

Dr. Vinay Chopra  
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CEO & Consultant Pathologist

NAME : Mr. ANIL  
AGE/ GENDER : 44 YRS/MALE  
COLLECTED BY :  
REFERRED BY :  
BARCODE NO. : A0465225  
CLIENT CODE. : KOS DIAGNOSTIC SHAHBAD  
CLIENT ADDRESS : 6349/1, NICHOLSON ROAD, AMBALA CANTT

PATIENT ID : 1580150  
REG. NO./LAB NO. : 042408140006  
REGISTRATION DATE : 14/Aug/2024 10:16 AM  
COLLECTION DATE : 14/Aug/2024 03:18PM  
REPORTING DATE : 14/Aug/2024 04:11PM

Test Name	Value	Unit	Biological Reference interval
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SWASTHYA WELLNESS PANEL: 15.0  
COMPLETE BLOOD COUNT (CBC)

RED BLOOD CELLS (RBCS) COUNT AND INDICES

HAEMOGLOBIN (HB) by CALORIMETRIC	18.3 <sup>H</sup>	gm/dL	12.0 - 17.0
RED BLOOD CELL (RBC) COUNT by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	6.29 <sup>H</sup>	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	56.6 <sup>H</sup>	%	40.0 - 54.0
MEAN CORPUSCULAR VOLUME (MCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	90	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	29.1	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	32.4	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	13.9	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	47.1	fL	35.0 - 56.0
MENTZERS INDEX by CALCULATED	14.31	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX by CALCULATED	19.89	RATIO	BETA THALASSEMIA TRAIT: < = 65.0 IRON DEFICIENCY ANEMIA: > 65.0

WHITE BLOOD CELLS (WBCS)

TOTAL LEUCOCYTE COUNT (TLC) by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	8140	/cmm	4000 - 11000
NUCLEATED RED BLOOD CELLS (nRBCS) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER & MICROSCOPY	NIL		0.00 - 20.00
NUCLEATED RED BLOOD CELLS (nRBCS) % by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER & MICROSCOPY	NIL	%	< 10 %

DIFFERENTIAL LEUCOCYTE COUNT (DLC)



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NEUTROPHILS <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	60	%	50 - 70
LYMPHOCYTES <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	32	%	20 - 40
EOSINOPHILS <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	2	%	1 - 6
MONOCYTES <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	6	%	2 - 12
BASOPHILS <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	0	%	0 - 1
<b><u>ABSOLUTE LEUKOCYTES (WBC) COUNT</u></b>			
ABSOLUTE NEUTROPHIL COUNT <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	4884	/cmm	2000 - 7500
ABSOLUTE LYMPHOCYTE COUNT <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	2605	/cmm	800 - 4900
ABSOLUTE EOSINOPHIL COUNT <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	163	/cmm	40 - 440
ABSOLUTE MONOCYTE COUNT <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	488	/cmm	80 - 880
<b><u>PLATELETS AND OTHER PLATELET PREDICTIVE MARKERS.</u></b>			
PLATELET COUNT (PLT) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	224000	/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>	12	fL	6.50 - 12.0
PLATELET LARGE CELL COUNT (P-LCC) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	91000 <sup>H</sup>	/cmm	30000 - 90000
PLATELET LARGE CELL RATIO (P-LCR) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	40.8	%	11.0 - 45.0
PLATELET DISTRIBUTION WIDTH (PDW) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	16.5	%	15.0 - 17.0

NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD

RECHECKED.



  
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## CLINICAL CHEMISTRY/BIOCHEMISTRY

### GLUCOSE FASTING (F)


GLUCOSE FASTING (F): PLASMA by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)	83.53	mg/dL	NORMAL: < 100.0 PREDIABETIC: 100.0 - 125.0 DIABETIC: > OR = 126.0
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#### 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.



  
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<b>LIPID PROFILE : BASIC</b>			
<b>CHOLESTEROL TOTAL: SERUM</b> by CHOLESTEROL OXIDASE PAP	217.26 <sup>H</sup>	mg/dL	OPTIMAL: < 200.0 BORDERLINE HIGH: 200.0 - 239.0 HIGH CHOLESTEROL: > OR = 240.0
<b>TRIGLYCERIDES: SERUM</b> by GLYCEROL PHOSPHATE OXIDASE (ENZYMATIC)	235.37 <sup>H</sup>	mg/dL	OPTIMAL: < 150.0 BORDERLINE HIGH: 150.0 - 199.0 HIGH: 200.0 - 499.0 VERY HIGH: > OR = 500.0
<b>HDL CHOLESTEROL (DIRECT): SERUM</b> by SELECTIVE INHIBITION	58.24	mg/dL	LOW HDL: < 30.0 BORDERLINE HIGH HDL: 30.0 - 60.0 HIGH HDL: > OR = 60.0
<b>LDL CHOLESTEROL: SERUM</b> by CALCULATED, SPECTROPHOTOMETRY	111.95	mg/dL	OPTIMAL: < 100.0 ABOVE OPTIMAL: 100.0 - 129.0 BORDERLINE HIGH: 130.0 - 159.0 HIGH: 160.0 - 189.0 VERY HIGH: > OR = 190.0
<b>NON HDL CHOLESTEROL: SERUM</b> by CALCULATED, SPECTROPHOTOMETRY	159.02 <sup>H</sup>	mg/dL	OPTIMAL: < 130.0 ABOVE OPTIMAL: 130.0 - 159.0 BORDERLINE HIGH: 160.0 - 189.0 HIGH: 190.0 - 219.0 VERY HIGH: > OR = 220.0
<b>VLDL CHOLESTEROL: SERUM</b> by CALCULATED, SPECTROPHOTOMETRY	47.07 <sup>H</sup>	mg/dL	0.00 - 45.00
<b>TOTAL LIPIDS: SERUM</b> by CALCULATED, SPECTROPHOTOMETRY	669.89	mg/dL	350.00 - 700.00
<b>CHOLESTEROL/HDL RATIO: SERUM</b> by CALCULATED, SPECTROPHOTOMETRY	3.73	RATIO	LOW RISK: 3.30 - 4.40 AVERAGE RISK: 4.50 - 7.0 MODERATE RISK: 7.10 - 11.0 HIGH RISK: > 11.0
<b>LDL/HDL RATIO: SERUM</b> by CALCULATED, SPECTROPHOTOMETRY	1.92	RATIO	LOW RISK: 0.50 - 3.0 MODERATE RISK: 3.10 - 6.0 HIGH RISK: > 6.0



  
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TRIGLYCERIDES/HDL RATIO: SERUM	4.04	RATIO	3.00 - 5.00

by CALCULATED, SPECTROPHOTOMETRY

**INTERPRETATION:**

- 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.
- 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.
- 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.
- NLA-2014 identifies Non HDL Cholesterol (an indicator of all atherogenic lipoproteins such as LDL, VLDL, IDL, Lp(a), 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.
- Additional testing for Apolipoprotein B, hsCRP, Lp(a) & LP-PLA2 should be considered among patients with moderate risk for ASCVD for risk refinement



  
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**LIVER FUNCTION TEST (COMPLETE)**

<b>BILIRUBIN TOTAL: SERUM</b> by DIAZOTIZATION, SPECTROPHOTOMETRY	1.23 <sup>H</sup>	mg/dL	<b>INFANT: 0.20 - 8.00</b> <b>ADULT: 0.00 - 1.20</b>
BILIRUBIN DIRECT (CONJUGATED): SERUM by DIAZO MODIFIED, SPECTROPHOTOMETRY	0.32	mg/dL	0.00 - 0.40
BILIRUBIN INDIRECT (UNCONJUGATED): SERUM by CALCULATED, SPECTROPHOTOMETRY	0.91	mg/dL	0.10 - 1.00
SGOT/AST: SERUM by IFCC, WITHOUT PYRIDOXAL PHOSPHATE	33.4	U/L	7.00 - 45.00
<b>SGPT/ALT: SERUM</b> by IFCC, WITHOUT PYRIDOXAL PHOSPHATE	<b>78.6<sup>H</sup></b>	<b>U/L</b>	<b>0.00 - 49.00</b>
AST/ALT RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	0.42	RATIO	0.00 - 46.00
ALKALINE PHOSPHATASE: SERUM by PARA NITROPHENYL PHOSPHATASE BY AMINO METHYL PROPANOL	86.02	U/L	40.0 - 130.0
GAMMA GLUTAMYL TRANSFERASE (GGT): SERUM by SZASZ, SPECTROPHOTOMETRY	52.26	U/L	0.00 - 55.0
TOTAL PROTEINS: SERUM by BIURET, SPECTROPHOTOMETRY	7.77	gm/dL	6.20 - 8.00
ALBUMIN: SERUM by BROMOCRESOL GREEN	4.59	gm/dL	3.50 - 5.50
GLOBULIN: SERUM by CALCULATED, SPECTROPHOTOMETRY	3.18	gm/dL	2.30 - 3.50
A : G RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	1.44	RATIO	1.00 - 2.00

**INTERPRETATION**

**NOTE:-** To be correlated in individuals having SGOT and SGPT values higher than Normal Reference 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)



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**DECREASED:**

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



  
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### KIDNEY FUNCTION TEST (COMPLETE)

UREA: SERUM <i>by UREASE - GLUTAMATE DEHYDROGENASE (GLDH)</i>	24.58	mg/dL	10.00 - 50.00
CREATININE: SERUM <i>by ENZYMATIC, SPECTROPHOTOMETRY</i>	1.08	mg/dL	0.40 - 1.40
BLOOD UREA NITROGEN (BUN): SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	11.49	mg/dL	7.0 - 25.0
BLOOD UREA NITROGEN (BUN)/CREATININE RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	10.64	RATIO	10.0 - 20.0
UREA/CREATININE RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	22.76	RATIO	
URIC ACID: SERUM <i>by URICASE - OXIDASE PEROXIDASE</i>	5.17	mg/dL	3.60 - 7.70
CALCIUM: SERUM <i>by ARSENAZO III, SPECTROPHOTOMETRY</i>	10.11	mg/dL	8.50 - 10.60
PHOSPHOROUS: SERUM <i>by PHOSPHOMOLYBDATE, SPECTROPHOTOMETRY</i>	3.48	mg/dL	2.30 - 4.70

### ELECTROLYTES

SODIUM: SERUM <i>by ISE (ION SELECTIVE ELECTRODE)</i>	143.6	mmol/L	135.0 - 150.0
POTASSIUM: SERUM <i>by ISE (ION SELECTIVE ELECTRODE)</i>	4.52	mmol/L	3.50 - 5.00
CHLORIDE: SERUM <i>by ISE (ION SELECTIVE ELECTRODE)</i>	107.7	mmol/L	90.0 - 110.0

### ESTIMATED GLOMERULAR FILTRATION RATE

ESTIMATED GLOMERULAR FILTRATION RATE (eGFR): SERUM <i>by CALCULATED</i>	86.8
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### 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.





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3. GI haemorrhage.
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 inappropriate antidiuretic hormone) 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.

**INAPPROPRIATE 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 FILTRATION RATE:**

CKD STAGE	DESCRIPTION	GFR ( mL/min/1.73m <sup>2</sup> )	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	



  
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<b>NAME</b>	: Mr. ANIL	<b>PATIENT ID</b>	: 1580150
<b>AGE/ GENDER</b>	: 44 YRS/MALE	<b>REG. NO./LAB NO.</b>	: 042408140006
<b>COLLECTED BY</b>	:	<b>REGISTRATION DATE</b>	: 14/Aug/2024 10:16 AM
<b>REFERRED BY</b>	:	<b>COLLECTION DATE</b>	: 14/Aug/2024 03:18PM
<b>BARCODE NO.</b>	: A0465224	<b>REPORTING DATE</b>	: 14/Aug/2024 04:43PM
<b>CLIENT CODE.</b>	: KOS DIAGNOSTIC SHAHBAD		
<b>CLIENT ADDRESS</b>	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
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**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 m<sup>2</sup> (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 fulfill 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

\*\*\* End Of Report \*\*\*



  
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