

Dr. Vinay Chopra
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 Chairman & Consultant Pathologist

Dr. Yugam Chopra
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NAME	: Mr. CHANDAN	PATIENT ID	: 1734487
AGE/ GENDER	: 39 YRS/MALE	REG. NO./LAB NO.	: 012501250005
COLLECTED BY	: SURJESH	REGISTRATION DATE	: 25/Jan/2025 08:39 AM
REFERRED BY	:	COLLECTION DATE	: 25/Jan/2025 09:41AM
BARCODE NO.	: 01524384	REPORTING DATE	: 25/Jan/2025 10:15AM
CLIENT CODE.	: KOS DIAGNOSTIC LAB		
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
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SWASTHYA WELLNESS PANEL: Y
COMPLETE BLOOD COUNT (CBC)

RED BLOOD CELLS (RBCS) COUNT AND INDICES


HAEMOGLOBIN (HB) <i>by CALORIMETRIC</i>	14.2	gm/dL	12.0 - 17.0
RED BLOOD CELL (RBC) COUNT <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDEANCE</i>	5.57^H	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	43.9	%	40.0 - 54.0
MEAN CORPUSCULAR VOLUME (MCV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	78.9^L	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	25.5^L	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	32.3	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	15	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	44.6	fL	35.0 - 56.0
MENTZERS INDEX <i>by CALCULATED</i>	14.17	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX <i>by CALCULATED</i>	21.25	RATIO	BETA THALASSEMIA TRAIT:<= 65.0 IRON DEFICIENCY ANEMIA: > 65.0

WHITE BLOOD CELLS (WBCS)

TOTAL LEUCOCYTE COUNT (TLC) <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	5390	/cmm	4000 - 11000
NUCLEATED RED BLOOD CELLS (nRBCS) <i>by AUTOMATED 6 PART HEMATOLOGY ANALYZER</i>	NIL		0.00 - 20.00
NUCLEATED RED BLOOD CELLS (nRBCS) % <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	NIL	%	< 10 %




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TEST PERFORMED AT KOS DIAGNOSTIC LAB, AMBALA CANTT.

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<u>DIFFERENTIAL LEUCOCYTE COUNT (DLC)</u>			
NEUTROPHILS <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	48^L	%	50 - 70
LYMPHOCYTES <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	36	%	20 - 40
EOSINOPHILS <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	5	%	1 - 6
MONOCYTES <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	11	%	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>	2587	/cmm	2000 - 7500
ABSOLUTE LYMPHOCYTE COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	1940	/cmm	800 - 4900
ABSOLUTE EOSINOPHIL COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	270	/cmm	40 - 440
ABSOLUTE MONOCYTE COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	593	/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>	299000	/cmm	150000 - 450000
PLATELETCRIT (PCT) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	0.34	%	0.10 - 0.36
MEAN PLATELET VOLUME (MPV) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	11	fL	6.50 - 12.0
PLATELET LARGE CELL COUNT (P-LCC) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	106000^H	/cmm	30000 - 90000
PLATELET LARGE CELL RATIO (P-LCR) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	35.5	%	11.0 - 45.0
PLATELET DISTRIBUTION WIDTH (PDW) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	16.4	%	15.0 - 17.0

NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD



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GLYCOSYLATED HAEMOGLOBIN (HBA1C)

GLYCOSYLATED HAEMOGLOBIN (HbA1c): WHOLE BLOOD <i>by HPLC (HIGH PERFORMANCE LIQUID CHROMATOGRAPHY)</i>	5.8	%	4.0 - 6.4
ESTIMATED AVERAGE PLASMA GLUCOSE <i>by HPLC (HIGH PERFORMANCE LIQUID CHROMATOGRAPHY)</i>	119.76	mg/dL	60.00 - 140.00

INTERPRETATION:

AS PER AMERICAN DIABETES ASSOCIATION (ADA):		
REFERENCE GROUP	GLYCOSYLATED HEMOGLOBIN (HBA1C) in %	
Non diabetic Adults >= 18 years	<5.7	
At Risk (Prediabetes)	5.7 – 6.4	
Diagnosing Diabetes	>= 6.5	
Therapeutic goals for glycemic control	Age > 19 Years	
	Goals of Therapy:	< 7.0
	Actions Suggested:	>8.0
	Age < 19 Years	
	Goal of therapy:	<7.5

COMMENTS:

- Glycosylated hemoglobin (HbA1c) test is three monthly monitoring done to assess compliance with therapeutic regimen in diabetic patients.
- Since Hb1c reflects long term fluctuations in blood glucose concentration, a diabetic patient who has recently under good control may still have high concentration of HbA1c. Converse is true for a diabetic previously under good control but now poorly controlled.
- Target goals of < 7.0 % may be beneficial in patients with short duration of diabetes, long life expectancy and no significant cardiovascular disease. In patients with significant complications of diabetes, limited life expectancy or extensive co-morbid conditions, targeting a goal of < 7.0% may not be appropriate. 4.High
- HbA1c (>9.0 -9.5 %) is strongly associated with risk of development and rapid progression of microvascular and nerve complications
- Any condition that shorten RBC life span like acute blood loss, hemolytic anemia falsely lower HbA1c results.
- HbA1c results from patients with HbSS, HbSC and HbD must be interpreted with caution, given the pathological processes including anemia, increased red cell turnover, and transfusion requirement that adversely impact HbA1c as a marker of long-term glycemic control.
- Specimens from patients with polycythemia or post-splenectomy may exhibit increase in HbA1c values due to a somewhat longer life span of the red cells.



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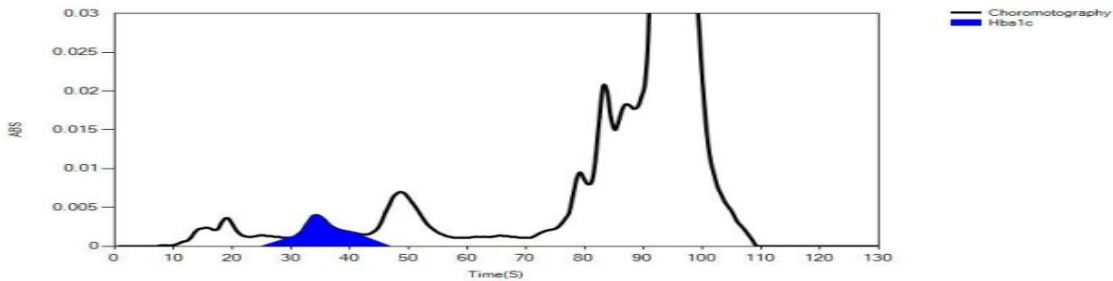
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LIFOTRONIC Graph Report

Name :	Case :	Patient Type :	Test Date : 25/01/2025 15:43:19
Age :	Department :	Sample Type : Whole Blood EDTA	Sample Id : 01524384
Gender :			Total Area : 12165

Peak Name	Retention Time(s)	Absorbance	Area	Result (Area %)
HbA0	69	3162	11128	91.5
HbA1c	36	70	573	5.8
La1c	25	40	243	2.5
HbF	18	14	39	0.1
Hba1b	14	37	101	1.0
Hba1a	11	24	81	0.8




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BARCODE NO.	: 01524384	REPORTING DATE	: 25/Jan/2025 10:46AM
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ERYTHROCYTE SEDIMENTATION RATE (ESR)

ERYTHROCYTE SEDIMENTATION RATE (ESR) <i>by RED CELL AGGREGATION BY CAPILLARY PHOTOMETRY</i>	26^H	mm/ 1st hr	0 - 20
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INTERPRETATION:

1. ESR is a non-specific test because an elevated result often indicates the presence of inflammation associated with infection, cancer and auto-immune disease, but does not tell the health practitioner exactly where the inflammation is in the body or what is causing it.
2. An ESR can be affected by other conditions besides inflammation. For this reason, the ESR is typically used in conjunction with other test such as C-reactive protein
3. This test may also be used to monitor disease activity and response to therapy in both of the above diseases as well as some others, such as systemic lupus erythematosus

CONDITION WITH LOW ESR

A low ESR can be seen with conditions that inhibit the normal sedimentation of red blood cells, such as a high red blood cell count (polycythaemia), significantly high white blood cell count (leucocytosis) , and some protein abnormalities. Some changes in red cell shape (such as sickle cells in sickle cell anaemia) also lower the ESR.

NOTE:

1. ESR and C - reactive protein (C-RP) are both markers of inflammation.
2. Generally, ESR does not change as rapidly as does CRP, either at the start of inflammation or as it resolves.
3. **CRP is not affected by as many other factors as is ESR, making it a better marker of inflammation.**
4. If the ESR is elevated, it is typically a result of two types of proteins, globulins or fibrinogen.
5. Women tend to have a higher ESR, and menstruation and pregnancy can cause temporary elevations.
6. Drugs such as dextran, methyldopa, oral contraceptives, penicillamine procainamide, theophylline, and vitamin A can increase ESR, while aspirin, cortisone, and quinine may decrease it



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CLINICAL CHEMISTRY/BIOCHEMISTRY

GLUCOSE FASTING (F)


GLUCOSE FASTING (F): PLASMA <i>by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)</i>	85.53	mg/dL	NORMAL: < 100.0 PREDIABETIC: 100.0 - 125.0 DIABETIC: > OR = 126.0
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INTERPRETATION

IN ACCORDANCE WITH AMERICAN DIABETES ASSOCIATION GUIDELINES:

1. A fasting plasma glucose level below 100 mg/dl is considered normal.
2. A fasting plasma glucose level between 100 - 125 mg/dl is considered as glucose intolerant or prediabetic. A fasting and post-prandial blood test (after consumption of 75 gms of glucose) is recommended for all such patients.
3. A fasting plasma glucose level of above 125 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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Test Name	Value	Unit	Biological Reference interval
LIPID PROFILE : BASIC			
CHOLESTEROL TOTAL: SERUM <i>by CHOLESTEROL OXIDASE PAP</i>	185.39	mg/dL	OPTIMAL: < 200.0 BORDERLINE HIGH: 200.0 - 239.0 HIGH CHOLESTEROL: > OR = 240.0
TRIGLYCERIDES: SERUM <i>by GLYCEROL PHOSPHATE OXIDASE (ENZYMATIC)</i>	75.37	mg/dL	OPTIMAL: < 150.0 BORDERLINE HIGH: 150.0 - 199.0 HIGH: 200.0 - 499.0 VERY HIGH: > OR = 500.0
HDL CHOLESTEROL (DIRECT): SERUM <i>by SELECTIVE INHIBITION</i>	55.61	mg/dL	LOW HDL: < 30.0 BORDERLINE HIGH HDL: 30.0 - 60.0 HIGH HDL: > OR = 60.0
LDL CHOLESTEROL: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	114.71	mg/dL	OPTIMAL: < 100.0 ABOVE OPTIMAL: 100.0 - 129.0 BORDERLINE HIGH: 130.0 - 159.0 HIGH: 160.0 - 189.0 VERY HIGH: > OR = 190.0
NON HDL CHOLESTEROL: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	129.78	mg/dL	OPTIMAL: < 130.0 ABOVE OPTIMAL: 130.0 - 159.0 BORDERLINE HIGH: 160.0 - 189.0 HIGH: 190.0 - 219.0 VERY HIGH: > OR = 220.0
VLDL CHOLESTEROL: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	15.07	mg/dL	0.00 - 45.00
TOTAL LIPIDS: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	446.15	mg/dL	350.00 - 700.00
CHOLESTEROL/HDL RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	3.33	RATIO	LOW RISK: 3.30 - 4.40 AVERAGE RISK: 4.50 - 7.0 MODERATE RISK: 7.10 - 11.0 HIGH RISK: > 11.0




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LDL/HDL RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	2.06	RATIO	LOW RISK: 0.50 - 3.0 MODERATE RISK: 3.10 - 6.0 HIGH RISK: > 6.0
TRIGLYCERIDES/HDL RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	1.36^L	RATIO	3.00 - 5.00

INTERPRETATION:

1. Measurements in the same patient can show physiological & analytical variations. Three serial samples 1 week apart are recommended for Total Cholesterol, Triglycerides, HDL & LDL Cholesterol.
2. As per NLA-2014 guidelines, all adults above the age of 20 years should be screened for lipid status. Selective screening of children above the age of 2 years with a family history of premature cardiovascular disease or those with at least one parent with high total cholesterol is recommended.
3. Low HDL levels are associated with increased risk for Atherosclerotic Cardiovascular disease (ASCVD) due to insufficient HDL being available to participate in reverse cholesterol transport, the process by which cholesterol is eliminated from peripheral tissues.
4. NLA-2014 identifies Non HDL Cholesterol (an indicator of all atherogenic lipoproteins such as LDL, VLDL, IDL, Lp(a), Chylomicron remnants) along with LDL-cholesterol as co-primary target for cholesterol lowering therapy. Note that major risk factors can modify treatment goals for LDL & Non HDL.
5. Additional testing for Apolipoprotein B, hsCRP, Lp(a) & LP-PLA2 should be considered among patients with moderate risk for ASCVD for risk refinement

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LIVER FUNCTION TEST (COMPLETE)

BILIRUBIN TOTAL: SERUM <i>by DIAZOTIZATION, SPECTROPHOTOMETRY</i>	0.38	mg/dL	INFANT: 0.20 - 8.00 ADULT: 0.00 - 1.20
BILIRUBIN DIRECT (CONJUGATED): SERUM <i>by DIAZO MODIFIED, SPECTROPHOTOMETRY</i>	0.1	mg/dL	0.00 - 0.40
BILIRUBIN INDIRECT (UNCONJUGATED): SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	0.28	mg/dL	0.10 - 1.00
SGOT/AST: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	17.8	U/L	7.00 - 45.00
SGPT/ALT: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	27.6	U/L	0.00 - 49.00
AST/ALT RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	0.64	RATIO	0.00 - 46.00
ALKALINE PHOSPHATASE: SERUM <i>by PARA NITROPHENYL PHOSPHATASE BY AMINO METHYL PROPANOL</i>	86.72	U/L	40.0 - 130.0
GAMMA GLUTAMYL TRANSFERASE (GGT): SERUM <i>by SZASZ, SPECTROPHOTOMETRY</i>	20.32	U/L	0.00 - 55.0
TOTAL PROTEINS: SERUM <i>by BIURET, SPECTROPHOTOMETRY</i>	7.24	gm/dL	6.20 - 8.00
ALBUMIN: SERUM <i>by BROMOCRESOL GREEN</i>	4.22	gm/dL	3.50 - 5.50
GLOBULIN: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	3.02	gm/dL	2.30 - 3.50
A : G RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	1.4	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 CHOLESTASIS	> 1.5
HEPATOCELLULAR CARCINOMA & CHRONIC HEPATITIS	> 1.3 (Slightly Increased)



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NAME	: Mr. CHANDAN	PATIENT ID	: 1734487
AGE/ GENDER	: 39 YRS/MALE	REG. NO./LAB NO.	: 012501250005
COLLECTED BY	: SURJESH	REGISTRATION DATE	: 25/Jan/2025 08:39 AM
REFERRED BY	:	COLLECTION DATE	: 25/Jan/2025 09:41AM
BARCODE NO.	: 01524384	REPORTING DATE	: 25/Jan/2025 12:51PM
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Test Name	Value	Unit	Biological Reference interval
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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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KIDNEY FUNCTION TEST (COMPLETE)

UREA: SERUM <i>by UREASE - GLUTAMATE DEHYDROGENASE (GLDH)</i>	21.15	mg/dL	10.00 - 50.00
CREATININE: SERUM <i>by ENZYMATIC, SPECTROPHOTOMETRY</i>	1.01	mg/dL	0.40 - 1.40
BLOOD UREA NITROGEN (BUN): SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	9.88	mg/dL	7.0 - 25.0
BLOOD UREA NITROGEN (BUN)/CREATININE RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	9.78^L	RATIO	10.0 - 20.0
UREA/CREATININE RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	20.94	RATIO	
URIC ACID: SERUM <i>by URICASE - OXIDASE PEROXIDASE</i>	4.69	mg/dL	3.60 - 7.70
CALCIUM: SERUM <i>by ARSENAZO III, SPECTROPHOTOMETRY</i>	9.07	mg/dL	8.50 - 10.60
PHOSPHOROUS: SERUM <i>by PHOSPHOMOLYBDATE, SPECTROPHOTOMETRY</i>	3.22	mg/dL	2.30 - 4.70

ELECTROLYTES

SODIUM: SERUM <i>by ISE (ION SELECTIVE ELECTRODE)</i>	137.6	mmol/L	135.0 - 150.0
POTASSIUM: SERUM <i>by ISE (ION SELECTIVE ELECTRODE)</i>	4.08	mmol/L	3.50 - 5.00
CHLORIDE: SERUM <i>by ISE (ION SELECTIVE ELECTRODE)</i>	103.2	mmol/L	90.0 - 110.0

ESTIMATED GLOMERULAR FILTRATION RATE

ESTIMATED GLOMERULAR FILTRATION RATE (eGFR): SERUM <i>by CALCULATED</i>	97
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INTERPRETATION:

To differentiate between pre- and post renal azotemia.

INCREASED RATIO (>20:1) WITH NORMAL CREATININE:

1. Prerenal azotemia (BUN rises without increase in creatinine) e.g. heart failure, salt depletion, dehydration, blood loss) due to decreased glomerular filtration rate.
2. Catabolic states with increased tissue breakdown.
3. GI haemorrhage.



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4. High protein intake.
 5. Impaired renal function plus
 6. Excess protein intake or production or tissue breakdown (e.g. infection, GI bleeding, thyrotoxicosis, Cushing's syndrome, high protein diet, burns, surgery, cachexia, high fever).
 7. Urine reabsorption (e.g. ureter colostomy)
 8. Reduced muscle mass (subnormal creatinine production)
 9. Certain drugs (e.g. tetracycline, glucocorticoids)
- INCREASED RATIO (>20:1) WITH ELEVATED CREATININE LEVELS:**
1. Postrenal azotemia (BUN rises disproportionately more than creatinine) (e.g. obstructive uropathy).
 2. Prerenal azotemia superimposed on renal disease.
- DECREASED RATIO (<10:1) WITH DECREASED BUN :**
1. Acute tubular necrosis.
 2. Low protein diet and starvation.
 3. Severe liver disease.
 4. Other causes of decreased urea synthesis.
 5. Repeated dialysis (urea rather than creatinine diffuses out of extracellular fluid).
 6. Inherited hyperammonemias (urea is virtually absent in blood).
 7. SIADH (syndrome of inappropriate antidiuretic hormone) due to tubular secretion of urea.
 8. Pregnancy.
- DECREASED RATIO (<10:1) WITH INCREASED CREATININE:**
1. Phenacimide therapy (accelerates conversion of creatine to creatinine).
 2. Rhabdomyolysis (releases muscle creatinine).
 3. Muscular patients who develop renal failure.
- INAPPROPRIATE RATIO:**
1. Diabetic ketoacidosis (acetoacetate causes false increase in creatinine with certain methodologies, resulting in normal ratio when dehydration should produce an increased BUN/creatinine ratio).
 2. Cephalosporin therapy (interferes with creatinine measurement).
- ESTIMATED GLOMERULAR FILTRATION RATE:**

CKD STAGE	DESCRIPTION	GFR (mL/min/1.73m2)	ASSOCIATED FINDINGS
G1	Normal kidney function	>90	No proteinuria
G2	Kidney damage with normal or high GFR	>90	Presence of Protein , Albumin or cast in urine
G3a	Mild decrease in GFR	60 -89	
G3b	Moderate decrease in GFR	30-59	
G4	Severe decrease in GFR	15-29	
G5	Kidney failure	<15	



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COMMENTS:


1. Estimated Glomerular filtration rate (eGFR) is the sum of filtration rates in all functioning nephrons and so an estimation of the GFR provides a measure of functioning nephrons of the kidney.
2. eGFR calculated using the 2009 CKD-EPI creatinine equation and GFR category reported as per KDIGO guideline 2012
3. In patients, with eGFR creatinine between 45-59 ml/min/1.73 m² (G3) and without any marker of Kidney damage, It is recommended to measure eGFR with Cystatin C for confirmation of CKD
4. eGFR category G1 OR G2 does not fulfill the criteria for CKD, in the absence of evidence of Kidney Damage
5. In a suspected case of Acute Kidney Injury (AKI), measurement of eGFR should be done after 48-96 hours of any Intervention or procedure
6. eGFR calculated by Serum Creatinine may be less accurate due to certain factors like Race, Muscle Mass, Diet, Certain Drugs. In such cases, eGFR should be calculated using Serum Cystatin C
7. **A decrease in eGFR implies either progressive renal disease, or a reversible process causing decreased nephron function (eg, severe dehydration).**

ADVICE:

KDIGO guideline, 2012 recommends Chronic Kidney Disease (CKD) should be classified based on cause, eGFR category and Albuminuria (ACR) category. GFR & ACR category combined together reflect risk of progression and helps Clinician to identify the individual who are progressing at more rapid rate than anticipated




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IRON PROFILE

IRON: SERUM <i>by FERROZINE, SPECTROPHOTOMETRY</i>	52.45^L	µg/dL	59.0 - 158.0
UNSATURATED IRON BINDING CAPACITY (UIBC) :SERUM <i>by FERROZINE, SPECTROPHOTOMETRY</i>	228.18	µg/dL	150.0 - 336.0
TOTAL IRON BINDING CAPACITY (TIBC) :SERUM <i>by SPECTROPHOTOMETRY</i>	280.63	µg/dL	230 - 430
%TRANSFERRIN SATURATION: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY (FERENE)</i>	18.69	%	15.0 - 50.0
TRANSFERRIN: SERUM <i>by SPECTROPHOTOMETRY (FERENE)</i>	199.25^L	mg/dL	200.0 - 350.0

INTERPRETATION:-

VARIABLES	ANEMIA OF CHRONIC DISEASE	IRON DEFICIENCY ANEMIA	THALASSEMIA α/β TRAIT
SERUM IRON:	Normal to Reduced	Reduced	Normal
TOTAL IRON BINDING CAPACITY:	Decreased	Increased	Normal
% TRANSFERRIN SATURATION:	Decreased	Decreased < 12-15 %	Normal
SERUM FERRITIN:	Normal to Increased	Decreased	Normal or Increased

IRON:

- 1.Serum iron studies is recommended for differential diagnosis of microcytic hypochromic anemia.i.e iron deficiency anemia, zinc deficiency anemia,anemia of chronic disease and thalassemia syndromes.
2. It is essential to isolate iron deficiency anemia from Beta thalassemia syndromes because during iron replacement which is therapeutic for iron deficiency anemia, is severely contra-indicated in Thalassemia.

TOTAL IRON BINDING CAPACITY (TIBC):

- 1.It is a direct measure of protein transferrin which transports iron from the gut to storage sites in the bone marrow.

% TRANSFERRIN SATURATION:

- 1.Occurs in idiopathic hemochromatosis and transfusional hemosiderosis where no unsaturated iron binding capacity is available for iron mobilization. Similar condition is seen in congenital deficiency of transferrin.



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ENDOCRINOLOGY

THYROID FUNCTION TEST: TOTAL

TRIIODOTHYRONINE (T3): SERUM <i>by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)</i>	1.158	ng/mL	0.35 - 1.93
THYROXINE (T4): SERUM <i>by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)</i>	9.14	µg/dL	4.87 - 12.60
THYROID STIMULATING HORMONE (TSH): SERUM <i>by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)</i>	0.835	µIU/mL	0.35 - 5.50

3rd GENERATION, ULTRASENSITIVE

INTERPRETATION:

TSH levels are subject to circadian 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 concentrations. TSH stimulates the production and secretion of the metabolically active hormones, thyroxine (T4) and triiodothyronine (T3). Failure at any level of regulation of the hypothalamic-pituitary-thyroid axis will result in either underproduction (hypothyroidism) or overproduction (hyperthyroidism) of T4 and/or T3.


CLINICAL CONDITION	T3	T4	TSH
Primary Hypothyroidism:	Reduced	Reduced	Increased (Significantly)
Subclinical Hypothyroidism:	Normal or Low Normal	Normal or Low Normal	High
Primary Hyperthyroidism:	Increased	Increased	Reduced (at times undetectable)
Subclinical Hyperthyroidism:	Normal or High Normal	Normal or High Normal	Reduced


LIMITATIONS:-

- T3 and T4 circulates in reversibly bound form with Thyroid binding globulins (TBG), and to a lesser extent albumin and Thyroid binding Pre Albumin so conditions in which TBG and protein levels alter such as pregnancy, excess estrogens, androgens, anabolic steroids and glucocorticoids may falsely affect the T3 and T4 levels and may cause false thyroid values for thyroid function tests.
- Normal levels of T4 can also be seen in Hyperthyroid patients with :T3 Thyrotoxicosis, Decreased binding capacity due to hypoproteinemia or ingestion of certain drugs (e.g.: phenytoin , salicylates).
- Serum T4 levels in neonates and infants are higher than values in the normal adult , due to the increased concentration of TBG in neonate serum.
- TSH may be normal in central hypothyroidism , recent rapid correction of hyperthyroidism or hypothyroidism , pregnancy , phenytoin therapy.

TRIIODOTHYRONINE (T3)		THYROXINE (T4)		THYROID STIMULATING HORMONE (TSH)	
Age	Refferance Range (ng/mL)	Age	Refferance Range (µg/dL)	Age	Reference Range (µIU/mL)
0 - 7 Days	0.20 - 2.65	0 - 7 Days	5.90 – 18.58	0 - 7 Days	2.43 - 24.3
7 Days - 3 Months	0.36 - 2.59	7 Days - 3 Months	6.39 - 17.66	7 Days - 3 Months	0.58 - 11.00
3 - 6 Months	0.51 - 2.52	3 - 6 Months	6.75 – 17.04	3 Days – 6 Months	0.70 - 8.40
6 - 12 Months	0.74 - 2.40	6 - 12 Months	7.10 – 16.16	6 – 12 Months	0.70 - 7.00




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Test Name	Value	Unit	Biological Reference interval
1 - 10 Years	0.92 - 2.28	1 - 10 Years	6.00 - 13.80
11- 19 Years	0.35 - 1.93	11 - 19 Years	4.87- 13.20
> 20 years (Adults)	0.35 - 1.93	> 20 Years (Adults)	4.87 - 12.60
RECOMMENDATIONS OF TSH LEVELS DURING PREGNANCY (μ IU/mL)			
	1st Trimester		0.10 - 2.50
	2nd Trimester		0.20 - 3.00
	3rd Trimester		0.30 - 4.10

INCREASED TSH LEVELS:

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

DECREASED TSH LEVELS:

- 1.Toxic multi-nodular goiter & Thyroiditis.
- 2.Over replacement of thyroid hormone in treatment of hypothyroidism.
- 3.Autonomously functioning Thyroid adenoma
- 4.Secondary pituitary or hypothalamic hypothyroidism
- 5.Acute psychiatric illness
- 6.Severe dehydration.
- 7.DRUGS: Glucocorticoids, Dopamine, Levodopa, T4 replacement therapy, Anti-thyroid drugs for thyrotoxicosis.
- 8.Pregnancy: 1st and 2nd Trimester



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IMMUNOPATHOLOGY/SEROLOGY

ANTI TISSUE TRANSGLUTAMINASE (tTG) ANTIBODY IgA

ANTI TISSUE TRANSGLUTAMINASE ANTIBODY IgA <i>by ELISA (ENZYME LINKED IMMUNOASSAY)</i>	7.25	IU/mL	NEGATIVE: < 20.0 POSITIVE: > 20.0
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INTERPRETATION:

1. Anti-transglutaminase antibodies (ATA) are autoantibodies against the transglutaminase protein.
2. Antibodies to tissue transglutaminase are found in patients with several conditions, including coeliac disease, juvenile diabetes, inflammatory bowel disease, and various forms of arthritis.
3. In coeliac disease, ATA are involved in the destruction of the villous extracellular matrix and target the destruction of intestinal villous epithelial cells by killer cells.
4. Deposits of anti-tTG in the intestinal epithelium predict coeliac disease.
5. Celiac disease (gluten-sensitive enteropathy, celiac sprue) results from an immune-mediated inflammatory process following ingestion of wheat, rye, or barley proteins that occurs in genetically susceptible individuals. The inflammation in celiac disease occurs primarily in the mucosa of the small intestine, which leads to villous atrophy.

CLINICAL MANIFESTATIONS RELATED TO GASTROINTESTINAL TRACT:

1. Abdominal pain
2. Malabsorption
3. Diarrhea and Constipation.

CLINICAL MANIFESTATION OF CELIAC DISEASE NOT RESTRICTED TO GIT:

1. Failure to grow (delayed puberty and short stature)
2. Iron deficiency anemia
3. Recurrent fetal loss
4. Osteoporosis and chronic fatigue
5. Recurrent aphthous stomatitis (canker sores)
6. Dental enamel hypoplasia, and dermatitis herpetiformis.
7. Patients with celiac disease may also present with neuropsychiatric manifestations including ataxia and peripheral neuropathy, and are at increased risk for development of non-Hodgkin lymphoma.
8. The disease is also associated with other clinical disorders including thyroiditis, type I diabetes mellitus, Down syndrome, and IgA deficiency.

NOTE:

1. The finding of tissue transglutaminase (tTG)-IgA antibodies is specific for celiac disease and possibly for dermatitis herpetiformis. For individuals with moderately to strongly positive results, a diagnosis of celiac disease is likely and the patient should undergo biopsy to confirm the diagnosis.
2. If patients strictly adhere to a gluten-free diet, the unit value of IgA-anti-tTG should begin to decrease within 6 to 12 months of onset of dietary therapy.

CAUTION:

1. This test should not be solely relied upon to establish a diagnosis of celiac disease. It should be used to identify patients who have an increased probability of having celiac disease and in whom a small intestinal biopsy is recommended.




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2. Affected individuals who have been on a gluten-free diet prior to testing may have a negative result.
3. For individuals who test negative, IgA deficiency should be considered. If total IgA is normal and tissue transglutaminase (tTG)-IgA is negative, there is a low probability of the patient having celiac disease and a biopsy may not be necessary.
4. If serology is negative or there is substantial clinical doubt remaining, then further investigation should be performed with endoscopy and bowel biopsy. This is especially important in patients with frank malabsorptive symptoms since many syndromes can mimic celiac disease. For the patient with frank malabsorptive symptoms, bowel biopsy should be performed regardless of serologic test results.
5. The antibody pattern in dermatitis herpetiformis may be more variable than in celiac disease; therefore, both endomysial and tTG antibody determinations are recommended to maximize the sensitivity of the serologic tests.

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VITAMINS

VITAMIN D/25 HYDROXY VITAMIN D3

VITAMIN D (25-HYDROXY VITAMIN D3): SERUM <i>by CLIA (CHEMILUMINESCENCE IMMUNOASSAY)</i>	10.3^L	ng/mL	DEFICIENCY: < 20.0 INSUFFICIENCY: 20.0 - 30.0 SUFFICIENCY: 30.0 - 100.0 TOXICITY: > 100.0
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INTERPRETATION:

DEFICIENT:	< 20	ng/mL
INSUFFICIENT:	21 - 29	ng/mL
PREFERRED RANGE:	30 - 100	ng/mL
INTOXICATION:	> 100	ng/mL

- Vitamin D compounds are derived from dietary ergocalciferol (from plants, Vitamin D2), or cholecalciferol (from animals, Vitamin D3), or by conversion of 7- dihydrocholecalciferol to Vitamin D3 in the skin upon Ultraviolet exposure.
- 25-OH--Vitamin D represents the main body resevoir and transport form of Vitamin D and transport form of Vitamin D, being stored in adipose tissue and tightly bound by a transport protein while in circulation.
- Vitamin D plays a primary role in the maintenance of calcium homeostatis. It promotes calcium absorption, renal calcium absorption and phosphate reabsorption, skeletal calcium deposition, calcium mobilization, mainly regulated by parathyroid hormone (PTH).
- Severe deficiency may lead to failure to mineralize newly formed osteoid in bone, resulting in rickets in children and osteomalacia in adults.

DECREASED:

- Lack of sunshine exposure.
- Inadequate intake, malabsorption (celiac disease)
- Depressed Hepatic Vitamin D 25- hydroxylase activity
- Secondary to advanced Liver disease
- Osteoporosis and Secondary Hyperparathroidism (Mild to Moderate deficiency)
- Enzyme Inducing drugs: anti-epileptic drugs like phenytoin, phenobarbital and carbamazepine, that increases Vitamin D metabolism.

INCREASED:

- Hypervitaminosis D is Rare, and is seen only after prolonged exposure to extremely high doses of Vitamin D. When it occurs, it can result in severe hypercalcemia and hyperphosphatemia.

CAUTION: Replacement therapy in deficient individuals must be monitored by periodic assessment of Vitamin D levels in order to prevent hypervitaminosis D

NOTE:- Dark coloured individuals as compare to whites, is at higher risk of developing Vitamin D deficiency due to excess of melanin pigment which interefere with Vitamin D absorption.



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AGE/ GENDER	: 39 YRS/MALE	REG. NO./LAB NO.	: 012501250005
COLLECTED BY	: SURJESH	REGISTRATION DATE	: 25/Jan/2025 08:39 AM
REFERRED BY	:	COLLECTION DATE	: 25/Jan/2025 09:41AM
BARCODE NO.	: 01524384	REPORTING DATE	: 25/Jan/2025 11:56AM
CLIENT CODE.	: KOS DIAGNOSTIC LAB		
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
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VITAMIN B12/COBALAMIN

VITAMIN B12/COBALAMIN: SERUM **131^L** pg/mL 190.0 - 890.0
by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)


INTERPRETATION:-


INCREASED VITAMIN B12	DECREASED VITAMIN B12
1. Ingestion of Vitamin C	1. Pregnancy
2. Ingestion of Estrogen	2. DRUGS: Aspirin, Anti-convulsants, Colchicine
3. Ingestion of Vitamin A	3. Ethanol ingestion
4. Hepatocellular injury	4. Contraceptive Hormones
5. Myeloproliferative disorder	5. Haemodialysis
6. Uremia	6. Multiple Myeloma

- Vitamin B12 (cobalamin) is necessary for hematopoiesis and normal neuronal function.
- In humans, it is obtained only from animal proteins and requires intrinsic factor (IF) for absorption.
- The body uses its vitamin B12 stores very economically, reabsorbing vitamin B12 from the ileum and returning it to the liver; very little is excreted.
- Vitamin B12 deficiency may be due to lack of IF secretion by gastric mucosa (eg, gastrectomy, gastric atrophy) or intestinal malabsorption (eg, ileal resection, small intestinal diseases).
- Vitamin B12 deficiency frequently causes macrocytic anemia, glossitis, peripheral neuropathy, weakness, hyperreflexia, ataxia, loss of proprioception, poor coordination, and affective behavioral changes. These manifestations may occur in any combination; many patients have the neurologic defects without macrocytic anemia.
- Serum methylmalonic acid and homocysteine levels are also elevated in vitamin B12 deficiency states.
- Follow-up testing for antibodies to intrinsic factor (IF) is recommended to identify this potential cause of vitamin B12 malabsorption.

NOTE: A normal serum concentration of vitamin B12 does not rule out tissue deficiency of vitamin B12. The most sensitive test for vitamin B12 deficiency at the cellular level is the assay for MMA. If clinical symptoms suggest deficiency, measurement of MMA and homocysteine should be considered, even if serum vitamin B12 concentrations are normal.




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REFERRED BY	:	COLLECTION DATE	: 25/Jan/2025 09:41AM
BARCODE NO.	: 01524384	REPORTING DATE	: 25/Jan/2025 02:11PM
CLIENT CODE.	: KOS DIAGNOSTIC LAB		
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Test Name	Value	Unit	Biological Reference interval
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TUMOUR MARKER

CARCINO EMBRYONIC ANTIGEN (CEA)

CARCINO EMBRYONIC ANTIGEN (CEA): SERUM	0.76	ng/mL	< 5.0
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by CLIA (CHEMILUMINESCENCE IMMUNOASSAY)

INTERPRETATION:

1. Carcinoembryonic antigen (CEA) is a glycoprotein normally found in embryonic endodermal epithelium.
2. Increased levels may be found in patients with primary colorectal cancer or other malignancies including medullary thyroid carcinoma and breast, gastrointestinal tract, liver, lung, ovarian, pancreatic, and prostatic cancers.
3. Serial monitoring of CEA should begin prior to initiation of cancer therapy to verify post therapy decrease in concentration and to establish a baseline for evaluating possible recurrence. Levels generally return to normal within 1 to 4 months after removal of cancerous tissue.


CLINICAL SIGNIFICANCE:


1. Monitoring colorectal cancer and selected other cancers such as medullary thyroid carcinoma
2. May be useful in assessing the effectiveness of chemotherapy or radiation treatment.

NOTE:

1. Carcinoembryonic antigen levels should not be used for screening of the general population for undetected cancers.
2. Grossly elevated carcino-embryonic antigen (CEA) concentrations (>20 ng/mL) in a patient with compatible symptoms are strongly suggestive of the presence of cancer and also suggest metastasis.
3. Most healthy subjects (97%) have values < or =3.0 ng/mL.
4. After removal of a colorectal tumor, the serum CEA concentration should return to normal by 6 weeks, unless there is residual tumor.
5. Increases in test values over time in a patient with a history of cancer suggest tumor recurrence.




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Test Name	Value	Unit	Biological Reference interval
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PROSTATE SPECIFIC ANTIGEN (PSA) - TOTAL

PROSTATE SPECIFIC ANTIGEN (PSA) - TOTAL:	0.898	ng/mL	0.0 - 4.0
SERUM			
<i>by CLIA (CHEMILUMINESCENCE IMMUNOASSAY)</i>			

INTERPRETATION:
NOTE:

1. This is a recommended test for detection of prostate cancer along with Digital Rectal Examination (DRE) in males above 50 years of age.
2. False negative / positive results are observed in patients receiving mouse monoclonal antibodies for diagnosis or therapy
3. PSA levels may appear consistently elevated / depressed due to the interference by heterophilic antibodies & nonspecific protein binding
4. Immediate PSA testing following digital rectal examination, ejaculation, prostatic massage, indwelling catheterization, ultrasonography and needle biopsy of prostate is not recommended as they falsely elevate levels
5. PSA values regardless of levels should not be interpreted as absolute evidence of the presence or absence of disease. All values should be correlated with clinical findings and results of other investigations
6. Sites of Non-prostatic PSA production are breast epithelium, salivary glands, peri-urethral & anal glands, cells of male urethra & breast milk
7. Physiological decrease in PSA level by 18% has been observed in hospitalized / sedentary patients either due to supine position or suspended sexual activity
8. The concentration of PSA in a given specimen, determined with assays from different manufacturers, may not be comparable due to differences in assay methods, calibration, and reagent specificity.

RECOMMENDED TESTING INTERVALS

1. Preoperatively (Baseline)
2. 2-4 Days Post operatively
3. Prior to discharge from hospital
4. Monthly Follow Up if levels are high and showing a rising trend

POST SURGERY	FREQUENCY OF TESTING
1st Year	Every 3 Months
2 nd Year	Every 4 Months
3 rd Year Onwards	Every 6 Months

CLINICAL USE:

1. An aid in the early detection of Prostate cancer when used in conjunction with Digital rectal examination in males more than 50 years of age and in those with two or more affected first degree relatives.
2. Followup and management of Prostate cancer patients.
3. Detect metastatic or persistent disease in patients following surgical or medical treatment of Prostate cancer

INCREASED LEVEL:

1. Prostate cancer
2. Benign Prostatic Hyperplasia
3. Prostatitis
4. Genitourinary infections



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Test Name	Value	Unit	Biological Reference interval
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CLINICAL PATHOLOGY

URINE ROUTINE & MICROSCOPIC EXAMINATION

PHYSICAL EXAMINATION

QUANTITY RECEIVED	10	ml	
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
COLOUR	AMBER YELLOW		PALE YELLOW
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
TRANSPARANCY	HAZY		CLEAR
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
SPECIFIC GRAVITY	>=1.030		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	Negative		NEGATIVE (-ve)
<i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>			
pH	6		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	Negative		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)	NEGATIVE (-ve)	/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>	2-4	/HPF	0 - 5
EPITHELIAL CELLS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	1-2	/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

*** End Of Report ***

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