



P K R JAIN HEALTHCARE INSTITUTE

NASIRPUR, Hissar Road, AMBALA CITY- (Haryana)

A PIONEER DIAGNOSTIC CENTRE

☎ 0171-2532620, 8222896961 ✉ pkrajainhealthcare@gmail.com

NAME : Mr. ASHWANI KUMAR
AGE/ GENDER : 66 YRS/MALE **PATIENT ID** : 1566134
COLLECTED BY : **REG. NO./LAB NO.** : 122407310009
REFERRED BY : **REGISTRATION DATE** : 31/Jul/2024 09:37 AM
BARCODE NO. : 12503911 **COLLECTION DATE** : 31/Jul/2024 09:58AM
CLIENT CODE. : P.K.R JAIN HEALTHCARE INSTITUTE **REPORTING DATE** : 31/Jul/2024 01:15PM
CLIENT ADDRESS : NASIRPUR, HISSAR ROAD, AMBALA CITY - HARYANA

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) by CALORIMETRIC	10.8 ^L	gm/dL	12.0 - 17.0
RED BLOOD CELL (RBC) COUNT by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	3.66	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	30.9 ^L	%	40.0 - 54.0
MEAN CORPUSCULAR VOLUME (MCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	84.4	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	29.6	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	35.1	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	15.7	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	50.6	fL	35.0 - 56.0
MENTZERS INDEX by CALCULATED	23.06	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX by CALCULATED	36.32	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	11860 ^H	/cmm	4000 - 11000
DIFFERENTIAL LEUCOCYTE COUNT (DLC)			
NEUTROPHILS by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	58	%	50 - 70
LYMPHOCYTES by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	22	%	20 - 40




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EOSINOPHILS by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	12 ^H	%	1 - 6
MONOCYTES by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	8	%	2 - 12
BASOPHILS by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	0	%	0 - 1
<u>ABSOLUTE LEUKOCYTES (WBC) COUNT</u>			
ABSOLUTE NEUTROPHIL COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	6879	/cmm	2000 - 7500
ABSOLUTE LYMPHOCYTE COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	2609 ^L	/cmm	800 - 4900
ABSOLUTE EOSINOPHIL COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	1423 ^H	/cmm	40 - 440
ABSOLUTE MONOCYTE COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	949 ^H	/cmm	80 - 880
ABSOLUTE BASOPHIL COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	0	/cmm	0 - 110
<u>PLATELETS AND OTHER PLATELET PREDICTIVE MARKERS.</u>			
PLATELET COUNT (PLT) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	95000 ^L	/cmm	150000 - 450000
PLATELET CRIT (PCT) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	0.09 ^L	%	0.10 - 0.36
MEAN PLATELET VOLUME (MPV) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	9	fL	6.50 - 12.0
PLATELET LARGE CELL COUNT (P-LCC) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	23000 ^L	/cmm	30000 - 90000
PLATELET LARGE CELL RATIO (P-LCR) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	24.7	%	11.0 - 45.0
PLATELET DISTRIBUTION WIDTH (PDW) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	16	%	15.0 - 17.0
NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD			




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PROTHROMBIN TIME STUDIES (PT/INR)

PT TEST (PATIENT) by PHOTO OPTICAL CLOT DETECTION	14.5	SECS	11.5 - 14.5
PT (CONTROL) by PHOTO OPTICAL CLOT DETECTION	12	SECS	
ISI by PHOTO OPTICAL CLOT DETECTION	1.1		
INTERNATIONAL NORMALISED RATIO (INR) by PHOTO OPTICAL CLOT DETECTION	1.23 ^H		0.80 - 1.20
PT INDEX by PHOTO OPTICAL CLOT DETECTION	82.76	%	

ADVICE KINDLY CORRELATE CLINICALLY


INTERPRETATION:-

- 1.INR is the parameter of choice in monitoring adequacy of oral anti-coagulant therapy. Appropriate therapeutic range varies with the disease and treatment intensity.
2. Prolonged INR suggests potential bleeding disorder /bleeding complications
3. Results should be clinically correlated.
4. Test conducted on Citrated Plasma

RECOMMENDED THERAPEUTIC RANGE FOR ORAL ANTI-COAGULANT THERAPY (INR)

INDICATION		INTERNATIONAL NORMALIZED RATIO (INR)
Treatment of venous thrombosis	Low Intensity	2.0 - 3.0
Treatment of pulmonary embolism		
Prevention of systemic embolism in tissue heart valves		
Valvular heart disease		
Acute myocardial infarction		
Atrial fibrillation		
Bileaflet mechanical valve in aortic position		
Recurrent embolism	High Intensity	2.5 - 3.5
Mechanical heart valve		
Antiphospholipid antibodies ⁺		




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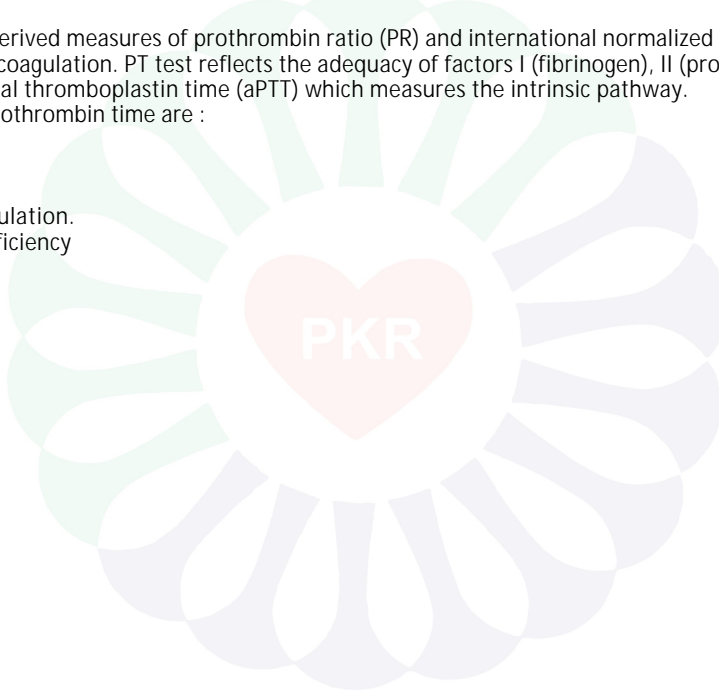
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COMMENTS:

The prothrombin time (PT) and its derived measures of prothrombin ratio (PR) and international normalized ratio (INR) are measures of the efficacy of the extrinsic pathway of coagulation. PT test reflects the adequacy of factors I (fibrinogen), II (prothrombin), V, VII, and X. It is used in conjunction with the activated partial thromboplastin time (aPTT) which measures the intrinsic pathway.

The common causes of prolonged prothrombin time are :

- 1.Oral Anticoagulant therapy.
- 2.Liver disease.
- 3.Vit K. deficiency.
- 4.Disseminated intra vascular coagulation.
- 5.Factor 5, 7 , 10 or Prothrombin deficiency




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CLINICAL CHEMISTRY/BIOCHEMISTRY

LIVER FUNCTION TEST (COMPLETE)

BILIRUBIN TOTAL: SERUM <i>by DIAZOTIZATION, SPECTROPHOTOMETRY</i>	2.67 ^H	mg/dL	INFANT: 0.20 - 8.00 ADULT: 0.00 - 1.20
BILIRUBIN DIRECT (CONJUGATED): SERUM <i>by DIAZO MODIFIED, SPECTROPHOTOMETRY</i>	1.22 ^H	mg/dL	0.00 - 0.40
BILIRUBIN INDIRECT (UNCONJUGATED): SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	1.45 ^H	mg/dL	0.10 - 1.00
SGOT/AST: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	31.8	U/L	7.00 - 45.00
SGPT/ALT: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	19.02	U/L	0.00 - 49.00
AST/ALT RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	1.67	RATIO	0.00 - 46.00
ALKALINE PHOSPHATASE: SERUM <i>by PARA NITROPHENYL PHOSPHATASE BY AMINO METHYL PROPANOL</i>	149.62 ^H	U/L	40.0 - 130.0
GAMMA GLUTAMYL TRANSFERASE (GGT): SERUM <i>by SZASZ, SPECTROPHOTOMETRY</i>	52.07	U/L	0.00 - 55.0
TOTAL PROTEINS: SERUM <i>by BIURET, SPECTROPHOTOMETRY</i>	7.19	gm/dL	6.20 - 8.00
ALBUMIN: SERUM <i>by BROMOCRESOL GREEN</i>	3.49 ^L	gm/dL	3.50 - 5.50
GLOBULIN: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	3.7 ^H	gm/dL	2.30 - 3.50
A : G RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	0.94 ^L	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




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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 (BASIC)

UREA: SERUM by UREASE - GLUTAMATE DEHYDROGENASE (GLDH)	36.53	mg/dL	10.00 - 50.00
CREATININE: SERUM by ENZYMATIC, SPECTROPHOTOMETRY	0.78	mg/dL	0.40 - 1.40
BLOOD UREA NITROGEN (BUN): SERUM by CALCULATED, SPECTROPHOTOMETRY	17.07	mg/dL	7.0 - 25.0
BLOOD UREA NITROGEN (BUN)/CREATININE RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	21.88 ^H	RATIO	10.0 - 20.0
UREA/CREATININE RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	46.83	RATIO	
URIC ACID: SERUM by URICASE - OXIDASE PEROXIDASE	4.78	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).



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TUMOUR MARKER

ALPHA FETO PROTEIN (AFP): TUMOR MARKER

ALPHA FETO PROTEIN (AFP)
TUMOUR MARKER: SERUM

2.68

IU/mL

SMOKERS: < 8.00
NON SMOKERS: < 8.00
HEPATO CELLULAR
CARCINOMA:100.0->350.0

INTERPRETATION:

1. Alpha-fetoprotein (AFP) is a glycoprotein that is produced in early fetal life by the liver, GIT & yolk sac and by a variety of tumors including hepatocellular carcinoma, hepatoblastoma, and nonseminomatous germ cell tumors of the ovary and testis (eg, yolk sac and embryonal carcinoma). Most studies report elevated AFP concentrations in approximately 70% of patients with hepatocellular carcinoma. Elevated AFP concentrations are found in 50% to 70% of patients with non seminomatous testicular tumors.
2. It is a major component of fetal plasma, reaching a peak concentration of 3mg/mL at 12 weeks of gestation. Following birth, it clears from circulation, falling to 100 ng/ mL by 150 days and reaching adult values by end of 1 year.
3. AFP is elevated during pregnancy. Persistence of AFP in the mother following birth is a rare hereditary condition.
3. Neonates have markedly elevated AFP levels (>100,000 ng/mL) that rapidly fall to below 100 ng/mL by 150 days and gradually return to normal over their first year.
4. Concentrations of AFP above the reference range also have been found in serum of patients with benign liver disease (eg, viral hepatitis, cirrhosis), gastrointestinal tract tumors and, along with carcinoembryonic antigen in ataxia telangiectasia.

CAUTION:

1. It is not recommended to use this assay for the initial diagnosis of the above mentioned malignancies.
2. It is best used for monitoring of therapy and to look for relapse of malignancies that have been surgically excised or cleared with chemo/radiotherapy.
3. Failure of the AFP value to return to normal by approximately 1 month after surgery suggests the presence of residual tumor.
4. Elevation of AFP after remission suggests tumor recurrence; however, tumors originally producing AFP may recur without an increase in AFP.

NOTE:

A difference of > 20% between two measurements is considered to be medically significant. The assay is used only as an adjunct to diagnosis and monitoring/ diagnosis should be confirmed by other tests/procedures.

*** End Of Report ***



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