

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

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

NAME	: Mrs. SWATI	PATIENT ID	: 1805381
AGE/ GENDER	: 39 YRS/FEMALE	REG. NO./LAB NO.	: 012503250042
COLLECTED BY	: SURJESH	REGISTRATION DATE	: 25/Mar/2025 11:53 AM
REFERRED BY	:	COLLECTION DATE	: 25/Mar/2025 11:58AM
BARCODE NO.	: 01527740	REPORTING DATE	: 25/Mar/2025 01:37PM
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

THYROID STIMULATING HORMONE (TSH)

THYROID STIMULATING HORMONE (TSH): SERUM 1.695 μ IU/mL 0.35 - 5.50

by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)

3rd GENERATION, ULTRASENSITIVE

INTERPRETATION:

AGE	REFERENCE RANGE (μ IU/mL)
0 – 5 DAYS	0.70 – 15.20
6 Days – 2 Months	0.70 – 11.00
3 – 11 Months	0.70 – 8.40
1 – 5 Years	0.70 – 7.00
6 – 10 Years	0.60 – 5.50
11 - 15	0.50 – 5.50
> 20 Years (Adults)	0.27 – 5.50
PREGNANCY	
1st Trimester	0.10 - 3.00
2nd Trimester	0.20 - 3.00
3rd Trimester	0.30 - 4.10

NOTE:- TSH levels are subjected 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 concentration.

USE:- TSH controls biosynthesis and release of thyroid hormones T4 & T3. It is a sensitive measure of thyroid function, especially useful in early or subclinical hypothyroidism, before the patient develops any clinical findings or goitre or any other thyroid function abnormality.

INCREASED LEVELS:

- 1.Primary or untreated hypothyroidism, may vary from 3 times to more than 100 times normal depending on degree of hypofunction.
- 2.Hypothyroid patients receiving insufficient thyroid replacement therapy.
- 3.Hashimotos thyroiditis.
- 4.DRUGS: Amphetamines, Iodine containing agents and dopamine antagonist.
- 5.Neonatal period, increase in 1st 2-3 days of life due to post-natal surge.

DECREASED LEVELS:

- 1.Toxic multi-nodular goitre & 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.





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7.DRUGS: Glucocorticoids, Dopamine, Levodopa, T4 replacement therapy, Anti-thyroid drugs for thyrotoxicosis.

8.Pregnancy: 1st and 2nd Trimester

LIMITATIONS:

- 1.TSH may be normal in central hypothyroidism, recent rapid correction of hyperthyroidism or hypothyroidism, pregnancy, phenytoin therapy.
- 2.Autoimmune disorders may produce spurious results.




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PROLACTIN

PROLACTIN: SERUM	9.61	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, hyperprolactinemia often results in amenorrhea or menorrhagia, 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.

*** End Of Report ***





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