

Dr. Vinay Chopra
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 Chairman & Consultant Pathologist

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

NAME	: Mrs. REEMA	PATIENT ID	: 1769405
AGE/ GENDER	: 38 YRS/FEMALE	REG. NO./LAB NO.	: 012502250011
COLLECTED BY	:	REGISTRATION DATE	: 25/Feb/2025 09:43 AM
REFERRED BY	:	COLLECTION DATE	: 25/Feb/2025 09:45AM
BARCODE NO.	: 01526105	REPORTING DATE	: 25/Feb/2025 11:24AM
CLIENT CODE.	: KOS DIAGNOSTIC LAB		
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
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ENDOCRINOLOGY
PROLACTIN

PROLACTIN: SERUM	> 200.00 ^H	ng/mL	3 - 25
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by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)

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 (valproic acid), anti-tuberculous medications (Isoniazid).

SIGNIFICANCE:

1. In loss of libido, galactorrhea, oligomenorrhea 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.





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BARCODE NO.	: 01526105	REPORTING DATE	: 25/Feb/2025 06:13PM
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Test Name	Value	Unit	Biological Reference interval
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ANTI MULLERIAN HORMONE (AMH) GEN II

ANTI MULLERIAN HORMONE (AMH) GEN II: SERUM **0.03^L** ng/mL 0.05 - 11.00
 by ECLIA (ELECTROCHEMILUMINESCENCE IMMUNOASSAY)

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 granulosa 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:

- During reproductive age, follicular AMH production begins during the primary stage, peaks in preantral stage & has influence on follicular sensitivity to FSH which is important in selection for follicular dominance. AMH levels thus represents the pool or number of primordial follicles but not the quality of oocytes. AMH does not vary significantly during menstrual cycle & hence can be measured independently of day of cycle.
- 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.
- Obese women are often associated with diminished ovarian reserve and can have 65% lower mean AMH levels than non-obese women.
- In females, AMH levels do not change significantly throughout the menstrual cycle and decrease with age.
- Assess Ovarian Reserve - correlates with the number of antral follicles in the ovaries.
- Evaluate fertility potential and ovarian response in IVF - Women with low AMH levels are more likely to be poor ovarian responders.
- 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 concentration 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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Test Name	Value	Unit	Biological Reference interval
	Categorization for fertility based on AMH for age group (20 to 45 yrs)	Follicle counts	(day 3)
Below 0.3	Very low	Below 4	Above 20
0.3 to 2.19	Low	4 - 10	Usually 16 - 20
2.19 to 4.00	Satisfactory	11 - 25	Within reference range or between 11 - 15
Above 4.00	Optimal	Upto 30 and Above	Within reference range or between 11 - 15 or Above 15
			to IVF/COH cycle
			Negligible/Poor
			Reduced
			Safe/Normal
			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 sufficient 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 from ng/mL to pmol/L can be performed by using equation $1 \text{ ng/mL} = 7.14 \text{ pmol/L}$

*** End Of Report ***





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