

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

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

NAME	: Mrs. PROMILA TRIKHA	PATIENT ID	: 1813809
AGE/ GENDER	: 87 YRS/FEMALE	REG. NO./LAB NO.	: 012504010050
COLLECTED BY	: SURJESH	REGISTRATION DATE	: 01/Apr/2025 12:39 PM
REFERRED BY	:	COLLECTION DATE	: 01/Apr/2025 12:40PM
BARCODE NO.	: 01528164	REPORTING DATE	: 01/Apr/2025 02:03PM
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 CHEMISTRY/BIOCHEMISTRY

UREA

UREA: SERUM	11.77	mg/dL	10.00 - 50.00
by UREASE - GLUTAMATE DEHYDROGENASE (GLDH)			




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CREATININE

CREATININE: SERUM	0.85	mg/dL	0.40 - 1.20
by ENZYMATIC, SPECTROPHOTOMETRY			




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ELECTROLYTES COMPLETE PROFILE

SODIUM: SERUM <i>by ISE (ION SELECTIVE ELECTRODE)</i>	134.3 ^L	mmol/L	135.0 - 150.0
POTASSIUM: SERUM <i>by ISE (ION SELECTIVE ELECTRODE)</i>	4.41	mmol/L	3.50 - 5.00
CHLORIDE: SERUM <i>by ISE (ION SELECTIVE ELECTRODE)</i>	100.73	mmol/L	90.0 - 110.0

INTERPRETATION:-

SODIUM:-

Sodium is the major cation of extra-cellular fluid. Its primary function in the body is to chemically maintain osmotic pressure & acid base balance & to transmit nerve impulse.

HYPONATREMIA (LOW SODIUM LEVEL) CAUSES:-

1. Low sodium intake.
2. Sodium loss due to diarrhea & vomiting with adequate water and inadequate salt replacement.
3. Diuretics abuses.
4. Salt loosing nephropathy.
5. Metabolic acidosis.
6. Adrenocortical insufficiency .
7. Hepatic failure.

HYPERNATREMIA (INCREASED SODIUM LEVEL) CAUSES:-

1. Hyperapnea (Prolonged)
2. Diabetes insipidus
3. Diabetic acidosis
4. Cushing's syndrome
5. Dehydration

POTASSIUM:-

Potassium is the major cation in the intracellular fluid. 90% of potassium is concentrated within the cells. When cells are damaged, potassium is released in the blood.

HYPOKALEMIA (LOW POTASSIUM LEVELS):-

1. Diarrhoea, vomiting & malabsorption.
2. Severe Burns.
3. Increased Secretions of Aldosterone

HYPERKALEMIA (INCREASED POTASSIUM LEVELS):-

1. Oliguria
2. Renal failure or Shock
3. Respiratory acidosis




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4.Hemolysis of blood			




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IMMUNOPATHOLOGY/SEROLOGY

ANTI THYROID PEROXIDASE (TPO/AMA) ANTIBODIES

ANTI TPO/AMA ANTIBODIES: SERUM	406.98 ^H	IU/mL	0.00 - 10.0
by CLIA (CHEMILUMINESCENCE IMMUNOASSAY)			DIABETES (II): < 25.0

INTERPRETATION:

1. Thyroperoxidase (TPO) is an enzyme involved in thyroid hormone synthesis, catalyzing the oxidation of iodide on tyrosine residues in thyroglobulin for the synthesis of triiodothyronine and thyroxine (tetraiodothyronine).
2. TPO is a membrane-associated hemo glycoprotein expressed only in thyrocytes and is one of the most important thyroid gland antigens.
3. Anti-TPO is technically superior and a more specific method for measuring thyroid auto-antibodies, It is especially useful in patients presenting with subclinical hypothyroidism where TSH is elevated but Free T4 levels are normal.

INCREASED LEVELS (Autoimmune thyroid disease):

1. Hashimoto thyroiditis.
2. Idiopathic myxedema.
3. Graves disease
4. Post-partum thyroiditis.
5. Primary hypothyroidism due to Hashimoto thyroiditis.

NOTE:

1. The highest TPO antibody levels are observed in patients suffering from Hashimoto thyroiditis. In this disease, the prevalence of TPO antibodies is about 90% of cases, confirming the autoimmune origin of the disease.
2. These auto-antibodies also frequently occur (60%-80%) in the course of Graves disease.
3. In patients with subclinical hypothyroidism, the presence of TPO antibodies is associated with an increased risk of developing overt hypothyroidism.





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MICROBIOLOGY

CULTURE AEROBIC BACTERIA AND ANTIBIOTIC SENSITIVITY: URINE

CULTURE AND SUSCEPTIBILITY: URINE

DATE OF SAMPLE	01-04-2025
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.

*** End Of Report ***





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