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

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



| | | | |
|---|---|---|---|
| **NAME** | **: Mrs. TAVINDER KAUR DUGGAL** | | |
| **AGE/ GENDER** | : 82 YRS/FEMALE | **PATIENT ID** | : 1781780 |
| **COLLECTED BY** | : SURJESH | **REG. NO./LAB NO.** | **: 012503070040** |
| **REFERRED BY** | : | **REGISTRATION DATE** | : 07/Mar/2025 10:58 AM |
| **BARCODE NO.** | : 01526629 | **COLLECTION DATE** | : 07/Mar/2025 11:19AM |
| **CLIENT CODE.** | : KOS DIAGNOSTIC LAB | **REPORTING DATE** | : 07/Mar/2025 11:33AM |
| **CLIENT ADDRESS** | : 6349/1, NICHOLSON ROAD, AMBALA CANTT | | |

# SWASTHYA WELLNESS PANEL: GT

## COMPLETE BLOOD COUNT (CBC)

| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|
| **RED BLOOD CELLS (RBCS) COUNT AND INDICES** | | | |
| HAEMOGLOBIN (HB)<br>*by CALORIMETRIC* | **10.8**[L] | gm/dL | 12.0 - 16.0 |
| RED BLOOD CELL (RBC) COUNT<br>*by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE* | 3.84 | Millions/cmm | 3.50 - 5.00 |
| PACKED CELL VOLUME (PCV)<br>*by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER* | **33.7**[L] | % | 37.0 - 50.0 |
| MEAN CORPUSCULAR VOLUME (MCV)<br>*by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER* | 87.9 | fL | 80.0 - 100.0 |
| MEAN CORPUSCULAR HAEMOGLOBIN (MCH)<br>*by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER* | 28.2 | pg | 27.0 - 34.0 |
| MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC)<br>*by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER* | 32.1 | g/dL | 32.0 - 36.0 |
| RED CELL DISTRIBUTION WIDTH (RDW-CV)<br>*by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER* | 14.8 | % | 11.00 - 16.00 |
| RED CELL DISTRIBUTION WIDTH (RDW-SD)<br>*by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER* | 48.8 | fL | 35.0 - 56.0 |
| MENTZERS INDEX<br>*by CALCULATED* | 22.89 | RATIO | BETA THALASSEMIA TRAIT: < 13.0<br>IRON DEFICIENCY ANEMIA: >13.0 |
| GREEN & KING INDEX<br>*by CALCULATED* | 33.97 | RATIO | BETA THALASSEMIA TRAIT:<= 65.0<br>IRON DEFICIENCY ANEMIA: > 65.0 |
| **WHITE BLOOD CELLS (WBCS)** | | | |
| TOTAL LEUCOCYTE COUNT (TLC)<br>*by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY* | 9230 | /cmm | 4000 - 11000 |
| NUCLEATED RED BLOOD CELLS (nRBCS)<br>*by AUTOMATED 6 PART HEMATOLOGY ANALYZER* | NIL | | 0.00 - 20.00 |
| NUCLEATED RED BLOOD CELLS (nRBCS) %<br>*by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER* | NIL | % | < 10 % |

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

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

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

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

| | | | |
|---|---|---|---|
| **NAME** | **: Mrs. TAVINDER KAUR DUGGAL** | | |
| **AGE/ GENDER** | : 82 YRS/FEMALE | **PATIENT ID** | : 1781780 |
| **COLLECTED BY** | : SURJESH | **REG. NO./LAB NO.** | **: 012503070040** |
| **REFERRED BY** | : | **REGISTRATION DATE** | : 07/Mar/2025 10:58 AM |
| **BARCODE NO.** | : 01526629 | **COLLECTION DATE** | : 07/Mar/2025 11:19AM |
| **CLIENT CODE.** | : KOS DIAGNOSTIC LAB | **REPORTING DATE** | : 07/Mar/2025 11:33AM |
| **CLIENT ADDRESS** | : 6349/1, NICHOLSON ROAD, AMBALA CANTT | | |

| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|
| **DIFFERENTIAL LEUCOCYTE COUNT (DLC)** | | | |
| NEUTROPHILS<br>*by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY* | 60 | % | 50 - 70 |
| LYMPHOCYTES<br>*by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY* | 33 | % | 20 - 40 |
| EOSINOPHILS<br>*by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY* | 3 | % | 1 - 6 |
| MONOCYTES<br>*by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY* | 4 | % | 2 - 12 |
| BASOPHILS<br>*by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY* | 0 | % | 0 - 1 |
| **ABSOLUTE LEUKOCYTES (WBC) COUNT** | | | |
| ABSOLUTE NEUTROPHIL COUNT<br>*by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY* | 5538 | /cmm | 2000 - 7500 |
| ABSOLUTE LYMPHOCYTE COUNT<br>*by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY* | 3046 | /cmm | 800 - 4900 |
| ABSOLUTE EOSINOPHIL COUNT<br>*by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY* | 277 | /cmm | 40 - 440 |
| ABSOLUTE MONOCYTE COUNT<br>*by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY* | 369 | /cmm | 80 - 880 |
| ABSOLUTE BASOPHIL COUNT<br>*by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY* | 0 | /cmm | 0 - 110 |
| ABSOLUTE IMMATURE GRANULOCYTE COUNT<br>*by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY* | 92 | /cmm | 0.0 - 999.0 |
| **PLATELETS AND OTHER PLATELET PREDICTIVE MARKERS.** | | | |
| PLATELET COUNT (PLT)<br>*by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE* | 311000 | /cmm | 150000 - 450000 |
| PLATELETCRIT (PCT)<br>*by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE* | 0.35 | % | 0.10 - 0.36 |
| MEAN PLATELET VOLUME (MPV)<br>*by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE* | 11 | fL | 6.50 - 12.0 |
| PLATELET LARGE CELL COUNT (P-LCC)<br>*by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE* | **107000$^{H}$** | /cmm | 30000 - 90000 |
| PLATELET LARGE CELL RATIO (P-LCR)<br>*by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE* | 34.5 | % | 11.0 - 45.0 |
| PLATELET DISTRIBUTION WIDTH (PDW)<br>*by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE* | 16.2 | % | 15.0 - 17.0 |

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

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

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

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

| | | | |
|---|---|---|---|
| **NAME** | **: Mrs. TAVINDER KAUR DUGGAL** | | |
| **AGE/ GENDER** | : 82 YRS/FEMALE | **PATIENT ID** | : 1781780 |
| **COLLECTED BY** | : SURJESH | **REG. NO./LAB NO.** | **: 012503070040** |
| **REFERRED BY** | : | **REGISTRATION DATE** | : 07/Mar/2025 10:58 AM |
| **BARCODE NO.** | : 01526629 | **COLLECTION DATE** | : 07/Mar/2025 11:19AM |
| **CLIENT CODE.** | : KOS DIAGNOSTIC LAB | **REPORTING DATE** | : 07/Mar/2025 11:33AM |
| **CLIENT ADDRESS** | : 6349/1, NICHOLSON ROAD, AMBALA CANTT | | |

| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|

NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD

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

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

| | | | |
|---|---|---|---|
| **NAME** | **: Mrs. TAVINDER KAUR DUGGAL** | | |
| **AGE/ GENDER** | : 82 YRS/FEMALE | **PATIENT ID** | : 1781780 |
| **COLLECTED BY** | : SURJESH | **REG. NO./LAB NO.** | **: 012503070040** |
| **REFERRED BY** | : | **REGISTRATION DATE** | : 07/Mar/2025 10:58 AM |
| **BARCODE NO.** | : 01526629 | **COLLECTION DATE** | : 07/Mar/2025 11:19AM |
| **CLIENT CODE.** | : KOS DIAGNOSTIC LAB | **REPORTING DATE** | : 07/Mar/2025 01:45PM |
| **CLIENT ADDRESS** | : 6349/1, NICHOLSON ROAD, AMBALA CANTT | | |

## GLYCOSYLATED HAEMOGLOBIN (HBA1C)

| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|
| GLYCOSYLATED HAEMOGLOBIN (HbA1c): WHOLE BLOOD<br>*by HPLC (HIGH PERFORMANCE LIQUID CHROMATOGRAPHY)* | **6.9$^{H}$** | % | 4.0 - 6.4 |
| ESTIMATED AVERAGE PLASMA GLUCOSE<br>*by HPLC (HIGH PERFORMANCE LIQUID CHROMATOGRAPHY)* | **151.33$^{H}$** | mg/dL | 60.00 - 140.00 |

***INTERPRETATION:***

| AS PER AMERICAN DIABETES ASSOCIATION (ADA): | | |
|---|---|---|
| **REFERENCE GROUP** | **GLYCOSYLATED HEMOGLOGIB (HBAIC) in %** | |
| Non diabetic Adults >= 18 years | <5.7 | |
| At Risk (Prediabetes) | 5.7 – 6.4 | |
| Diagnosing Diabetes | >= 6.5 | |
| Therapeutic goals for glycemic control | **Age > 19 Years** | |
| | Goals of Therapy: | < 7.0 |
| | Actions Suggested: | >8.0 |
| | **Age < 19 Years** | |
| | Goal of therapy: | <7.5 |

**COMMENTS:**

1.Glycosylated hemoglobin (HbA1c) test is three monthly monitoring done to assess compliace with therapeutic regimen in diabetic patients.

*2.Since Hb1c reflects long term fluctuations in blood glucose concentration, a diabetic patient who has recently under good control may still have high concentration of HbAlc. Converse is true for a diabetic previously under good control but now poorly controlled.*

*3.Target goals of < 7.0 % may be beneficial in patients with short duration of diabetes, long life expectancy and no significant cardiovascular disease. In patients with significant complications of diabetes, limited life expectancy or extensive co-morbid conditions, targetting a goal of < 7.0% may not be appropiate.*

4.High HbA1c (>9.0 -9.5 %) is strongly associated with risk of development and rapid progression of microvascular and nerve complications

5.Any condition that shorten RBC life span like acute blood loss, hemolytic anemia falsely lower HbA1c results.

6.HbA1c results from patients with HbSS,HbSC and HbD must be interpreted with caution , given the pathological processes including anemia,increased red cell turnover, and transfusion requirement that adversely impact HbA1c as a marker of long-term gycemic control.

7.Specimens from patients with polycythemia or post-splenctomy may exhibit increse in HbA1c values due to a somewhat longer life span of the red cells.

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

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

| | | | |
|---|---|---|---|
| **NAME** | **: Mrs. TAVINDER KAUR DUGGAL** | | |
| **AGE/ GENDER** | : 82 YRS/FEMALE | **PATIENT ID** | : 1781780 |
| **COLLECTED BY** | : SURJESH | **REG. NO./LAB NO.** | **: 012503070040** |
| **REFERRED BY** | : | **REGISTRATION DATE** | : 07/Mar/2025 10:58 AM |
| **BARCODE NO.** | : 01526629 | **COLLECTION DATE** | : 07/Mar/2025 11:19AM |
| **CLIENT CODE.** | : KOS DIAGNOSTIC LAB | **REPORTING DATE** | : 07/Mar/2025 12:18PM |
| **CLIENT ADDRESS** | : 6349/1, NICHOLSON ROAD, AMBALA CANTT | | |

| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|

## ERYTHROCYTE SEDIMENTATION RATE (ESR)

| | | | |
|---|---|---|---|
| ERYTHROCYTE SEDIMENTATION RATE (ESR)<br>*by RED CELL AGGREGATION BY CAPILLARY PHOTOMETRY* | **72$^{H}$** | mm/1st hr | 0 - 20 |

**INTERPRETATION:**

1. ESR is a non-specific test because an elevated result often indicates the presence of inflammation associated with infection, cancer and auto-immune disease, but does not tell the health practitioner exactly where the inflammation is in the body or what is causing it.
2. An ESR can be affected by other conditions besides inflammation. For this reason, the ESR is typically used in conjunction with other test such as C-reactive protein
3. This test may also be used to monitor disease activity and response to therapy in both of the above diseases as well as some others, such as systemic lupus erythematosus

**CONDITION WITH LOW ESR**

A low ESR can be seen with conditions that inhibit the normal sedimentation of red blood cells, such as a high red blood cell count (polycythaemia), significantly high white blood cell count (leucocytosis) , and some protein abnormalities. Some changes in red cell shape (such as sickle cells in sickle cell anaemia) also lower the ESR.

**NOTE:**

1. ESR and C - reactive protein (C-RP) are both markers of inflammation.
2. Generally, ESR does not change as rapidly as does CRP, either at the start of inflammation or as it resolves.
3. **CRP is not affected by as many other factors as is ESR, making it a better marker of inflammation.**
4. If the ESR is elevated, it is typically a result of two types of proteins, globulins or fibrinogen.
5. Women tend to have a higher ESR, and menstruation and pregnancy can cause temporary elevations.
6. Drugs such as dextran, methyldopa, oral contraceptives, penicillamine procainamide, theophylline, and vitamin A can increase ESR, while aspirin, cortisone, and quinine may decrease it

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

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

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

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



| | | | |
|---|---|---|---|
| **NAME** | **: Mrs. TAVINDER KAUR DUGGAL** | | |
| **AGE/ GENDER** | : 82 YRS/FEMALE | **PATIENT ID** | : 1781780 |
| **COLLECTED BY** | : SURJESH | **REG. NO./LAB NO.** | **: 012503070040** |
| **REFERRED BY** | : | **REGISTRATION DATE** | : 07/Mar/2025 10:58 AM |
| **BARCODE NO.** | : 01526629 | **COLLECTION DATE** | : 07/Mar/2025 11:19AM |
| **CLIENT CODE.** | : KOS DIAGNOSTIC LAB | **REPORTING DATE** | : 07/Mar/2025 11:52AM |
| **CLIENT ADDRESS** | : 6349/1, NICHOLSON ROAD, AMBALA CANTT | | |

| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|

## PROTHROMBIN TIME STUDIES (PT/INR)

| | | | |
|---|---|---|---|
| PT TEST (PATIENT)<br>*by PHOTO OPTICAL CLOT DETECTION* | 13.6 | SECS | 11.5 - 14.5 |
| PT (CONTROL)<br>*by PHOTO OPTICAL CLOT DETECTION* | 12 | SECS | |
| ISI<br>*by PHOTO OPTICAL CLOT DETECTION* | 1.1 | | |
| INTERNATIONAL NORMALISED RATIO (INR)<br>*by PHOTO OPTICAL CLOT DETECTION* | 1.15 | | 0.80 - 1.20 |
| PT INDEX<br>*by PHOTO OPTICAL CLOT DETECTION* | 88.24 | % | |

***INTERPRETATION:-***

1.INR is the parameter of choice in monitoring adequacy of oral anti-coagulant therapy. Appropiate 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 | | |
| Recurrent embolism | High Intensity | 2.5 - 3.5 |
| Mechanical heart valve | | |
| Antiphospholipid antibodies+ | | |

**COMMENTS:**

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

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

| | | | |
|---|---|---|---|
| **NAME** | **: Mrs. TAVINDER KAUR DUGGAL** | | |
| **AGE/ GENDER** | : 82 YRS/FEMALE | **PATIENT ID** | : 1781780 |
| **COLLECTED BY** | : SURJESH | **REG. NO./LAB NO.** | **: 012503070040** |
| **REFERRED BY** | : | **REGISTRATION DATE** | : 07/Mar/2025 10:58 AM |
| **BARCODE NO.** | : 01526629 | **COLLECTION DATE** | : 07/Mar/2025 11:19AM |
| **CLIENT CODE.** | : KOS DIAGNOSTIC LAB | **REPORTING DATE** | : 07/Mar/2025 11:52AM |
| **CLIENT ADDRESS** | : 6349/1, NICHOLSON ROAD, AMBALA CANTT | | |

| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|

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 dificiency

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

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

| | | | |
|---|---|---|---|
| **NAME** | **: Mrs. TAVINDER KAUR DUGGAL** | | |
| **AGE/ GENDER** | : 82 YRS/FEMALE | **PATIENT ID** | : 1781780 |
| **COLLECTED BY** | : SURJESH | **REG. NO./LAB NO.** | **: 012503070040** |
| **REFERRED BY** | : | **REGISTRATION DATE** | : 07/Mar/2025 10:58 AM |
| **BARCODE NO.** | : 01526629 | **COLLECTION DATE** | : 07/Mar/2025 11:19AM |
| **CLIENT CODE.** | : KOS DIAGNOSTIC LAB | **REPORTING DATE** | : 07/Mar/2025 11:52AM |
| **CLIENT ADDRESS** | : 6349/1, NICHOLSON ROAD, AMBALA CANTT | | |

| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|

## ACTIVATED PARTIAL THROMBOPLASTIN TIME (APTT)

| | | | |
|---|---|---|---|
| APTT (PATIENT VALUE)<br>*by PHOTO OPTICAL CLOT DETECTION* | 33.7 | SECS | 28.6 - 38.2 |

***INTERPRETATION:-***

The activated partial thromboplastin time (aPTT or APTT) is a performance indicator measuring the efficacy of both the **intrinsic** (now referred to as the contact activation pathway) and the common coagulation pathways. Apart from detecting abnormalities in blood clotting, it is also used to monitor the treatment effects with heparin, a major anticoagulant. It is used in conjunction with the prothrombin time (PT) which measures the extrinsic pathway.

**COMMON CAUSES OF PROLONGED APTT :-**

1. Disseminated intravascular coagulation.
2. Liver disease.
3. Massive transfusion with stored blood.
4. Heparin administration or contamination.
5. A circulating Anticogulant.
6. Deficiency of a coagulation Factor other than factor 7.

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

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

| | | | |
|---|---|---|---|
| **NAME** | **: Mrs. TAVINDER KAUR DUGGAL** | | |
| **AGE/ GENDER** | : 82 YRS/FEMALE | **PATIENT ID** | : 1781780 |
| **COLLECTED BY** | : SURJESH | **REG. NO./LAB NO.** | **: 012503070040** |
| **REFERRED BY** | : | **REGISTRATION DATE** | : 07/Mar/2025 10:58 AM |
| **BARCODE NO.** | : 01526629 | **COLLECTION DATE** | : 07/Mar/2025 11:19AM |
| **CLIENT CODE.** | : KOS DIAGNOSTIC LAB | **REPORTING DATE** | : 07/Mar/2025 03:45PM |
| **CLIENT ADDRESS** | : 6349/1, NICHOLSON ROAD, AMBALA CANTT | | |

| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|

## CLINICAL CHEMISTRY/BIOCHEMISTRY

### GLUCOSE FASTING (F)

| | | | |
|---|---|---|---|
| GLUCOSE FASTING (F): PLASMA<br>*by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)* | 92.09 | mg/dL | NORMAL: < 100.0<br>PREDIABETIC: 100.0 - 125.0<br>DIABETIC: > 0R = 126.0 |

***INTERPRETATION***

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

1. A fasting plasma glucose level below 100 mg/dl is considered normal.
2. A fasting plasma glucose level between 100 - 125 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 fasting plasma glucose level of above 125 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.

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

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

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

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



| | | | |
|---|---|---|---|
| **NAME** | **: Mrs. TAVINDER KAUR DUGGAL** | | |
| **AGE/ GENDER** | : 82 YRS/FEMALE | **PATIENT ID** | : 1781780 |
| **COLLECTED BY** | : SURJESH | **REG. NO./LAB NO.** | **: 012503070040** |
| **REFERRED BY** | : | **REGISTRATION DATE** | : 07/Mar/2025 10:58 AM |
| **BARCODE NO.** | : 01526629 | **COLLECTION DATE** | : 07/Mar/2025 11:19AM |
| **CLIENT CODE.** | : KOS DIAGNOSTIC LAB | **REPORTING DATE** | : 07/Mar/2025 02:36PM |
| **CLIENT ADDRESS** | : 6349/1, NICHOLSON ROAD, AMBALA CANTT | | |

## LIPID PROFILE : BASIC

| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|
| CHOLESTEROL TOTAL: SERUM<br>*by CHOLESTEROL OXIDASE PAP* | 179.69 | mg/dL | OPTIMAL: < 200.0<br>BORDERLINE HIGH: 200.0 - 239.0<br>HIGH CHOLESTEROL: > OR = 240.0 |
| TRIGLYCERIDES: SERUM<br>*by GLYCEROL PHOSPHATE OXIDASE (ENZYMATIC)* | **259.62$^{H}$** | mg/dL | OPTIMAL: < 150.0<br>BORDERLINE HIGH: 150.0 - 199.0<br>HIGH: 200.0 - 499.0<br>VERY HIGH: > OR = 500.0 |
| HDL CHOLESTEROL (DIRECT): SERUM<br>*by SELECTIVE INHIBITION* | 49.3 | mg/dL | LOW HDL: < 30.0<br>BORDERLINE HIGH HDL: 30.0 - 60.0<br>HIGH HDL: > OR = 60.0 |
| LDL CHOLESTEROL: SERUM<br>*by CALCULATED, SPECTROPHOTOMETRY* | 78.47 | mg/dL | OPTIMAL: < 100.0<br>ABOVE OPTIMAL: 100.0 - 129.0<br>BORDERLINE HIGH: 130.0 - 159.0<br>HIGH: 160.0 - 189.0<br>VERY HIGH: > OR = 190.0 |
| NON HDL CHOLESTEROL: SERUM<br>*by CALCULATED, SPECTROPHOTOMETRY* | **130.39$^{H}$** | mg/dL | OPTIMAL: < 130.0<br>ABOVE OPTIMAL: 130.0 - 159.0<br>BORDERLINE HIGH: 160.0 - 189.0<br>HIGH: 190.0 - 219.0<br>VERY HIGH: > OR = 220.0 |
| VLDL CHOLESTEROL: SERUM<br>*by CALCULATED, SPECTROPHOTOMETRY* | **51.92$^{H}$** | mg/dL | 0.00 - 45.00 |
| TOTAL LIPIDS: SERUM<br>*by CALCULATED, SPECTROPHOTOMETRY* | 619 | mg/dL | 350.00 - 700.00 |
| CHOLESTEROL/HDL RATIO: SERUM<br>*by CALCULATED, SPECTROPHOTOMETRY* | 3.64 | RATIO | LOW RISK: 3.30 - 4.40<br>AVERAGE RISK: 4.50 - 7.0<br>MODERATE RISK: 7.10 - 11.0<br>HIGH RISK: > 11.0 |

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

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

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

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

| | | | |
|---|---|---|---|
| **NAME** | **: Mrs. TAVINDER KAUR DUGGAL** | | |
| **AGE/ GENDER** | : 82 YRS/FEMALE | **PATIENT ID** | : 1781780 |
| **COLLECTED BY** | : SURJESH | **REG. NO./LAB NO.** | **: 012503070040** |
| **REFERRED BY** | : | **REGISTRATION DATE** | : 07/Mar/2025 10:58 AM |
| **BARCODE NO.** | : 01526629 | **COLLECTION DATE** | : 07/Mar/2025 11:19AM |
| **CLIENT CODE.** | : KOS DIAGNOSTIC LAB | **REPORTING DATE** | : 07/Mar/2025 02:36PM |
| **CLIENT ADDRESS** | : 6349/1, NICHOLSON ROAD, AMBALA CANTT | | |

| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|
| LDL/HDL RATIO: SERUM<br>*by CALCULATED, SPECTROPHOTOMETRY* | 1.59 | RATIO | LOW RISK: 0.50 - 3.0<br>MODERATE RISK: 3.10 - 6.0<br>HIGH RISK: > 6.0 |
| TRIGLYCERIDES/HDL RATIO: SERUM<br>*by CALCULATED, SPECTROPHOTOMETRY* | **5.27$^{H}$** | RATIO | 3.00 - 5.00 |

***INTERPRETATION:***

1.Measurements in the same patient can show physiological& analytical variations. Three serial samples 1 week apart are recommended for Total Cholesterol, Triglycerides, HDL & LDL Cholesterol.
2. As per NLA-2014 guidelines, all adults above the age of 20 years should be screened for lipid status. Selective screening of children above the age of 2 years with a family history of premature cardiovascular disease or those with at least one parent with high total cholesterol is recommended.
3. Low HDL levels are associated with increased risk for Atherosclerotic Cardiovascular disease (ASCVD) due to insufficient HDL being available to participate in reverse cholesterol transport, the process by which cholesterol is eliminated from peripheral tissues.
4. NLA-2014 identifies Non HDL Cholesterol (an indicator of all atherogeniclipoproteins such as LDL , VLDL, IDL, Lpa, Chylomicron remnants) along with LDL-cholesterol as co- primary target for cholesterol lowering therapy. Note that major risk factors can modify treatment goals for LDL &Non HDL.
5. Additional testing for Apolipoprotein B, hsCRP,Lp(a ) & LP-PLA2 should be considered among patients with moderate risk for ASCVD for risk refinement

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

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

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

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



| | | | |
|---|---|---|---|
| **NAME** | **: Mrs. TAVINDER KAUR DUGGAL** | | |
| **AGE / GENDER** | : 82 YRS/FEMALE | **PATIENT ID** | : 1781780 |
| **COLLECTED BY** | : SURJESH | **REG. NO./LAB NO.** | **: 012503070040** |
| **REFERRED BY** | : | **REGISTRATION DATE** | : 07/Mar/2025 10:58 AM |
| **BARCODE NO.** | : 01526629 | **COLLECTION DATE** | : 07/Mar/2025 11:19AM |
| **CLIENT CODE.** | : KOS DIAGNOSTIC LAB | **REPORTING DATE** | : 07/Mar/2025 02:36PM |
| **CLIENT ADDRESS** | : 6349/1, NICHOLSON ROAD, AMBALA CANTT | | |

## LIVER FUNCTION TEST (COMPLETE)

| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|
| BILIRUBIN TOTAL: SERUM<br>*by DIAZOTIZATION, SPECTROPHOTOMETRY* | 0.29 | mg/dL | INFANT: 0.20 - 8.00<br>ADULT: 0.00 - 1.20 |
| BILIRUBIN DIRECT (CONJUGATED): SERUM<br>*by DIAZO MODIFIED, SPECTROPHOTOMETRY* | 0.08 | mg/dL | 0.00 - 0.40 |
| BILIRUBIN INDIRECT (UNCONJUGATED): SERUM<br>*by CALCULATED, SPECTROPHOTOMETRY* | 0.21 | mg/dL | 0.10 - 1.00 |
| SGOT/AST: SERUM<br>*by IFCC, WITHOUT PYRIDOXAL PHOSPHATE* | 20.75 | U/L | 7.00 - 45.00 |
| SGPT/ALT: SERUM<br>*by IFCC, WITHOUT PYRIDOXAL PHOSPHATE* | 22.44 | U/L | 0.00 - 49.00 |
| AST/ALT RATIO: SERUM<br>*by CALCULATED, SPECTROPHOTOMETRY* | 0.92 | RATIO | 0.00 - 46.00 |
| ALKALINE PHOSPHATASE: SERUM<br>*by PARA NITROPHENYL PHOSPHATASE BY AMINO METHYL PROPANOL* | **166.11$^{H}$** | U/L | 40.0 - 130.0 |
| GAMMA GLUTAMYL TRANSFERASE (GGT): SERUM<br>*by SZASZ, SPECTROPHTOMETRY* | **82.13$^{H}$** | U/L | 0.00 - 55.0 |
| TOTAL PROTEINS: SERUM<br>*by BIURET, SPECTROPHOTOMETRY* | 6.43 | gm/dL | 6.20 - 8.00 |
| ALBUMIN: SERUM<br>*by BROMOCRESOL GREEN* | 3.75 | gm/dL | 3.50 - 5.50 |
| GLOBULIN: SERUM<br>*by CALCULATED, SPECTROPHOTOMETRY* | 2.68 | gm/dL | 2.30 - 3.50 |
| A : G RATIO: SERUM<br>*by CALCULATED, SPECTROPHOTOMETRY* | 1.4 | RATIO | 1.00 - 2.00 |

***INTERPRETATION***

***NOTE***:- **To be correlated in individuals having SGOT and SGPT values higher than Normal Referance 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 CHOLESTATIS | > 1.5 |
| HEPATOCELLULAR CARCINOMA & CHRONIC HEPATITIS | > 1.3 (Slightly Increased) |

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

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

| | | | |
|---|---|---|---|
| **NAME** | **: Mrs. TAVINDER KAUR DUGGAL** | | |
| **AGE/ GENDER** | : 82 YRS/FEMALE | **PATIENT ID** | : 1781780 |
| **COLLECTED BY** | : SURJESH | **REG. NO./LAB NO.** | **: 012503070040** |
| **REFERRED BY** | : | **REGISTRATION DATE** | : 07/Mar/2025 10:58 AM |
| **BARCODE NO.** | : 01526629 | **COLLECTION DATE** | : 07/Mar/2025 11:19AM |
| **CLIENT CODE.** | : KOS DIAGNOSTIC LAB | **REPORTING DATE** | : 07/Mar/2025 02:36PM |
| **CLIENT ADDRESS** | : 6349/1, NICHOLSON ROAD, AMBALA CANTT | | |

| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|

**DECREASED:**

1. Acute Hepatitis due to virus, drugs, toxins (with AST increased 3 to 10 times upper limit of normal)
2. Extra Hepatic cholestatis: 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 |

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

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

| | | | |
|---|---|---|---|
| **NAME** | **: Mrs. TAVINDER KAUR DUGGAL** | | |
| **AGE/ GENDER** | : 82 YRS/FEMALE | **PATIENT ID** | : 1781780 |
| **COLLECTED BY** | : SURJESH | **REG. NO./LAB NO.** | **: 012503070040** |
| **REFERRED BY** | : | **REGISTRATION DATE** | : 07/Mar/2025 10:58 AM |
| **BARCODE NO.** | : 01526629 | **COLLECTION DATE** | : 07/Mar/2025 11:19AM |
| **CLIENT CODE.** | : KOS DIAGNOSTIC LAB | **REPORTING DATE** | : 07/Mar/2025 03:50PM |
| **CLIENT ADDRESS** | : 6349/1, NICHOLSON ROAD, AMBALA CANTT | | |

| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|
| **KIDNEY FUNCTION TEST (COMPLETE)** | | | |
| UREA: SERUM<br>*by UREASE - GLUTAMATE DEHYDROGENASE (GLDH)* | 32.6 | mg/dL | 10.00 - 50.00 |
| CREATININE: SERUM<br>*by ENZYMATIC, SPECTROPHOTOMETERY* | **1.47$^{H}$** | mg/dL | 0.40 - 1.20 |
| BLOOD UREA NITROGEN (BUN): SERUM<br>*by CALCULATED, SPECTROPHOTOMETRY* | 15.23 | mg/dL | 7.0 - 25.0 |
| BLOOD UREA NITROGEN (BUN)/CREATININE RATIO: SERUM<br>*by CALCULATED, SPECTROPHOTOMETRY* | 10.36 | RATIO | 10.0 - 20.0 |
| UREA/CREATININE RATIO: SERUM<br>*by CALCULATED, SPECTROPHOTOMETRY* | 22.18 | RATIO | |
| URIC ACID: SERUM<br>*by URICASE - OXIDASE PEROXIDASE* | **7.29$^{H}$** | mg/dL | 2.50 - 6.80 |
| CALCIUM: SERUM<br>*by ARSENAZO III, SPECTROPHOTOMETRY* | 9.9 | mg/dL | 8.50 - 10.60 |
| PHOSPHOROUS: SERUM<br>*by PHOSPHOMOLYBDATE, SPECTROPHOTOMETRY* | 3.38 | mg/dL | 2.30 - 4.70 |
| **ELECTROLYTES** | | | |
| SODIUM: SERUM<br>*by ISE (ION SELECTIVE ELECTRODE)* | 144.6 | mmol/L | 135.0 - 150.0 |
| POTASSIUM: SERUM<br>*by ISE (ION SELECTIVE ELECTRODE)* | 4.97 | mmol/L | 3.50 - 5.00 |
| CHLORIDE: SERUM<br>*by ISE (ION SELECTIVE ELECTRODE)* | 108.45 | mmol/L | 90.0 - 110.0 |
| **ESTIMATED GLOMERULAR FILTERATION RATE** | | | |
| ESTIMATED GLOMERULAR FILTERATION RATE (eGFR): SERUM<br>*by CALCULATED* | 35.4 | | |

***INTERPRETATION:***

To differentiate between pre- and post renal azotemia.

**INCREASED RATIO (>20:1) WITH NORMAL CREATININE:**

1. Prerenal azotemia (BUN rises without increase in creatinine) e.g. heart failure, salt depletion,dehydration, blood loss) due to decreased glomerular filtration rate.
2. Catabolic states with increased tissue breakdown.
3. GI haemorrhage.

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

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

| | | | |
|---|---|---|---|
| **NAME** | **: Mrs. TAVINDER KAUR DUGGAL** | | |
| **AGE/ GENDER** | : 82 YRS/FEMALE | **PATIENT ID** | : 1781780 |
| **COLLECTED BY** | : SURJESH | **REG. NO./LAB NO.** | **: 012503070040** |
| **REFERRED BY** | : | **REGISTRATION DATE** | : 07/Mar/2025 10:58 AM |
| **BARCODE NO.** | : 01526629 | **COLLECTION DATE** | : 07/Mar/2025 11:19AM |
| **CLIENT CODE.** | : KOS DIAGNOSTIC LAB | **REPORTING DATE** | : 07/Mar/2025 03:50PM |
| **CLIENT ADDRESS** | : 6349/1, NICHOLSON ROAD, AMBALA CANTT | | |

| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|

4. High protein intake.
5. Impaired renal function plus
6. Excess protein intake or production or tissue breakdown (e.g. infection, GI bleeding, thyrotoxicosis, Cushing's syndrome, high protein diet, burns, surgery, cachexia, high fever).
7. Urine reabsorption (e.g. ureter colostomy)
8. Reduced muscle mass (subnormal creatinine production)
9. Certain drugs (e.g. tetracycline, glucocorticoids)

**INCREASED RATIO (>20:1) WITH ELEVATED CREATININE LEVELS:**

1. Postrenal azotemia (BUN rises disproportionately more than creatinine) (e.g. obstructive uropathy).
2. Prerenal azotemia superimposed on renal disease.

**DECREASED RATIO (<10:1) WITH DECREASED BUN :**

1. Acute tubular necrosis.
2. Low protein diet and starvation.
3. Severe liver disease.
4. Other causes of decreased urea synthesis.
5. Repeated dialysis (urea rather than creatinine diffuses out of extracellular fluid).
6. Inherited hyperammonemias (urea is virtually absent in blood).
7. SIADH (syndrome of inappropiate antidiuretic harmone) due to tubular secretion of urea.
8. Pregnancy.

**DECREASED RATIO (<10:1) WITH INCREASED CREATININE:**

1. Phenacimide therapy (accelerates conversion of creatine to creatinine).
2. Rhabdomyolysis (releases muscle creatinine).
3. Muscular patients who develop renal failure.

**INAPPROPIATE RATIO:**

1. Diabetic ketoacidosis (acetoacetate causes false increase in creatinine with certain methodologies,resulting in normal ratio when dehydration should produce an increased BUN/creatinine ratio).
2. Cephalosporin therapy (interferes with creatinine measurement).

**ESTIMATED GLOMERULAR FILTERATION RATE:**

| CKD STAGE | DESCRIPTION | GFR ( mL/min/1.73m2 ) | ASSOCIATED FINDINGS |
|---|---|---|---|
| G1 | Normal kidney function | >90 | No proteinuria |
| G2 | Kidney damage with normal or high GFR | >90 | Presence of Protein , Albumin or cast in urine |
| G3a | Mild decrease in GFR | 60 -89 | |
| G3b | Moderate decrease in GFR | 30-59 | |
| G4 | Severe decrease in GFR | 15-29 | |
| G5 | Kidney failure | <15 | |

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

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

| | | | |
|---|---|---|---|
| **NAME** | **: Mrs. TAVINDER KAUR DUGGAL** | | |
| **AGE/ GENDER** | : 82 YRS/FEMALE | **PATIENT ID** | : 1781780 |
| **COLLECTED BY** | : SURJESH | **REG. NO./LAB NO.** | **: 012503070040** |
| **REFERRED BY** | : | **REGISTRATION DATE** | : 07/Mar/2025 10:58 AM |
| **BARCODE NO.** | : 01526629 | **COLLECTION DATE** | : 07/Mar/2025 11:19AM |
| **CLIENT CODE.** | : KOS DIAGNOSTIC LAB | **REPORTING DATE** | : 07/Mar/2025 03:50PM |
| **CLIENT ADDRESS** | : 6349/1, NICHOLSON ROAD, AMBALA CANTT | | |

| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|

COMMENTS:

1. Estimated Glomerular filtration rate (eGFR) is the sum of filtration rates in all functioning nephrons and so an estimation of the GFR provides a measure of functioning nephrons of the kidney.
2. eGFR calculated using the 2009 CKD-EPI creatinine equation and GFR category reported as per KDIGO guideline 2012
3. In patients, with eGFR creatinine between 45-59 ml/min/1.73 m2 (G3) and without any marker of Kidney damage, It is recommended to measure eGFR with Cystatin C for confirmation of CKD
4. eGFR category G1 OR G2 does not fullfill the criteria for CKD, in the absence of evidence of Kidney Damage
5. In a suspected case of Acute Kidney Injury (AKI), measurement of eGFR should be done after 48-96 hours of any Intervention or procedure
6. eGFR calculated by Serum Creatinine may be less accurate due to certain factors like Race, Muscle Mass, Diet, Certain Drugs. In such cases, eGFR should be calculated using Serum Cystatin C
***7. A decrease in eGFR implies either progressive renal disease, or a reversible process causing decreased nephron function (eg, severe dehydration).***

***ADVICE:***

KDIGO guideline, 2012 recommends Chronic Kidney Disease (CKD) should be classified based on cause, eGFR category and Albuminuria (ACR) category. GFR & ACR category combined together reflect risk of progression and helps Clinician to identify the individual who are progressing at more rapid rate than anticipated

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

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

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

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



| | | | |
|---|---|---|---|
| **NAME** | **: Mrs. TAVINDER KAUR DUGGAL** | | |
| **AGE/ GENDER** | : 82 YRS/FEMALE | **PATIENT ID** | : 1781780 |
| **COLLECTED BY** | : SURJESH | **REG. NO./LAB NO.** | **: 012503070040** |
| **REFERRED BY** | : | **REGISTRATION DATE** | : 07/Mar/2025 10:58 AM |
| **BARCODE NO.** | : 01526629 | **COLLECTION DATE** | : 07/Mar/2025 11:19AM |
| **CLIENT CODE.** | : KOS DIAGNOSTIC LAB | **REPORTING DATE** | : 07/Mar/2025 02:13PM |
| **CLIENT ADDRESS** | : 6349/1, NICHOLSON ROAD, AMBALA CANTT | | |

| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|

## ENDOCRINOLOGY

### THYROID FUNCTION TEST: TOTAL

| | | | |
|---|---|---|---|
| TRIIODOTHYRONINE (T3): SERUM<br>*by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)* | 0.95 | ng/mL | 0.35 - 1.93 |
| THYROXINE (T4): SERUM<br>*by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)* | 9.35 | µgm/dL | 4.87 - 12.60 |
| THYROID STIMULATING HORMONE (TSH): SERUM<br>*by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)* | 1.46 | 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 |

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

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

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

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

| | | | |
|---|---|---|---|
| **NAME** | **: Mrs. TAVINDER KAUR DUGGAL** | | |
| **AGE/ GENDER** | : 82 YRS/FEMALE | **PATIENT ID** | : 1781780 |
| **COLLECTED BY** | : SURJESH | **REG. NO./LAB NO.** | **: 012503070040** |
| **REFERRED BY** | : | **REGISTRATION DATE** | : 07/Mar/2025 10:58 AM |
| **BARCODE NO.** | : 01526629 | **COLLECTION DATE** | : 07/Mar/2025 11:19AM |
| **CLIENT CODE.** | : KOS DIAGNOSTIC LAB | **REPORTING DATE** | : 07/Mar/2025 02:13PM |
| **CLIENT ADDRESS** | : 6349/1, NICHOLSON ROAD, AMBALA CANTT | | |

| 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

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

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

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

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



| | | | |
|---|---|---|---|
| **NAME** | **: Mrs. TAVINDER KAUR DUGGAL** | | |
| **AGE/ GENDER** | : 82 YRS/FEMALE | **PATIENT ID** | : 1781780 |
| **COLLECTED BY** | : SURJESH | **REG. NO./LAB NO.** | **: 012503070040** |
| **REFERRED BY** | : | **REGISTRATION DATE** | : 07/Mar/2025 10:58 AM |
| **BARCODE NO.** | : 01526629 | **COLLECTION DATE** | : 07/Mar/2025 11:19AM |
| **CLIENT CODE.** | : KOS DIAGNOSTIC LAB | **REPORTING DATE** | : 07/Mar/2025 02:13PM |
| **CLIENT ADDRESS** | : 6349/1, NICHOLSON ROAD, AMBALA CANTT | | |

| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|

## IMMUNOPATHOLOGY/SEROLOGY

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

| | | | |
|---|---|---|---|
| HEPATITIS C ANTIBODY (HCV) TOTAL: SERUM<br>*by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)* | 0.12 | S/CO | NEGATIVE: < 1.00<br>POSITIVE: > 1.00 |
| HEPATITIS C ANTIBODY (HCV) TOTAL RESULT<br>*by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)* | NON - REACTIVE | | |

***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 prevelance 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.*

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

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

| | | | |
|---|---|---|---|
| **NAME** | **: Mrs. TAVINDER KAUR DUGGAL** | | |
| **AGE/ GENDER** | : 82 YRS/FEMALE | **PATIENT ID** | : 1781780 |
| **COLLECTED BY** | : SURJESH | **REG. NO./LAB NO.** | **: 012503070040** |
| **REFERRED BY** | : | **REGISTRATION DATE** | : 07/Mar/2025 10:58 AM |
| **BARCODE NO.** | : 01526629 | **COLLECTION DATE** | : 07/Mar/2025 11:19AM |
| **CLIENT CODE.** | : KOS DIAGNOSTIC LAB | **REPORTING DATE** | : 07/Mar/2025 02:13PM |
| **CLIENT ADDRESS** | : 6349/1, NICHOLSON ROAD, AMBALA CANTT | | |

| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|

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

| | | | |
|---|---|---|---|
| HIV 1/2 AND P24 ANTIGEN: SERUM<br>*by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)* | 0.11 | S/CO | NEGATIVE: < 1.00<br>POSITIVE: > 1.00 |
| HIV 1/2 AND P24 ANTIGEN RESULT<br>*by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)* | 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 menas 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.

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

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

| | | | |
|---|---|---|---|
| **NAME** | **: Mrs. TAVINDER KAUR DUGGAL** | | |
| **AGE/ GENDER** | : 82 YRS/FEMALE | **PATIENT ID** | : 1781780 |
| **COLLECTED BY** | : SURJESH | **REG. NO./LAB NO.** | **: 012503070040** |
| **REFERRED BY** | : | **REGISTRATION DATE** | : 07/Mar/2025 10:58 AM |
| **BARCODE NO.** | : 01526629 | **COLLECTION DATE** | : 07/Mar/2025 11:19AM |
| **CLIENT CODE.** | : KOS DIAGNOSTIC LAB | **REPORTING DATE** | : 07/Mar/2025 02:13PM |
| **CLIENT ADDRESS** | : 6349/1, NICHOLSON ROAD, AMBALA CANTT | | |

| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|

## HEPATITIS B SURFACE ANTIGEN (HBsAg) ULTRA

| | | | |
|---|---|---|---|
| HEPATITIS B SURFACE ANTIGEN (HBsAg): SERUM<br>*by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)* | 0.29 | S/CO | NEGATIVE: < 1.0<br>POSITIVE: > 1.0 |
| HEPATITIS B SURFACE ANTIGEN (HBsAg) RESULT<br>*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 symtoms. Persistence of HBsAg for more than 6 months indicates carrier state or Chronic Liver disease.

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

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

| | | | |
|---|---|---|---|
| **NAME** | **: Mrs. TAVINDER KAUR DUGGAL** | | |
| **AGE/ GENDER** | : 82 YRS/FEMALE | **PATIENT ID** | : 1781780 |
| **COLLECTED BY** | : SURJESH | **REG. NO./LAB NO.** | **: 012503070040** |
| **REFERRED BY** | : | **REGISTRATION DATE** | : 07/Mar/2025 10:58 AM |
| **BARCODE NO.** | : 01526629 | **COLLECTION DATE** | : 07/Mar/2025 11:19AM |
| **CLIENT CODE.** | : KOS DIAGNOSTIC LAB | **REPORTING DATE** | : 07/Mar/2025 11:52AM |
| **CLIENT ADDRESS** | : 6349/1, NICHOLSON ROAD, AMBALA CANTT | | |

| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|

## VDRL

| | | | |
|---|---|---|---|
| VDRL<br>*by IMMUNOCHROMATOGRAPHY* | NON REACTIVE | | NON REACTIVE |

***INTERPRETATION:***

1.Does not become positive until 7 - 10 days after appearance ofchancre.
2.***High titer (>1:16) - active disease.***
3.***Low titer (<1:8) - biological falsepositive test in 90% cases or due to late or late latent syphillis.***
4.Treatment of primary syphillis causes progressive decline tonegative VDRL within 2 years.
5.Rising titer (4X) indicates relapse,reinfection, or treatment failure and need for retreatment.
6.May benonreactive in early primary, late latent, and late syphillis (approx. 25% ofcases).
***7.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:**

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

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

1.Serious underlying disease e.g., collagen vascular diseases, leprosy ,malignancy.
2.Intravenous drug users.
3.Rheumatoid arthritis, thyroiditis, AIDS, Sjogren's syndrome.
4.<l0 % of patients older thanage 70 years.
5.Patients taking some anti-hypertensive drugs.

*** End Of Report ***

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

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