

Dr. Vinay Chopra  
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<b>NAME</b>	: Miss. SHALINI GUGLANI	<b>PATIENT ID</b>	: 1781675
<b>AGE/ GENDER</b>	: 38 YRS/FEMALE	<b>REG. NO./LAB NO.</b>	: 012503070004
<b>COLLECTED BY</b>	:	<b>REGISTRATION DATE</b>	: 07/Mar/2025 07:42 AM
<b>REFERRED BY</b>	:	<b>COLLECTION DATE</b>	: 07/Mar/2025 07:42AM
<b>BARCODE NO.</b>	: 01526593	<b>REPORTING DATE</b>	: 07/Mar/2025 08:45AM
<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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### HAEMATOTOLOGY

#### COMPLETE BLOOD COUNT (CBC)

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

HAEMOGLOBIN (HB) <i>by CALORIMETRIC</i>	13.1	gm/dL	12.0 - 16.0
RED BLOOD CELL (RBC) COUNT <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	4.53	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	39.8	%	37.0 - 50.0
MEAN CORPUSCULAR VOLUME (MCV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	88	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	29	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	32.9	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	13.7	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	45.4	fL	35.0 - 56.0
MENTZERS INDEX <i>by CALCULATED</i>	19.43	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX <i>by CALCULATED</i>	26.69	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>	8120	/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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<b><u>DIFFERENTIAL LEUCOCYTE COUNT (DLC)</u></b>			
NEUTROPHILS <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	74 <sup>H</sup>	%	50 - 70
LYMPHOCYTES <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	21	%	20 - 40
EOSINOPHILS <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	1 <sup>L</sup>	%	1 - 6
MONOCYTES <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	4	%	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>	6009	/cmm	2000 - 7500
ABSOLUTE LYMPHOCYTE COUNT <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	1705	/cmm	800 - 4900
ABSOLUTE EOSINOPHIL COUNT <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	81	/cmm	40 - 440
ABSOLUTE MONOCYTE COUNT <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	325	/cmm	80 - 880
ABSOLUTE BASOPHIL COUNT <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	0	/cmm	0 - 110
ABSOLUTE IMMATURE GRANULOCYTE COUNT <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	0	/cmm	0.0 - 999.0
<b><u>PLATELETS AND OTHER PLATELET PREDICTIVE MARKERS.</u></b>			
PLATELET COUNT (PLT) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	228000	/cmm	150000 - 450000
PLATELETCRIT (PCT) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	0.27	%	0.10 - 0.36
MEAN PLATELET VOLUME (MPV) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	12	fL	6.50 - 12.0
PLATELET LARGE CELL COUNT (P-LCC) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	89000	/cmm	30000 - 90000
PLATELET LARGE CELL RATIO (P-LCR) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	39.2	%	11.0 - 45.0
PLATELET DISTRIBUTION WIDTH (PDW) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	16.2	%	15.0 - 17.0



  
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NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD



  
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## CLINICAL CHEMISTRY/BIOCHEMISTRY

### IRON PROFILE

IRON: SERUM <i>by FERROZINE, SPECTROPHOTOMETRY</i>	53.29	µg/dL	37.0 - 145.0
UNSATURATED IRON BINDING CAPACITY (UIBC) :SERUM <i>by FERROZINE, SPECTROPHOTOMETRY</i>	246.85	µg/dL	150.0 - 336.0
TOTAL IRON BINDING CAPACITY (TIBC) :SERUM <i>by SPECTROPHOTOMETRY</i>	300.14	µg/dL	230 - 430
%TRANSFERRIN SATURATION: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY (FERENE)</i>	17.76	%	15.0 - 50.0
TRANSFERRIN: SERUM <i>by SPECTROPHOTOMETRY (FERENE)</i>	213.1	mg/dL	200.0 - 350.0

#### INTERPRETATION:-

VARIABLES	ANEMIA OF CHRONIC DISEASE	IRON DEFICIENCY ANEMIA	THALASSEMIA α/β TRAIT
SERUM IRON:	Normal to Reduced	Reduced	Normal
TOTAL IRON BINDING CAPACITY:	Decreased	Increased	Normal
% TRANSFERRIN SATURATION:	Decreased	Decreased < 12-15 %	Normal
SERUM FERRITIN:	Normal to Increased	Decreased	Normal or Increased

#### IRON:

1. Serum iron studies is recommended for differential diagnosis of microcytic hypochromic anemia. i.e iron deficiency anemia, zinc deficiency anemia, anemia of chronic disease and thalassemia syndromes.

2. It is essential to isolate iron deficiency anemia from Beta thalassemia syndromes because during iron replacement which is therapeutic for iron deficiency anemia, is severely contra-indicated in Thalassemia.

#### TOTAL IRON BINDING CAPACITY (TIBC):

1. It is a direct measure of protein transferrin which transports iron from the gut to storage sites in the bone marrow.

#### % TRANSFERRIN SATURATION:

1. Occurs in idiopathic hemochromatosis and transfusional hemosiderosis where no unsaturated iron binding capacity is available for iron mobilization. Similar condition is seen in congenital deficiency of transferrin.



  
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## VITAMINS

### VITAMIN B12/COBALAMIN

VITAMIN B12/COBALAMIN: SERUM **122<sup>L</sup>** pg/mL 190.0 - 890.0  
 by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)

#### INTERPRETATION:-

INCREASED VITAMIN B12	DECREASED VITAMIN B12
1.Ingestion of Vitamin C	1.Pregnancy
2.Ingestion of Estrogen	2.DRUGS:Aspirin, Anti-convulsants, Colchicine
3.Ingestion of Vitamin A	3.Ethanol lgestion
4.Hepatocellular injury	4. Contraceptive Harmones
5.Myeloproliferative disorder	5.Haemodialysis
6.Uremia	6. Multiple Myeloma

1.Vitamin B12 (cobalamin) is necessary for hematopoiesis and normal neuronal function.  
 2.In humans, it is obtained only from animal proteins and requires intrinsic factor (IF) for absorption.  
 3.The body uses its vitamin B12 stores very economically, reabsorbing vitamin B12 from the ileum and returning it to the liver; very little is excreted.  
 4.Vitamin B12 deficiency may be due to lack of IF secretion by gastric mucosa (eg, gastrectomy, gastric atrophy) or intestinal malabsorption (eg, ileal resection, small intestinal diseases).  
 5.Vitamin B12 deficiency frequently causes macrocytic anemia, glossitis, peripheral neuropathy, weakness, hyperreflexia, ataxia, loss of proprioception, poor coordination, and affective behavioral changes. These manifestations may occur in any combination; many patients have the neurologic defects without macrocytic anemia.  
 6.Serum methylmalonic acid and homocysteine levels are also elevated in vitamin B12 deficiency states.  
 7.Follow-up testing for antibodies to intrinsic factor (IF) is recommended to identify this potential cause of vitamin B12 malabsorption.  
**NOTE:**A normal serum concentration of vitamin B12 does not rule out tissue deficiency of vitamin B12. The most sensitive test for vitamin B12 deficiency at the cellular level is the assay for MMA. If clinical symptoms suggest deficiency, measurement of MMA and homocysteine should be considered, even if serum vitamin B12 concentrations are normal.



  
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## TUMOUR MARKER

### CANCER ANTIGEN 125 (CA 125): OVARIAN CANCER MARKER

CANCER ANTIGEN (CA) -125: SERUM      6.4      U/mL      0.0 - 35.0

by CMIA (CHEMILUMINESCENCE MICROPARTICLE IMMUNOASSAY)

#### INTERPRETATION:

1. Cancer antigen 125 (CA 125) is a glycoprotein antigen normally expressed in tissues derived from coelomic epithelia (ovary, fallopian tube, peritoneum, pleura, pericardium, colon, kidney, stomach).
2. Serum CA 125 is elevated in approximately 80% of women with advanced epithelial ovarian cancer, but assay sensitivity is suboptimal in early disease stages. The average reported sensitivities are 50% for stage I and 90% for stage II or greater.
3. Elevated serum CA 125 levels have been reported in individuals with a variety of nonovarian malignancies including cervical, liver, pancreatic, lung, colon, stomach, biliary tract, uterine, fallopian tube, breast, and endometrial carcinomas.

#### SIGNIFICANCE:

1. Evaluating patients' response to cancer therapy, especially for ovarian carcinoma
2. Predicting recurrent ovarian cancer or intra-peritoneal tumor. In monitoring studies, elevations of cancer antigen 125 (CA 125) >35 U/mL after de-bulking surgery and chemotherapy indicate that residual disease is likely (>95% accuracy). However, normal levels do not rule-out recurrence.
3. A persistently rising CA 125 value suggests progressive malignant disease and poor therapeutic response.
4. Physiologic half-life of CA 125 is approximately 5 days.
5. In patients with advanced disease who have undergone cyto-reductive surgery and are on chemotherapy, a prolonged half-life (>20 days) may be associated with a shortened disease-free survival.

#### NOTE:

1. CA 125 levels. Hence this assay, regardless of level, should not be interpreted as absolute evidence for the presence or absence of malignant disease. The assay value should be used in conjunction with findings from clinical evaluation and other diagnostic procedures. It is not recommended to use this test for the initial diagnosis of ovarian cancer.
2. Falsely Elevated serum CA 125 levels have been reported in individuals with a variety of nonmalignant conditions including: cirrhosis, hepatitis, endometriosis, first trimester pregnancy, ovarian cysts, and pelvic inflammatory disease. Elevated levels during the menstrual cycle also have been reported.

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





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