
# P K R JAIN HEALTHCARE INSTITUTE

NASIRPUR, Hissar Road, AMBALA CITY- (Haryana)

A PIONEER DIAGNOSTIC CENTRE

0171-2532620, 8222896961 pkrjainhealthcare@gmail.com


TEST PERFORMED AT KOS DIAGNOSTIC LAB, AMBALA CANTT.

| | | | |
|---|---|---|---|
| **NAME** | **: Mr. GURDEEP SINGH** | | |
| **AGE/ GENDER** | : 65 YRS/MALE | **PATIENT ID** | : 1228873 |
| **COLLECTED BY** | : | **REG. NO./LAB NO.** | **: 122408060001** |
| **REFERRED BY** | : | **REGISTRATION DATE** | : 06/Aug/2024 08:13 AM |
| **BARCODE NO.** | : 12503998 | **COLLECTION DATE** | : 06/Aug/2024 08:15AM |
| **CLIENT CODE.** | : P.K.R JAIN HEALTHCARE INSTITUTE | **REPORTING DATE** | : 06/Aug/2024 01:00PM |
| **CLIENT ADDRESS** | : NASIRPUR, HISSAR ROAD, AMBALA CITY - HARYANA | | |

## 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* | 14.1 | gm/dL | 12.0 - 17.0 |
| RED BLOOD CELL (RBC) COUNT<br>*by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE* | 4.58 | Millions/cmm | 3.50 - 5.00 |
| PACKED CELL VOLUME (PCV)<br>*by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER* | 40 | % | 40.0 - 54.0 |
| MEAN CORPUSCULAR VOLUME (MCV)<br>*by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER* | 87.2 | fL | 80.0 - 100.0 |
| MEAN CORPUSCULAR HAEMOGLOBIN (MCH)<br>*by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER* | 30.9 | pg | 27.0 - 34.0 |
| MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC)<br>*by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER* | 35.4 | g/dL | 32.0 - 36.0 |
| RED CELL DISTRIBUTION WIDTH (RDW-CV)<br>*by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER* | 13.1 | % | 11.00 - 16.00 |
| RED CELL DISTRIBUTION WIDTH (RDW-SD)<br>*by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER* | 44.3 | fL | 35.0 - 56.0 |
| MENTZERS INDEX<br>*by CALCULATED* | 19.04 | RATIO | BETA THALASSEMIA TRAIT: < 13.0<br>IRON DEFICIENCY ANEMIA: >13.0 |
| GREEN & KING INDEX<br>*by CALCULATED* | 25.03 | 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* | 9860 | /cmm | 4000 - 11000 |
| **DIFFERENTIAL LEUCOCYTE COUNT (DLC)** | | | |
| NEUTROPHILS<br>*by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY* | 61 | % | 50 - 70 |
| LYMPHOCYTES<br>*by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY* | 30 | % | 20 - 40 |

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| Test Name | Value | Unit | Biological Reference interval |
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| EOSINOPHILS<br>*by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY* | 4 | % | 1 - 6 |
| MONOCYTES<br>*by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY* | 5 | % | 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* | 6015 | /cmm | 2000 - 7500 |
| ABSOLUTE LYMPHOCYTE COUNT<br>*by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY* | 2958 | /cmm | 800 - 4900 |
| ABSOLUTE EOSINOPHIL COUNT<br>*by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY* | 394 | /cmm | 40 - 440 |
| ABSOLUTE MONOCYTE COUNT<br>*by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY* | 493 | /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* | 165000 | /cmm | 150000 - 450000 |
| PLATELETCRIT (PCT)<br>*by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE* | 0.16 | % | 0.10 - 0.36 |
| MEAN PLATELET VOLUME (MPV)<br>*by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE* | 9 | fL | 6.50 - 12.0 |
| PLATELET LARGE CELL COUNT (P-LCC)<br>*by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE* | 38000 | /cmm | 30000 - 90000 |
| PLATELET LARGE CELL RATIO (P-LCR)<br>*by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE* | 22.8 | % | 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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## ERYTHROCYTE SEDIMENTATION RATE (ESR)

| | | | |
|---|---|---|---|
| **ERYTHROCYTE SEDIMENTATION RATE (ESR)** *by MODIFIED WESTERGREN AUTOMATED METHOD* | **40H** | **mm/1st hr** | **0 - 20** |

**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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## CLINICAL CHEMISTRY/BIOCHEMISTRY

### GLUCOSE FASTING (F)

| | | | |
|---|---|---|---|
| **GLUCOSE FASTING (F): PLASMA**<br>*by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)* | **125.79$^{H}$** | **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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| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|
| | **LIPID PROFILE : BASIC** | | |
| CHOLESTEROL TOTAL: SERUM<br>*by CHOLESTEROL OXIDASE PAP* | 78.3 | 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)* | 114.56 | 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*** | **28.57[L]** | **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* | 26.82 | 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* | 49.73 | 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* | 22.91 | mg/dL | 0.00 - 45.00 |
| **TOTAL LIPIDS: SERUM**<br>***by CALCULATED, SPECTROPHOTOMETRY*** | **271.16[L]** | **mg/dL** | **350.00 - 700.00** |
| CHOLESTEROL/HDL RATIO: SERUM<br>*by CALCULATED, SPECTROPHOTOMETRY* | 2.74 | 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 |
| LDL/HDL RATIO: SERUM<br>*by CALCULATED, SPECTROPHOTOMETRY* | 0.94 | RATIO | LOW RISK: 0.50 - 3.0<br>MODERATE RISK: 3.10 - 6.0<br>HIGH RISK: > 6.0 |

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| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|
| TRIGLYCERIDES/HDL RATIO: SERUM<br>*by CALCULATED, SPECTROPHOTOMETRY* | 4.01 | 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* | 0.31 | mg/dL | INFANT: 0.20 - 8.00<br>ADULT: 0.00 - 1.20 |
| BILIRUBIN DIRECT (CONJUGATED): SERUM<br>*by DIAZO MODIFIED, SPECTROPHOTOMETRY* | 0.13 | mg/dL | 0.00 - 0.40 |
| BILIRUBIN INDIRECT (UNCONJUGATED): SERUM<br>*by CALCULATED, SPECTROPHOTOMETRY* | 0.18 | mg/dL | 0.10 - 1.00 |
| SGOT/AST: SERUM<br>*by IFCC, WITHOUT PYRIDOXAL PHOSPHATE* | 16.78 | U/L | 7.00 - 45.00 |
| SGPT/ALT: SERUM<br>*by IFCC, WITHOUT PYRIDOXAL PHOSPHATE* | 11.37 | U/L | 0.00 - 49.00 |
| AST/ALT RATIO: SERUM<br>*by CALCULATED, SPECTROPHOTOMETRY* | 1.48 | RATIO | 0.00 - 46.00 |
| **ALKALINE PHOSPHATASE: SERUM**<br>***by PARA NITROPHENYL PHOSPHATASE BY AMINO METHYL PROPANOL*** | **134.81$^{H}$** | **U/L** | **40.0 - 130.0** |
| GAMMA GLUTAMYL TRANSFERASE (GGT): SERUM<br>*by SZASZ, SPECTROPHTOMETRY* | 23.2 | U/L | 0.00 - 55.0 |
| TOTAL PROTEINS: SERUM<br>*by BIURET, SPECTROPHOTOMETRY* | 7.63 | gm/dL | 6.20 - 8.00 |
| ALBUMIN: SERUM<br>*by BROMOCRESOL GREEN* | 3.98 | gm/dL | 3.50 - 5.50 |
| **GLOBULIN: SERUM**<br>***by CALCULATED, SPECTROPHOTOMETRY*** | **3.65$^{H}$** | **gm/dL** | **2.30 - 3.50** |
| A : G RATIO: SERUM<br>*by CALCULATED, SPECTROPHOTOMETRY* | 1.09 | 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 |
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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 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** *by UREASE - GLUTAMATE DEHYDROGENASE (GLDH)* | **83.97$^{H}$** | **mg/dL** | **10.00 - 50.00** |
| **CREATININE: SERUM** *by ENZYMATIC, SPECTROPHOTOMETERY* | **2.43$^{H}$** | **mg/dL** | **0.40 - 1.40** |
| **BLOOD UREA NITROGEN (BUN): SERUM** *by CALCULATED, SPECTROPHOTOMETRY* | **39.24$^{H}$** | **mg/dL** | **7.0 - 25.0** |
| BLOOD UREA NITROGEN (BUN)/CREATININE RATIO: SERUM *by CALCULATED, SPECTROPHOTOMETRY* | 16.15 | RATIO | 10.0 - 20.0 |
| UREA/CREATININE RATIO: SERUM *by CALCULATED, SPECTROPHOTOMETRY* | 34.56 | RATIO | |
| URIC ACID: SERUM *by URICASE - OXIDASE PEROXIDASE* | 5.68 | mg/dL | 3.60 - 7.70 |
| CALCIUM: SERUM *by ARSENAZO III, SPECTROPHOTOMETRY* | 9.18 | mg/dL | 8.50 - 10.60 |
| PHOSPHOROUS: SERUM *by PHOSPHOMOLYBDATE, SPECTROPHOTOMETRY* | 3.64 | mg/dL | 2.30 - 4.70 |
| **ELECTROLYTES** | | | |
| SODIUM: SERUM *by ISE (ION SELECTIVE ELECTRODE)* | 139.3 | mmol/L | 135.0 - 150.0 |
| POTASSIUM: SERUM *by ISE (ION SELECTIVE ELECTRODE)* | 4.03 | mmol/L | 3.50 - 5.00 |
| CHLORIDE: SERUM *by ISE (ION SELECTIVE ELECTRODE)* | 104.48 | mmol/L | 90.0 - 110.0 |
| **ESTIMATED GLOMERULAR FILTERATION RATE** | | | |
| ESTIMATED GLOMERULAR FILTERATION RATE (eGFR): SERUM *by CALCULATED* | 28.8 | | |

***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.

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| **NAME** | **: Mr. GURDEEP SINGH** | | |
| **AGE/ GENDER** | : 65 YRS/MALE | **PATIENT ID** | : 1228873 |
| **COLLECTED BY** | : | **REG. NO./LAB NO.** | **: 122408060001** |
| **REFERRED BY** | : | **REGISTRATION DATE** | : 06/Aug/2024 08:13 AM |
| **BARCODE NO.** | : 12503998 | **COLLECTION DATE** | : 06/Aug/2024 08:15AM |
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| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|

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, 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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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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# P K R JAIN HEALTHCARE INSTITUTE

NASIRPUR, Hissar Road, AMBALA CITY- (Haryana)

A PIONEER DIAGNOSTIC CENTRE

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| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|
| **ENDOCRINOLOGY** | | | |
| **INTACT PARATHYROID HORMONE (PTH)** | | | |
| **INTACT PARATHROID HORMONE (PTH): SERUM** *by CLIA (CHEMILUMINESCENCE IMMUNOASSAY)* | **142.3$^{H}$** | **pg/mL** | **9.5 - 75.0** |

## Intrepretation:-

Parathyroid hormone (PTH) is produced and secreted by the parathyroid glands, which are located along the posterior aspect of the thyroid gland. The serum calcium level regulates PTH secretion via negative feedback through the parathyroid calcium sensing receptor (CASR). Decreased calcium levels stimulate PTH release. Secreted PTH interacts with its specific type II G-protein receptor, causing rapid increases in renal tubular reabsorption of calcium and decreased phosphorus reabsorption. It also participates in long-term calciostatic functions by enhancing mobilization of calcium from bone and increasing renal synthesis of 1,25-dihydroxy vitamin D, which, in turn, increases intestinal calcium absorption.

The assay is useful for:

- Differential diagnosis of hypercalcemia
- Diagnosis of primary, secondary, and tertiary hyperparathyroidism
- Diagnosis of hypoparathyroidism
- Monitoring end-stage renal failure patients for possible renal osteodystrophy

Interpretation of results:

- An (appropriately) low PTH level and high phosphorus level in a hypercalcemic patient suggests that the hypercalcemia is not caused by PTH or PTH-like substances.
- An (appropriately) low PTH level with a low phosphorus level in a hypercalcemic patient suggests the diagnosis of paraneoplastic hypercalcemia.
- A low or normal PTH in a patient with hypocalcemia suggests hypoparathyroidism.

Low serum calcium and high PTH levels in a patient with normal renal function suggest resistance to PTH action (pseudohypoparathyroidism type 1a, 1b, 1c, or 2) or, very rarely, bio-ineffective PTH.

Elevated PTH value with a normal serum calcium in many cases in India is due to secondary hyperparathyroidism, primary cause being Vitamin D deficiency.

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## IMMUNOPATHOLOGY/SEROLOGY

### HEPATITIS C VIRUS (HCV) ANTIBODIES SCREENING

| | | | |
|---|---|---|---|
| HEPATITIS C ANTIBODY (HCV) TOTAL RESULT<br>*by IMMUNOCHROMATOGRAPHY* | NON - REACTIVE | | |

***INTERPRETATION:***

1.Anti HCV total antibody assay identifies presence IgG antibodies in the serum . It is a useful screening test with a specificity of nearly 99%.
2.It becomes positive approximately 24 weeks after exposure. The test can not isolate an active ongoing HCV infection from an old infection that has been cleared. All positive results must be confirmed for active disease by an HCV PCR test .

**FALSE NEGATIVE RESULTS SEEN IN:**

1.Window period
2.Immunocompromised states.

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

## ANTI HUMAN IMMUNODEFICIENCY VIRUS (HIV) ANTIBODIES HIV (1 & 2) SCREENING

HIV 1/2 AND P24 ANTIGEN RESULT — NON - REACTIVE

*by IMMUNOCHROMATOGRAPHY*

***INTERPRETATION:-***

1.AIDS is caused by at least 2 known types of HIV viruses, HIV-1 and HIV HIV-2.
2.This NACO approved immuno-chromatographic solid phase ELISA assay detects antibodies against both HIV-1 and HIV-2 viruses.
3.The test is used for routine serologic screening of patients at risk for HIV-1 or HIV-2 infection.
4.All screening ELISA assays for HIV antibody detection have high sensitivity but have low specificity.
5.At this laboratory, all positive samples are cross checked for positivity with two alternate assays prior to reporting.

**NOTE:-**

1.Confirmatory testing by Western blot is recommended for patients who are reactive for HIV by this assay.
2.Antibodies against HIV-1 and HIV-2 are usually not detectable until 6 to 12 weeks following exposure (window period) and are almost always detectable by 12 months.
3.The test is not recommended for children born to HIV infected mothers till the child turns two years old (as HIV antibodies may be transmitted passively to the child trans-placentally).

**FALSE NEGATIVE RESULT SEEN IN:**

1.Window period
2.Severe immuno-suppression including advanced AIDS.

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

## HEPATITIS B SURFACE ANTIGEN (HBsAg) SCREENING

| | | | |
|---|---|---|---|
| HEPATITIS B SURFACE ANTIGEN (HBsAg) RESULT<br>*by IMMUNOCHROMATOGRAPHY* | NON - REACTIVE | | |

***INTERPRETATION:-***

1.HBsAG is the first serological marker of HBV infection to appear in the blood (approximately 30-60 days after infection and prior to the onset of clinical disease). It is also the last viral protein to disappear from blood and usually disappears by three months after infection in self limiting acute Hepatitis B viral infection.

2.Persistence of HBsAg in blood for more than six months implies chronic infection. It is the most common marker used for diagnosis of an acute Hepatitis B infection but has very limited role in assessing patients suffering from chronic hepatitis.

**FALSE NEGATIVE RESULT SEEN IN:**

1.Window period.

2.Infection with HBsAg mutant strains

3.Hepatitis B Surface antigen (HBsAg) is the earliest indicator of HBV infection. Usually it appears in 27 - 41 days (as early as 14 days).

4.Appears 7 - 26 days before biochemical abnormalities. Peaks as ALT rises. Persists during the acute illness. Usually disappears 12- 20 weeks after the onset of symptoms / laboratory abnormalities in 90% of cases.

5.Is the most reliable serologic marker of HBV infection. Persistence > 6 months defines carrier state. May also be found in chronic infection.Hepatitis B vaccination does not cause a positive HBsAg. Titers are not of clinical value.

**NOTE:-**

1.All reactive HBsAG Should be reconfirmed with neutralization test(HBsAg confirmatory test).

2.Anti - HAV IgM appears at the same time as symptoms in > 99% of cases, peaks within the first month, becomes nondetectable in 12 months (usually 6 months). Presence confirms diagnosis of recent acute infection.

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## CLINICAL PATHOLOGY

### URINE ROUTINE & MICROSCOPIC EXAMINATION

| Test Name | Value | Unit | Biological Reference interval |
|---|---|---|---|
| **PHYSICAL EXAMINATION** | | | |
| QUANTITY RECIEVED<br>*by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY* | 30 | ml | |
| COLOUR<br>*by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY* | PALE YELLOW | | PALE YELLOW |
| TRANSPARANCY<br>*by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY* | CLEAR | | CLEAR |
| SPECIFIC GRAVITY<br>*by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY* | 1.01 | | 1.002 - 1.030 |
| **CHEMICAL EXAMINATION** | | | |
| REACTION<br>*by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY* | ACIDIC | | |
| PROTEIN<br>*by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY* | NEGATIVE (-ve) | | NEGATIVE (-ve) |
| SUGAR<br>*by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY* | TRACE | | NEGATIVE (-ve) |
| pH<br>*by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY* | 5.5 | | 5.0 - 7.5 |
| BILIRUBIN<br>*by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY* | NEGATIVE (-ve) | | NEGATIVE (-ve) |
| NITRITE<br>*by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY.* | NEGATIVE (-ve) | | NEGATIVE (-ve) |
| UROBILINOGEN<br>*by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY* | NOT DETECTED | EU/dL | 0.2 - 1.0 |
| KETONE BODIES<br>*by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY* | NEGATIVE (-ve) | | NEGATIVE (-ve) |
| BLOOD<br>*by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY* | NEGATIVE (-ve) | | NEGATIVE (-ve) |
| ASCORBIC ACID<br>*by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY* | NEGATIVE (-ve) | | NEGATIVE (-ve) |
| **MICROSCOPIC EXAMINATION** | | | |

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|---|---|---|---|
| RED BLOOD CELLS (RBCs)<br>*by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT* | NEGATIVE (-ve) | /HPF | 0 - 3 |
| PUS CELLS<br>*by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT* | 3-4 | /HPF | 0 - 5 |
| EPITHELIAL CELLS<br>*by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT* | 2-3 | /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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