



PKR JAIN HEALTHCARE INSTITUTE

NASIRPUR, Hissar Road, AMBALA CITY- (Haryana)

A PIONEER DIAGNOSTIC CENTRE

■ 0171-2532620, 8222896961 ■ pkrjainhealthcare@gmail.com

: Mr. SUKHDARSHAN **NAME**

AGE/ GENDER : 57 YRS/MALE **PATIENT ID** : 1590811

COLLECTED BY REG. NO./LAB NO. : 122408250005

REFERRED BY **REGISTRATION DATE** : 25/Aug/2024 09:09 AM BARCODE NO. : 12504296 **COLLECTION DATE** : 25/Aug/2024 02:57PM CLIENT CODE. : P.K.R JAIN HEALTHCARE INSTITUTE REPORTING DATE : 25/Aug/2024 11:28AM

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

Test Name Value Unit **Biological Reference interval**

SWASTHYA WELLNESS PANEL: 1.4 COMPLETE BLOOD COUNT (CBC)

RED BLOOD CELLS (RBCS) COUNT AND INDICES

by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY

by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY

by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY

| by CALORIMETRIC RED BLOOD CELL (RBC) COUNT 4.85 Millions/cmm 3.50 - 5.00 | |
|--|-----|
| DED DI COD CELL (DDC) COLINIT 4 05 Millions (cmm 2 50 5 00 | |
| | |
| by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE | |
| PACKED CELL VOLUME (PCV) 42.2 % 40.0 - 54.0 | |
| by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER | |
| MEAN CORPUSCULAR VOLUME (MCV) 87 fl 80.0 - 100.0 | |
| by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER | |
| MEAN CORPUSCULAR HAEMOGLOBIN (MCH) 31.1 pg 27.0 - 34.0 | |
| by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER | |
| MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) 35.8 g/dL 32.0 - 36.0 | |
| by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER | |
| RED CELL DISTRIBUTION WIDTH (RDW-CV) 13.5 % 11.00 - 16.00 | |
| by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER | |
| RED CELL DISTRIBUTION WIDTH (RDW-SD) 45.4 fL 35.0 - 56.0 | |
| by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER | |
| MENTZERS INDEX 17.94 RATIO BETA THALASSEMIA TRAIT: < 13 | |
| by CALCULATED IRON DEFICIENCY ANEMIA: >13 | .0 |
| GREEN & KING INDEX 24.19 RATIO BETA THALASSEMIA TRAIT:<= 6 | 5.0 |
| by CALCULATED IRON DEFICIENCY ANEMIA: > 65 | 0.0 |
| WHITE BLOOD CELLS (WBCS) | |
| TOTAL LEUCOCYTE COUNT (TLC) 11620 ^H /cmm 4000 - 11000 | |
| by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY | |
| DIFFERENTIAL LEUCOCYTE COUNT (DLC) | |

60

31



NEUTROPHILS

LYMPHOCYTES

EOSINOPHILS

CONSULTANT PATHOLOGIST MBBS, MD (PATHOLOGY & MICROBIOLOGY)

DR.YUGAM CHOPRA CONSULTANT PATHOLOGIST MBBS, MD (PATHOLOGY)



50 - 70

20 - 40

1 - 6





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| Test Name | Value | Unit | Biological Reference interval |
|--|-------------------|------|-------------------------------|
| MONOCYTES by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY | 5 | % | 2 - 12 |
| BASOPHILS by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY ABSOLUTE LEUKOCYTES (WBC) COUNT | 0 | % | 0 - 1 |
| ABSOLUTE NEUTROPHIL COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY | 6972 | /cmm | 2000 - 7500 |
| ABSOLUTE LYMPHOCYTE COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY | 3602 ^L | /cmm | 800 - 4900 |
| ABSOLUTE EOSINOPHIL COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY | 465 ^H | /cmm | 40 - 440 |
| ABSOLUTE MONOCYTE COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY | 581 | /cmm | 80 - 880 |
| ABSOLUTE BASOPHIL COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY PLATELETS AND OTHER PLATELET PREDICTIVE MARKE | 0 : RS. | /cmm | 0 - 110 |
| PLATELET COUNT (PLT) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE | 190000 | /cmm | 150000 - 450000 |
| PLATELETCRIT (PCT) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE | 0.22 | % | 0.10 - 0.36 |
| MEAN PLATELET VOLUME (MPV) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE | 12 | fL | 6.50 - 12.0 |
| PLATELET LARGE CELL COUNT (P-LCC) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE | 73000 | /cmm | 30000 - 90000 |
| PLATELET LARGE CELL RATIO (P-LCR) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE | 38.2 | % | 11.0 - 45.0 |
| PLATELET DISTRIBUTION WIDTH (PDW) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD | 16.3 | % | 15.0 - 17.0 |



CONSULTANT PATHOLOGIST MBBS, MD (PATHOLOGY & MICROBIOLOGY) MBBS, MD (PATHOLOGY)

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4.0 - 6.4

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Test Name Value Unit **Biological Reference interval**

GLYCOSYLATED HAEMOGLOBIN (HBA1C)

GLYCOSYLATED HAEMOGLOBIN (HbA1c): 9.8H

WHOLE BLOOD

by HPLC (HIGH PERFORMANCE LIQUID CHROMATOGRAPHY)

ESTIMATED AVERAGE PLASMA GLUCOSE

by HPLC (HIGH PERFORMANCE LIQUID CHROMATOGRAPHY)

60.00 - 140.00 mg/dL 234.56^H

INTERPRETATION:

| AS PER AMERICAN DIABETES ASSOCIATION (ADA): | | | |
|--|--------------------|-------|--|
| REFERENCE GROUP GLYCOSYLATED HEMOGLOGIB (HBAIC) in % | | | |
| Non diabetic Adults >= 18 years | <5.7 | | |
| At Risk (Prediabetes) | 5.7 – 6.4 | | |
| Diagnosing Diabetes | >= 6.5 | | |
| | Age > 19 Ye | ars | |
| Therapeutic goals for glycemic control | Goals of Therapy: | < 7.0 | |
| | Actions Suggested: | >8.0 | |
| | Age < 19 Ye | ars | |
| | Goal of therapy: | <7.5 | |

COMMENTS:

- 1.Glycosylated hemoglobin (HbA1c) test is three monthly monitoring done to assess compliace with therapeutic regimen in diabetic patients. 2. Since Hb1c reflects long term fluctuations in blood glucose concentration, a diabetic patient who has recently under good control may still have high concentration of HbAlc. Converse is true for a diabetic previously under good control but now poorly controlled.
- 3. Target goals of < 7.0 % may be beneficial in patients with short duration of diabetes, long life expectancy and no significant cardiovascular disease. In patients with significant complications of diabetes, limited life expectancy or extensive co-morbid conditions, targetting a goal of < 7.0% may not be
- 4. High HbA1c (>9.0 -9.5 %) is strongly associated with risk of development and rapid progression of microvascular and nerve complications 5. Any condition that shorten RBC life span like acute blood loss, hemolytic anemia falsely lower HbA1c results.
- 6.HbA1c results from patients with HbSS,HbSC and HbD must be interpreted with caution, given the pathological processes including anemia, increased red cell turnover, and transfusion requirement that adversely impact HbA1c as a marker of long-term gycemic control.

7. Specimens from patients with polycythemia or post-splenctomy may exhibit increse in HbA1c values due to a somewhat longer life span of the red cells



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Value Unit **Biological Reference interval** Test Name

ERYTHROCYTE SEDIMENTATION RATE (ESR)

ERYTHROCYTE SEDIMENTATION RATE (ESR)

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 autoimmune 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.

- ESR and C reactive protein (C-RP) are both markers of inflammation.
 Generally, ESR does not change as rapidly as does CRP, either at the start of inflammation or as it resolves.
 CRP is not affected by as many other factors as is ESR, making it a better marker of inflammation.
 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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Value Unit **Biological Reference interval** Test Name

CLINICAL CHEMISTRY/BIOCHEMISTRY **GLUCOSE FASTING (F)**

GLUCOSE FASTING (F): PLASMA 171.15^H mg/dL NORMAL: < 100.0

by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD) PREDIABETIC: 100.0 - 125.0 **DIABETIC:** > **0R** = **126.0**

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 | 179.1 | mg/dL | OPTIMAL: < 200.0 BORDERLINE HIGH: 200.0 - 239.0 HIGH CHOLESTEROL: > OR = 240.0 |
| TRIGLYCERIDES: SERUM by GLYCEROL PHOSPHATE OXIDASE (ENZYMATIC) | 90.66 | 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 | 66.32 | mg/dL | LOW HDL: < 30.0 BORDERLINE HIGH HDL: 30.0 - 60.0 HIGH HDL: > OR = 60.0 |
| LDL CHOLESTEROL: SERUM by CALCULATED, SPECTROPHOTOMETRY | 94.65 | 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 | 112.78 | 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 | 18.13 | mg/dL | 0.00 - 45.00 |
| TOTAL LIPIDS: SERUM by CALCULATED, SPECTROPHOTOMETRY | 448.86 | mg/dL | 350.00 - 700.00 |
| CHOLESTEROL/HDL RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY | 2.7 | 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 | 1.43 | 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 1.37^L **RATIO** 3.00 - 5.00by CALCULATED, SPECTROPHOTOMETRY

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

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)

| BILIRUBIN TOTAL: SERUM by DIAZOTIZATION, SPECTROPHOTOMETRY | 0.89 | mg/dL | INFANT: 0.20 - 8.00 ADULT: 0.00 - 1.20 |
|--|--------|-------|---|
| BILIRUBIN DIRECT (CONJUGATED): SERUM by DIAZO MODIFIED, SPECTROPHOTOMETRY | 0.29 | mg/dL | 0.00 - 0.40 |
| BILIRUBIN INDIRECT (UNCONJUGATED): SERUM by CALCULATED, SPECTROPHOTOMETRY | 0.6 | mg/dL | 0.10 - 1.00 |
| SGOT/AST: SERUM by IFCC, WITHOUT PYRIDOXAL PHOSPHATE | 17.53 | U/L | 7.00 - 45.00 |
| SGPT/ALT: SERUM by IFCC, WITHOUT PYRIDOXAL PHOSPHATE | 19.87 | U/L | 0.00 - 49.00 |
| AST/ALT RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY | 0.88 | RATIO | 0.00 - 46.00 |
| ALKALINE PHOSPHATASE: SERUM by Para Nitrophenyl phosphatase by amino methyl propanol | 102.94 | U/L | 40.0 - 130.0 |
| GAMMA GLUTAMYL TRANSFERASE (GGT): SERUM by SZASZ, SPECTROPHTOMETRY | 29.88 | U/L | 0.00 - 55.0 |
| TOTAL PROTEINS: SERUM by BIURET, SPECTROPHOTOMETRY | 7.21 | gm/dL | 6.20 - 8.00 |
| ALBUMIN: SERUM by BROMOCRESOL GREEN | 4.4 | gm/dL | 3.50 - 5.50 |
| GLOBULIN: SERUM by CALCULATED, SPECTROPHOTOMETRY | 2.81 | gm/dL | 2.30 - 3.50 |
| A : G RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY | 1.57 | 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 |



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Test Name Value Unit **Biological Reference interval**

HEPATOCELLULAR CARCINOMA & CHRONIC HEPATITIS > 1.3 (Slightly Increased)

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)

| | MIDITEL FORTOTTOTT TEOT | (00.1 22.12) | |
|---|-------------------------|--------------|---------------|
| UREA: SERUM by UREASE - GLUTAMATE DEHYDROGENASE (| 31.88 | mg/dL | 10.00 - 50.00 |
| CREATININE: SERUM | 0.89 | mg/dL | 0.40 - 1.40 |
| by ENZYMATIC, SPECTROPHOTOMETERY | 0.0, | 97 0.12 | 0.100 |
| BLOOD UREA NITROGEN (BUN): SERUM by CALCULATED, SPECTROPHOTOMETRY | 14.9 | mg/dL | 7.0 - 25.0 |
| BLOOD UREA NITROGEN (BUN)/CREATINI | NE 16.74 | RATIO | 10.0 - 20.0 |
| RATIO: SERUM | | | |
| by CALCULATED, SPECTROPHOTOMETRY | | | |
| UREA/CREATININE RATIO: SERUM | 35.82 | RATIO | |
| by CALCULATED, SPECTROPHOTOMETRY | 2.72 | | 2 (0 7 70 |
| URIC ACID: SERUM by URICASE - OXIDASE PEROXIDASE | 3.62 | mg/dL | 3.60 - 7.70 |
| CALCIUM: SERUM | 9.99 | mg/dL | 8.50 - 10.60 |
| by ARSENAZO III, SPECTROPHOTOMETRY | | J | |
| PHOSPHOROUS: SERUM | 2.75 | mg/dL | 2.30 - 4.70 |
| by PHOSPHOMOLYBDATE, SPECTROPHOTOM | ETRY | | |
| <u>ELECTROLYTES</u> | | | |
| SODIUM: SERUM | 141.9 | mmol/L | 135.0 - 150.0 |
| by ISE (ION SELECTIVE ELECTRODE) | | | |
| POTASSIUM: SERUM | 4.01 | mmol/L | 3.50 - 5.00 |
| by ISE (ION SELECTIVE ELECTRODE) | 107.40 | 1.71 | 00.0 110.0 |
| CHLORIDE: SERUM by ISE (ION SELECTIVE ELECTRODE) | 106.43 | mmol/L | 90.0 - 110.0 |
| ESTIMATED GLOMERULAR FILTERATION F | DATE | | |
| | | | |
| ESTIMATED GLOMERULAR FILTERATION F | RATE 100 | | |

(eGFR): SERUM by CALCULATED

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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REFERRED BY **REGISTRATION DATE** : 25/Aug/2024 09:09 AM BARCODE NO. : 12504296 **COLLECTION DATE** : 25/Aug/2024 02:57PM

CLIENT CODE. : P.K.R JAIN HEALTHCARE INSTITUTE REPORTING DATE : 25/Aug/2024 11:28AM

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

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:

| STIMATED GEOMEROEAR TIETERATION RATE. | | | | |
|---------------------------------------|--------------------------|-----------------------|--------------------------|--|
| CKD STAGE | DESCRIPTION | GFR (mL/min/1.73m2) | ASSOCIATED FINDINGS | |
| G1 | Normal kidney function | >90 | No proteinuria | |
| G2 | Kidney damage with | >90 | Presence of Protein, | |
| | normal or high GFR | | 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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440 Dated 17.5.2012 u/s 80 G OF INCOME TAX ACT. PAN NO. AAAAP1600. REPORT ATTRACTS THE CONDITIONS PRINTED OVERLEAF (P.T.O.)





A PIONEER DIAGNOSTIC CENTRE

■ 0171-2532620, 8222896961 **■** pkrjainhealthcare@gmail.com

REPORTING DATE

: 25/Aug/2024 11:28AM

NAME : Mr. SUKHDARSHAN

AGE/ GENDER : 57 YRS/MALE **PATIENT ID** : 1590811

COLLECTED BY REG. NO./LAB NO. : 122408250005

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: P.K.R JAIN HEALTHCARE INSTITUTE

Test Name Value Unit **Biological Reference interval**

COMMENTS:

CLIENT CODE.

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).

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 ADDRESS : NASIRPUR, HISSAR ROAD, AMBALA CITY - HARYANA

Test Name Value Unit **Biological Reference interval**

IRON PROFILE

IRON: SERUM 139.9 59.0 - 158.0 μg/dL by FERROZINE, SPECTROPHOTOMETRY

UNSATURATED IRON BINDING CAPACITY (UIBC) 150.0 - 336.0 114.34^L μg/dL

by FERROZINE, SPECTROPHOTOMETERY

TOTAL IRON BINDING CAPACITY (TIBC) 254.24 μg/dL 230 - 430 :SERUM

by SPECTROPHOTOMETERY

15.0 - 50.0 %TRANSFERRIN SATURATION: SERUM 55.03^H

by CALCULATED, SPECTROPHOTOMETERY (FERENE) mg/dL 200.0 - 350.0

TRANSFERRIN: SERUM 180.51^L

by SPECTROPHOTOMETERY (FERENE)

INTERPRETATION:

| INTERFRETATION." | | | |
|------------------------------|---------------------------|------------------------|-----------------------|
| VARIABLES | ANEMIA OF CHRONIC DISEASE | IRON DEFICIENCY ANEMIA | THALASSEMIA α/β TRAIT |
| SERUM IRON: | Normal to Reduced | Reduced | Normal |
| TOTAL IRON BINDING CAPACITY: | Decreased | Increased | Normal |
| % TRANSFERRIN SATURATION: | Decreased | Decreased < 12-15 % | Normal |
| SERUM FERRITIN: | Normal to Increased | Decreased | Normal or Increased |

1. Serum iron studies is recommended for differential diagnosis of microcytic hypochromic anemia.i.e iron deficiency anemia, zinc deficiency

anemia, anemia of chronic disease and thalassemia syndromes.

2. It is essential to isolate iron deficiency anemia from Beta thalassemia syndromes because during iron replacement which is therapeutic for iron deficiency anemia, is severely contra-indicated in Thalassemia. **TOTAL IRON BINDING CAPACITY (TIBC):**

1. It is a direct measure of protein transferrin which transports iron from the gut to storage sites in the bone marrow.

% TRANSFERRIN SATURATION:

1.Occurs in idiopathic hemochromatosis and transfusional hemosiderosis where no unsaturated iron binding capacity is available for iron mobilization. Similar condition is seen in congenital deficiency of transferrin.



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REPORTING DATE

: 25/Aug/2024 01:05PM

: Mr. SUKHDARSHAN **NAME**

AGE/ GENDER : 57 YRS/MALE **PATIENT ID** : 1590811

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Test Name Value Unit **Biological Reference interval**

ENDOCRINOLOGY

THYROID FUNCTION TEST: TOTAL

1.32 TRIIODOTHYRONINE (T3): SERUM ng/mL 0.35 - 1.93by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)

THYROXINE (T4): SERUM 8.58 4.87 - 12.60 μgm/dL

by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)

THYROID STIMULATING HORMONE (TSH): SERUM 1.21 μIU/mL 0.35 - 5.50

by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)

3rd GENERATION, ULTRASENSITIVE

INTERPRETATION:

CLIENT CODE.

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 | Т3 | 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 |

- 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
- 3. Serum T4 levies 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 (μΙυ/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 | | |
| | RECC | OMMENDATIONS OF TSH L | EVELS DURING PRE | GNANCY (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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NEGATIVE (-ve)

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Value Unit **Biological Reference interval** Test Name

CLINICAL PATHOLOGY URINE ROUTINE & MICROSCOPIC EXAMINATION

REPORTING DATE

PHYSICAL EXAMINATION

CLIENT CODE.

| QUANTITY RECIEVED | 30 | ml |
|--------------------------------------|--------|----|
| by DIP STICK/REFLECTANCE SPECTROPHOT | OMETRY | |

PALE YELLOW PALE YELLOW COLOUR

TRANSPARANCY HAZY **CLEAR**

by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY 1.02 1.002 - 1.030 SPECIFIC GRAVITY

by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY

by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY

by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY

by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY

CHEMICAL EXAMINATION

REACTION **ACIDIC**

PROTEIN NEGATIVE (-ve)

by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY **SUGAR NEGATIVE** (-ve) **NEGATIVE** (-ve)

by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY

рΗ 6.5 5.0 - 7.5by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY

BILIRUBIN NEGATIVE (-ve) **NEGATIVE** (-ve)

by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY **NITRITE**

NEGATIVE (-ve) **NEGATIVE** (-ve) by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY.

EU/dL **NOT DETECTED UROBILINOGEN** 0.2 - 1.0by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY

KETONE BODIES NEGATIVE (-ve) NEGATIVE (-ve) by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY

TRACE NEGATIVE (-ve) **BLOOD**

NEGATIVE (-ve) ASCORBIC ACID **NEGATIVE** (-ve)

by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY MICROSCOPIC EXAMINATION



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| Test Name | Value | Unit | Biological Reference interval |
|--|----------------|------|-------------------------------|
| RED BLOOD CELLS (RBCs) by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT | 5-7 | /HPF | 0 - 3 |
| PUS CELLS by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT | 3-4 | /HPF | 0 - 5 |
| EPITHELIAL CELLS by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT | 2-4 | /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 |

*** End Of Report



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DR.YUGAM CHOPRA CONSULTANT PATHOLOGIST

