NAME	**: Baby. ANAYA WALIA**		
AGE/ GENDER	: 7 YRS/FEMALE	**PATIENT ID**	: 1743056
COLLECTED BY	: SURJESH	**REG. NO./LAB NO.**	**: 012502020019**
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BARCODE NO.	: 01524800	**COLLECTION DATE**	: 02/Feb/2025 09:48AM
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CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

SWASTHYA WELLNESS PANEL: 1.0

COMPLETE BLOOD COUNT (CBC)

Test Name	Value	Unit	Biological Reference interval
RED BLOOD CELLS (RBCS) COUNT AND INDICES			
HAEMOGLOBIN (HB) *by CALORIMETRIC*	12.1	gm/dL	12.0 - 16.0
RED BLOOD CELL (RBC) COUNT *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	5.22	Millions/cmm	3.50 - 5.50
PACKED CELL VOLUME (PCV) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	37.6	%	35.0 - 49.0
MEAN CORPUSCULAR VOLUME (MCV) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	**71.9**^{L}	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	**23.2**^{L}	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	32.3	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	15.2	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	41.4	fL	35.0 - 56.0
MENTZERS INDEX *by CALCULATED*	13.77	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX *by CALCULATED*	20.95	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*	7380	/cmm	5000 - 15000
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

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MD (Pathology)
CEO & Consultant Pathologist

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Test Name	Value	Unit	Biological Reference interval
DIFFERENTIAL LEUCOCYTE COUNT (DLC)			
NEUTROPHILS *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	**42^{L}**	%	50 - 70
LYMPHOCYTES *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	**48^{H}**	%	20 - 45
EOSINOPHILS *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	1	%	1 - 6
MONOCYTES *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	9	%	3 - 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*	3100	/cmm	2000 - 7500
ABSOLUTE LYMPHOCYTE COUNT *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	3542	/cmm	800 - 4900
ABSOLUTE EOSINOPHIL COUNT *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	74	/cmm	40 - 440
ABSOLUTE MONOCYTE COUNT *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	664	/cmm	80 - 880
PLATELETS AND OTHER PLATELET PREDICTIVE MARKERS.			
PLATELET COUNT (PLT) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	172000	/cmm	150000 - 450000
PLATELETCRIT (PCT) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	0.24	%	0.10 - 0.36
MEAN PLATELET VOLUME (MPV) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	**14^{H}**	fL	6.50 - 12.0
PLATELET LARGE CELL COUNT (P-LCC) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	**99000^{H}**	/cmm	30000 - 90000
PLATELET LARGE CELL RATIO (P-LCR) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	**57.9^{H}**	%	11.0 - 45.0
PLATELET DISTRIBUTION WIDTH (PDW) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	16.4	%	15.0 - 17.0

NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD

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

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MBBS , MD (PATHOLOGY)

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Test Name	Value	Unit	Biological Reference interval

ERYTHROCYTE SEDIMENTATION RATE (ESR)

ERYTHROCYTE SEDIMENTATION RATE (ESR)	14	mm/1st hr	0 - 20

by RED CELL AGGREGATION BY CAPILLARY PHOTOMETRY

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

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

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PERIPHERAL BLOOD SMEAR

TEST NAME:

PERIPHERAL BLOOD FILM/SMEAR (PBF)

RED BLOOD CELLS (RBC'S):

Mild anisocytosis with a few microcytes.RBCs mostly appear normochromic.No polychromatic cells or normoblasts present.

WHITE BLOOD CELLS (WBC'S):

No immature leucocytes seen.

PLATELETS:

Platelets appear adequate.

HEMOPARASITES:

NOT SEEN.

IMPRESSION:

Mild microcytic normochromic picture

DR.VINAY CHOPRA
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Test Name	Value	Unit	Biological Reference interval

PERIPHERAL BLOOD SMEAR FOR MALARIA

PERIPHERAL BLOOD SMEAR FOR MALARIAL PARASITE (MP) *by MICROSCOPY*	NO MALARIA PARASITE (MP) SEEN IN SMEAR EXAMINED		

DR.VINAY CHOPRA
CONSULTANT PATHOLOGIST
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Test Name	Value	Unit	Biological Reference interval

CLINICAL CHEMISTRY/BIOCHEMISTRY

GLUCOSE FASTING (F)

GLUCOSE FASTING (F): PLASMA *by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)*	90.46	mg/dL	NORMAL: < 100.0 PREDIABETIC: 100.0 - 125.0 DIABETIC: > 0R = 126.0

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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MBBS, MD (PATHOLOGY & MICROBIOLOGY)

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LIPID PROFILE : BASIC

Test Name	Value	Unit	Biological Reference interval
CHOLESTEROL TOTAL: SERUM *by CHOLESTEROL OXIDASE PAP*	136.2	mg/dL	OPTIMAL: < 200.0 BORDERLINE HIGH: 200.0 - 239.0 HIGH CHOLESTEROL: > OR = 240.0
TRIGLYCERIDES: SERUM *by GLYCEROL PHOSPHATE OXIDASE (ENZYMATIC)*	96.18	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 *by SELECTIVE INHIBITION*	31.31	mg/dL	LOW HDL: < 30.0 BORDERLINE HIGH HDL: 30.0 - 60.0 HIGH HDL: > OR = 60.0
LDL CHOLESTEROL: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	85.65	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 *by CALCULATED, SPECTROPHOTOMETRY*	104.89	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 *by CALCULATED, SPECTROPHOTOMETRY*	19.24	mg/dL	0.00 - 45.00
TOTAL LIPIDS: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	368.58	mg/dL	350.00 - 700.00
CHOLESTEROL/HDL RATIO: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	4.35	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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Test Name	Value	Unit	Biological Reference interval
LDL/HDL RATIO: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	2.74	RATIO	LOW RISK: 0.50 - 3.0 MODERATE RISK: 3.10 - 6.0 HIGH RISK: > 6.0
TRIGLYCERIDES/HDL RATIO: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	3.07	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 atherogeniclipoproteins such as LDL , VLDL, IDL, Lpa, 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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MBBS, MD (PATHOLOGY & MICROBIOLOGY)

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LIVER FUNCTION TEST (COMPLETE)

Test Name	Value	Unit	Biological Reference interval
BILIRUBIN TOTAL: SERUM *by DIAZOTIZATION, SPECTROPHOTOMETRY*	0.55	mg/dL	INFANT: 0.20 - 8.00 ADULT: 0.00 - 1.20
BILIRUBIN DIRECT (CONJUGATED): SERUM *by DIAZO MODIFIED, SPECTROPHOTOMETRY*	0.09	mg/dL	0.00 - 0.40
BILIRUBIN INDIRECT (UNCONJUGATED): SERUM *by CALCULATED, SPECTROPHOTOMETRY*	0.46	mg/dL	0.10 - 1.00
SGOT/AST: SERUM *by IFCC, WITHOUT PYRIDOXAL PHOSPHATE*	34	U/L	7.00 - 45.00
SGPT/ALT: SERUM *by IFCC, WITHOUT PYRIDOXAL PHOSPHATE*	37	U/L	0.00 - 49.00
AST/ALT RATIO: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	0.92	RATIO	0.00 - 46.00
ALKALINE PHOSPHATASE: SERUM *by PARA NITROPHENYL PHOSPHATASE BY AMINO METHYL PROPANOL*	267.66	U/L	50.00 - 370.00
GAMMA GLUTAMYL TRANSFERASE (GGT): SERUM *by SZASZ, SPECTROPHTOMETRY*	18.37	U/L	0.00 - 55.0
TOTAL PROTEINS: SERUM *by BIURET, SPECTROPHOTOMETRY*	6.9	gm/dL	6.20 - 8.00
ALBUMIN: SERUM *by BROMOCRESOL GREEN*	4.68	gm/dL	3.50 - 5.50
GLOBULIN: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	**2.22**^{L}	gm/dL	2.30 - 3.50
A : G RATIO: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	**2.11**^{H}	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
HEPATOCELLULAR CARCINOMA & CHRONIC HEPATITIS	> 1.3 (Slightly Increased)

DR.VINAY CHOPRA
CONSULTANT PATHOLOGIST
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Test Name	Value	Unit	Biological Reference interval

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

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Test Name	Value	Unit	Biological Reference interval
KIDNEY FUNCTION TEST (COMPLETE)			
UREA: SERUM *by UREASE - GLUTAMATE DEHYDROGENASE (GLDH)*	22.56	mg/dL	10.00 - 50.00
CREATININE: SERUM *by ENZYMATIC, SPECTROPHOTOMETERY*	0.66	mg/dL	0.40 - 1.20
BLOOD UREA NITROGEN (BUN): SERUM *by CALCULATED, SPECTROPHOTOMETRY*	10.54	mg/dL	7.0 - 25.0
BLOOD UREA NITROGEN (BUN)/CREATININE RATIO: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	15.97	RATIO	10.0 - 20.0
UREA/CREATININE RATIO: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	34.18	RATIO	
URIC ACID: SERUM *by URICASE - OXIDASE PEROXIDASE*	4.39	mg/dL	2.50 - 6.80
CALCIUM: SERUM *by ARSENAZO III, SPECTROPHOTOMETRY*	9.56	mg/dL	8.50 - 10.60
PHOSPHOROUS: SERUM *by PHOSPHOMOLYBDATE, SPECTROPHOTOMETRY*	4.65	mg/dL	2.30 - 4.70
ELECTROLYTES			
SODIUM: SERUM *by ISE (ION SELECTIVE ELECTRODE)*	139.65	mmol/L	135.0 - 150.0
POTASSIUM: SERUM *by ISE (ION SELECTIVE ELECTRODE)*	4.58	mmol/L	3.50 - 5.00
CHLORIDE: SERUM *by ISE (ION SELECTIVE ELECTRODE)*	104.74	mmol/L	90.0 - 110.0
ESTIMATED GLOMERULAR FILTERATION RATE			
ESTIMATED GLOMERULAR FILTERATION RATE (eGFR): SERUM *by CALCULATED*	139.5		

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.

DR.VINAY CHOPRA
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COLLECTED BY	: SURJESH	**REG. NO./LAB NO.**	**: 012502020019**
REFERRED BY	:	**REGISTRATION DATE**	: 02/Feb/2025 09:31 AM
BARCODE NO.	: 01524800	**COLLECTION DATE**	: 02/Feb/2025 09:48AM
CLIENT CODE.	: KOS DIAGNOSTIC LAB	**REPORTING DATE**	: 02/Feb/2025 12:09PM
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval

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 inappropiate antidiuretic harmone) 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.

INAPPROPIATE 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 FILTERATION 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	

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

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

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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 fullfill 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

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

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

Dr. Vinay Chopra
MD (Pathology & Microbiology)
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Test Name	Value	Unit	Biological Reference interval

IMMUNOPATHOLOGY/SEROLOGY

TYPHOID COMBO SCREEN (TYPHOID ANTIGEN, IgG AND IgM): SERUM

TYPHOID ANTIGEN - SERUM *by ICT (IMMUNOCHROMATOGRAPHY)*	NEGATIVE (-ve)		NEGATIVE (-ve)
TYPHI DOT ANTIBODY IgG *by ICT (IMMUNOCHROMATOGRAPHY)*	NEGATIVE (-ve)		NEGATIVE (-ve)
TYPHI DOT ANTIBODY IgM *by ICT (IMMUNOCHROMATOGRAPHY)*	NEGATIVE (-ve)		NEGATIVE (-ve)

INTE*RPRETATION:*

Typhoid fever is a life threatening illness caused by the bacterium Salmonella typhus.The infection is acquired typically by ingestion. On reaching the gut, the bacilli attach themselves to the epithelial cells of the intestinal villi and penetrate the lamina and submucosa. They are then phagocytosed there by polymorphs and mesenteric lymph nodes, where they multiply and, via the thoracic duct, enter the blood stream. A transient bacteremia follows, during which the bacilli are seeded in the liver, gall bladder, spleen, bone marrow, lymph nodes, and kidneys, where further multiplication takes place. Towards the end of the incubation period, there occurs a massive bacteremia from these sites, heralding the onset of the clinical symptoms.

The diagnosis of typhoid consists of isolation of the bacilli and the demonstration of antibodies. The isolation of the bacilli is very time consuming and antibody detection is not very specific. Other tests include the Widal reaction. The advantage of this test is that it takes only 10-20 minutes and requires only a small amount of stool/serum/plasma to perform. It is the easiest and most specific method for detecting S. typhi infection.

RELATIVE SENSTIVITY OF TYPHOID ANTIGEN DETECTION: 98.7%
RELATIVE SPECIFICITY OF TYPHOID ANTIGEN DETECTION: 97.4%

DETECTABLE IgM RESPONSE:

ONSET OF FEVER	PERCENT POSITIVE
4 - 6 DAYS	43.5
6 - 9 DAYS	92.9
> 9 DAYS	99.5

1.This is a solid phase, immunochromatographic ELISA assay that detects specific IgM and IgG Antibodies against the OUTER MEMBRAN PROTEIN(OMP) of theSalmonella species. IgM antibodies appear in the serum 2-3 days post infection and are indicative of a recent infection while the IgG antibodies appear later and are useful for presumptive diagnosis of Enteric fever if the patient presents more than a week after onset of symptoms.

2.This is a useful screening assay for the early detection of Enteric fever and has a high sensitivity. However the test has moderate specificity and false positive results may be obtained in the following situations:

- Antibodies against Salmonella may cross react with other antibodies.
- Unrelated infections may lead to production of specific Salmonella antibodies if the patient has previously been exposed to

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

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Test Name	Value	Unit	Biological Reference interval

Salmonella infection **(ANAMNESTIC RESPONSE)**.

NOTE:-Rapid blood culture performed during 1st week of infection is highly recommended for confirmation of all IgM positive results. In case the patient has presented after the first week of infection, a thorough clinical correlation and confirmatory Widal test must be performed to establish the diagnosis.

DR.VINAY CHOPRA
CONSULTANT PATHOLOGIST
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Test Name	Value	Unit	Biological Reference interval

C-REACTIVE PROTEIN (CRP)

C-REACTIVE PROTEIN (CRP) QUANTITATIVE: SERUM *by NEPHLOMETRY*	**38.11^{H}**	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
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Test Name	Value	Unit	Biological Reference interval

CLINICAL PATHOLOGY

URINE ROUTINE & MICROSCOPIC EXAMINATION

PHYSICAL EXAMINATION

QUANTITY RECIEVED *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	10	ml	
COLOUR *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	PALE YELLOW		PALE YELLOW
TRANSPARANCY *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	HAZY		CLEAR
SPECIFIC GRAVITY *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	1.02		1.002 - 1.030

CHEMICAL EXAMINATION

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

MICROSCOPIC EXAMINATION

RED BLOOD CELLS (RBCs)	NEGATIVE (-ve)	/HPF	0 - 3

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Test Name	Value	Unit	Biological Reference interval
by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT			
PUS CELLS	2-4	/HPF	0 - 5
by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT			
EPITHELIAL CELLS	1-2	/HPF	ABSENT
by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT			
CRYSTALS	NEGATIVE (-ve)		NEGATIVE (-ve)
by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT			
CASTS	NEGATIVE (-ve)		NEGATIVE (-ve)
by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT			
BACTERIA	NEGATIVE (-ve)		NEGATIVE (-ve)
by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT			
OTHERS	NEGATIVE (-ve)		NEGATIVE (-ve)
by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT			
TRICHOMONAS VAGINALIS (PROTOZOA)	ABSENT		ABSENT
by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT			

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MBBS, MD (PATHOLOGY & MICROBIOLOGY)

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CONSULTANT PATHOLOGIST
MBBS , MD (PATHOLOGY)

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MD (Pathology & Microbiology)
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CLIENT CODE.	: KOS DIAGNOSTIC LAB	**REPORTING DATE**	: 04/Feb/2025 04:49PM
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval

MICROBIOLOGY

CULTURE AEROBIC BACTERIA AND ANTIBIOTIC SENSITIVITY: URINE

CULTURE AND SUSCEPTIBILITY: URINE

DATE OF SAMPLE	02-02-2025
SPECIMEN SOURCE	URINE
INCUBATION PERIOD *by AUTOMATED BROTH CULTURE*	48 HOURS
CULTURE *by AUTOMATED BROTH CULTURE*	STERILE
ORGANISM *by AUTOMATED BROTH CULTURE*	NO AEROBIC PYOGENIC ORGANISM GROWN AFTER 48 HOURS OF INCUBATION AT 37*C

AEROBIC SUSCEPTIBILITY: URINE

INTERPRETATION:

1. In urine culture and sensitivity, presence of more than 100,000 organism per mL in midstream sample of urine is considered clinically significant. However in symptomatic patients , a smaller number of bacteria (100 to 10000/mL) may signify infection.
2. Colony count of 100 to 10000/ mL indicate infection, if isolate from specimen obtained by suprapubic aspiration or “in-and-out” catheterization or from patients with indwelling catheters.

SUSCEPTIBILITY:

1. A test interpreted as **SENSTITIVE** implies that infection due to isolate may be appropriately treated with the dosage of an antimicrobial agent recommended for that type of infection and infecting species, unless otherwise indicated..
2. A test interpreted as **INTERMEDIATE** implies that the” Infection due to the isolate may be appropriately treated in body sites where the drugs are physiologically concentrated or when a high dosage of drug can be used”.
3. A test interpreted as **RESISTANT** implies that the “isolates are not inhibited by the usually achievable concentration of the agents with normal dosage, schedule and/or fall in the range where specific microbial resistance mechanism are likely (e.g. beta-lactamases), and clinical efficacy has not been reliable in treatment studies.

CAUTION:

Conditions which can cause a false Negative culture:

1. Patient is on antibiotics. Please repeat culture post therapy.
2. Anaerobic bacterial infection.
3. Fastidious aerobic bacteria which are not able to grow on routine culture media.
4. Besides all these factors, at least in 25-40 % of cases there is no direct correlation between in vivo clinical picture.
5. Renal tuberculosis to be confirmed by AFB studies.

*** End Of Report ***

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

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