

**Dr. Vinay Chopra**  
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 Chairman & Consultant Pathologist

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

<b>NAME</b>	: <b>Master. SUKHPREET SINGH</b>	<b>PATIENT ID</b>	: 1766127
<b>AGE/ GENDER</b>	: 7 YRS/MALE	<b>REG. NO./LAB NO.</b>	: <b>012502220039</b>
<b>COLLECTED BY</b>	:	<b>REGISTRATION DATE</b>	: 22/Feb/2025 12:02 PM
<b>REFERRED BY</b>	: Dr. ARUN WALIA (AMBALA CANTT)	<b>COLLECTION DATE</b>	: 22/Feb/2025 12:09PM
<b>BARCODE NO.</b>	: 01525959	<b>REPORTING DATE</b>	: 22/Feb/2025 12:20PM
<b>CLIENT CODE.</b>	: KOS DIAGNOSTIC LAB		
<b>CLIENT ADDRESS</b>	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
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### HAEMATOLOGY

#### TOTAL LEUCOCYTE COUNT (TLC)

TOTAL LEUCOCYTE COUNT (TLC)	5080	/cmm	5000 - 15000
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD			



  
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### DIFFERENTIAL LEUCOCYTE COUNT (DLC)

NEUTROPHILS <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	63	%	50 - 70
LYMPHOCYTES <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	25	%	20 - 45
EOSINOPHILS <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	0 <sup>L</sup>	%	1 - 6
MONOCYTES <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	12	%	3 - 12
BASOPHILS <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	0	%	0 - 1

NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD



  
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<b>CLIENT CODE.</b>	: KOS DIAGNOSTIC LAB	<b>REPORTING DATE</b>	: 22/Feb/2025 12:40PM
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## IMMUNOPATHOLOGY/SEROLOGY

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

TYPHOID ANTIGEN - SERUM <i>by ICT (IMMUNOCHROMATOGRAPHY)</i>	NEGATIVE (-ve)	NEGATIVE (-ve)
TYPHI DOT ANTIBODY IgG <i>by ICT (IMMUNOCHROMATOGRAPHY)</i>	NEGATIVE (-ve)	NEGATIVE (-ve)
TYPHI DOT ANTIBODY IgM <i>by ICT (IMMUNOCHROMATOGRAPHY)</i>	NEGATIVE (-ve)	NEGATIVE (-ve)

#### INTERPRETATION:

Typhoid fever is a life threatening illness caused by the bacterium *Salmonella typhi*. 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 SENSITIVITY 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 the *Salmonella* 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



*[Signature]*

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Salmonella infection (ANAMNESTIC RESPONSE).

NOTE:-Rapid blood culture performed during 1<sup>st</sup> 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.



  
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### C-REACTIVE PROTEIN (CRP)

C-REACTIVE PROTEIN (CRP) QUANTITATIVE:	2.65	mg/L	0.0 - 6.0
SERUM			
by NEPHLOMETRY			

#### 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.

\*\*\* End Of Report \*\*\*



  
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