

Dr. Vinay Chopra
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 Chairman & Consultant Pathologist

Dr. Yugam Chopra
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 CEO & Consultant Pathologist

NAME	: Mr. TUSHAR	PATIENT ID	: 1809560
AGE/ GENDER	: 24 YRS/MALE	REG. NO./LAB NO.	: 042503280004
COLLECTED BY	:	REGISTRATION DATE	: 28/Mar/2025 11:34 AM
REFERRED BY	:	COLLECTION DATE	: 28/Mar/2025 03:27PM
BARCODE NO.	: A1260742	REPORTING DATE	: 28/Mar/2025 04:22PM
CLIENT CODE.	: KOS DIAGNOSTIC SHAHBAD		
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
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HAEMATOLOGY

COMPLETE BLOOD COUNT (CBC)

RED BLOOD CELLS (RBCS) COUNT AND INDICES

HAEMOGLOBIN (HB) <i>by CALORIMETRIC</i>	13	gm/dL	12.0 - 17.0
RED BLOOD CELL (RBC) COUNT <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	4.72	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	40	%	40.0 - 54.0
MEAN CORPUSCULAR VOLUME (MCV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	84.7	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	27.6	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	32.6	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	14.9	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	47.3	fL	35.0 - 56.0
MENTZERS INDEX <i>by CALCULATED</i>	17.94	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX <i>by CALCULATED</i>	82.23	RATIO	BETA THALASSEMIA TRAIT: <= 74.1 IRON DEFICIENCY ANEMIA: >= 74.1

WHITE BLOOD CELLS (WBCS)

TOTAL LEUCOCYTE COUNT (TLC) <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	16560 ^H	/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) %	NIL	%	< 10 %




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by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER			
<u>DIFFERENTIAL LEUCOCYTE COUNT (DLC)</u>			
NEUTROPHILS	85 ^H	%	50 - 70
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
LYMPHOCYTES	9 ^L	%	20 - 40
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
EOSINOPHILS	0 ^L	%	1 - 6
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
MONOCYTES	6	%	2 - 12
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
BASOPHILS	0	%	0 - 1
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
<u>ABSOLUTE LEUKOCYTES (WBC) COUNT</u>			
ABSOLUTE NEUTROPHIL COUNT	14076 ^H	/cmm	2000 - 7500
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
ABSOLUTE LYMPHOCYTE COUNT	1490	/cmm	800 - 4900
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
ABSOLUTE EOSINOPHIL COUNT	0 ^L	/cmm	40 - 440
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
ABSOLUTE MONOCYTE COUNT	994 ^H	/cmm	80 - 880
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
<u>PLATELETS AND OTHER PLATELET PREDICTIVE MARKERS.</u>			
PLATELET COUNT (PLT)	141000 ^L	/cmm	150000 - 450000
by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE			
PLATELETCRIT (PCT)	0.2	%	0.10 - 0.36
by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE			
MEAN PLATELET VOLUME (MPV)	14 ^H	fL	6.50 - 12.0
by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE			
PLATELET LARGE CELL COUNT (P-LCC)	76000	/cmm	30000 - 90000
by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE			
PLATELET LARGE CELL RATIO (P-LCR)	54 ^H	%	11.0 - 45.0
by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE			
PLATELET DISTRIBUTION WIDTH (PDW)	16.8	%	15.0 - 17.0
by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE			

NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD




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CLINICAL CHEMISTRY/BIOCHEMISTRY

URIC ACID

URIC ACID: SERUM	6.2	mg/dL	3.60 - 7.70
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by URICASE - OXIDASE PEROXIDASE

INTERPRETATION:-

1.GOUT occurs when high levels of Uric Acid in the blood cause crystals to form & accumulate around a joint.
 2.Uric Acid is the end product of purine metabolism . Uric acid is excreted to a large degree by the kidneys and to a smaller degree in the intestinal tract by microbial degradation.

INCREASED:-

(A).DUE TO INCREASED PRODUCTION:-

- 1.Idiopathic primary gout.
- 2.Excessive dietary purines (organ meats,legumes,anchovies, etc).
- 3.Cytolytic treatment of malignancies especially leukemias & lymphomas.
- 4.Polycythemia vera & myeloid metaplasia.
- 5.Psoriasis.
- 6.Sickle cell anaemia etc.

(B).DUE TO DECREASED EXCRETION (BY KIDNEYS)

- 1.Alcohol ingestion.
- 2.Thiazide diuretics.
- 3.Lactic acidosis.
- 4.Aspirin ingestion (less than 2 grams per day).
- 5.Diabetic ketoacidosis or starvation.
- 6.Renal failure due to any cause etc.

DECREASED:-

(A).DUE TO DIETARY DEFICIENCY

- 1.Dietary deficiency of Zinc, Iron and molybdenum.
- 2.Fanconi syndrome & Wilsons disease.
- 3.Multiple sclerosis .
- 4.Syndrome of inappropriate antidiuretic hormone (SIADH) secretion & low purine diet etc.

(B).DUE TO INCREASED EXCRETION

- 1.Drugs:-Probenecid , sulphinpyrazone, aspirin doses (more than 4 grams per day), corticosteroids and ACTH, anti-coagulants and estrogens etc.





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IMMUNOPATHOLOGY/SEROLOGY WIDAL SLIDE AGGLUTINATION TEST

SALMONELLA TYPHI O by SLIDE AGGLUTINATION	1 : 20	TITRE	1 : 80
SALMONELLA TYPHI H by SLIDE AGGLUTINATION	1 : 20	TITRE	1 : 160
SALMONELLA PARATYPHI AH by SLIDE AGGLUTINATION	NIL	TITRE	1 : 160
SALMONELLA PARATYPHI BH 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 repetition 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 O agglutinins indicate recent infection.

*** End Of Report ***





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