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

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

NAME	**: Mrs. KAVITA YADAV**		
AGE/ GENDER	: 42 YRS/FEMALE	**PATIENT ID**	: 1744248
COLLECTED BY	:	**REG. NO./LAB NO.**	**: 012502030056**
REFERRED BY	:	**REGISTRATION DATE**	: 03/Feb/2025 04:19 PM
BARCODE NO.	: 01524898	**COLLECTION DATE**	: 03/Feb/2025 04:24PM
CLIENT CODE.	: KOS DIAGNOSTIC LAB	**REPORTING DATE**	: 03/Feb/2025 08:13PM
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval

ENDOCRINOLOGY

THYROID FUNCTION TEST: TOTAL

TRIIODOTHYRONINE (T3): SERUM *by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)*	0.795	ng/mL	0.35 - 1.93
THYROXINE (T4): SERUM *by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)*	7.51	µgm/dL	4.87 - 12.60
THYROID STIMULATING HORMONE (TSH): SERUM *by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)*	**5.696^{H}**	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:-

1. 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.
2. 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).
3. 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.
4. 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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CONSULTANT PATHOLOGIST
MBBS, MD (PATHOLOGY & MICROBIOLOGY)

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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	1 – 10 Years	0.60 - 5.50
11- 19 Years	0.35 - 1.93	11 - 19 Years	4.87- 13.20	11 – 19 Years	0.50 – 5.50
> 20 years (Adults)	0.35 - 1.93	> 20 Years (Adults)	4.87 - 12.60	> 20 Years (Adults)	0.35– 5.50
RECOMMENDATIONS OF TSH LEVELS DURING PREGNANCY (µIU/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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Test Name	Value	Unit	Biological Reference interval

LUTEINISING HORMONE (LH)

LUTEINISING HORMONE (LH): SERUM *by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)*	101.65	mIU/mL	MALES: 0.57 - 12.07 FOLLICULAR PHASE: 1.80 - 11.78 MID-CYCLE PEAK: 7.59 - 89.08 LUTEAL PHASE: 0.56 - 14.0 POST MENOPAUSAL WITHOUT HRT: 5.16 - 61.99

INTERPRETATION:

1. Luteinizing hormone (LH) is a glycoprotein hormone consisting of 2 non covalently bound subunits (alpha and beta). Gonadotropin-releasing hormone from the hypothalamus controls the secretion of the gonadotropins, FSH and LH, from the anterior pituitary.
2. In both males and females, LH is essential for reproduction. In females, the menstrual cycle is divided by a mid cycle surge of both LH and FSH into a follicular phase and a luteal phase.
3. This "LH surge" triggers ovulation thereby not only releasing the egg, but also initiating the conversion of the residual follicle into a corpus luteum that, in turn, produces progesterone to prepare the endometrium for a possiblei mplantation.
4. LH supports thecal cells in the ovary that provide androgens and hormonal precursors for estradiol production. LH in males acts on testicular interstitial cells of Leydig to cause increased synthesis of testosterone.

The test is useful in the following situations:

1. An adjunctin the evaluation of menstrual irregularities.
2. Evaluating patients with suspected hypogonadism
3. Predicting ovulation & Evaluating infertility
4. Diagnosing pituitary disorders
5. In both males and females, primary hypogonadism results in an elevation of basal follicle-stimulating hormone and luteinizing hormone levels.

FSH AND LH ELEVTED IN:

1. Primary gonadal failure
2. Complete testicular feminization syndrome
3. Precocious puberty (either idiopathic or secondary to a central nervous system lesion)
4. Menopause
5. Primary ovarian hypo dysfunction in females
6. Polycystic ovary disease in females
7. Primary hypogonadism in males

LH IS DECREASED IN:

1 .Primary ovarian hyper function in females
2. Primary hypergonadism in males

NOTE

1 .FSH and LH are both decreased in failure of the pituitary or hypothalamus.

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Test Name	Value	Unit	Biological Reference interval

FOLLICLE STIMULATING HORMONE (FSH)

FOLLICLE STIMULATING HORMONE (FSH): SERUM *by CLIA (CHEMILUMINESCENCE IMMUNOASSAY)*	> 150.00	mIU/mL	FEMALE FOLLICULAR PHASE: 3.03 - 8.08 FEMALE MID-CYCLE PEAK: 2.55 - 16.69 FEAMLE LUTEAL PHASE: 1.38 - 5.47 FEMALE POST-MENOPAUSAL: 26.72 - 133.41 MALE: 0.95 - 11.95

INTERPRETATION:

1. Gonadotropin-releasing hormone from the hypothalamus controls the secretion of the gonadotropins, follicle-stimulating hormone (FSH) and luteinizing hormone (LH) from the anterior pituitary.
2. The menstrual cycle is divided by a midcycle surge of both FSH and LH into a follicular phase and a luteal phase.
3. FSH appears to control gametogenesis in both males and females.

The test is useful in the following settings:

1. An adjunct in the evaluation of menstrual irregularities.
2. Evaluating patients with suspected hypogonadism.
3. Predicting ovulation
4. Evaluating infertility
5. Diagnosing pituitary disorders
6. In both males and females, primary hypogonadism results in an elevation of basal follicle-stimulating hormone (FSH) and luteinizing hormone (LH) levels.

FSH and LH LEVELS ELEVATED IN:

1. Primary gonadal failure
2. Complete testicular feminization syndrome.
3. Precocious puberty (either idiopathic or secondary to a central nervous system lesion)
4. Menopause (postmenopausal FSH levels are generally >40 IU/L)
5. Primary ovarian hypofunction in females
6. Primary hypogonadism in males

NOTE:

1. Normal or decreased FSH is seen in polycystic ovarian disease in females
2. FSH and LH are both decreased in failure of the pituitary or hypothalamus.

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MBBS, MD (PATHOLOGY & MICROBIOLOGY)

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CONSULTANT PATHOLOGIST
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Test Name	Value	Unit	Biological Reference interval

PROLACTIN

PROLACTIN: SERUM *by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)*	**30.5^{H}**	ng/mL	3 - 25

INTERPRETATION:

1.Prolactin is secreted by the anterior pituitary gland and controlled by the hypothalamus.
2.The major chemical controlling prolactin secretion is dopamine, which inhibits prolactin secretion from the pituitary.
3.Physiological function of prolactin is the stimulation of milk production. In normal individuals, the prolactin level rises in response to physiologic stimuli such as sleep, exercise, nipple stimulation, sexual intercourse, hypoglycemia, postpartum period, and also is elevated in the newborn infant.

INCREASED (HYPERPROLACTEMIA):

1.Prolactin-secreting pituitary adenoma (prolactinoma, which is 5 times more frequent in females than males).
2.Functional and organic disease of the hypothalamus.
3.Primary hypothyroidism.
4.Section compression of the pituitary stalk.
5.Chest wall lesions and renal failure.
6.Ectopic tumors.
7.DRUGS:- Anti-Dopaminergic drugs like antipsychotic drugs, antinausea/antiemetic drugs, Drugs that affect CNS serotonin metabolism, serotonin receptors, or serotonin reuptake (anti-depressants of all classes, ergot derivatives, some illegal drugs such as cannabis), Antihypertensive drugs ,Opiates, High doses of estrogen or progesterone,anticonvulsants (valporic acid), anti-tuberculous medications (Isoniazid).

SIGNIFICANCE:

1.In loss of libido, galactorrhea, oligomHyperprolactinemia often results enorrhea or amenorrhea, and infertility in premenopausal females.
2.Loss of libido, impotence, infertility, and hypogonadism in males. Postmenopausal and premenopausal women, as well as men, can also suffer from decreased muscle mass and osteoporosis.
3. In males, prolactin levels >13 ng/mL are indicative of hyperprolactinemia.
4. In women, prolactin levels >27 ng/mL in the absence of pregnancy and postpartum lactation are indicative of hyperprolactinemia.
5.Clear symptoms and signs of hyperprolactinemia are often absent in patients with serum prolactin levels <100 ng/mL.
4. Mild to moderately increased levels of serum prolactin are not a reliable guide for determining whether a prolactin-producing pituitary adenoma is present, 5.Whereas levels >250 ng/mL are usually associated with a prolactin-secreting tumor.

CAUTION:

Prolactin values that exceed the reference values may be due to macroprolactin (prolactin bound to immunoglobulin). Macroprolactin should be evaluated if signs and symptoms of hyperprolactinemia are absent, or pituitary imaging studies are not informative.

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

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

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Test Name	Value	Unit	Biological Reference interval

ESTRADIOL (E2)

ESTRADIOL (E2): SERUM *by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)*	< 10	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

INTEPRETATION:

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 lutenizing 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
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

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

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CONSULTANT PATHOLOGIST
MBBS , MD (PATHOLOGY)

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Test Name	Value	Unit	Biological Reference interval

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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Test Name	Value	Unit	Biological Reference interval

ANTI MULLERIAN HORMONE (AMH) GEN II

ANTI MULLERIAN HORMONE (AMH) GEN II: SERUM *by ECLIA (ELECTROCHEMILUMINESCENCE IMMUNOASSAY)*	0.07	ng/mL	0.02 - 6.35

INTERPRETATION:-

A Correlation of FERTILITY POTENTIAL and AMH levels are :

OVARIAN FERTILITY POTENTIAL	AMH VALUES IN (ng/mL)
OPTIMAL FERTILITY:	4.00 – 6.80 ng/mL
SATISFACTORY FERTILITY:	2.20 – 4.00 ng/mL
LOW FERTILITY:	0.30 – 2.20 ng/mL
VERY LOW/UNDETECTABLE:	0.00 – 0.30 ng/mL
HIGH LEVEL:	>6.8 ng/mL (PCOD/GRANULOSA CELL TUMOUR)

Anti Mullerian Hormone (AMH) is also known as Mullerian Inhibiting Substance provided by sertoli cells of the testis in males and by ovarian granulose cells in females upto antral stage in females.

IN MALES:
1.It is used to evaluate testicular presence and function in infants with intersex conditions or ambiguous genitalia, and to distinguish between cryptorchidism and anorchia in males

IN FEMALES:
1.During reproductive age, follicular AMH productionbegins during the primary stage, peaks in preantral stage & has influence on follicular sensitivity to FSH which is impoetant in selection for follicular dominance. AMH levels thus represents the pool or number of primordial follicles but not thequality of oocytes.AMH does not vary significantly during menstrual cycle & hence can be measured independently of day of cycle.
2.Polycystic ovarian syndrome can elevate AMH 2 to 5 fold higher than age specific reference range & predict anovulatory, irregular cycles, ovarian tumours like Granulosa cell tumour are often associated with higher AMH levels.
3.Obese women are often associated with diminished ovarian reserve and can have 65% lower mean AMH levels than non-obese women.
4.In females , AMH levels do not change significantly throughout the menstrual cycle and decrease with age.
5.Assess Ovarian Reserve - correlates with the number of antral follicies in the ovaries.
6.Evaluate fertility potential and ovarian response in IVF- Women with low AMG levels are more likely to the poor ovarian responders.
7.Assess the condition of Polycystic Ovary and premature ovarian failure.

A combination of Age, Ultrasound markers-Ovarian Volume and Antral Follicle Count, AMH and FSH levels are useful for optimal assessment of ovarian reserve. Studies in various fertility clinics are ongoing to establish optimal AMH concentretaion for predicting response to invitro fertilization, however,given below is suggested interpretative reference.

AMH levels (ng/mL)	Suggested patient	Anticipated Antral	Anticipated FSH levels	Anticipated Response

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	Categorization for fertility based on AMH for age group (20 to 45 yrs)	**Follicle counts**	**(day 3)**	**to IVF/COH cycle**
Below 0.3	Very low	Below 4	Above 20	Negligible/Poor
0.3 to 2.19	Low	4 - 10	Usually 16 - 20	Reduced
2.19 t0 4.00	Satisfactory	11 - 25	Within reference range or between 11 - 15	Safe/Normal
Above 4.00	Optimal	Upto 30 and Above	Within reference range or between 11 – 15 or Above 15	Possibly Excessive

INCREASED:
1.Polycystic ovarian syndrome (most common)
2. Ovarian Tumour: Granulosa cell tumour

DECREASED:
1.Anorchia , Abnormal or absence of testis in males
2.Pseudohermaphroditism
3.Post Menopause

NOTE:
1.AMH measurement alone is seldom suffcient for diagnosis and results should be interpreted in the light of clinical finding and other relevant test such as ovarian ultrasonography(In fertility applications); abdominal or testicular ultrasound(intersex or testicular function applications); measurement of sex steroids (estradiol,Progesterone,Testosterone),FSH, Inhibin B (For fertility), and Inhibin A and B (for tumour work up).
2.Conversion of AMH grom ng/mL to pmol/L can be performed by using equation 1 ng/mL = 7.14 pmol/L

*** End Of Report ***

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