

Dr. Vinay Chopra
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 Chairman & Consultant Pathologist

Dr. Yugam Chopra
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NAME	: Mrs. NIKITA	PATIENT ID	: 1785558
AGE/ GENDER	: 30 YRS/FEMALE	REG. NO./LAB NO.	: 012503100047
COLLECTED BY	:	REGISTRATION DATE	: 10/Mar/2025 01:27 PM
REFERRED BY	: LOOMBA HOSPITAL (AMBALA CANTT)	COLLECTION DATE	: 10/Mar/2025 01:35PM
BARCODE NO.	: 01526878	REPORTING DATE	: 10/Mar/2025 01:54PM
CLIENT CODE.	: KOS DIAGNOSTIC LAB		
CLIENT ADDRESS	: 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>	11.7 ^L	gm/dL	12.0 - 16.0
RED BLOOD CELL (RBC) COUNT <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	4.2	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	35.4 ^L	%	37.0 - 50.0
MEAN CORPUSCULAR VOLUME (MCV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	84.2	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	27.8	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	33.1	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	14.3	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	45.2	fL	35.0 - 56.0
MENTZERS INDEX <i>by CALCULATED</i>	20.05	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX <i>by CALCULATED</i>	28.61	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 & MICROSCOPY</i>	7730	/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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<u>DIFFERENTIAL LEUCOCYTE COUNT (DLC)</u>			
NEUTROPHILS <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	69	%	50 - 70
LYMPHOCYTES <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	24	%	20 - 40
EOSINOPHILS <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	2	%	1 - 6
MONOCYTES <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	5	%	2 - 12
BASOPHILS <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	0	%	0 - 1
<u>ABSOLUTE LEUKOCYTES (WBC) COUNT</u>			
ABSOLUTE NEUTROPHIL COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	5334	/cmm	2000 - 7500
ABSOLUTE LYMPHOCYTE COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	1855	/cmm	800 - 4900
ABSOLUTE EOSINOPHIL COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	155	/cmm	40 - 440
ABSOLUTE MONOCYTE COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	386	/cmm	80 - 880
ABSOLUTE BASOPHIL COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	0	/cmm	0 - 110
ABSOLUTE IMMATURE GRANULOCYTE COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	0	/cmm	0.0 - 999.0
<u>PLATELETS AND OTHER PLATELET PREDICTIVE MARKERS.</u>			
PLATELET COUNT (PLT) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	319000	/cmm	150000 - 450000
PLATELETCRIT (PCT) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	0.28	%	0.10 - 0.36
MEAN PLATELET VOLUME (MPV) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	9	fL	6.50 - 12.0
PLATELET LARGE CELL COUNT (P-LCC) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	58000	/cmm	30000 - 90000
PLATELET LARGE CELL RATIO (P-LCR) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	18.3	%	11.0 - 45.0
PLATELET DISTRIBUTION WIDTH (PDW) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	15.8	%	15.0 - 17.0





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NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD




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BLOOD GROUP (ABO) AND RH FACTOR TYPING

ABO GROUP
 by SLIDE AGGLUTINATION
 RH FACTOR TYPE
 by SLIDE AGGLUTINATION

O
 POSITIVE




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CLINICAL CHEMISTRY/BIOCHEMISTRY
GLUCOSE RANDOM (R)

GLUCOSE RANDOM (R): PLASMA by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)	82.3	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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ENDOCRINOLOGY

THYROID FUNCTION TEST: TOTAL

TRIIODOTHYRONINE (T3): SERUM by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)	0.827	ng/mL	0.35 - 1.93
THYROXINE (T4): SERUM by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)	6.77	µg/dL	4.87 - 12.60
THYROID STIMULATING HORMONE (TSH): SERUM by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)	2.006	µIU/mL	0.35 - 5.50

3rd GENERATION, ULTRA SENSITIVE

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	Reference Range (ng/mL)	Age	Reference 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




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Test Name	Value	Unit	Biological Reference interval
1 - 10 Years	0.92 - 2.28	1 - 10 Years	6.00 - 13.80
11- 19 Years	0.35 - 1.93	11 - 19 Years	4.87- 13.20
> 20 years (Adults)	0.35 - 1.93	> 20 Years (Adults)	4.87 - 12.60
RECOMMENDATIONS OF TSH LEVELS DURING PREGNANCY (μ U/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




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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
by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)			POSITIVE: > 1.00

HEPATITIS C ANTIBODY (HCV) TOTAL NON - REACTIVE

RESULT
by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)

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:

- Indicator of past or present infection, but does not differentiate between Acute/ Chronic/Resolved Infection.
- Routine screening of low and high prevalence population including blood donors.

NOTE:

- False positive results are seen in Auto-immune disease, Rheumatoid Factor, HYpergammaglobulinemia, Paraproteinemia, Passive antibody transfer, Anti-idiotypes and Anti-superoxide dismutase.
- False negative results are seen in early Acute infection, Immunosuppression and Immuno— incompetence.
- 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	0.1	S/CO	NEGATIVE: < 1.00 POSITIVE: > 1.00
by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)			
HIV 1/2 AND P24 ANTIGEN RESULT	NON - REACTIVE		
by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)			

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):	0.27	S/CO	NEGATIVE: < 1.0
SERUM			POSITIVE: > 1.0

by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)

HEPATITIS B SURFACE ANTIGEN (HBsAg) NON REACTIVE

RESULT
by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)

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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VDRL

VDRL by IMMUNOCHROMATOGRAPHY	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 of negative VDRL within 2 years.
- Rising titer (4X) indicates relapse, reinfection, or treatment failure and need for retreatment.
- May be nonreactive in early primary, late latent, and late syphilis (approx. 25% of cases).
- Reactive and weakly reactive tests should always be confirmed with FTA-ABS (fluorescent treponemal antibody absorption test).**

SHORT TERM FALSE POSITIVE TEST RESULTS (<6 MONTHS DURATION) MAY OCCUR IN:

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

LONG TERM 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 than age 70 years.
- Patients taking some anti-hypertensive drugs.




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NAME	: Mrs. NIKITA	PATIENT ID	: 1785558
AGE/ GENDER	: 30 YRS/FEMALE	REG. NO./LAB NO.	: 012503100047
COLLECTED BY	:	REGISTRATION DATE	: 10/Mar/2025 01:27 PM
REFERRED BY	: LOOMBA HOSPITAL (AMBALA CANTT)	COLLECTION DATE	: 10/Mar/2025 01:35PM
BARCODE NO.	: 01526878	REPORTING DATE	: 10/Mar/2025 03:52PM
CLIENT CODE.	: KOS DIAGNOSTIC LAB		
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
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CLINICAL PATHOLOGY

URINE ROUTINE & MICROSCOPIC EXAMINATION

PHYSICAL EXAMINATION

QUANTITY RECEIVED	10	ml	
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
COLOUR	AMBER YELLOW		PALE YELLOW
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
TRANSPARANCY	CLEAR		CLEAR
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
SPECIFIC GRAVITY	<=1.005		1.002 - 1.030
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			

CHEMICAL EXAMINATION

REACTION	ALKALINE		
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
PROTEIN	Negative		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
SUGAR	Negative		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
pH	7.5		5.0 - 7.5
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
BILIRUBIN	Negative		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
NITRITE	Negative		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
UROBILINOGEN	Normal	EU/dL	0.2 - 1.0
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
KETONE BODIES	Negative		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
BLOOD	Negative		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
ASCORBIC ACID	NEGATIVE (-ve)		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			

MICROSCOPIC EXAMINATION

RED BLOOD CELLS (RBCs)	NEGATIVE (-ve)	/HPF	0 - 3
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Test Name	Value	Unit	Biological Reference interval
by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT			
PUS CELLS	1-3	/HPF	0 - 5
by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT			
EPITHELIAL CELLS	3-5	/HPF	ABSENT
by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT			
CRYSTALS	NEGATIVE (-ve)		NEGATIVE (-ve)
by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT			
CASTS	NEGATIVE (-ve)		NEGATIVE (-ve)
by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT			
BACTERIA	NEGATIVE (-ve)		NEGATIVE (-ve)
by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT			
OTHERS	NEGATIVE (-ve)		NEGATIVE (-ve)
by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT			
TRICHOMONAS VAGINALIS (PROTOZOA)	ABSENT		ABSENT
by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT			

*** End Of Report ***




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