



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. MANGAT RAM	PATIENT ID	: 1626772
AGE/ GENDER	: 75 YRS/MALE	REG. NO./LAB NO.	: 122409270014
COLLECTED BY	:	REGISTRATION DATE	: 27/Sep/2024 09:53 AM
REFERRED BY	:	COLLECTION DATE	: 27/Sep/2024 09:59 AM
BARCODE NO.	: 12504960	REPORTING DATE	: 27/Sep/2024 11:11 AM
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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HAEMATOLOGY

COMPLETE BLOOD COUNT (CBC)

RED BLOOD CELLS (RBCS) COUNT AND INDICES

HAEMOGLOBIN (HB) <i>by CALORIMETRIC</i>	11.9 ^L	gm/dL	12.0 - 17.0
RED BLOOD CELL (RBC) COUNT <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDEANCE</i>	4.52	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	34.4 ^L	%	40.0 - 54.0
MEAN CORPUSCULAR VOLUME (MCV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	76.2 ^L	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	26.2 ^L	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	34.4	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	19.5 ^H	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	54	fL	35.0 - 56.0
MENTZERS INDEX <i>by CALCULATED</i>	16.86	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX <i>by CALCULATED</i>	32.71	RATIO	BETA THALASSEMIA TRAIT: <= 65.0 IRON DEFICIENCY ANEMIA: > 65.0

WHITE BLOOD CELLS (WBCS)

TOTAL LEUCOCYTE COUNT (TLC) <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	7550	/cmm	4000 - 11000
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DIFFERENTIAL LEUCOCYTE COUNT (DLC)

NEUTROPHILS <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	62	%	50 - 70
LYMPHOCYTES <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	23	%	20 - 40
EOSINOPHILS <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	4	%	1 - 6



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MONOCYTES <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	11	%	2 - 12
BASOPHILS <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	0	%	0 - 1
<u>ABSOLUTE LEUKOCYTES (WBC) COUNT</u>			
ABSOLUTE NEUTROPHIL COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	4681	/cmm	2000 - 7500
ABSOLUTE LYMPHOCYTE COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	1736	/cmm	800 - 4900
ABSOLUTE EOSINOPHIL COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	302	/cmm	40 - 440
ABSOLUTE MONOCYTE COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	830	/cmm	80 - 880
ABSOLUTE BASOPHIL COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	0	/cmm	0 - 110
<u>PLATELETS AND OTHER PLATELET PREDICTIVE MARKERS.</u>			
PLATELET COUNT (PLT) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	170000	/cmm	150000 - 450000
PLATELETCRIT (PCT) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	0.19	%	0.10 - 0.36
MEAN PLATELET VOLUME (MPV) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	11	fL	6.50 - 12.0
PLATELET LARGE CELL COUNT (P-LCC) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	67000	/cmm	30000 - 90000
PLATELET LARGE CELL RATIO (P-LCR) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	39.5	%	11.0 - 45.0
PLATELET DISTRIBUTION WIDTH (PDW) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	15.3	%	15.0 - 17.0
NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD			



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CLINICAL CHEMISTRY/BIOCHEMISTRY

KIDNEY FUNCTION TEST (BASIC)

UREA: SERUM <i>by UREASE - GLUTAMATE DEHYDROGENASE (GLDH)</i>	26.62	mg/dL	10.00 - 50.00
CREATININE: SERUM <i>by ENZYMATIC, SPECTROPHOTOMETRY</i>	0.92	mg/dL	0.40 - 1.40
BLOOD UREA NITROGEN (BUN): SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	12.44	mg/dL	7.0 - 25.0
BLOOD UREA NITROGEN (BUN)/CREATININE RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	13.52	RATIO	10.0 - 20.0
UREA/CREATININE RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	28.93	RATIO	
URIC ACID: SERUM <i>by URICASE - OXIDASE PEROXIDASE</i>	6.44	mg/dL	3.60 - 7.70



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INTERPRETATION:

Normal range for a healthy person on normal diet: 12 - 20

To Differentiate between pre- and postrenal 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.

3.GI hemorrhage.

4.High protein intake.

5.Impaired renal function plus .

6.Excess protein intake or production or tissue breakdown (e.g. infection, GI bleeding, thyrotoxicosis, Cushings syndrome, high protein diet, burns,surgery, cachexia, high fever).

7.Urine reabsorption (e.g. ureterocolostomy)

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).



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ELECTROLYTES COMPLETE PROFILE

SODIUM: SERUM <i>by ISE (ION SELECTIVE ELECTRODE)</i>	135.1	mmol/L	135.0 - 150.0
POTASSIUM: SERUM <i>by ISE (ION SELECTIVE ELECTRODE)</i>	3.8	mmol/L	3.50 - 5.00
CHLORIDE: SERUM <i>by ISE (ION SELECTIVE ELECTRODE)</i>	101.32	mmol/L	90.0 - 110.0

INTERPRETATION:-

SODIUM:-

Sodium is the major cation of extra-cellular fluid. Its primary function in the body is to chemically maintain osmotic pressure & acid base balance & to transmit nerve impulse.

HYPONATREMIA (LOW SODIUM LEVEL) CAUSES:-

1. Low sodium intake.
2. Sodium loss due to diarrhea & vomiting with adequate water and iadequate salt replacement.
3. Diuretics abuses.
4. Salt loosing nephropathy.
5. Metabolic acidosis.
6. Adrenocortical issuficiency .
7. Hepatic failure.

HYPERNATREMIA (INCREASED SODIUM LEVEL) CAUSES:-

1. Hyperapnea (Prolonged)
2. Diabetes insipidus
3. Diabetic acidosis
4. Cushings syndrome
5. Dehydration

POTASSIUM:-

Potassium is the major cation in the intracellular fluid. 90% of potassium is concentrated within the cells. When cells are damaged, potassium is released in the blood.

HYPOKALEMIA (LOW POTASSIUM LEVELS):-

1. Diarrhoea, vomiting & malabsorption.
2. Severe Burns.
3. Increased Secretions of Aldosterone

HYPERKALEMIA (INCREASED POTASSIUM LEVELS):-

1. Oliguria
2. Renal failure or Shock
3. Respiratory acidosis



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4.Hemolysis of blood

*** End Of Report ***



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