

Dr. Vinay Chopra
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 Chairman & Consultant Pathologist

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

NAME	: Mrs. NANCY	PATIENT ID	: 1742308
AGE/ GENDER	: 32 YRS/FEMALE	REG. NO./LAB NO.	: 012502010040
COLLECTED BY	:	REGISTRATION DATE	: 01/Feb/2025 02:25 PM
REFERRED BY	: LOOMBA HOSPITAL (AMBALA CANTT)	COLLECTION DATE	: 01/Feb/2025 02:26PM
BARCODE NO.	: 01524773	REPORTING DATE	: 01/Feb/2025 03:03PM
CLIENT CODE.	: KOS DIAGNOSTIC LAB		
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
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HAEMATOLOGY

HAEMOGLOBIN (HB)

HAEMOGLOBIN (HB) by CALORIMETRIC	12.5	gm/dL	12.0 - 16.0
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INTERPRETATION:-

Hemoglobin is the protein molecule in red blood cells that carries oxygen from the lungs to the body's tissues and returns carbon dioxide from the tissues back to the lungs.

A low hemoglobin level is referred to as ANEMIA or low red blood count.

ANEMIA (DECREASED HAEMOGLOBIN):

- 1) Loss of blood (traumatic injury, surgery, bleeding, colon cancer or stomach ulcer)
- 2) Nutritional deficiency (iron, vitamin B12, folate)
- 3) Bone marrow problems (replacement of bone marrow by cancer)
- 4) Suppression by red blood cell synthesis by chemotherapy drugs
- 5) Kidney failure
- 6) Abnormal hemoglobin structure (sickle cell anemia or thalassemia).

POLYCYTHEMIA (INCREASED HAEMOGLOBIN):

- 1) People in higher altitudes (Physiological)
- 2) Smoking (Secondary Polycythemia)
- 3) Dehydration produces a falsely rise in hemoglobin due to increased haemoconcentration
- 4) Advanced lung disease (for example, emphysema)
- 5) Certain tumors
- 6) A disorder of the bone marrow known as polycythemia rubra vera,
- 7) Abuse of the drug erythropoietin (Epogen) by athletes for blood doping purposes (increasing the amount of oxygen available to the body by chemically raising the production of red blood cells).

NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD




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ENDOCRINOLOGY

ESTRADIOL (E2)

ESTRADIOL (E2): SERUM	42	pg/mL	FEMALE FOLLICULAR PHASE: 19.5 - 144.2 FEMALE MID CYCLE PHASE: 63.9 - 356.7 FEMALE PRE OVULATORY PHASE: 136.0 - 251.0 FEMALE LUTEAL PHASE: 55.8 - 214.2 POST MENOPAUSAL:< 50.0
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by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)

INTERPRETATION:

OTHER MATERNAL FACTORS AND PREGNANCY	UNITS	RANGE
Hormonal Contraceptives	pg/mL	15.0 – 95.0
1st Trimester (0 – 12 Weeks)	pg/mL	38.0 – 3175.0
2nd Trimester (13 – 28 Weeks)	pg/mL	678.0 – 16633.0
3rd Trimester (29 – 40 Weeks)	pg/mL	43.0 – 33781.0
Post Menopausal	Pg/mL	< 50.0
MALES:	pg/mL	< 40.0

1. Estrogens are involved in development and maintenance of the female phenotype, germ cell maturation, and pregnancy. They also are important for many other, nongender-specific processes, including growth, nervous system maturation, bone metabolism/remodeling, and endothelial responsiveness.

2. E2 is produced primarily in ovaries and testes by aromatization of testosterone.

3. Small amounts are produced in the adrenal glands and some peripheral tissues, most notably fat. E2 levels in premenopausal women fluctuate during the menstrual cycle.

4. They are lowest during the early follicular phase. E2 levels then rise gradually until 2 to 3 days before ovulation, at which stage they start to increase much more rapidly and peak just before the ovulation-inducing luteinizing hormone (LH)/follicle stimulating hormone (FSH) surge at 5 to 10 times the early follicular levels. This is followed by a modest decline during the ovulatory phase. E2 levels then increase again gradually until the midpoint of the luteal phase and thereafter decline to trough, early follicular levels.

INDICATIONS FOR ASSAY: -

1. Evaluation of hypogonadism and oligo-amenorrhea in females.
2. Assessing ovarian status, including follicle development, for assisted reproduction protocols (eg, in vitro fertilization)
3. In conjunction with luteinizing hormone measurements, monitoring of estrogen replacement therapy in hypogonadal premenopausal women
4. Evaluation of feminization, including gynecomastia, in males.
5. Diagnosis of estrogen-producing neoplasms in males, and, to a lesser degree, females




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6. As part of the diagnosis and work-up of precocious and delayed puberty in females, and, to a lesser degree, males
7. As part of the diagnosis and work-up of suspected disorders of sex steroid metabolism, eg: aromatase deficiency and 17 alpha-hydroxylase deficiency
8. As an adjunct to clinical assessment, imaging studies and bone mineral density measurement in the fracture risk assessment of postmenopausal women, and, to a lesser degree, older men
9. Monitoring low-dose female hormone replacement therapy in post-menopausal women
10. Monitoring antiestrogen therapy (eg, aromatase inhibitor therapy).

CAUSES FOR INCREASED E2 LEVELS:

1. High androgen levels caused by tumors or androgen therapy (medical or sport performance enhancing), with secondary elevations in E1 and E2 due to aromatization
2. Obesity with increased tissue production of E1
3. Decreased E1 and E2 clearance in liver disease
4. Estrogen producing tumors
5. Estrogen Ingestion




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PROGESTERONE

PROGESTERONE: SERUM <i>by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)</i>	0.55	ng/mL	MALES: 0.21 - 2.10 NON PREGNANT WOMEN MID FOLLICULAR PHASE: 0.29 - 1.55 MID LUTEAL PHASE: 5.11 - 18.78 PREGNANT WOMEN FIRST TRIMESTER: 4.69 - 51.31 SECOND TRIMESTER: 19.24 - 45.55
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INTERPRETATION:

EXPECTED VALUES OF PROGESTERONE DURING PREGNANCY

	UNITS (ng/mL)
First trimester (0 - 12 Wweeks)	15.8 - 46.0
Second trimester (13 - 28 Wweeks)	15.6 - 74.0
Third trimester (29 - 40 Wweeks)	45.0 - 143.0
Post Menopausal	< 1.40

1. Progesterone is produced by the adrenal glands, corpus luteum, and placenta.

2. After ovulation, there is a significant rise in serum Progesterone levels as the corpus luteum begins To produce progesterone in increasing amounts. This causes changes in the uterus, preparing it for implantation of a fertilized egg. If implantation occurs, the trophoblast begins to secrete human chorionic gonadotropin, which maintains the corpus luteum and its secretion of progesterone. If there is no implantation, the corpus luteum degenerates and circulating progesterone levels decrease rapidly, reaching follicular phase levels about 4 days before the next menstrual period.

The test is indicated for:

1. Ascertaining whether ovulation occurred in a menstrual cycle
2. Evaluation of placental function in pregnancy
3. Workup of some patients with adrenal or testicular tumors

NOTE:

In patients receiving therapy with high biotin doses (ie, >5 mg/day), no specimen should be drawn until at least 8 hours after the last biotin administration.

*** End Of Report ***




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