

**Dr. Vinay Chopra**  
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**Dr. Yugam Chopra**  
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<b>NAME</b>	: Mr. AKSHIT	<b>PATIENT ID</b>	: 1767680
<b>AGE/ GENDER</b>	: 32 YRS/MALE	<b>REG. NO./LAB NO.</b>	: 012502230049
<b>COLLECTED BY</b>	:	<b>REGISTRATION DATE</b>	: 23/Feb/2025 05:11 PM
<b>REFERRED BY</b>	:	<b>COLLECTION DATE</b>	: 23/Feb/2025 05:14PM
<b>BARCODE NO.</b>	: 01526041	<b>REPORTING DATE</b>	: 23/Feb/2025 05:28PM
<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**  
**COMPLETE BLOOD COUNT (CBC)**


**RED BLOOD CELLS (RBCS) COUNT AND INDICES**


HAEMOGLOBIN (HB) <i>by CALORIMETRIC</i>	14.2	gm/dL	12.0 - 17.0
RED BLOOD CELL (RBC) COUNT <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDEANCE</i>	<b>5.33<sup>H</sup></b>	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	44.5	%	40.0 - 54.0
MEAN CORPUSCULAR VOLUME (MCV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	83.3	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	<b>26.7<sup>L</sup></b>	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	32	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	14.8	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	46.3	fL	35.0 - 56.0
MENTZERS INDEX <i>by CALCULATED</i>	15.63	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX <i>by CALCULATED</i>	23.18	RATIO	BETA THALASSEMIA TRAIT:<= 65.0 IRON DEFICIENCY ANEMIA: > 65.0

**WHITE BLOOD CELLS (WBCS)**

TOTAL LEUCOCYTE COUNT (TLC) <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	4970	/cmm	4000 - 11000
NUCLEATED RED BLOOD CELLS (nRBCS) <i>by AUTOMATED 6 PART HEMATOLOGY ANALYZER</i>	NIL		0.00 - 20.00
NUCLEATED RED BLOOD CELLS (nRBCS) % <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	NIL	%	< 10 %



  
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TEST PERFORMED AT KOS DIAGNOSTIC LAB, AMBALA CANTT.

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<b><u>DIFFERENTIAL LEUCOCYTE COUNT (DLC)</u></b>			
NEUTROPHILS <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	69	%	50 - 70
LYMPHOCYTES <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	<b>19<sup>L</sup></b>	%	20 - 40
EOSINOPHILS <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	5	%	1 - 6
MONOCYTES <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	7	%	2 - 12
BASOPHILS <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	0	%	0 - 1
<b><u>ABSOLUTE LEUKOCYTES (WBC) COUNT</u></b>			
ABSOLUTE NEUTROPHIL COUNT <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	3429	/cmm	2000 - 7500
ABSOLUTE LYMPHOCYTE COUNT <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	944	/cmm	800 - 4900
ABSOLUTE EOSINOPHIL COUNT <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	248	/cmm	40 - 440
ABSOLUTE MONOCYTE COUNT <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	348	/cmm	80 - 880
<b><u>PLATELETS AND OTHER PLATELET PREDICTIVE MARKERS.</u></b>			
PLATELET COUNT (PLT) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	180000	/cmm	150000 - 450000
PLATELET CRIT (PCT) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	0.22	%	0.10 - 0.36
MEAN PLATELET VOLUME (MPV) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	<b>12<sup>H</sup></b>	fL	6.50 - 12.0
PLATELET LARGE CELL COUNT (P-LCC) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	81000	/cmm	30000 - 90000
PLATELET LARGE CELL RATIO (P-LCR) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	45	%	11.0 - 45.0
PLATELET DISTRIBUTION WIDTH (PDW) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	17	%	15.0 - 17.0
NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD			



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**PROTHROMBIN TIME STUDIES (PT/INR)**

PT TEST (PATIENT) <i>by PHOTO OPTICAL CLOT DETECTION</i>	11.7	SECS	11.5 - 14.5
PT (CONTROL) <i>by PHOTO OPTICAL CLOT DETECTION</i>	12	SECS	
ISI <i>by PHOTO OPTICAL CLOT DETECTION</i>	1.1		
INTERNATIONAL NORMALISED RATIO (INR) <i>by PHOTO OPTICAL CLOT DETECTION</i>	0.97		0.80 - 1.20
PT INDEX <i>by PHOTO OPTICAL CLOT DETECTION</i>	102.56	%	

**INTERPRETATION:-**

1. INR is the parameter of choice in monitoring adequacy of oral anti-coagulant therapy. Appropriate therapeutic range varies with the disease and treatment intensity.
2. Prolonged INR suggests potential bleeding disorder /bleeding complications
3. Results should be clinically correlated.
4. Test conducted on Citrated Plasma

**RECOMMENDED THERAPEUTIC RANGE FOR ORAL ANTI-COAGULANT THERAPY (INR)**

INDICATION	INTERNATIONAL NORMALIZED RATIO (INR)
Treatment of venous thrombosis	Low Intensity 2.0 - 3.0
Treatment of pulmonary embolism	
Prevention of systemic embolism in tissue heart valves	
Valvular heart disease	
Acute myocardial infarction	
Atrial fibrillation	
Bileaflet mechanical valve in aortic position	High Intensity 2.5 - 3.5
Recurrent embolism	
Mechanical heart valve	
Antiphospholipid antibodies <sup>+</sup>	

**COMMENTS:**



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The prothrombin time (PT) and its derived measures of prothrombin ratio (PR) and international normalized ratio (INR) are measures of the efficacy of the extrinsic pathway of coagulation. PT test reflects the adequacy of factors I (fibrinogen), II (prothrombin), V, VII, and X. It is used in conjunction with the activated partial thromboplastin time (aPTT) which measures the intrinsic pathway.

The common causes of prolonged prothrombin time are :

- 1.Oral Anticoagulant therapy.
- 2.Liver disease.
- 3.Vit K. deficiency.
- 4.Disseminated intra vascular coagulation.
- 5.Factor 5, 7 , 10 or Prothrombin deficiency

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**CLINICAL CHEMISTRY/BIOCHEMISTRY**

**GLUCOSE RANDOM (R)**

GLUCOSE RANDOM (R): PLASMA <i>by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)</i>	85.05	mg/dL	NORMAL: < 140.00 PREDIABETIC: 140.0 - 200.0 DIABETIC: > OR = 200.0
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**INTERPRETATION**

**IN ACCORDANCE WITH AMERICAN DIABETES ASSOCIATION GUIDELINES:**

1. A random plasma glucose level below 140 mg/dl is considered normal.
2. A random glucose level between 140 - 200 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 random glucose level of above 200 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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**SGOT/SGPT PROFILE**

SGOT/AST: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	26.27	U/L	7.00 - 45.00
SGPT/ALT: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	33.64	U/L	0.00 - 49.00
SGOT/SGPT RATIO <i>by CALCULATED, SPECTROPHOTOMETRY</i>	0.78		

**INTERPRETATION**

**NOTE:-** To be correlated in individuals having SGOT and SGPT values higher than Normal Reference 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 CHOLESTASIS	> 1.5
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 cholestasis: 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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**CREATININE**

CREATININE: SERUM <i>by ENZYMATIC, SPECTROPHOTOMETRY</i>	0.79	mg/dL	0.40 - 1.40
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**IMMUNOPATHOLOGY/SEROLOGY**

**HEPATITIS C VIRUS (HCV) ANTIBODY: TOTAL**

HEPATITIS C ANTIBODY (HCV) TOTAL: SERUM	0.09	S/CO	NEGATIVE: < 1.00
<i>by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)</i>			POSITIVE: > 1.00
HEPATITIS C ANTIBODY (HCV) TOTAL RESULT	NON - REACTIVE		
<i>by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)</i>			

**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 prevalence 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.



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

HIV 1/2 AND P24 ANTIGEN: SERUM <i>by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)</i>	0.19	S/CO	NEGATIVE: < 1.00 POSITIVE: > 1.00
HIV 1/2 AND P24 ANTIGEN RESULT <i>by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)</i>	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 means 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.



  
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**HEPATITIS B SURFACE ANTIGEN (HBsAg) ULTRA**

HEPATITIS B SURFACE ANTIGEN (HBsAg): SERUM <i>by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)</i>	0.38	S/CO	NEGATIVE: < 1.0 POSITIVE: > 1.0
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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 symptoms. Persistence of HBsAg for more than 6 months indicates carrier state or Chronic Liver disease.



  
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TEST PERFORMED AT KOS DIAGNOSTIC LAB, AMBALA CANTT.

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

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

<b>NAME</b>	: Mr. AKSHIT	<b>PATIENT ID</b>	: 1767680
<b>AGE/ GENDER</b>	: 32 YRS/MALE	<b>REG. NO./LAB NO.</b>	: 012502230049
<b>COLLECTED BY</b>	:	<b>REGISTRATION DATE</b>	: 23/Feb/2025 05:11 PM
<b>REFERRED BY</b>	:	<b>COLLECTION DATE</b>	: 23/Feb/2025 05:14PM
<b>BARCODE NO.</b>	: 01526041	<b>REPORTING DATE</b>	: 23/Feb/2025 07:17PM
<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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**VDRL**

VDRL <i>by IMMUNOCHROMATOGRAPHY</i>	NON REACTIVE		NON REACTIVE
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**INTERPRETATION:**

- Does not become positive until 7 - 10 days after appearance of chancre.
- High titer (>1:16) - active disease.**
- Low titer (<1:8) - biological falsepositive test in 90% cases or due to late or late latent syphilis.**
- Treatment of primary syphilis causes progressive decline tonegative VDRL within 2 years.
- Rising titer (4X) indicates relapse, reinfection, or treatment failure and need for retreatment.
- May benonreactive in early primary, late latent, and late syphilis (approx. 25% ofcases).
- Reactive and weakly reactive tests should always be confirmedwith FTA-ABS (fluorescent treponemal antibody absorptiontest).**

**SHORTTERM FALSE POSITIVE TEST RESULTS (<6 MONTHS DURATION) MAY OCCURIN:**

- Acute viral illnesses (e.g., hepatitis, measles, infectious mononucleosis)
- M. pneumoniae; Chlamydia; Malaria infection.
- Some immunizations
- Pregnancy (rare)

**LONGTERM FALSE POSITIVE TEST RESULTS (>6 MONTHS DURATION) MAY OCCUR IN:**

- Serious underlying disease e.g., collagen vascular diseases, leprosy ,malignancy.
- Intravenous drug users.
- Rheumatoid arthritis, thyroiditis, AIDS, Sjogren's syndrome.
- <10 % of patients older thanage 70 years.
- Patients taking some anti-hypertensive drugs.

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



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