



P K R JAIN HEALTHCARE INSTITUTE

NASIRPUR, Hissar Road, AMBALA CITY- (Haryana)

A PIONEER DIAGNOSTIC CENTRE

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

| | | | |
|----------------|--|-------------------|------------------------|
| NAME | : Mr. PARVEEN | PATIENT ID | : 1620785 |
| AGE/ GENDER | : 34 YRS/MALE | REG. NO./LAB NO. | : 122409210032 |
| COLLECTED BY | : | REGISTRATION DATE | : 21/Sep/2024 04:20 PM |
| REFERRED BY | : | COLLECTION DATE | : 21/Sep/2024 04:44PM |
| BARCODE NO. | : 12504860 | REPORTING DATE | : 21/Sep/2024 08:57PM |
| CLIENT CODE. | : P.K.R JAIN HEALTHCARE INSTITUTE | | |
| CLIENT ADDRESS | : NASIRPUR, HISSAR ROAD, AMBALA CITY - HARYANA | | |

| Test Name | Value | Unit | Biological Reference interval |
|-----------|-------|------|-------------------------------|
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SWASTHYA WELLNESS PANEL: 1.0

COMPLETE BLOOD COUNT (CBC)

RED BLOOD CELLS (RBCS) COUNT AND INDICES

| | | | |
|--|-------------------|--------------|---|
| HAEMOGLOBIN (HB) by CALORIMETRIC | 16.5 | gm/dL | 12.0 - 17.0 |
| RED BLOOD CELL (RBC) COUNT by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE | 5.06 ^H | Millions/cmm | 3.50 - 5.00 |
| PACKED CELL VOLUME (PCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER | 45.1 | % | 40.0 - 54.0 |
| MEAN CORPUSCULAR VOLUME (MCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER | 89.2 | fL | 80.0 - 100.0 |
| MEAN CORPUSCULAR HAEMOGLOBIN (MCH) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER | 32.6 | pg | 27.0 - 34.0 |
| MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER | 36.5 ^H | g/dL | 32.0 - 36.0 |
| RED CELL DISTRIBUTION WIDTH (RDW-CV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER | 15.2 | % | 11.00 - 16.00 |
| RED CELL DISTRIBUTION WIDTH (RDW-SD) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER | 52.5 | fL | 35.0 - 56.0 |
| MENTZERS INDEX by CALCULATED | 17.63 | RATIO | BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0 |
| GREEN & KING INDEX by CALCULATED | 26.79 | 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 | 15660 ^H | /cmm | 4000 - 11000 |
| DIFFERENTIAL LEUCOCYTE COUNT (DLC) | | | |
| NEUTROPHILS by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY | 36 ^L | % | 50 - 70 |
| LYMPHOCYTES by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY | 49 ^H | % | 20 - 40 |
| EOSINOPHILS by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY | 0 ^L | % | 1 - 6 |




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| MONOCYTES by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY | 15 ^H | % | 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 | 5638 | /cmm | 2000 - 7500 |
| ABSOLUTE LYMPHOCYTE COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY | 7673 ^H | /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 | 2349 ^H | /cmm | 80 - 880 |
| ABSOLUTE BASOPHIL COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY | 0 | /cmm | 0 - 110 |
| <u>PLATELETS AND OTHER PLATELET PREDICTIVE MARKERS.</u> | | | |
| PLATELET COUNT (PLT) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE | 125000 ^L | /cmm | 150000 - 450000 |
| PLATELETCRIT (PCT) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE | 0.14 | % | 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 | 47000 | /cmm | 30000 - 90000 |
| PLATELET LARGE CELL RATIO (P-LCR) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE | 38.1 | % | 11.0 - 45.0 |
| PLATELET DISTRIBUTION WIDTH (PDW) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE | 17 | % | 15.0 - 17.0 |
| NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD | | | |




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ERYTHROCYTE SEDIMENTATION RATE (ESR)

ERYTHROCYTE SEDIMENTATION RATE (ESR) 13 mm/1st hr 0 - 20

by RED CELL AGGREGATION BY CAPILLARY PHOTOMETRY

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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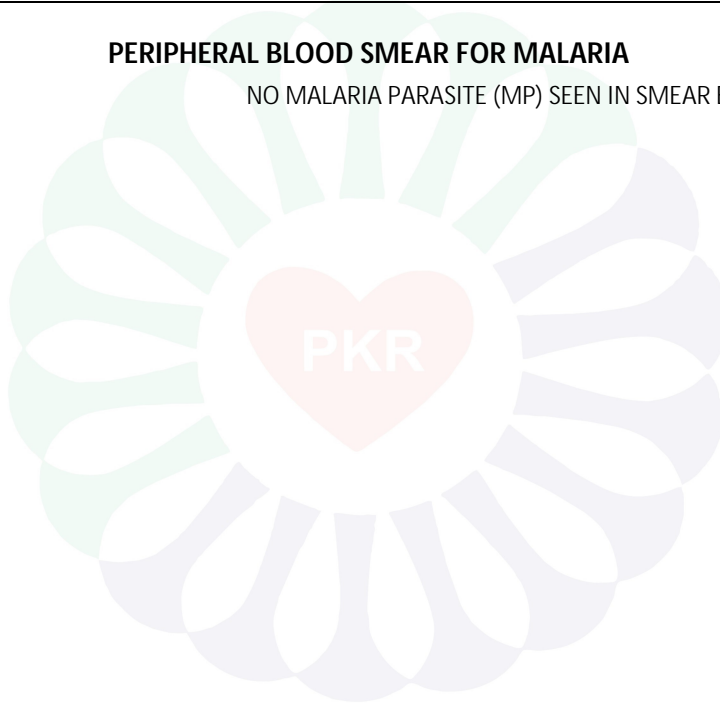
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PERIPHERAL BLOOD SMEAR FOR MALARIA

PERIPHERAL BLOOD SMEAR
FOR MALARIAL PARASITE (MP)
by MICROSCOPY

NO MALARIA PARASITE (MP) SEEN IN SMEAR EXAMINED




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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
by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)

108.69^H mg/dL


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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| LIPID PROFILE : BASIC | | | |
| CHOLESTEROL TOTAL: SERUM <i>by CHOLESTEROL OXIDASE PAP</i> | 129.55 | mg/dL | OPTIMAL: < 200.0 BORDERLINE HIGH: 200.0 - 239.0 HIGH CHOLESTEROL: > OR = 240.0 |
| TRIGLYCERIDES: SERUM <i>by GLYCEROL PHOSPHATE OXIDASE (ENZYMATIC)</i> | 262.32 ^H | 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 <i>by SELECTIVE INHIBITION</i> | 22.51 ^L | mg/dL | LOW HDL: < 30.0 BORDERLINE HIGH HDL: 30.0 - 60.0 HIGH HDL: > OR = 60.0 |
| LDL CHOLESTEROL: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i> | 54.58 | 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 <i>by CALCULATED, SPECTROPHOTOMETRY</i> | 107.04 | 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 <i>by CALCULATED, SPECTROPHOTOMETRY</i> | 52.46 ^H | mg/dL | 0.00 - 45.00 |
| TOTAL LIPIDS: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i> | 521.42 | mg/dL | 350.00 - 700.00 |
| CHOLESTEROL/HDL RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i> | 5.76 ^H | 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 <i>by CALCULATED, SPECTROPHOTOMETRY</i> | 2.42 | RATIO | LOW RISK: 0.50 - 3.0 MODERATE RISK: 3.10 - 6.0 HIGH RISK: > 6.0 |




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| TRIGLYCERIDES/HDL RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY | 11.65 ^H | RATIO | 3.00 - 5.00 |

INTERPRETATION:

- 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.
- 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.
- 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.
- NLA-2014 identifies Non HDL Cholesterol (an indicator of all atherogenic lipoproteins such as LDL, VLDL, IDL, Lp(a), 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.
- 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 <i>by DIAZOTIZATION, SPECTROPHOTOMETRY</i> | 2.1 ^H | mg/dL | INFANT: 0.20 - 8.00 ADULT: 0.00 - 1.20 |
| BILIRUBIN DIRECT (CONJUGATED): SERUM <i>by DIAZO MODIFIED, SPECTROPHOTOMETRY</i> | 0.92 ^H | mg/dL | 0.00 - 0.40 |
| BILIRUBIN INDIRECT (UNCONJUGATED): SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i> | 1.18 ^H | mg/dL | 0.10 - 1.00 |
| SGOT/AST: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i> | 298.82 ^H | U/L | 7.00 - 45.00 |
| SGPT/ALT: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i> | 235.19 ^H | U/L | 0.00 - 49.00 |
| AST/ALT RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i> | 1.27 | RATIO | 0.00 - 46.00 |
| ALKALINE PHOSPHATASE: SERUM <i>by PARA NITROPHENYL PHOSPHATASE BY AMINO METHYL PROPANOL</i> | 180.9 ^H | U/L | 40.0 - 130.0 |
| GAMMA GLUTAMYL TRANSFERASE (GGT): SERUM <i>by SZASZ, SPECTROPHOTOMETRY</i> | 270.48 ^H | U/L | 0.00 - 55.0 |
| TOTAL PROTEINS: SERUM <i>by BIURET, SPECTROPHOTOMETRY</i> | 6.19 ^L | gm/dL | 6.20 - 8.00 |
| ALBUMIN: SERUM <i>by BROMOCRESOL GREEN</i> | 3.69 | gm/dL | 3.50 - 5.50 |
| GLOBULIN: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i> | 2.5 | gm/dL | 2.30 - 3.50 |
| A : G RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i> | 1.48 | RATIO | 1.00 - 2.00 |

INTERPRETATION

NOTE:- To be correlated in individuals having SGOT and SGPT values higher than Normal Reference Range.

USE:- Differential diagnosis of diseases of hepatobiliary system and pancreas.

INCREASED:

| | |
|--|----------------------------|
| DRUG HEPATOTOXICITY | > 2 |
| ALCOHOLIC HEPATITIS | > 2 (Highly Suggestive) |
| CIRRHOSIS | 1.4 - 2.0 |
| INTRAHEPATIC CHOLESTATIS | > 1.5 |
| HEPATOCELLULAR CARCINOMA & CHRONIC HEPATITIS | > 1.3 (Slightly Increased) |




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DECREASED:

1. Acute Hepatitis due to virus, drugs, toxins (with AST increased 3 to 10 times upper limit of normal)
2. Extra Hepatic cholestasis: 0.8 (normal or slightly decreased).

PROGNOSTIC SIGNIFICANCE:

| | |
|----------------------|-----------|
| NORMAL | < 0.65 |
| GOOD PROGNOSTIC SIGN | 0.3 - 0.6 |
| POOR PROGNOSTIC SIGN | 1.2 - 1.6 |




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KIDNEY FUNCTION TEST (COMPLETE)

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| UREA: SERUM by UREASE - GLUTAMATE DEHYDROGENASE (GLDH) | 34.84 | mg/dL | 10.00 - 50.00 |
| CREATININE: SERUM by ENZYMATIC, SPECTROPHOTOMETRY | 0.93 | mg/dL | 0.40 - 1.40 |
| BLOOD UREA NITROGEN (BUN): SERUM by CALCULATED, SPECTROPHOTOMETRY | 16.28 | mg/dL | 7.0 - 25.0 |
| BLOOD UREA NITROGEN (BUN)/CREATININE RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY | 17.51 | RATIO | 10.0 - 20.0 |
| UREA/CREATININE RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY | 37.46 | RATIO | |
| URIC ACID: SERUM by URICASE - OXIDASE PEROXIDASE | 7.2 | mg/dL | 3.60 - 7.70 |
| CALCIUM: SERUM by ARSENAZO III, SPECTROPHOTOMETRY | 9.1 | mg/dL | 8.50 - 10.60 |
| PHOSPHOROUS: SERUM by PHOSPHOMOLYBDATE, SPECTROPHOTOMETRY | 2.79 | mg/dL | 2.30 - 4.70 |

ELECTROLYTES

| | | | |
|--|--------|--------|---------------|
| SODIUM: SERUM by ISE (ION SELECTIVE ELECTRODE) | 137.5 | mmol/L | 135.0 - 150.0 |
| POTASSIUM: SERUM by ISE (ION SELECTIVE ELECTRODE) | 4.37 | mmol/L | 3.50 - 5.00 |
| CHLORIDE: SERUM by ISE (ION SELECTIVE ELECTRODE) | 103.13 | mmol/L | 90.0 - 110.0 |

ESTIMATED GLOMERULAR FILTRATION RATE

| | |
|--|-------|
| ESTIMATED GLOMERULAR FILTRATION RATE (eGFR): SERUM by CALCULATED | 110.5 |
|--|-------|

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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P K R JAIN HEALTHCARE INSTITUTE

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A PIONEER DIAGNOSTIC CENTRE

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

NAME : Mr. PARVEEN
AGE/ GENDER : 34 YRS/MALE **PATIENT ID** : 1620785
COLLECTED BY : **REG. NO./LAB NO.** : 122409210032
REFERRED BY : **REGISTRATION DATE** : 21/Sep/2024 04:20 PM
BARCODE NO. : 12504860 **COLLECTION DATE** : 21/Sep/2024 04:44PM
CLIENT CODE. : P.K.R JAIN HEALTHCARE INSTITUTE **REPORTING DATE** : 21/Sep/2024 08:57PM
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|-----------|-------|------|-------------------------------|
|-----------|-------|------|-------------------------------|

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 inappropriate antidiuretic hormone) due to tubular secretion of urea.
8. Pregnancy.

DECREASED RATIO (<10:1) WITH INCREASED CREATININE:

1. Phenacimide therapy (accelerates conversion of creatine to creatinine).
2. Rhabdomyolysis (releases muscle creatinine).
3. Muscular patients who develop renal failure.

INAPPROPRIATE RATIO:

1. Diabetic ketoacidosis (acetoacetate causes false increase in creatinine with certain methodologies, resulting in normal ratio when dehydration should produce an increased BUN/creatinine ratio).
2. Cephalosporin therapy (interferes with creatinine measurement).

ESTIMATED GLOMERULAR FILTRATION RATE:

| CKD STAGE | DESCRIPTION | GFR (mL/min/1.73m ²) | 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 fulfill 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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IMMUNOPATHOLOGY/SEROLOGY

WIDAL SLIDE AGGLUTINATION TEST

| | | | |
|---|---------|-------|---------|
| SALMONELLA TYPHI O by SLIDE AGGLUTINATION | 1 : 160 | TITRE | 1 : 80 |
| SALMONELLA TYPHI H by SLIDE AGGLUTINATION | 1 : 80 | TITRE | 1 : 160 |
| SALMONELLA PARATYPHI AH by SLIDE AGGLUTINATION | 1 : 20 | TITRE | 1 : 160 |
| SALMONELLA PARATYPHI BH by SLIDE AGGLUTINATION | 1 : 20 | TITRE | 1 : 160 |

INTERPRETATION:

1. Titres of 1:80 or more for "O" agglutinin is considered significant.
2. Titres of 1:160 or more for "H" agglutinin is considered significant.

LIMITATIONS:


1. Agglutinins usually appear by 5th to 6th day of illness of enteric fever, hence a negative result in early stage is inconclusive. The titre then rises till 3rd or 4th week, after which it declines gradually.
2. Lower titres may be found in normal individuals.
3. A single positive result has less significance than the rising agglutination titre, since demonstration of rising titre four or more in 1st and 3rd week is considered as a definite evidence of infection.
4. A simultaneous rise in H agglutinins is suggestive of paratyphoid infection.

NOTE:

1. Individuals with prior infection or immunization with TAB vaccine may develop an ANAMNESTIC RESPONSE (False-Positive) during an unrelated fever i.e High titres of antibodies to various antigens. This may be differentiated by repetition of the test after a week.
2. The anamnestic response shows only a transient rise, while in enteric fever rise is sustained.
3. H agglutinins tend to persist for many months after vaccination but O agglutinins tend to disappear sooner i.e within 6 months. Therefore rise in O agglutinins indicate recent infection.




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CLINICAL PATHOLOGY

URINE ROUTINE & MICROSCOPIC EXAMINATION

PHYSICAL EXAMINATION

| | | | |
|--|----------------|----|---------------|
| QUANTITY RECIEVED | 25 | ml | |
| by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY | | | |
| COLOUR | PALE YELLOW | | PALE YELLOW |
| by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY | | | |
| TRANSPARANCY | HAZY | | CLEAR |
| by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY | | | |
| SPECIFIC GRAVITY | 1 ^L | | 1.002 - 1.030 |
| by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY | | | |

CHEMICAL EXAMINATION

| | | | |
|---|----------------|-------|----------------|
| REACTION | ACIDIC | | |
| by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY | | | |
| PROTEIN | 1+ | | NEGATIVE (-ve) |
| by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY | | | |
| SUGAR | NEGATIVE (-ve) | | NEGATIVE (-ve) |
| by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY | | | |
| pH | 6 | | 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 | POSITIVE (+ve) | EU/dL | 0.2 - 1.0 |
| by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY | | | |
| KETONE BODIES | NEGATIVE (-ve) | | NEGATIVE (-ve) |
| by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY | | | |
| BLOOD | NEGATIVE (-ve) | | 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> | NEGATIVE (-ve) | /HPF | 0 - 3 |
| PUS CELLS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i> | 5-6 | /HPF | 0 - 5 |
| EPITHELIAL CELLS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i> | 1-2 | /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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