

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

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

NAME : Mr. GURPINDER SINGH
AGE/ GENDER : 38 YRS/MALE
COLLECTED BY :
REFERRED BY :
BARCODE NO. : A0465848
CLIENT CODE. : KOS DIAGNOSTIC SHAHBAD
CLIENT ADDRESS : 6349/1, NICHOLSON ROAD, AMBALA CANTT

PATIENT ID : 1658393
REG. NO./LAB NO. : 042411020002
REGISTRATION DATE : 02/Nov/2024 11:08 AM
COLLECTION DATE : 02/Nov/2024 02:54PM
REPORTING DATE : 02/Nov/2024 04:18PM

Test Name	Value	Unit	Biological Reference interval
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CLINICAL CHEMISTRY/BIOCHEMISTRY

KIDNEY FUNCTION TEST (BASIC)

UREA: SERUM by UREASE - GLUTAMATE DEHYDROGENASE (GLDH)	26.59	mg/dL	10.00 - 50.00
CREATININE: SERUM by ENZYMATIC, SPECTROPHOTOMETRY	1.06	mg/dL	0.40 - 1.40
BLOOD UREA NITROGEN (BUN): SERUM by CALCULATED, SPECTROPHOTOMETRY	12.43	mg/dL	7.0 - 25.0
BLOOD UREA NITROGEN (BUN)/CREATININE RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	11.73	RATIO	10.0 - 20.0
UREA/CREATININE RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	25.08	RATIO	
URIC ACID: SERUM by URICASE - OXIDASE PEROXIDASE	5.44	mg/dL	3.60 - 7.70



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INTERPRETATION:

Normal range for a healthy person on normal diet: 12 - 20

To Differentiate between pre- and postrenal 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.
3. GI hemorrhage.
4. High protein intake.
5. Impaired renal function plus .
6. Excess protein intake or production or tissue breakdown (e.g. infection, GI bleeding, thyrotoxicosis, Cushings syndrome, high protein diet, burns, surgery, cachexia, high fever).
7. Urine reabsorption (e.g. ureterocolostomy)
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).

*** End Of Report ***





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