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|---|---|---|---|
| **NAME** | **: Mr. VIKRAMDEEP SINGH** | | |
| **AGE/ GENDER** | : 31 YRS/MALE | **PATIENT ID** | : 1669702 |
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# SWASTHYA WELLNESS PANEL: 1.0

## COMPLETE BLOOD COUNT (CBC)

| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|
| **RED BLOOD CELLS (RBCS) COUNT AND INDICES** | | | |
| HAEMOGLOBIN (HB)<br>*by CALORIMETRIC* | 16.3 | gm/dL | 12.0 - 17.0 |
| RED BLOOD CELL (RBC) COUNT<br>*by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE* | **5.93**$^{H}$ | Millions/cmm | 3.50 - 5.00 |
| PACKED CELL VOLUME (PCV)<br>*by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER* | 50.1 | % | 40.0 - 54.0 |
| MEAN CORPUSCULAR VOLUME (MCV)<br>*by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER* | 84.5 | fL | 80.0 - 100.0 |
| MEAN CORPUSCULAR HAEMOGLOBIN (MCH)<br>*by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER* | 27.4 | pg | 27.0 - 34.0 |
| MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC)<br>*by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER* | 32.5 | g/dL | 32.0 - 36.0 |
| RED CELL DISTRIBUTION WIDTH (RDW-CV)<br>*by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER* | 13.3 | % | 11.00 - 16.00 |
| RED CELL DISTRIBUTION WIDTH (RDW-SD)<br>*by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER* | 42.4 | fL | 35.0 - 56.0 |
| MENTZERS INDEX<br>*by CALCULATED* | 14.25 | RATIO | BETA THALASSEMIA TRAIT: < 13.0<br>IRON DEFICIENCY ANEMIA: >13.0 |
| GREEN & KING INDEX<br>*by CALCULATED* | 18.89 | RATIO | BETA THALASSEMIA TRAIT:<= 65.0<br>IRON DEFICIENCY ANEMIA: > 65.0 |
| **WHITE BLOOD CELLS (WBCS)** | | | |
| TOTAL LEUCOCYTE COUNT (TLC)<br>*by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY* | 6500 | /cmm | 4000 - 11000 |
| NUCLEATED RED BLOOD CELLS (nRBCS)<br>*by AUTOMATED 6 PART HEMATOLOGY ANALYZER* | NIL | | 0.00 - 20.00 |
| NUCLEATED RED BLOOD CELLS (nRBCS) %<br>*by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER* | NIL | % | < 10 % |

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| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|
| **DIFFERENTIAL LEUCOCYTE COUNT (DLC)** | | | |
| NEUTROPHILS<br>*by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY* | 59 | % | 50 - 70 |
| LYMPHOCYTES<br>*by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY* | 25 | % | 20 - 40 |
| EOSINOPHILS<br>*by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY* | **8$^{H}$** | % | 1 - 6 |
| MONOCYTES<br>*by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY* | 8 | % | 2 - 12 |
| BASOPHILS<br>*by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY* | 0 | % | 0 - 1 |
| **ABSOLUTE LEUKOCYTES (WBC) COUNT** | | | |
| ABSOLUTE NEUTROPHIL COUNT<br>*by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY* | 3835 | /cmm | 2000 - 7500 |
| ABSOLUTE LYMPHOCYTE COUNT<br>*by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY* | 1625 | /cmm | 800 - 4900 |
| ABSOLUTE EOSINOPHIL COUNT<br>*by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY* | **520$^{H}$** | /cmm | 40 - 440 |
| ABSOLUTE MONOCYTE COUNT<br>*by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY* | 520 | /cmm | 80 - 880 |
| ABSOLUTE BASOPHIL COUNT<br>*by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY* | 0 | /cmm | 0 - 110 |
| **PLATELETS AND OTHER PLATELET PREDICTIVE MARKERS.** | | | |
| PLATELET COUNT (PLT)<br>*by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE* | 288000 | /cmm | 150000 - 450000 |
| PLATELETCRIT (PCT)<br>*by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE* | 0.33 | % | 0.10 - 0.36 |
| MEAN PLATELET VOLUME (MPV)<br>*by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE* | 11 | fL | 6.50 - 12.0 |
| PLATELET LARGE CELL COUNT (P-LCC)<br>*by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE* | **103000$^{H}$** | /cmm | 30000 - 90000 |
| PLATELET LARGE CELL RATIO (P-LCR)<br>*by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE* | 35.7 | % | 11.0 - 45.0 |
| PLATELET DISTRIBUTION WIDTH (PDW)<br>*by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE* | 16.1 | % | 15.0 - 17.0 |

NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD

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| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|

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| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|

## ERYTHROCYTE SEDIMENTATION RATE (ESR)

| | | | |
|---|---|---|---|
| ERYTHROCYTE SEDIMENTATION RATE (ESR) | 5 | mm/1st hr | 0 - 20 |

*by RED CELL AGGREGATION BY CAPILLARY PHOTOMETRY*

**INTERPRETATION:**

1. ESR is a non-specific test because an elevated result often indicates the presence of inflammation associated with infection, cancer and auto-immune disease, but does not tell the health practitioner exactly where the inflammation is in the body or what is causing it.
2. An ESR can be affected by other conditions besides inflammation. For this reason, the ESR is typically used in conjunction with other test such as C-reactive protein
3. This test may also be used to monitor disease activity and response to therapy in both of the above diseases as well as some others, such as systemic lupus erythematosus

**CONDITION WITH LOW ESR**

A low ESR can be seen with conditions that inhibit the normal sedimentation of red blood cells, such as a high red blood cell count (polycythaemia), significantly high white blood cell count (leucocytosis) , and some protein abnormalities. Some changes in red cell shape (such as sickle cells in sickle cell anaemia) also lower the ESR.

**NOTE:**

1. ESR and C - reactive protein (C-RP) are both markers of inflammation.
2. Generally, ESR does not change as rapidly as does CRP, either at the start of inflammation or as it resolves.
3. **CRP is not affected by as many other factors as is ESR, making it a better marker of inflammation.**
4. If the ESR is elevated, it is typically a result of two types of proteins, globulins or fibrinogen.
5. Women tend to have a higher ESR, and menstruation and pregnancy can cause temporary elevations.
6. Drugs such as dextran, methyldopa, oral contraceptives, penicillamine procainamide, theophylline, and vitamin A can increase ESR, while aspirin, cortisone, and quinine may decrease it

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| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|

## PERIPHERAL BLOOD SMEAR FOR MALARIA

| | | | |
|---|---|---|---|
| PERIPHERAL BLOOD SMEAR FOR MALARIAL PARASITE (MP) *by MICROSCOPY* | NO MALARIA PARASITE (MP) SEEN IN SMEAR EXAMINED | | |

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| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|

## CLINICAL CHEMISTRY/BIOCHEMISTRY

### GLUCOSE FASTING (F)

| | | | |
|---|---|---|---|
| GLUCOSE FASTING (F): PLASMA<br>*by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)* | 89.64 | mg/dL | NORMAL: < 100.0<br>PREDIABETIC: 100.0 - 125.0<br>DIABETIC: > 0R = 126.0 |

***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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## GLUCOSE POST PRANDIAL (PP)

| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|
| GLUCOSE POST PRANDIAL (PP): PLASMA<br>*by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)* | 100.22 | mg/dL | NORMAL: < 140.00<br>PREDIABETIC: 140.0 - 200.0<br>DIABETIC: > 0R = 200.0 |

***INTERPRETATION***

**IN ACCORDANCE WITH AMERICAN DIABETES ASSOCIATION GUIDELINES:**

1. A post-prandial plasma glucose level below 140 mg/dl is considered normal.
2. A post-prandial glucose level between 140 - 200 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 post-prandial plasma glucose level of above 200 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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## LIPID PROFILE : BASIC

| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|
| CHOLESTEROL TOTAL: SERUM<br>*by CHOLESTEROL OXIDASE PAP* | 148.45 | mg/dL | OPTIMAL: < 200.0<br>BORDERLINE HIGH: 200.0 - 239.0<br>HIGH CHOLESTEROL: > OR = 240.0 |
| TRIGLYCERIDES: SERUM<br>*by GLYCEROL PHOSPHATE OXIDASE (ENZYMATIC)* | 142.52 | mg/dL | OPTIMAL: < 150.0<br>BORDERLINE HIGH: 150.0 - 199.0<br>HIGH: 200.0 - 499.0<br>VERY HIGH: > OR = 500.0 |
| HDL CHOLESTEROL (DIRECT): SERUM<br>*by SELECTIVE INHIBITION* | 36.92 | mg/dL | LOW HDL: < 30.0<br>BORDERLINE HIGH HDL: 30.0 - 60.0<br>HIGH HDL: > OR = 60.0 |
| LDL CHOLESTEROL: SERUM<br>*by CALCULATED, SPECTROPHOTOMETRY* | 83.03 | mg/dL | OPTIMAL: < 100.0<br>ABOVE OPTIMAL: 100.0 - 129.0<br>BORDERLINE HIGH: 130.0 - 159.0<br>HIGH: 160.0 - 189.0<br>VERY HIGH: > OR = 190.0 |
| NON HDL CHOLESTEROL: SERUM<br>*by CALCULATED, SPECTROPHOTOMETRY* | 111.53 | mg/dL | OPTIMAL: < 130.0<br>ABOVE OPTIMAL: 130.0 - 159.0<br>BORDERLINE HIGH: 160.0 - 189.0<br>HIGH: 190.0 - 219.0<br>VERY HIGH: > OR = 220.0 |
| VLDL CHOLESTEROL: SERUM<br>*by CALCULATED, SPECTROPHOTOMETRY* | 28.5 | mg/dL | 0.00 - 45.00 |
| TOTAL LIPIDS: SERUM<br>*by CALCULATED, SPECTROPHOTOMETRY* | 439.42 | mg/dL | 350.00 - 700.00 |
| CHOLESTEROL/HDL RATIO: SERUM<br>*by CALCULATED, SPECTROPHOTOMETRY* | 4.02 | RATIO | LOW RISK: 3.30 - 4.40<br>AVERAGE RISK: 4.50 - 7.0<br>MODERATE RISK: 7.10 - 11.0<br>HIGH RISK: > 11.0 |

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| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|
| LDL/HDL RATIO: SERUM<br>*by CALCULATED, SPECTROPHOTOMETRY* | 2.25 | RATIO | LOW RISK: 0.50 - 3.0<br>MODERATE RISK: 3.10 - 6.0<br>HIGH RISK: > 6.0 |
| TRIGLYCERIDES/HDL RATIO: SERUM<br>*by CALCULATED, SPECTROPHOTOMETRY* | 3.86 | RATIO | 3.00 - 5.00 |

***INTERPRETATION:***

1.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.
2. 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.
3. 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.
4. NLA-2014 identifies Non HDL Cholesterol (an indicator of all atherogeniclipoproteins such as LDL , VLDL, IDL, Lpa, 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.
5. 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)

| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|
| BILIRUBIN TOTAL: SERUM<br>*by DIAZOTIZATION, SPECTROPHOTOMETRY* | **2.62$^{H}$** | mg/dL | INFANT: 0.20 - 8.00<br>ADULT: 0.00 - 1.20 |
| BILIRUBIN DIRECT (CONJUGATED): SERUM<br>*by DIAZO MODIFIED, SPECTROPHOTOMETRY* | 0.39 | mg/dL | 0.00 - 0.40 |
| BILIRUBIN INDIRECT (UNCONJUGATED): SERUM<br>*by CALCULATED, SPECTROPHOTOMETRY* | **2.23$^{H}$** | mg/dL | 0.10 - 1.00 |
| SGOT/AST: SERUM<br>*by IFCC, WITHOUT PYRIDOXAL PHOSPHATE* | 19.3 | U/L | 7.00 - 45.00 |
| SGPT/ALT: SERUM<br>*by IFCC, WITHOUT PYRIDOXAL PHOSPHATE* | 12.8 | U/L | 0.00 - 49.00 |
| AST/ALT RATIO: SERUM<br>*by CALCULATED, SPECTROPHOTOMETRY* | 1.51 | RATIO | 0.00 - 46.00 |
| ALKALINE PHOSPHATASE: SERUM<br>*by PARA NITROPHENYL PHOSPHATASE BY AMINO METHYL PROPANOL* | 119.86 | U/L | 40.0 - 130.0 |
| GAMMA GLUTAMYL TRANSFERASE (GGT): SERUM<br>*by SZASZ, SPECTROPHTOMETRY* | 12.87 | U/L | 0.00 - 55.0 |
| TOTAL PROTEINS: SERUM<br>*by BIURET, SPECTROPHOTOMETRY* | 7.54 | gm/dL | 6.20 - 8.00 |
| ALBUMIN: SERUM<br>*by BROMOCRESOL GREEN* | 3.97 | gm/dL | 3.50 - 5.50 |
| GLOBULIN: SERUM<br>*by CALCULATED, SPECTROPHOTOMETRY* | **3.57$^{H}$** | gm/dL | 2.30 - 3.50 |
| A : G RATIO: SERUM<br>*by CALCULATED, SPECTROPHOTOMETRY* | 1.11 | RATIO | 1.00 - 2.00 |

***INTERPRETATION***

***NOTE***:- **To be correlated in individuals having SGOT and SGPT values higher than Normal Referance 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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| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|

**DECREASED:**

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

| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|
| UREA: SERUM<br>*by UREASE - GLUTAMATE DEHYDROGENASE (GLDH)* | 22.53 | mg/dL | 10.00 - 50.00 |
| CREATININE: SERUM<br>*by ENZYMATIC, SPECTROPHOTOMETERY* | 1.21 | mg/dL | 0.40 - 1.40 |
| BLOOD UREA NITROGEN (BUN): SERUM<br>*by CALCULATED, SPECTROPHOTOMETRY* | 10.53 | mg/dL | 7.0 - 25.0 |
| BLOOD UREA NITROGEN (BUN)/CREATININE RATIO: SERUM<br>*by CALCULATED, SPECTROPHOTOMETRY* | **8.7**[L] | RATIO | 10.0 - 20.0 |
| UREA/CREATININE RATIO: SERUM<br>*by CALCULATED, SPECTROPHOTOMETRY* | 18.62 | RATIO | |
| URIC ACID: SERUM<br>*by URICASE - OXIDASE PEROXIDASE* | 6.17 | mg/dL | 3.60 - 7.70 |
| CALCIUM: SERUM<br>*by ARSENAZO III, SPECTROPHOTOMETRY* | 10.16 | mg/dL | 8.50 - 10.60 |
| PHOSPHOROUS: SERUM<br>*by PHOSPHOMOLYBDATE, SPECTROPHOTOMETRY* | 2.53 | mg/dL | 2.30 - 4.70 |
| **ELECTROLYTES** | | | |
| SODIUM: SERUM<br>*by ISE (ION SELECTIVE ELECTRODE)* | 140.4 | mmol/L | 135.0 - 150.0 |
| POTASSIUM: SERUM<br>*by ISE (ION SELECTIVE ELECTRODE)* | 3.9 | mmol/L | 3.50 - 5.00 |
| CHLORIDE: SERUM<br>*by ISE (ION SELECTIVE ELECTRODE)* | 105.3 | mmol/L | 90.0 - 110.0 |
| **ESTIMATED GLOMERULAR FILTERATION RATE** | | | |
| ESTIMATED GLOMERULAR FILTERATION RATE (eGFR): SERUM<br>*by CALCULATED* | 82.1 | | |

***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.

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| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|

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 inappropiate antidiuretic harmone) 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.

**INAPPROPIATE 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 FILTERATION 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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| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|

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 fullfill 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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| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|

## IMMUNOPATHOLOGY/SEROLOGY

### C-REACTIVE PROTEIN (CRP)

| | | | |
|---|---|---|---|
| C-REACTIVE PROTEIN (CRP) QUANTITATIVE: SERUM<br>*by NEPHLOMETRY* | 2.31 | mg/L | 0.0 - 6.0 |

***INTERPRETATION:***

1. C-reactive protein (CRP) is one of the most sensitive acute-phase reactants for inflammation.
2. CRP levels can increase dramatically (100-fold or more) after severe trauma, bacterial infection, inflammation, surgery, or neoplastic proliferation.
3. CRP levels (Quantitative) has been used to assess activity of inflammatory disease, to detect infections after surgery, to detect transplant rejection, and to monitor these inflammatory processes.
4. As compared to ESR, CRP shows an earlier rise in inflammatory disorders which begins in 4-6 hrs, the intensity of the rise being higher than ESR and the recovery being earlier than ESR. Unlike ESR, CRP levels are not influenced by hematologic conditions like Anemia, Polycythemia etc.,
5. Elevated values are consistent with an acute inflammatory process.

**NOTE:**

1. Elevated C-reactive protein (CRP) values are nonspecific and should not be interpreted without a complete clinical history.
2. Oral contraceptives may increase CRP levels.

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| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|

## RHEUMATOID FACTOR (RA): QUANTITATIVE - SERUM

| | | | |
|---|---|---|---|
| RHEUMATOID (RA) FACTOR QUANTITATIVE: SERUM<br>*by NEPHLOMETRY* | 3.18 | IU/mL | NEGATIVE: < 18.0<br>BORDERLINE: 18.0 - 25.0<br>POSITIVE: > 25.0 |

***INTERPRETATION:-***

**RHEUMATOID FACTOR (RA):**

1. Rheumatoid factors (RF) are antibodies that are directed against the Fc fragment of IgG altered in its tertiary structure.
2. Over 75% of patients with rheumatoid arthritis (RA) have an IgM antibody to IgG immunoglobulin. This autoantibody (RF) is diagnostically useful although it may not be etiologically related to RA.
3. Inflammatory Markers such as ESR & C-Reactive protein (CRP) are normal in about 60 % of patients with positive RA.
4. The titer of RF correlates poorly with disease activity, but those patients with high titers tend to have more severe disease course.
5. The test is useful for diagnosis and prognosis of rheumatoid arthritis.

**RHEUMATOID ARTHIRITIS:**

1. Rheumatoid Arthiritis is a systemic autoimmune disease that is multi-functional in origin and is characterized by chronic inflammation of the membrane lining (synovium) joints which ledas to progressive joint destruction and in most cases to disability and reduction of quality life.
2. The disease spredas from small to large joints, with greatest damage in early phase.
3. The diagnosis of RA is primarily based on clinical, radiological & immunological features.The most frequent serological test is the measurement of RA factor.

**CAUTION (FALSE POSTIVE):-**

*1. RA factor is not specific for Rheumatoid arthiritis, as it is often present in healthy individuals with other autoimmune diseases and chronic infections.*
*2. Non rheumatoid and rheumatoid arthritis (RA) populations are not clearly separate with regard to the presence of rheumatoid factor (RF) (15% of RA patients have a nonreactive titer and 8% of nonrheumatoid patients have a positive titer).*
*3. Patients with various nonrheumatoid diseases,characterized by chronic inflammation may have positive tests for RF. These diseases include systemic lupus erythematosus, polymyositis, tuberculosis, syphilis, viral hepatitis, infectious mononucleosis, and influenza.*
*4. Anti-CCP have been discovered in joints of patients with RA, but not in other form of joint disease.Anti-CCP2 is HIGHLY SENSITIVE (71%) & more specific (98%) than RA factor.*
*5. Upto 30 % of patients with Seronegative Rheumatoid arthiritis also show Anti-CCP antibodies.*
*6. The positive predictive value of Anti-CCP antibodies for Rheumatoid Arthiritis is far greater than Rheumatoid factor.*

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## WIDAL SLIDE AGGLUTINATION TEST

| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|
| SALMONELLA TYPHI O<br>*by SLIDE AGGLUTINATION* | 1 : 40 | TITRE | 1 : 80 |
| SALMONELLA TYPHI H<br>*by SLIDE AGGLUTINATION* | 1 : 20 | TITRE | 1 : 160 |
| SALMONELLA PARATYPHI AH<br>*by SLIDE AGGLUTINATION* | NIL | TITRE | 1 : 160 |
| SALMONELLA PARATYPHI BH<br>*by SLIDE AGGLUTINATION* | NIL | TITRE | 1 : 160 |

***INTERPRETATION:***

*1.Titres of 1:80 or more for "O" agglutinin is considered significant.*
*2.Titres of 1:160 or more for "H" agglutinin is considered significant.*

**LIMITATIONS:**

1.Agglutinins usually appear by 5th to 6th day of illness of enteric fever, hence a negative result in early stage is inconclusive.The titre then rises till 3rd or 4th week, after which it declines gradually.
2.Lower titres may be found in normal individuals.
3.A single positive result has less significance than the rising agglutination titre, since demonstration of rising titre four or more in 1st and 3rd week is considered as a definite evidence of infection.
4.A simultaneous rise in H agglutinins is suggestive of paratyphoid infection.

**NOTE:**

*1.Individuals with prior infection or immunization with TAB vaccine may develop an ANAMNESTIC RESPONSE (False-Positive) during an unrelated fever i.e High titres of antibodies to various antigens.This may be differentiated by repitition of the test after a week.*
*2.The anamnestic response shows only a transient rise, while in enteric fever rise is sustained.*
*3.H agglutinins tend to persist for many months after vaccination but O agglutinins tend to disappear sooner i.e within 6 months.Therefore rise in Oagglutinins indicate recent infection.*

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# CLINICAL PATHOLOGY

## URINE ROUTINE & MICROSCOPIC EXAMINATION

| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|
| **PHYSICAL EXAMINATION** | | | |
| QUANTITY RECIEVED | 10 | ml | |
| *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY* | | | |
| COLOUR | PALE YELLOW | | PALE YELLOW |
| *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY* | | | |
| TRANSPARANCY | CLEAR | | CLEAR |
| *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY* | | | |
| SPECIFIC GRAVITY | 1.01 | | 1.002 - 1.030 |
| *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY* | | | |
| **CHEMICAL EXAMINATION** | | | |
| REACTION | ALKALINE | | |
| *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY* | | | |
| PROTEIN | Negative | | NEGATIVE (-ve) |
| *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY* | | | |
| SUGAR | Negative | | NEGATIVE (-ve) |
| *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY* | | | |
| pH | 7.5 | | 5.0 - 7.5 |
| *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY* | | | |
| BILIRUBIN | Negative | | NEGATIVE (-ve) |
| *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY* | | | |
| NITRITE | Negative | | NEGATIVE (-ve) |
| *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY.* | | | |
| UROBILINOGEN | Normal | EU/dL | 0.2 - 1.0 |
| *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY* | | | |
| KETONE BODIES | Negative | | NEGATIVE (-ve) |
| *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY* | | | |
| BLOOD | Negative | | NEGATIVE (-ve) |
| *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY* | | | |
| ASCORBIC ACID | NEGATIVE (-ve) | | NEGATIVE (-ve) |
| *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY* | | | |
| **MICROSCOPIC EXAMINATION** | | | |
| RED BLOOD CELLS (RBCs) | NEGATIVE (-ve) | /HPF | 0 - 3 |

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| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|
| *by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT* | | | |
| PUS CELLS<br>*by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT* | 1-3 | /HPF | 0 - 5 |
| EPITHELIAL CELLS<br>*by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT* | 0-2 | /HPF | ABSENT |
| CRYSTALS<br>*by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT* | NEGATIVE (-ve) | | NEGATIVE (-ve) |
| CASTS<br>*by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT* | NEGATIVE (-ve) | | NEGATIVE (-ve) |
| BACTERIA<br>*by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT* | NEGATIVE (-ve) | | NEGATIVE (-ve) |
| OTHERS<br>*by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT* | NEGATIVE (-ve) | | NEGATIVE (-ve) |
| TRICHOMONAS VAGINALIS (PROTOZOA)<br>*by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT* | ABSENT | | ABSENT |

*** End Of Report ***

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