

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

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

NAME	: Mr. KRISHAN KUMAR	PATIENT ID	: 1725269
AGE/ GENDER	: 69 YRS/MALE	REG. NO./LAB NO.	: 012501160018
COLLECTED BY	: SURJESH	REGISTRATION DATE	: 16/Jan/2025 10:30 AM
REFERRED BY	:	COLLECTION DATE	: 16/Jan/2025 10:38AM
BARCODE NO.	: 01523949	REPORTING DATE	: 16/Jan/2025 11:23AM
CLIENT CODE.	: KOS DIAGNOSTIC LAB		
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
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CLINICAL CHEMISTRY/BIOCHEMISTRY

UREA

UREA: SERUM	38.97	mg/dL	10.00 - 50.00
<i>by UREASE - GLUTAMATE DEHYDROGENASE (GLDH)</i>			




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CREATININE

CREATININE: SERUM by ENZYMATIC, SPECTROPHOTOMETRY	0.94	mg/dL	0.40 - 1.40
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POTASSIUM

POTASSIUM: SERUM by ISE (ION SELECTIVE ELECTRODE)	5.43^H	mmol/L	3.50 - 5.00
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INTERPRETATION:-

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
4. Hemolysis of blood




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IMMUNOPATHOLOGY/SEROLOGY

HEPATITIS B SURFACE ANTIGEN (HBsAg) ULTRA

HEPATITIS B SURFACE ANTIGEN (HBsAg):	0.23	S/CO	NEGATIVE: < 1.0
SERUM			POSITIVE: > 1.0

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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CLINICAL PATHOLOGY

URINE ROUTINE & MICROSCOPIC EXAMINATION

PHYSICAL EXAMINATION

QUANTITY RECEIVED	10	ml	
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
COLOUR	PALE YELLOW		PALE YELLOW
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
TRANSPARANCY	HAZY		CLEAR
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
SPECIFIC GRAVITY	1.02		1.002 - 1.030
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			

CHEMICAL EXAMINATION

REACTION	ACIDIC		
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
PROTEIN	2+		NEGATIVE (-ve)
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
SUGAR	2+		NEGATIVE (-ve)
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
pH	5.5		5.0 - 7.5
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
BILIRUBIN	Negative		NEGATIVE (-ve)
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
NITRITE	Negative		NEGATIVE (-ve)
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
UROBILINOGEN	Normal	EU/dL	0.2 - 1.0
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
KETONE BODIES	Negative		NEGATIVE (-ve)
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
BLOOD	TRACE		NEGATIVE (-ve)
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
ASCORBIC ACID	NEGATIVE (-ve)		NEGATIVE (-ve)
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			

MICROSCOPIC EXAMINATION

RED BLOOD CELLS (RBCs)	2-3	/HPF	0 - 3
<i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>			




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Test Name	Value	Unit	Biological Reference interval
PUS CELLS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	10-12	/HPF	0 - 5
EPITHELIAL CELLS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	2-3	/HPF	ABSENT
CRYSTALS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	NEGATIVE (-ve)		NEGATIVE (-ve)
CASTS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	NEGATIVE (-ve)		NEGATIVE (-ve)
BACTERIA <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	NEGATIVE (-ve)		NEGATIVE (-ve)
OTHERS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	NEGATIVE (-ve)		NEGATIVE (-ve)
TRICHOMONAS VAGINALIS (PROTOZOA) <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	ABSENT		ABSENT
Rechecked			




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MICROALBUMIN/CREATININE RATIO - RANDOM URINE

MICROALBUMIN: RANDOM URINE by SPECTROPHOTOMETRY	466.2 ^H	mg/L	0 - 25
CREATININE: RANDOM URINE by SPECTROPHOTOMETRY	57.53	mg/dL	20 - 320
MICROALBUMIN/CREATININE RATIO - RANDOM URINE by SPECTROPHOTOMETRY	810.36 ^H	mg/g	0 - 30

INTERPRETATION:-

PHYSIOLOGICALLY NORMAL:	mg/L	0 - 30
MICROALBUMINURIA:	mg/L	30 - 300
GROSS PROTEINURIA:	mg/L	> 300

Long standing un-treated Diabetes and Hypertension can lead to renal dysfunction.

2. Diabetic nephropathy or kidney disease is the most common cause of end stage renal disease(ERSD) or kidney failure.

3. Presence of Microalbuminuria is an early indicator of onset of compromised renal function in these patients.

4. Microalbuminuria is the condition when urinary albumin excretion is between 30-300 mg & above this it is called as macroalbuminuria, the presence of which indicates serious kidney disease.

5. Microalbuminuria is not only associated with kidney disease but of cardiovascular disease in patients with diabetes & hypertension.

6. Microalbuminuria reflects vascular damage & appear to be a marker of early arterial disease & endothelial dysfunction.

NOTE:- IF A PATIENT HAS = 1+ PROTEINURIA (30 mg/dl OR 300 mg/L) BY URINE DIPSTICK (URINE ANALYSIS), OVERT PROTEINURIA IS PRESENT AND TESTING FOR MICROALBUMIN IS INAPPROPRIATE. IN SUCH A CASE, URINE PROTEIN:CREATININE RATIO OR 24 HOURS TOTAL URINE MICROPROTEIN IS APPROPRIATE.

*** End Of Report ***




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