

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

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

NAME	: Mrs. RADHA RANI	PATIENT ID	: 1369940
AGE/ GENDER	: 72 YRS/FEMALE	REG. NO./LAB NO.	: 042411110003
COLLECTED BY	:	REGISTRATION DATE	: 11/Nov/2024 11:19 AM
REFERRED BY	:	COLLECTION DATE	: 11/Nov/2024 03:20PM
BARCODE NO.	: A0465945	REPORTING DATE	: 11/Nov/2024 03:47PM
CLIENT CODE.	: KOS DIAGNOSTIC SHAHBAD		
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

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) <i>by CALORIMETRIC</i>	9.1 ^L	gm/dL	12.0 - 16.0
RED BLOOD CELL (RBC) COUNT <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	3.08 ^L	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	30.3 ^L	%	37.0 - 50.0
MEAN CORPUSCULAR VOLUME (MCV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	98.3	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	29.6	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	30.1 ^L	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	14.2	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	52	fL	35.0 - 56.0
MENTZERS INDEX <i>by CALCULATED</i>	31.92	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX <i>by CALCULATED</i>	45.4	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>	6990	/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>	61	%	50 - 70
LYMPHOCYTES <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	24	%	20 - 40
EOSINOPHILS <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	5	%	1 - 6
MONOCYTES <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	10	%	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>	4264	/cmm	2000 - 7500
ABSOLUTE LYMPHOCYTE COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	1678	/cmm	800 - 4900
ABSOLUTE EOSINOPHIL COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	350	/cmm	40 - 440
ABSOLUTE MONOCYTE COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	699	/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>	246000	/cmm	150000 - 450000
PLATELETCRIT (PCT) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	0.3	%	0.10 - 0.36
MEAN PLATELET VOLUME (MPV) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	12 ^H	fL	6.50 - 12.0
PLATELET LARGE CELL COUNT (P-LCC) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	105000 ^H	/cmm	30000 - 90000
PLATELET LARGE CELL RATIO (P-LCR) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	42.6	%	11.0 - 45.0
PLATELET DISTRIBUTION WIDTH (PDW) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	16.7	%	15.0 - 17.0

NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD





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CLINICAL CHEMISTRY/BIOCHEMISTRY

GLUCOSE FASTING (F)

GLUCOSE FASTING (F): PLASMA by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)	131.02^H	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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Test Name	Value	Unit	Biological Reference interval
LIPID PROFILE : BASIC			
CHOLESTEROL TOTAL: SERUM <i>by CHOLESTEROL OXIDASE PAP</i>	117.86	mg/dL	OPTIMAL: < 200.0 BORDERLINE HIGH: 200.0 - 239.0 HIGH CHOLESTEROL: > OR = 240.0
TRIGLYCERIDES: SERUM <i>by GLYCEROL PHOSPHATE OXIDASE (ENZYMATIC)</i>	77.5	mg/dL	OPTIMAL: < 150.0 BORDERLINE HIGH: 150.0 - 199.0 HIGH: 200.0 - 499.0 VERY HIGH: > OR = 500.0
HDL CHOLESTEROL (DIRECT): SERUM <i>by SELECTIVE INHIBITION</i>	39.12	mg/dL	LOW HDL: < 30.0 BORDERLINE HIGH HDL: 30.0 - 60.0 HIGH HDL: > OR = 60.0
LDL CHOLESTEROL: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	63.24	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
NON HDL CHOLESTEROL: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	78.74	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
VLDL CHOLESTEROL: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	15.5	mg/dL	0.00 - 45.00
TOTAL LIPIDS: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	313.22^L	mg/dL	350.00 - 700.00
CHOLESTEROL/HDL RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	3.01	RATIO	LOW RISK: 3.30 - 4.40 AVERAGE RISK: 4.50 - 7.0 MODERATE RISK: 7.10 - 11.0 HIGH RISK: > 11.0




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LDL/HDL RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	1.62	RATIO	LOW RISK: 0.50 - 3.0 MODERATE RISK: 3.10 - 6.0 HIGH RISK: > 6.0
TRIGLYCERIDES/HDL RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	1.98 ^L	RATIO	3.00 - 5.00

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)

BILIRUBIN TOTAL: SERUM <i>by DIAZOTIZATION, SPECTROPHOTOMETRY</i>	0.37	mg/dL	INFANT: 0.20 - 8.00 ADULT: 0.00 - 1.20
BILIRUBIN DIRECT (CONJUGATED): SERUM <i>by DIAZO MODIFIED, SPECTROPHOTOMETRY</i>	0.16	mg/dL	0.00 - 0.40
BILIRUBIN INDIRECT (UNCONJUGATED): SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	0.21	mg/dL	0.10 - 1.00
SGOT/AST: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	26.6	U/L	7.00 - 45.00
SGPT/ALT: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	15.8	U/L	0.00 - 49.00
AST/ALT RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	1.68	RATIO	0.00 - 46.00
ALKALINE PHOSPHATASE: SERUM <i>by PARA NITROPHENYL PHOSPHATASE BY AMINO METHYL PROPANOL</i>	199.38^H	U/L	40.0 - 130.0
GAMMA GLUTAMYL TRANSFERASE (GGT): SERUM <i>by SZASZ, SPECTROPHOTOMETRY</i>	14.42	U/L	0.00 - 55.0
TOTAL PROTEINS: SERUM <i>by BIURET, SPECTROPHOTOMETRY</i>	6.24	gm/dL	6.20 - 8.00
ALBUMIN: SERUM <i>by BROMOCRESOL GREEN</i>	3.77	gm/dL	3.50 - 5.50
GLOBULIN: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	2.47	gm/dL	2.30 - 3.50
A : G RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	1.53	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 CHOLESTASIS	> 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>	95.81^H	mg/dL	10.00 - 50.00
CREATININE: SERUM <i>by ENZYMATIC, SPECTROPHOTOMETRY</i>	1.73^H	mg/dL	0.40 - 1.20
BLOOD UREA NITROGEN (BUN): SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	44.77^H	mg/dL	7.0 - 25.0
BLOOD UREA NITROGEN (BUN)/CREATININE RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	25.88^H	RATIO	10.0 - 20.0
UREA/CREATININE RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	55.38	RATIO	
URIC ACID: SERUM <i>by URICASE - OXIDASE PEROXIDASE</i>	4.81	mg/dL	2.50 - 6.80
CALCIUM: SERUM <i>by ARSENAZO III, SPECTROPHOTOMETRY</i>	8.28^L	mg/dL	8.50 - 10.60
PHOSPHOROUS: SERUM <i>by PHOSPHOMOLYBDATE, SPECTROPHOTOMETRY</i>	2.11^L	mg/dL	2.30 - 4.70

ELECTROLYTES

SODIUM: SERUM <i>by ISE (ION SELECTIVE ELECTRODE)</i>	144.8	mmol/L	135.0 - 150.0
POTASSIUM: SERUM <i>by ISE (ION SELECTIVE ELECTRODE)</i>	3.65	mmol/L	3.50 - 5.00
CHLORIDE: SERUM <i>by ISE (ION SELECTIVE ELECTRODE)</i>	108.6	mmol/L	90.0 - 110.0

ESTIMATED GLOMERULAR FILTRATION RATE

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.
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,




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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/1.73m2)	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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 DR.YUGAM CHOPRA

CONSULTANT PATHOLOGIST
 MBBS , MD (PATHOLOGY)



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

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

NAME	: Mrs. RADHA RANI	PATIENT ID	: 1369940
AGE/ GENDER	: 72 YRS/FEMALE	REG. NO./LAB NO.	: 042411110003
COLLECTED BY	:	REGISTRATION DATE	: 11/Nov/2024 11:19 AM
REFERRED BY	:	COLLECTION DATE	: 11/Nov/2024 03:20PM
BARCODE NO.	: A0465944	REPORTING DATE	: 11/Nov/2024 05:47PM
CLIENT CODE.	: KOS DIAGNOSTIC SHAHBAD		
CLIENT ADDRESS	: 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 m² (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




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COLLECTED BY	:	REGISTRATION DATE	: 11/Nov/2024 11:19 AM
REFERRED BY	:	COLLECTION DATE	: 11/Nov/2024 03:25PM
BARCODE NO.	: A0465946	REPORTING DATE	: 13/Nov/2024 04:05PM
CLIENT CODE.	: KOS DIAGNOSTIC SHAHBAD		
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
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MICROBIOLOGY

CULTURE AEROBIC BACTERIA AND ANTIBIOTIC SENSITIVITY: URINE

CULTURE AND SUSCEPTIBILITY: URINE

DATE OF SAMPLE	11-11-2024
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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