 ^L	%	0.10 - 0.36
MEAN PLATELET VOLUME (MPV) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	11	fL	6.50 - 12.0
PLATELET LARGE CELL COUNT (P-LCC) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	21000 ^L	/cmm	30000 - 90000
PLATELET LARGE CELL RATIO (P-LCR) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	28.5	%	11.0 - 45.0
PLATELET DISTRIBUTION WIDTH (PDW) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	16.7 ^H	%	15.0 - 17.0
ADVICE	KINDLY CORRELATE CLINICALLY		



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Test Name Value Unit **Biological Reference interval**

REPORTING DATE

NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD

RECHECKED.

CLIENT CODE.



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Test Name Value Unit Biological Reference interval

CLINICAL CHEMISTRY/BIOCHEMISTRY LIVER FUNCTION TEST (COMPLETE)

BILIRUBIN TOTAL: SERUM by DIAZOTIZATION, SPECTROPHOTOMETRY	0.31	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	0.2	mg/dL	0.10 - 1.00
SGOT/AST: SERUM by IFCC, WITHOUT PYRIDOXAL PHOSPHATE	49.2 ^H	U/L	7.00 - 45.00
SGPT/ALT: SERUM by IFCC, WITHOUT PYRIDOXAL PHOSPHATE	14.5	U/L	0.00 - 49.00
AST/ALT RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	3.39	RATIO	0.00 - 46.00
ALKALINE PHOSPHATASE: SERUM by para nitrophenyl phosphatase by amino methyl propanol	76.15	U/L	40.0 - 130.0
GAMMA GLUTAMYL TRANSFERASE (GGT): SERUM by SZASZ, SPECTROPHTOMETRY	21.38	U/L	0.00 - 55.0
TOTAL PROTEINS: SERUM by biuret, spectrophotometry	7.78	gm/dL	6.20 - 8.00
ALBUMIN: SERUM by BROMOCRESOL GREEN	3.17 ^L	gm/dL	3.50 - 5.50
GLOBULIN: SERUM by CALCULATED, SPECTROPHOTOMETRY	4.61 ^H	gm/dL	2.30 - 3.50
A: GRATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	0.69 ^L	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.

month local.	
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

REPORTING DATE

HEPATOCELLULAR CARCINOMA & CHRONIC HEPATITIS > 1.3 (Slightly Increased)

CLIENT CODE.

- 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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Test Name Value Unit Biological Reference interval

UREA

UREA: SERUM
by UREASE - GLUTAMATE DEHYDROGENASE (GLDH)

123.54^H mg/dL 10.00 - 50.00



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Test Name Value Unit **Biological Reference interval**

CREATININE

CREATININE: SERUM 2.9H mg/dL 0.40 - 1.20by ENZYMATIC, SPECTROPHOTOMETRY



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Test Name Value Unit Biological Reference interval

URIC ACID

URIC ACID: SERUM 17.01^H mg/dL 2.50 - 6.80

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 leukemais & lymphomas.

4. Polycythemai vera & myeloid metaplasia.

5. Psoriasis.

6. Sickle cell anaemia etc.

(B).DUE TO DECREASED EXCREATION (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 EXCREATION

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



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Test Name	Value	Unit	Biological Reference interval
	ELECTROLYTES COMI	PLETE PROFILE	

SODIUM: SERUM by ISE (ION SELECTIVE ELECTRODE)	147.2	mmol/L	135.0 - 150.0
POTASSIUM: SERUM by ISE (ION SELECTIVE ELECTRODE)	4.34	mmol/L	3.50 - 5.00
CHLORIDE: SERUM by ISE (ION SELECTIVE ELECTRODE)	110.4 ^H	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 iadequate salt replacement.
- 3. Diuretics abuses.
- 4. Salt loosing nephropathy.
- 5. Metabolic acidosis.
- 6. Adrenocortical issuficiency.
- 7. Hepatic failure.

HYPERNATREMIA (INCREASED SODIUM LEVEL) CAUSES:-

- 1. Hyperapnea (Prolonged)
- 2. Diabetes insipidus
- 3. Diabetic acidosis
- 4. Cushings 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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End Of Report *



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