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

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

NAME	**: Mr. PARVEEN GUPTA**		
AGE/ GENDER	: 67 YRS/MALE	**PATIENT ID**	: 1738121
COLLECTED BY	:	**REG. NO./LAB NO.**	**: 012501280042**
REFERRED BY	:	**REGISTRATION DATE**	: 28/Jan/2025 04:25 PM
BARCODE NO.	: 01524574	**COLLECTION DATE**	: 28/Jan/2025 04:29PM
CLIENT CODE.	: KOS DIAGNOSTIC LAB	**REPORTING DATE**	: 28/Jan/2025 05:28PM
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

HAEMATOLOGY

COMPLETE BLOOD COUNT (CBC)

Test Name	Value	Unit	Biological Reference interval
RED BLOOD CELLS (RBCS) COUNT AND INDICES			
HAEMOGLOBIN (HB) *by CALORIMETRIC*	13	gm/dL	12.0 - 17.0
RED BLOOD CELL (RBC) COUNT *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	4.7	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	41	%	40.0 - 54.0
MEAN CORPUSCULAR VOLUME (MCV) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	87.2	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	27.7	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	**31.8**^{L}	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	14.7	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	48.1	fL	35.0 - 56.0
MENTZERS INDEX *by CALCULATED*	18.55	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX *by CALCULATED*	27.31	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*	**21790**^{H}	/cmm	4000 - 11000
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 %

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

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

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

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

NAME	**: Mr. PARVEEN GUPTA**		
AGE/ GENDER	: 67 YRS/MALE	**PATIENT ID**	: 1738121
COLLECTED BY	:	**REG. NO./LAB NO.**	**: 012501280042**
REFERRED BY	:	**REGISTRATION DATE**	: 28/Jan/2025 04:25 PM
BARCODE NO.	: 01524574	**COLLECTION DATE**	: 28/Jan/2025 04:29PM
CLIENT CODE.	: KOS DIAGNOSTIC LAB	**REPORTING DATE**	: 28/Jan/2025 05:28PM
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
DIFFERENTIAL LEUCOCYTE COUNT (DLC)			
NEUTROPHILS *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	**21^{L}**	%	50 - 70
LYMPHOCYTES *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	**77^{H}**	%	20 - 40
EOSINOPHILS *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	**0^{L}**	%	1 - 6
MONOCYTES *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	2	%	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*	4576	/cmm	2000 - 7500
ABSOLUTE LYMPHOCYTE COUNT *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	**16778^{H}**	/cmm	800 - 4900
ABSOLUTE EOSINOPHIL COUNT *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	**0^{L}**	/cmm	40 - 440
ABSOLUTE MONOCYTE COUNT *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	436	/cmm	80 - 880
PLATELETS AND OTHER PLATELET PREDICTIVE MARKERS.			
PLATELET COUNT (PLT) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	205000	/cmm	150000 - 450000
PLATELETCRIT (PCT) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	0.25	%	0.10 - 0.36
MEAN PLATELET VOLUME (MPV) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	**12^{H}**	fL	6.50 - 12.0
PLATELET LARGE CELL COUNT (P-LCC) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	86000	/cmm	30000 - 90000
PLATELET LARGE CELL RATIO (P-LCR) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	42.2	%	11.0 - 45.0
PLATELET DISTRIBUTION WIDTH (PDW) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	16.9	%	15.0 - 17.0

NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD

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

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

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

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

NAME	**: Mr. PARVEEN GUPTA**		
AGE/ GENDER	: 67 YRS/MALE	**PATIENT ID**	: 1738121
COLLECTED BY	:	**REG. NO./LAB NO.**	**: 012501280042**
REFERRED BY	:	**REGISTRATION DATE**	: 28/Jan/2025 04:25 PM
BARCODE NO.	: 01524574	**COLLECTION DATE**	: 28/Jan/2025 04:29PM
CLIENT CODE.	: KOS DIAGNOSTIC LAB	**REPORTING DATE**	: 28/Jan/2025 07:50PM
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

CLINICAL CHEMISTRY/BIOCHEMISTRY

LIVER FUNCTION TEST (COMPLETE)

Test Name	Value	Unit	Biological Reference interval
BILIRUBIN TOTAL: SERUM *by DIAZOTIZATION, SPECTROPHOTOMETRY*	0.29	mg/dL	INFANT: 0.20 - 8.00 ADULT: 0.00 - 1.20
BILIRUBIN DIRECT (CONJUGATED): SERUM *by DIAZO MODIFIED, SPECTROPHOTOMETRY*	0.15	mg/dL	0.00 - 0.40
BILIRUBIN INDIRECT (UNCONJUGATED): SERUM *by CALCULATED, SPECTROPHOTOMETRY*	0.14	mg/dL	0.10 - 1.00
SGOT/AST: SERUM *by IFCC, WITHOUT PYRIDOXAL PHOSPHATE*	19.72	U/L	7.00 - 45.00
SGPT/ALT: SERUM *by IFCC, WITHOUT PYRIDOXAL PHOSPHATE*	22.24	U/L	0.00 - 49.00
AST/ALT RATIO: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	0.89	RATIO	0.00 - 46.00
ALKALINE PHOSPHATASE: SERUM *by PARA NITROPHENYL PHOSPHATASE BY AMINO METHYL PROPANOL*	86.47	U/L	40.0 - 130.0
GAMMA GLUTAMYL TRANSFERASE (GGT): SERUM *by SZASZ, SPECTROPHTOMETRY*	30.96	U/L	0.00 - 55.0
TOTAL PROTEINS: SERUM *by BIURET, SPECTROPHOTOMETRY*	6.86	gm/dL	6.20 - 8.00
ALBUMIN: SERUM *by BROMOCRESOL GREEN*	4.19	gm/dL	3.50 - 5.50
GLOBULIN: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	2.67	gm/dL	2.30 - 3.50
A : G RATIO: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	1.57	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

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

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

NAME	**: Mr. PARVEEN GUPTA**		
AGE/ GENDER	: 67 YRS/MALE	**PATIENT ID**	: 1738121
COLLECTED BY	:	**REG. NO./LAB NO.**	**: 012501280042**
REFERRED BY	:	**REGISTRATION DATE**	: 28/Jan/2025 04:25 PM
BARCODE NO.	: 01524574	**COLLECTION DATE**	: 28/Jan/2025 04:29PM
CLIENT CODE.	: KOS DIAGNOSTIC LAB	**REPORTING DATE**	: 28/Jan/2025 07:50PM
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

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 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

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

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

NAME	**: Mr. PARVEEN GUPTA**		
AGE/ GENDER	: 67 YRS/MALE	**PATIENT ID**	: 1738121
COLLECTED BY	:	**REG. NO./LAB NO.**	**: 012501280042**
REFERRED BY	:	**REGISTRATION DATE**	: 28/Jan/2025 04:25 PM
BARCODE NO.	: 01524574	**COLLECTION DATE**	: 28/Jan/2025 04:29PM
CLIENT CODE.	: KOS DIAGNOSTIC LAB	**REPORTING DATE**	: 30/Jan/2025 10:18AM
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

BETA 2 MICROGLOBULIN: SERUM

Test Name	Value	Unit	Biological Reference interval
BETA-2-MICROGLOBULIN: SERUM *by CLIA (CHEMILUMINESCENCE IMMUNOASSAY)*	1805	ng/mL	607 - 2454

INTERPRETATION:

NOTE:

1.False negative / positive results are observed in patients receiving mouse monoclonal antibodies for diagnosis or therapy.
2.Beta 2 microglobulin 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.

CLINICAL USE:

1.Prognostic indicator of Multiple myeloma and other hematopoietic malignancies.
2.An aid in the management of patients with Renal dysfunction and Rheumatoid arthritis

INCREASED LEVELS:

1.Lymphoproliferative disorders like Multiple myeloma, B cell Lymphoma and Chronic
2.Lymphocytic leukemia Inflammatory disorders like Rheumatoid arthritis, SLE, Sjogren's syndrome & Crohn's disease
3.Renal dysfunction

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

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

NAME	**: Mr. PARVEEN GUPTA**		
AGE/ GENDER	: 67 YRS/MALE	**PATIENT ID**	: 1738121
COLLECTED BY	:	**REG. NO./LAB NO.**	**: 012501280042**
REFERRED BY	:	**REGISTRATION DATE**	: 28/Jan/2025 04:25 PM
BARCODE NO.	: 01524574	**COLLECTION DATE**	: 28/Jan/2025 04:29PM
CLIENT CODE.	: KOS DIAGNOSTIC LAB	**REPORTING DATE**	: 29/Jan/2025 10:41AM
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval

IMMUNOPATHOLOGY/SEROLOGY

HEPATITIS B VIRUS CORE ANTIBODY (HBcAb): TOTAL

HEPATITIS B CORE ANTIBODY (HBcAb) TOTAL QUANTITATIVE *by CLIA (CHEMILUMINESCENCE IMMUNOASSAY)*	0.8	U/mL	< 0.85
HEPATITIS B CORE ANTIBODY (HBcAb) TOTAL RESULT *by CLIA (CHEMILUMINESCENCE IMMUNOASSAY)*	NON - REACTIVE		NON - REACTIVE

INTERPRETATION:

NEGATIVE	U/mL	< 0.85
EQUIVOCAL	U/mL	0.85 - 1.15
POSITIVE	U/mL	>1.15

NOTE:
1.Discrepant results may be observed in patients receiving mouse monoclonal antibodies for diagnosis or therapy
2.For heparinized patients, draw specimen prior to heparin therapy as presence of fibrin leads to erroneous results

COMMENTS:
1.Anti- HBc Total is the first antibody to appear usually 4-10 weeks after appearance of HBsAg, at the same time as clinical illness and persists for years or maybe lifetime.
2.It is almost always present during chronic HBV infection. It detects virtually all individuals who have been previously infected with HBV.
3.Detection of Anti HBc Total positive donors reduces incidence of post transmission Hepatitis and possibility of other viral infections like HIV due to frequency of dual infections.
4.This antibody may be seen in 2% of routine donors without any other serological marker and with normal liver enzyme levels. This indicates recovery from subclinical HBV infections.
5.Anti HBc Total is not protective and cannot be used to distinguish Acute from Chronic infection.

USES:
1.As a marker for HBV infection
2.As a screening test for blood donors

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

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

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

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

NAME	**: Mr. PARVEEN GUPTA**		
AGE/ GENDER	: 67 YRS/MALE	**PATIENT ID**	: 1738121
COLLECTED BY	:	**REG. NO./LAB NO.**	**: 012501280042**
REFERRED BY	:	**REGISTRATION DATE**	: 28/Jan/2025 04:25 PM
BARCODE NO.	: 01524574	**COLLECTION DATE**	: 28/Jan/2025 04:29PM
CLIENT CODE.	: KOS DIAGNOSTIC LAB	**REPORTING DATE**	: 28/Jan/2025 06:41PM
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval

HEPATITIS C VIRUS (HCV) ANTIBODY: TOTAL

HEPATITIS C ANTIBODY (HCV) TOTAL: SERUM *by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)*	0.07	S/CO	NEGATIVE: < 1.00 POSITIVE: > 1.00
HEPATITIS C ANTIBODY (HCV) TOTAL RESULT *by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)*	NON - REACTIVE		

INTERPRETATION:-

RESULT (INDEX)	REMARKS
< 1.00	NON - REACTIVE/NOT - DETECTED
> =1.00	REACTIVE/ASYMPTOMATIC/INFECTIVE STATE/CARRIER STATE.

Hepatitis C (HCV) is an RNA virus of Favivirus group transmitted via blood transfusions, transplantation, injection drug abusers, accidental needle punctures in healthcare workers, dialysis patients and rarely from mother to infant. 10 % of new cases show sexual transmission. As compared to HAV & HBV , chronic infection with HCV occurs in 85 % of infected individuals. In high risk population, the predictive value of Anti HCV for HCV infection is > 99% whereas in low risk populations it is only 25 %.

USES:

1. Indicator of past or present infection, but does not differentiate between Acute/ Chronic/Resolved Infection.
2. Routine screening of low and high prevelance population including blood donors.

NOTE:

1. False positive results are seen in Auto-immune disease, Rheumatoid Factor, HYpergammaglobulinemia, Paraproteinemia, Passive antibody transfer, Anti-idiotypes and Anti-superoxide dismutase.
2. False negative results are seen in early Acute infection, Immunosuppression and Immuno—incompetence.
3. *HCV-RNA PCR recommended in all reactive results to differentiate between past and present infection.*

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

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

NAME	**: Mr. PARVEEN GUPTA**		
AGE/ GENDER	: 67 YRS/MALE	**PATIENT ID**	: 1738121
COLLECTED BY	:	**REG. NO./LAB NO.**	**: 012501280042**
REFERRED BY	:	**REGISTRATION DATE**	: 28/Jan/2025 04:25 PM
BARCODE NO.	: 01524574	**COLLECTION DATE**	: 28/Jan/2025 04:29PM
CLIENT CODE.	: KOS DIAGNOSTIC LAB	**REPORTING DATE**	: 28/Jan/2025 06:41PM
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval

ANTI HUMAN IMMUNODEFICIENCY VIRUS (HIV) DUO ULTRA WITH (P-24 ANTIGEN DETECTION)

HIV 1/2 AND P24 ANTIGEN: SERUM *by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)*	0.09	S/CO	NEGATIVE: < 1.00 POSITIVE: > 1.00
HIV 1/2 AND P24 ANTIGEN RESULT *by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)*	NON - REACTIVE		

INTERPRETATION:-

RESULT (INDEX)	REMARKS
< 1.00	NON - REACTIVE
> = 1.00	PROVISIONALLY REACTIVE

Non-Reactive result implies that antibodies to HIV 1/ 2 have not been detected in the sample . This menas that patient has either not been exposed to HIV 1/ 2 infection or the sample has been tested during the “window phase” i.e. before the development of detectable levels of antibodies. Hence a Non Reactive result does not exclude the possibility of exposure or infection with HIV 1/ 2.

RECOMMENDATIONS:

1. Results to be clinically correlated
2. Rarely falsenegativity/positivity may occur.

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

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

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

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

NAME	**: Mr. PARVEEN GUPTA**		
AGE/ GENDER	: 67 YRS/MALE	**PATIENT ID**	: 1738121
COLLECTED BY	:	**REG. NO./LAB NO.**	**: 012501280042**
REFERRED BY	:	**REGISTRATION DATE**	: 28/Jan/2025 04:25 PM
BARCODE NO.	: 01524574	**COLLECTION DATE**	: 28/Jan/2025 04:29PM
CLIENT CODE.	: KOS DIAGNOSTIC LAB	**REPORTING DATE**	: 28/Jan/2025 07:50PM
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval

C-REACTIVE PROTEIN (CRP)

C-REACTIVE PROTEIN (CRP) QUANTITATIVE: SERUM *by NEPHLOMETRY*	3.66	mg/L	0.0 - 6.0

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.

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

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

NAME	**: Mr. PARVEEN GUPTA**		
AGE/ GENDER	: 67 YRS/MALE	**PATIENT ID**	: 1738121
COLLECTED BY	:	**REG. NO./LAB NO.**	**: 012501280042**
REFERRED BY	:	**REGISTRATION DATE**	: 28/Jan/2025 04:25 PM
BARCODE NO.	: 01524574	**COLLECTION DATE**	: 28/Jan/2025 04:29PM
CLIENT CODE.	: KOS DIAGNOSTIC LAB	**REPORTING DATE**	: 28/Jan/2025 06:40PM
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval

HEPATITIS B SURFACE ANTIGEN (HBsAg) ULTRA

HEPATITIS B SURFACE ANTIGEN (HBsAg): SERUM *by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)*	0.21	S/CO	NEGATIVE: < 1.0 POSITIVE: > 1.0
HEPATITIS B SURFACE ANTIGEN (HBsAg) RESULT *by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)*	NON REACTIVE		

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 symtoms. Persistence of HBsAg for more than 6 months indicates carrier state or Chronic Liver disease.

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

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

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

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

NAME	**: Mr. PARVEEN GUPTA**		
AGE/ GENDER	: 67 YRS/MALE	**PATIENT ID**	: 1738121
COLLECTED BY	:	**REG. NO./LAB NO.**	**: 012501280042**
REFERRED BY	:	**REGISTRATION DATE**	: 28/Jan/2025 04:25 PM
BARCODE NO.	: 01524574	**COLLECTION DATE**	: 28/Jan/2025 04:29PM
CLIENT CODE.	: KOS DIAGNOSTIC LAB	**REPORTING DATE**	: 28/Jan/2025 06:40PM
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval

VITAMINS

VITAMIN D/25 HYDROXY VITAMIN D3

VITAMIN D (25-HYDROXY VITAMIN D3): SERUM *by CLIA (CHEMILUMINESCENCE IMMUNOASSAY)*	**23.5[L]**	ng/mL	DEFICIENCY: < 20.0 INSUFFICIENCY: 20.0 - 30.0 SUFFICIENCY: 30.0 - 100.0 TOXICITY: > 100.0

INTERPRETATION:

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

1.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.
2.25-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.
3.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 harmone (PTH).
4.Severe deficiency may lead to failure to mineralize newly formed osteoid in bone, resulting in rickets in children and osteomalacia in adults.

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

INCREASED:
1. 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 hyperphophatemia.

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.*

*** End Of Report ***

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

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