

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

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

| | | | |
|-----------------------|--|--------------------------|------------------------|
| NAME | : Dr. DIVYANSHI | PATIENT ID | : 1791244 |
| AGE/ GENDER | : 27 YRS/FEMALE | REG. NO./LAB NO. | : 012503130063 |
| COLLECTED BY | : | REGISTRATION DATE | : 13/Mar/2025 08:16 PM |
| REFERRED BY | : | COLLECTION DATE | : 13/Mar/2025 10:05PM |
| BARCODE NO. | : 01527088 | REPORTING DATE | : 13/Mar/2025 09:03PM |
| CLIENT CODE. | : KOS DIAGNOSTIC LAB | | |
| CLIENT ADDRESS | : 6349/1, NICHOLSON ROAD, AMBALA CANTT | | |

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

HAEMATOTOLOGY

COMPLETE BLOOD COUNT (CBC)

RED BLOOD CELLS (RBCS) COUNT AND INDICES

| | | | |
|---|-------|--------------|--|
| HAEMOGLOBIN (HB) <i>by CALORIMETRIC</i> | 13.3 | gm/dL | 12.0 - 16.0 |
| RED BLOOD CELL (RBC) COUNT <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i> | 4.81 | Millions/cmm | 3.50 - 5.00 |
| PACKED CELL VOLUME (PCV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i> | 40.2 | % | 37.0 - 50.0 |
| MEAN CORPUSCULAR VOLUME (MCV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i> | 83.7 | fL | 80.0 - 100.0 |
| MEAN CORPUSCULAR HAEMOGLOBIN (MCH) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i> | 27.3 | pg | 27.0 - 34.0 |
| MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i> | 32.6 | 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> | 43.1 | fL | 35.0 - 56.0 |
| MENTZERS INDEX <i>by CALCULATED</i> | 17.4 | RATIO | BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0 |
| GREEN & KING INDEX <i>by CALCULATED</i> | 23.54 | 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> | 18180 ^H | /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> | 81 ^H | % | 50 - 70 |
| LYMPHOCYTES <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i> | 15 ^L | % | 20 - 40 |
| EOSINOPHILS <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i> | 0 ^L | % | 1 - 6 |
| MONOCYTES <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i> | 4 | % | 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> | 14726 ^H | /cmm | 2000 - 7500 |
| ABSOLUTE LYMPHOCYTE COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i> | 2727 | /cmm | 800 - 4900 |
| ABSOLUTE EOSINOPHIL COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i> | 0 ^L | /cmm | 40 - 440 |
| ABSOLUTE MONOCYTE COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i> | 727 | /cmm | 80 - 880 |
| ABSOLUTE BASOPHIL COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i> | 0 | /cmm | 0 - 110 |
| <u>PLATELETS AND OTHER PLATELET PREDICTIVE MARKERS.</u> | | | |
| PLATELET COUNT (PLT) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i> | 578000 ^H | /cmm | 150000 - 450000 |
| PLATELETCRIT (PCT) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i> | 0.54 ^H | % | 0.10 - 0.36 |
| MEAN PLATELET VOLUME (MPV) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i> | 10 | fL | 6.50 - 12.0 |
| PLATELET LARGE CELL COUNT (P-LCC) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i> | 125000 ^H | /cmm | 30000 - 90000 |
| PLATELET LARGE CELL RATIO (P-LCR) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i> | 21.6 | % | 11.0 - 45.0 |
| PLATELET DISTRIBUTION WIDTH (PDW) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i> | 16 | % | 15.0 - 17.0 |
| ADVICE | KINDLY CORRELATE CLINICALLY | | |



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NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD

RECHECKED




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ERYTHROCYTE SEDIMENTATION RATE (ESR)

ERYTHROCYTE SEDIMENTATION RATE (ESR) **27^H** mm/1st hr 0 - 20
by RED CELL AGGREGATION BY CAPILLARY PHOTOMETRY

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




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PERIPHERAL BLOOD SMEAR

TEST NAME:

PERIPHERAL BLOOD FILM/SMEAR (PBF)

RED BLOOD CELLS (RBC'S):

RBCs mostly appear normocytic & normochromic.No polychromatic cells or normoblasts noted.

WHITE BLOOD CELLS (WBC'S):

Smear show leucocytosis with neutrophilia.No immature leucocytes appreciated.

PLATELETS:

Platelets adequate.

HEMOPARASITES:

NOT SEEN.

IMPRESSION:

Normocytic normochromic picture & Neutrophilia.




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IMMUNOPATHOLOGY/SEROLOGY WIDAL SLIDE AGGLUTINATION TEST

| | | | |
|---|--------|-------|---------|
| SALMONELLA TYPHI O by SLIDE AGGLUTINATION | 1 : 20 | TITRE | 1 : 80 |
| SALMONELLA TYPHI H by SLIDE AGGLUTINATION | 1 : 20 | TITRE | 1 : 160 |
| SALMONELLA PARATYPHI AH by SLIDE AGGLUTINATION | NIL | TITRE | 1 : 160 |
| SALMONELLA PARATYPHI BH by SLIDE AGGLUTINATION | NIL | TITRE | 1 : 160 |

INTERPRETATION:

1. Titres of 1:80 or more for "O" agglutinin is considered significant.
2. Titres of 1:160 or more for "H" agglutinin is considered significant.

LIMITATIONS:

1. Agglutinins usually appear by 5th to 6th day of illness of enteric fever, hence a negative result in early stage is inconclusive. The titre then rises till 3rd or 4th week, after which it declines gradually.
2. Lower titres may be found in normal individuals.
3. A single positive result has less significance than the rising agglutination titre, since demonstration of rising titre four or more in 1st and 3rd week is considered as a definite evidence of infection.
4. A simultaneous rise in H agglutinins is suggestive of paratyphoid infection.

NOTE:

1. Individuals with prior infection or immunization with TAB vaccine may develop an ANAMNESTIC RESPONSE (False-Positive) during an unrelated fever i.e High titres of antibodies to various antigens. This may be differentiated by repetition of the test after a week.
2. The anamnestic response shows only a transient rise, while in enteric fever rise is sustained.
3. H agglutinins tend to persist for many months after vaccination but O agglutinins tend to disappear sooner i.e within 6 months. Therefore rise in O agglutinins indicate recent infection.




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CLINICAL PATHOLOGY

URINE ROUTINE & MICROSCOPIC EXAMINATION

PHYSICAL EXAMINATION

| | | | |
|--|-------------|----|---------------|
| QUANTITY RECEIVED | 10 | ml | |
| by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY | | | |
| COLOUR | PALE YELLOW | | PALE YELLOW |
| by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY | | | |
| TRANSPARANCY | CLEAR | | CLEAR |
| by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY | | | |
| SPECIFIC GRAVITY | 1.01 | | 1.002 - 1.030 |
| by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY | | | |

CHEMICAL EXAMINATION

| | | | |
|--|----------------|-------|----------------|
| REACTION | ACIDIC | | |
| by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY | | | |
| PROTEIN | Negative | | NEGATIVE (-ve) |
| by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY | | | |
| SUGAR | Negative | | NEGATIVE (-ve) |
| by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY | | | |
| pH | 6.5 | | 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 | 2-3 | /HPF | 0 - 5 |
| by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT | | | |
| EPITHELIAL CELLS | 3-4 | /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 | | | |




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MICROBIOLOGY

CULTURE AEROBIC BACTERIA AND ANTIBIOTIC SENSITIVITY: URINE

CULTURE AND SUSCEPTIBILITY: URINE

| | |
|----------------------------|--|
| DATE OF SAMPLE | 13-03-2025 |
| SPECIMEN SOURCE | URINE |
| INCUBATION PERIOD | 48 HOURS |
| by AUTOMATED BROTH CULTURE | |
| CULTURE | STERILE |
| by AUTOMATED BROTH CULTURE | |
| ORGANISM | NO AEROBIC PYOGENIC ORGANISM GROWN AFTER 48 HOURS OF |
| by AUTOMATED BROTH CULTURE | INCUBATION AT 37°C |

AEROBIC SUSCEPTIBILITY: URINE

INTERPRETATION:

1. In urine culture and sensitivity, presence of more than 100,000 organism per mL in midstream sample of urine is considered clinically significant. However in symptomatic patients, a smaller number of bacteria (100 to 10000/mL) may signify infection.

2. Colony count of 100 to 10000/ mL indicate infection, if isolate from specimen obtained by suprapubic aspiration or "in-and-out" catheterization or from patients with indwelling catheters.

SUSCEPTIBILITY:

1. A test interpreted as **SENSITIVE** implies that infection due to isolate may be appropriately treated with the dosage of an antimicrobial agent recommended for that type of infection and infecting species, unless otherwise indicated..

2. A test interpreted as **INTERMEDIATE** implies that the "infection due to the isolate may be appropriately treated in body sites where the drugs are physiologically concentrated or when a high dosage of drug can be used".

3. A test interpreted as **RESISTANT** implies that the "isolates are not inhibited by the usually achievable concentration of the agents with normal dosage, schedule and/or fall in the range where specific microbial resistance mechanism are likely (e.g. beta-lactamases), and clinical efficacy has not been reliable in treatment studies.

CAUTION:

Conditions which can cause a false Negative culture:

1. Patient is on antibiotics. Please repeat culture post therapy.
2. Anaerobic bacterial infection.
3. Fastidious aerobic bacteria which are not able to grow on routine culture media.
4. Besides all these factors, at least in 25-40 % of cases there is no direct correlation between in vivo clinical picture.
5. Renal tuberculosis to be confirmed by AFB studies.




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CULTURE AEROBIC BACTERIA AND ANTIBIOTIC SENSITIVITY (CONVENTIONAL): BLOOD

BLOOD CULTURE AND SUSCEPTIBILITY

| | |
|-------------------|--------------------------|
| DATE OF SAMPLE | 13-03-2025 |
| SPECIMEN SOURCE | BLOOD |
| INCUBATION PERIOD | 72 HOURS (3 SUBCULTURES) |
| CULTURE | STERILE |

by AUTOMATED BROTH CULTURE

ORGANISM NO AEROBIC PYOGENIC ORGANISM GROWN AFTER 72 HOURS OF INCUBATION AT 37°C

by AUTOMATED BROTH CULTURE

AEROBIC SUSCEPTIBILITY BLOOD

INTERPRETATION

SUSCEPTIBILITY:

1. A test interpreted as **SENSITIVE** implies that infection due to isolate may be appropriately treated with the dosage of an antimicrobial agent recommended for that type of infection and infecting species, unless otherwise indicated.
2. A test interpreted as **INTERMEDIATE** implies that the "Infection due to the isolate may be appropriately treated in body sites where the drugs are physiologically concentrated or when a high dosage of drug can be used".
3. A test interpreted as **RESISTANT** implies that the "isolates are not inhibited by the usually achievable concentration of the agents with normal dosage, schedule and/or fall in the range where specific microbial resistance mechanism are likely (e.g. beta-lactamases), and clinical efficacy has not been reliable in treatment studies.

CAUTION:

Conditions which can cause a false Negative culture:

1. Patient is on antibiotics. Please repeat culture post therapy.
2. Anaerobic bacterial infection.
3. Fastidious aerobic bacteria which are not able to grow on routine culture media.
4. Besides all these factors, at least in 25-40 % of cases there is no direct correlation between in vivo clinical picture.
5. Renal tuberculosis to be confirmed by AFB studies.

*** End Of Report ***





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



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

