



P K R JAIN HEALTHCARE INSTITUTE

NASIRPUR, Hissar Road, AMBALA CITY- (Haryana)

A PIONEER DIAGNOSTIC CENTRE

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

NAME : Mrs. ARCHANA AGGARWAL
AGE/ GENDER : 43 YRS/FEMALE
COLLECTED BY :
REFERRED BY :
BARCODE NO. : 12504266
CLIENT CODE. : P.K.R JAIN HEALTHCARE INSTITUTE
CLIENT ADDRESS : NASIRPUR, HISSAR ROAD, AMBALA CITY - HARYANA

PATIENT ID : 1588664
REG. NO./LAB NO. : 122408230001
REGISTRATION DATE : 23/Aug/2024 08:13 AM
COLLECTION DATE : 23/Aug/2024 09:31AM
REPORTING DATE : 23/Aug/2024 02:13PM

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	11.8 ^L	gm/dL	12.0 - 16.0
RED BLOOD CELL (RBC) COUNT by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	4.14	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	33.8 ^L	%	37.0 - 50.0
MEAN CORPUSCULAR VOLUME (MCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	81.7	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	28.5	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	34.9	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	13.3	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	40.4	fL	35.0 - 56.0
MENTZERS INDEX by CALCULATED	19.73	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX by CALCULATED	26.24	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	9890	/cmm	4000 - 11000
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DIFFERENTIAL LEUCOCYTE COUNT (DLC)

NEUTROPHILS by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	66	%	50 - 70
LYMPHOCYTES by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	27	%	20 - 40
EOSINOPHILS by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	2	%	1 - 6



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MONOCYTES by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	5	%	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	6527	/cmm	2000 - 7500
ABSOLUTE LYMPHOCYTE COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	2670	/cmm	800 - 4900
ABSOLUTE EOSINOPHIL COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	198	/cmm	40 - 440
ABSOLUTE MONOCYTE COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	494	/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	196000	/cmm	150000 - 450000
PLATELET CRIT (PCT) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	0.22	%	0.10 - 0.36
MEAN PLATELET VOLUME (MPV) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	11	fL	6.50 - 12.0
PLATELET LARGE CELL COUNT (P-LCC) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	72000	/cmm	30000 - 90000
PLATELET LARGE CELL RATIO (P-LCR) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	36.8	%	11.0 - 45.0
PLATELET DISTRIBUTION WIDTH (PDW) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	16.3	%	15.0 - 17.0
NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD			




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TEST PERFORMED AT KOS DIAGNOSTIC LAB, AMBALA CANTT.

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CLINICAL CHEMISTRY/BIOCHEMISTRY

GLUCOSE FASTING (F)

GLUCOSE FASTING (F): PLASMA

96.24

mg/dL

by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)

NORMAL: < 100.0

PREDIABETIC: 100.0 - 125.0

DIABETIC: > OR = 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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URIC ACID

URIC ACID: SERUM by URICASE - OXIDASE PEROXIDASE	4.71	mg/dL	2.50 - 6.80
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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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CALCIUM

CALCIUM: SERUM	10.08	mg/dL	8.50 - 10.60
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by ARSENAZO III, SPECTROPHOTOMETRY

INTERPRETATION:-

1. Serum calcium (total) estimation is used for the diagnosis and monitoring of a wide range of disorders including diseases of bone, kidney, parathyroid gland, or gastrointestinal tract.
2. Calcium levels may also reflect abnormal vitamin D or protein levels.
3. The calcium content of an adult is somewhat over 1 kg (about 2% of the body weight). Of this, 99% is present as calcium hydroxyapatite in bones and <1% is present in the extra-osseous intracellular space or extracellular space (ECS).
4. In serum, calcium is bound to a considerable extent to proteins (approximately 40%), 10% is in the form of inorganic complexes, and 50% is present as free or ionized calcium.

NOTE:- Calcium ions affect the contractility of the heart and the skeletal musculature, and are essential for the function of the nervous system. In addition, calcium ions play an important role in blood clotting and bone mineralization.

HYPOCALCEMIA (LOW CALCIUM LEVELS) CAUSES :-

1. Due to the absence or impaired function of the parathyroid glands or impaired vitamin-D synthesis.
2. Chronic renal failure is also frequently associated with hypocalcemia due to decreased vitamin-D synthesis as well as hyperphosphatemia and skeletal resistance to the action of parathyroid hormone (PTH).
3. **NOTE:-** A characteristic symptom of hypocalcemia is latent or manifest tetany and osteomalacia.

HYPERCALCEMIA (INCREASE CALCIUM LEVELS) CAUSES:-

1. Increased mobilization of calcium from the skeletal system or increased intestinal absorption.
2. Primary hyperparathyroidism (pHPT)
3. Bone metastasis of carcinoma of the breast, prostate, thyroid gland, or lung.

NOTE:- Severe hypercalcemia may result in cardiac arrhythmia.




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VITAMINS

VITAMIN D/25 HYDROXY VITAMIN D3

VITAMIN D (25-HYDROXY VITAMIN D3): SERUM
by CLIA (CHEMILUMINESCENCE IMMUNOASSAY)

16.9^L

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
PREFERRED RANGE:	30 - 100	ng/mL
INTOXICATION:	> 100	ng/mL

- 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.
- 25-OH--Vitamin D represents the main body reservoir 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.
- Vitamin D plays a primary role in the maintenance of calcium homeostasis. It promotes calcium absorption, renal calcium absorption and phosphate reabsorption, skeletal calcium deposition, calcium mobilization, mainly regulated by parathyroid hormone (PTH).
- Severe deficiency may lead to failure to mineralize newly formed osteoid in bone, resulting in rickets in children and osteomalacia in adults.

DECREASED:

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

INCREASED:

- 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 hyperphosphatemia.

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 interfere with Vitamin D absorption.




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CLINICAL PATHOLOGY

URINE ROUTINE & MICROSCOPIC EXAMINATION

PHYSICAL EXAMINATION

QUANTITY RECIEVED	20	ml	
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
COLOUR	PALE YELLOW		PALE YELLOW
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
TRANSPARANCY	TURBID		CLEAR
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
SPECIFIC GRAVITY	1.02		1.002 - 1.030
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			

CHEMICAL EXAMINATION

REACTION	ACIDIC		
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
PROTEIN	NEGATIVE (-ve)		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
SUGAR	NEGATIVE (-ve)		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
pH	5.5		5.0 - 7.5
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
BILIRUBIN	NEGATIVE (-ve)		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
NITRITE	NEGATIVE (-ve)		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY.			
UROBILINOGEN	NOT DETECTED	EU/dL	0.2 - 1.0
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
KETONE BODIES	NEGATIVE (-ve)		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
BLOOD	1+		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
ASCORBIC ACID	NEGATIVE (-ve)		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			

MICROSCOPIC EXAMINATION




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RED BLOOD CELLS (RBCs) <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	18-20	/HPF	0 - 3
PUS CELLS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	6-8	/HPF	0 - 5
EPITHELIAL CELLS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	8-10	/HPF	ABSENT
CRYSTALS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	NEGATIVE (-ve)		NEGATIVE (-ve)
CASTS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	NEGATIVE (-ve)		NEGATIVE (-ve)
BACTERIA <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	NEGATIVE (-ve)		NEGATIVE (-ve)
OTHERS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	NEGATIVE (-ve)		NEGATIVE (-ve)
TRICHOMONAS VAGINALIS (PROTOZOA) <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	ABSENT		ABSENT

*** End Of Report ***




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