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. BHUPINDER SINGH**		
AGE/ GENDER	: 42 YRS/MALE	**PATIENT ID**	: 1575446
COLLECTED BY	:	**REG. NO./LAB NO.**	**: 122408090009**
REFERRED BY	:	**REGISTRATION DATE**	: 09/Aug/2024 10:48 AM
BARCODE NO.	: 12504070	**COLLECTION DATE**	: 09/Aug/2024 03:40PM
CLIENT CODE.	: P.K.R JAIN HEALTHCARE INSTITUTE	**REPORTING DATE**	: 09/Aug/2024 03:46PM
CLIENT ADDRESS	: NASIRPUR, HISSAR ROAD, AMBALA CITY - HARYANA		

SWASTHYA WELLNESS PANEL: 1.2

COMPLETE BLOOD COUNT (CBC)

Test Name	Value	Unit	Biological Reference interval
RED BLOOD CELLS (RBCS) COUNT AND INDICES			
HAEMOGLOBIN (HB) *by CALORIMETRIC*	14.1	gm/dL	12.0 - 17.0
RED BLOOD CELL (RBC) COUNT *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	4.32	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	40	%	40.0 - 54.0
MEAN CORPUSCULAR VOLUME (MCV) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	92.5	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	32.5	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	35.2	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	14.3	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	49.1	fL	35.0 - 56.0
MENTZERS INDEX *by CALCULATED*	21.41	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX *by CALCULATED*	30.49	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***	**22410^{H}**	**/cmm**	**4000 - 11000**
NUCLEATED RED BLOOD CELLS (nRBCS) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER & MICROSCOPY*	NIL		0.00 - 20.00
NUCLEATED RED BLOOD CELLS (nRBCS) % *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER & MICROSCOPY*	NIL	%	< 10 %

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Test Name	Value	Unit	Biological Reference interval
DIFFERENTIAL LEUCOCYTE COUNT (DLC)			
NEUTROPHILS *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	**90 H**	**%**	**50 - 70**
LYMPHOCYTES *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	**4 L**	**%**	**20 - 40**
EOSINOPHILS *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	**0 L**	**%**	**1 - 6**
MONOCYTES *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	6	%	2 - 12
BASOPHILS *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	0	%	0 - 1
ABSOLUTE LEUKOCYTES (WBC) COUNT			
ABSOLUTE NEUTROPHIL COUNT *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	**20169 H**	**/cmm**	**2000 - 7500**
ABSOLUTE LYMPHOCYTE COUNT *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	896	/cmm	800 - 4900
ABSOLUTE EOSINOPHIL COUNT *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	**0 L**	**/cmm**	**40 - 440**
ABSOLUTE MONOCYTE COUNT *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	**1345 H**	**/cmm**	**80 - 880**
ABSOLUTE BASOPHIL COUNT *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	0	/cmm	0 - 110
PLATELETS AND OTHER PLATELET PREDICTIVE MARKERS.			
PLATELET COUNT (PLT) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	398000	/cmm	150000 - 450000
PLATELETCRIT (PCT) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	0.3	%	0.10 - 0.36
MEAN PLATELET VOLUME (MPV) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	8	fL	6.50 - 12.0
PLATELET LARGE CELL COUNT (P-LCC) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	44000	/cmm	30000 - 90000
PLATELET LARGE CELL RATIO (P-LCR) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	11.1	%	11.0 - 45.0
PLATELET DISTRIBUTION WIDTH (PDW) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	15.6	%	15.0 - 17.0

NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD

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Test Name	Value	Unit	Biological Reference interval

RECHECKED

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Test Name	Value	Unit	Biological Reference interval

ERYTHROCYTE SEDIMENTATION RATE (ESR)

ERYTHROCYTE SEDIMENTATION RATE (ESR)	6	mm/1st hr	0 - 20

by MODIFIED WESTERGREN AUTOMATED METHOD

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

CLINICAL CHEMISTRY/BIOCHEMISTRY

GLUCOSE FASTING (F)

GLUCOSE FASTING (F): PLASMA *by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)*	**108.62^{H}**	**mg/dL**	**NORMAL: < 100.0** **PREDIABETIC: 100.0 - 125.0** **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 *by CHOLESTEROL OXIDASE PAP*	**282.96^{H}**	**mg/dL**	**OPTIMAL: < 200.0** **BORDERLINE HIGH: 200.0 - 239.0** **HIGH CHOLESTEROL: > OR = 240.0**
TRIGLYCERIDES: SERUM *by GLYCEROL PHOSPHATE OXIDASE (ENZYMATIC)*	144.48	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 *by SELECTIVE INHIBITION*	**103.01^{H}**	**mg/dL**	**LOW HDL: < 30.0** **BORDERLINE HIGH HDL: 30.0 - 60.0** **HIGH HDL: > OR = 60.0**
LDL CHOLESTEROL: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	**151.05^{H}**	**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 *by CALCULATED, SPECTROPHOTOMETRY*	**179.95^{H}**	**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 *by CALCULATED, SPECTROPHOTOMETRY*	28.9	mg/dL	0.00 - 45.00
TOTAL LIPIDS: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	**710.4^{H}**	**mg/dL**	**350.00 - 700.00**
CHOLESTEROL/HDL RATIO: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	2.75	RATIO	LOW RISK: 3.30 - 4.40 AVERAGE RISK: 4.50 - 7.0 MODERATE RISK: 7.10 - 11.0 HIGH RISK: > 11.0
LDL/HDL RATIO: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	1.47	RATIO	LOW RISK: 0.50 - 3.0 MODERATE RISK: 3.10 - 6.0 HIGH RISK: > 6.0

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Test Name	Value	Unit	Biological Reference interval
TRIGLYCERIDES/HDL RATIO: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	**1.4^{L}**	**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 *by DIAZOTIZATION, SPECTROPHOTOMETRY*	0.87	mg/dL	INFANT: 0.20 - 8.00 ADULT: 0.00 - 1.20
BILIRUBIN DIRECT (CONJUGATED): SERUM *by DIAZO MODIFIED, SPECTROPHOTOMETRY*	0.19	mg/dL	0.00 - 0.40
BILIRUBIN INDIRECT (UNCONJUGATED): SERUM *by CALCULATED, SPECTROPHOTOMETRY*	0.68	mg/dL	0.10 - 1.00
SGOT/AST: SERUM *by IFCC, WITHOUT PYRIDOXAL PHOSPHATE*	25.01	U/L	7.00 - 45.00
SGPT/ALT: SERUM ***by IFCC, WITHOUT PYRIDOXAL PHOSPHATE***	**60.05^{H}**	**U/L**	**0.00 - 49.00**
AST/ALT RATIO: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	0.42	RATIO	0.00 - 46.00
ALKALINE PHOSPHATASE: SERUM *by PARA NITROPHENYL PHOSPHATASE BY AMINO METHYL PROPANOL*	56.89	U/L	40.0 - 130.0
GAMMA GLUTAMYL TRANSFERASE (GGT): SERUM *by SZASZ, SPECTROPHTOMETRY*	54.81	U/L	0.00 - 55.0
TOTAL PROTEINS: SERUM *by BIURET, SPECTROPHOTOMETRY*	6.49	gm/dL	6.20 - 8.00
ALBUMIN: SERUM *by BROMOCRESOL GREEN*	4.05	gm/dL	3.50 - 5.50
GLOBULIN: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	2.44	gm/dL	2.30 - 3.50
A : G RATIO: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	1.66	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 *by UREASE - GLUTAMATE DEHYDROGENASE (GLDH)*	**50.2^{H}**	**mg/dL**	**10.00 - 50.00**
CREATININE: SERUM *by ENZYMATIC, SPECTROPHOTOMETERY*	1.1	mg/dL	0.40 - 1.40
BLOOD UREA NITROGEN (BUN): SERUM *by CALCULATED, SPECTROPHOTOMETRY*	23.4	mg/dL	7.0 - 25.0
BLOOD UREA NITROGEN (BUN)/CREATININE RATIO: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	**21.33^{H}**	**RATIO**	**10.0 - 20.0**
UREA/CREATININE RATIO: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	45.64	RATIO	
URIC ACID: SERUM *by URICASE - OXIDASE PEROXIDASE*	3.73	mg/dL	3.60 - 7.70
CALCIUM: SERUM *by ARSENAZO III, SPECTROPHOTOMETRY*	9.91	mg/dL	8.50 - 10.60
PHOSPHOROUS: SERUM *by PHOSPHOMOLYBDATE, SPECTROPHOTOMETRY*	3.76	mg/dL	2.30 - 4.70
ELECTROLYTES			
SODIUM: SERUM *by ISE (ION SELECTIVE ELECTRODE)*	135.9	mmol/L	135.0 - 150.0
POTASSIUM: SERUM *by ISE (ION SELECTIVE ELECTRODE)*	4.88	mmol/L	3.50 - 5.00
CHLORIDE: SERUM *by ISE (ION SELECTIVE ELECTRODE)*	101.93	mmol/L	90.0 - 110.0
ESTIMATED GLOMERULAR FILTERATION RATE			
ESTIMATED GLOMERULAR FILTERATION RATE (eGFR): SERUM *by CALCULATED*	86		

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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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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NASIRPUR, Hissar Road, AMBALA CITY- (Haryana)

A PIONEER DIAGNOSTIC CENTRE

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NAME	**: Mr. BHUPINDER SINGH**		
AGE/ GENDER	: 42 YRS/MALE	**PATIENT ID**	: 1575446
COLLECTED BY	:	**REG. NO./LAB NO.**	**: 122408090009**
REFERRED BY	:	**REGISTRATION DATE**	: 09/Aug/2024 10:48 AM
BARCODE NO.	: 12504070	**COLLECTION DATE**	: 09/Aug/2024 03:40PM
CLIENT CODE.	: P.K.R JAIN HEALTHCARE INSTITUTE	**REPORTING DATE**	: 09/Aug/2024 05:12PM
CLIENT ADDRESS	: NASIRPUR, HISSAR ROAD, AMBALA CITY - HARYANA		

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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CLIENT CODE.	: P.K.R JAIN HEALTHCARE INSTITUTE	**REPORTING DATE**	: 09/Aug/2024 04:22PM
CLIENT ADDRESS	: NASIRPUR, HISSAR ROAD, AMBALA CITY - HARYANA		

Test Name	Value	Unit	Biological Reference interval

ENDOCRINOLOGY

THYROID FUNCTION TEST: TOTAL

TRIIODOTHYRONINE (T3): SERUM *by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)*	0.616	ng/mL	0.35 - 1.93
THYROXINE (T4): SERUM *by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)*	5.49	µgm/dL	4.87 - 12.60
THYROID STIMULATING HORMONE (TSH): SERUM *by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)*	0.521	µIU/mL	0.35 - 5.50

3rd GENERATION, ULTRASENSITIVE

INTERPRETATION:

*TSH levels are subject to circadian variation, reaching peak levels between 2-4 a.m and at a minimum between 6-10 pm. The variation is of the order of 50%.Hence time of the day has influence on the measured serum TSH concentrations.*TSH stimulates the production and secretion of the metabolically active hormones, thyroxine (T4)and trilodothyronine (T3).Failure at any level of regulation of the hypothalamic-pituitary-thyroid axis will result in either underproduction (hypothyroidism) or overproduction(hyperthyroidism) of T4 and/or T3.

CLINICAL CONDITION	T3	T4	TSH
Primary Hypothyroidism:	Reduced	Reduced	Increased (Significantly)
Subclinical Hypothyroidism:	Normal or Low Normal	Normal or Low Normal	High
Primary Hyperthyroidism:	Increased	Increased	Reduced (at times undetectable)
Subclinical Hyperthyroidism:	Normal or High Normal	Normal or High Normal	Reduced

LIMITATIONS:-

1. T3 and T4 circulates in reversibly bound form with Thyroid binding globulins (TBG),and to a lesser extent albumin and Thyroid binding Pre Albumin so conditions in which TBG and protein levels alter such as pregnancy, excess estrogens, androgens, anabolic steroids and glucocorticoids may falsely affect the T3 and T4 levels and may cause false thyroid values for thyroid function tests.
2. Normal levels of T4 can also be seen in Hyperthyroid patients with :T3 Thyrotoxicosis, Decreased binding capacity due to hypoproteinemia or ingestion of certain drugs (eg: phenytoin , salicylates).
3. Serum T4 levles in neonates and infants are higher than values in the normal adult , due to the increased concentration of TBG in neonate serum.
4. TSH may be normal in central hypothyroidism , recent rapid correction of hyperthyroidism or hypothroidism , pregnancy , phenytoin therapy.

TRIIODOTHYRONINE (T3)		THYROXINE (T4)		THYROID STIMULATING HORMONE (TSH)	
Age	**Refferance Range (ng/mL)**	**Age**	**Refferance Range (µg/dL)**	**Age**	**Reference Range (µIU/mL)**
0 - 7 Days	**0.20 - 2.65**	**0 - 7 Days**	**5.90 – 18.58**	**0 - 7 Days**	**2.43 - 24.3**
7 Days - 3 Months	**0.36 - 2.59**	**7 Days - 3 Months**	**6.39 - 17.66**	**7 Days - 3 Months**	**0.58 - 11.00**
3 - 6 Months	**0.51 - 2.52**	**3 - 6 Months**	**6.75 – 17.04**	**3 Days – 6 Months**	**0.70 - 8.40**

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Test Name			Value	Unit	Biological Reference interval
6 - 12 Months	0.74 - 2.40	6 - 12 Months	7.10 – 16.16	6 – 12 Months	0.70 - 7.00
1 - 10 Years	0.92 - 2.28	1 - 10 Years	6.00 - 13.80	1 – 10 Years	0.60 - 5.50
11- 19 Years	0.35 - 1.93	11 - 19 Years	4.87- 13.20	11 – 19 Years	0.50 – 5.50
> 20 years (Adults)	0.35 - 1.93	> 20 Years (Adults)	4.87 - 12.60	> 20 Years (Adults)	0.35– 5.50
RECOMMENDATIONS OF TSH LEVELS DURING PREGNANCY (µIU/mL)					
1st Trimester			0.10 – 2.50		
2nd Trimester			0.20 – 3.00		
3rd Trimester			0.30 – 4.10		

INCREASED TSH LEVELS:

1.Primary or untreated hypothyroidism may vary from 3 times to more than 100 times normal depending upon degree of hypofunction.
2.Hypothyroid patients receiving insufficient thyroid replacement therapy.
3.Hashimotos thyroiditis
4.DRUGS: Amphetamines, idonie containing agents & dopamine antagonist.
5.Neonatal period, increase in 1st 2-3 days of life due to post-natal surge

DECREASED TSH LEVELS:

1.Toxic multi-nodular goitre & Thyroiditis.
2.Over replacement of thyroid harmone in treatment of hypothyroidism.
3.Autonomously functioning Thyroid adenoma
4.Secondary pituatary or hypothalmic hypothyroidism
5.Acute psychiatric illness
6.Severe dehydration.
7.DRUGS: Glucocorticoids, Dopamine, Levodopa, T4 replacement therapy, Anti-thyroid drugs for thyrotoxicosis.
8.Pregnancy: 1st and 2nd Trimester

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CLIENT CODE.	: P.K.R JAIN HEALTHCARE INSTITUTE	**REPORTING DATE**	: 09/Aug/2024 01:59PM
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Test Name	Value	Unit	Biological Reference interval

VITAMINS

VITAMIN D/25 HYDROXY VITAMIN D3

VITAMIN D (25-HYDROXY VITAMIN D3): SERUM *by CLIA (CHEMILUMINESCENCE IMMUNOASSAY)*	**14.29L**	**ng/mL**	**DEFICIENCY: < 20.0** **INSUFFICIENCY: 20.0 - 30.0** **SUFFICIENCY: 30.0 - 100.0** **TOXICITY: > 100.0**

INTERPRETATION:

DEFICIENT:	< 20	ng/mL
INSUFFICIENT:	21 - 29	ng/mL
PREFFERED RANGE:	30 - 100	ng/mL
INTOXICATION:	> 100	ng/mL

1.Vitamin D compounds are derived from dietary ergocalciferol (from plants, Vitamin D2), or cholecalciferol (from animals, Vitamin D3), or by conversion of 7- dihydrocholecalciferol to Vitamin D3 in the skin upon Ultraviolet exposure.
2.25-OH--Vitamin D represents the main body resevoir and transport form of Vitamin D and transport form of Vitamin D, being stored in adipose tissue and tightly bound by a transport protein while in circulation.
3.Vitamin D plays a primary role in the maintenance of calcium homeostatis. It promotes calcium absorption, renal calcium absorption and phosphate reabsorption, skeletal calcium deposition, calcium mobilization, mainly regulated by parathyroid harmone (PTH).
4.Severe deficiency may lead to failure to mineralize newly formed osteoid in bone, resulting in rickets in children and osteomalacia in adults.

DECREASED:
1.Lack of sunshine exposure.
2.Inadequate intake, malabsorption (celiac disease)
3.Depressed Hepatic Vitamin D 25- hydroxylase activity
4.Secondary to advanced Liver disease
5.Osteoporosis and Secondary Hyperparathroidism (Mild to Moderate deficiency)
6.Enzyme Inducing drugs: anti-epileptic drugs like phenytoin, phenobarbital and carbamazepine, that increases Vitamin D metabolism.

INCREASED:
1. Hypervitaminosis D is Rare, and is seen only after prolonged exposure to extremely high doses of Vitamin D. When it occurs, it can result in severe hypercalcemia and hyperphophatemia.

CAUTION: Replacement therapy in deficient individuals must be monitored by periodic assessment of Vitamin D levels in order to prevent hypervitaminosis D

NOTE:*-Dark coloured individuals as compare to whites, is at higher risk of developing Vitamin D deficiency due to excess of melanin pigment which interefere with Vitamin D absorption.*

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CLIENT ADDRESS	: NASIRPUR, HISSAR ROAD, AMBALA CITY - HARYANA		

CLINICAL PATHOLOGY

URINE ROUTINE & MICROSCOPIC EXAMINATION

Test Name	Value	Unit	Biological Reference interval
PHYSICAL EXAMINATION			
QUANTITY RECIEVED *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	10	ml	
COLOUR *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	AMBER YELLOW		PALE YELLOW
TRANSPARANCY *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	HAZY		CLEAR
SPECIFIC GRAVITY *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	1.01		1.002 - 1.030
CHEMICAL EXAMINATION			
REACTION *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	ACIDIC		
PROTEIN *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	Negative		NEGATIVE (-ve)
SUGAR *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	Negative		NEGATIVE (-ve)
pH *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	7		5.0 - 7.5
BILIRUBIN *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	Negative		NEGATIVE (-ve)
NITRITE *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY.*	Negative		NEGATIVE (-ve)
UROBILINOGEN *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	Normal	EU/dL	0.2 - 1.0
KETONE BODIES *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	Negative		NEGATIVE (-ve)
BLOOD *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	Negative		NEGATIVE (-ve)
ASCORBIC ACID *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	NEGATIVE (-ve)		NEGATIVE (-ve)
MICROSCOPIC EXAMINATION			

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Test Name	Value	Unit	Biological Reference interval
RED BLOOD CELLS (RBCs) *by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT*	NEGATIVE (-ve)	/HPF	0 - 3
PUS CELLS *by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT*	2-4	/HPF	0 - 5
EPITHELIAL CELLS *by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT*	1-2	/HPF	ABSENT
CRYSTALS *by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT*	NEGATIVE (-ve)		NEGATIVE (-ve)
CASTS *by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT*	NEGATIVE (-ve)		NEGATIVE (-ve)
BACTERIA *by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT*	NEGATIVE (-ve)		NEGATIVE (-ve)
OTHERS *by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT*	NEGATIVE (-ve)		NEGATIVE (-ve)
TRICHOMONAS VAGINALIS (PROTOZOA) *by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT*	ABSENT		ABSENT

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BARCODE NO.	: 12504070	**COLLECTION DATE**	: 09/Aug/2024 03:40PM
CLIENT CODE.	: P.K.R JAIN HEALTHCARE INSTITUTE	**REPORTING DATE**	: 11/Aug/2024 04:56PM
CLIENT ADDRESS	: NASIRPUR, HISSAR ROAD, AMBALA CITY - HARYANA		

Test Name	Value	Unit	Biological Reference interval

MICROBIOLOGY

CULTURE AEROBIC BACTERIA AND ANTIBIOTIC SENSITIVITY: URINE

CULTURE AND SUSCEPTIBILITY: URINE

DATE OF SAMPLE	09-08-2024
SPECIMEN SOURCE	URINE
INCUBATION PERIOD *by AUTOMATED BROTH CULTURE*	48 HOURS
CULTURE *by AUTOMATED BROTH CULTURE*	STERILE
ORGANISM *by AUTOMATED BROTH CULTURE*	NO AEROBIC PYOGENIC ORGANISM GROWN AFTER 48 HOURS OF 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 **SENSTITIVE** 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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