



P K R JAIN HEALTHCARE INSTITUTE

NASIRPUR, Hissar Road, AMBALA CITY- (Haryana)

A PIONEER DIAGNOSTIC CENTRE

☎ 0171-2532620, 8222896961

✉ pkrjainhealthcare@gmail.com

NAME : Mr. SHANKAR
AGE/ GENDER : 45 YRS/MALE
COLLECTED BY :
REFERRED BY :
BARCODE NO. : 12505006
CLIENT CODE. : P.K.R JAIN HEALTHCARE INSTITUTE
CLIENT ADDRESS : NASIRPUR, HISSAR ROAD, AMBALA CITY - HARYANA

PATIENT ID : 1630855
REG. NO./LAB NO. : 122410010004
REGISTRATION DATE : 01/Oct/2024 08:59 AM
COLLECTION DATE : 01/Oct/2024 09:02AM
REPORTING DATE : 01/Oct/2024 12:15PM

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	15.3	gm/dL	12.0 - 17.0
RED BLOOD CELL (RBC) COUNT by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	4.53	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	43.2	%	40.0 - 54.0
MEAN CORPUSCULAR VOLUME (MCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	95.4	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	33.8	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	35.4	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	12.2	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	44.5	fL	35.0 - 56.0
MENTZERS INDEX by CALCULATED	21.06	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX by CALCULATED	25.71	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	7410	/cmm	4000 - 11000
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DIFFERENTIAL LEUCOCYTE COUNT (DLC)

NEUTROPHILS by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	58	%	50 - 70
LYMPHOCYTES by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	34	%	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	6	%	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	4298	/cmm	2000 - 7500
ABSOLUTE LYMPHOCYTE COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	2519 ^L	/cmm	800 - 4900
ABSOLUTE EOSINOPHIL COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	148	/cmm	40 - 440
ABSOLUTE MONOCYTE COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	445	/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	124000 ^L	/cmm	150000 - 450000
PLATELETCRIT (PCT) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	0.18	%	0.10 - 0.36
MEAN PLATELET VOLUME (MPV) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	15 ^H	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	58.6 ^H	%	11.0 - 45.0
PLATELET DISTRIBUTION WIDTH (PDW) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	16.6	%	15.0 - 17.0

NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD




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BLOOD GROUP (ABO) AND RH FACTOR TYPING

ABO GROUP
by SLIDE AGGLUTINATION
RH FACTOR TYPE
by SLIDE AGGLUTINATION

A
POSITIVE




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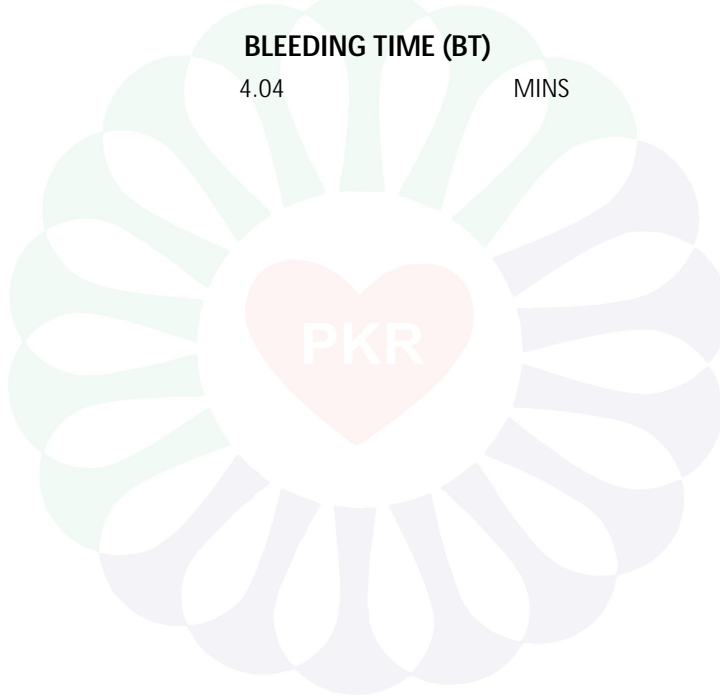
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BLEEDING TIME (BT) by DUKE METHOD	4.04	MINS	1 - 5
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CLOTTING TIME (CT)

CLOTTING TIME (CT) by CAPILLARY TUBE METHOD	6.43	MINS	4 - 9
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TEST PERFORMED AT KOS DIAGNOSTIC LAB, AMBALA CANTT.

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PROTHROMBIN TIME STUDIES (PT/INR)

PT TEST (PATIENT) by PHOTO OPTICAL CLOT DETECTION	11.6	SECS	11.5 - 14.5
PT (CONTROL) by PHOTO OPTICAL CLOT DETECTION	12	SECS	
ISI by PHOTO OPTICAL CLOT DETECTION	1.1		
INTERNATIONAL NORMALISED RATIO (INR) by PHOTO OPTICAL CLOT DETECTION	0.96		0.80 - 1.20
PT INDEX by PHOTO OPTICAL CLOT DETECTION	103.45	%	

INTERPRETATION:-

- 1.INR is the parameter of choice in monitoring adequacy of oral anti-coagulant therapy. Appropriate therapeutic range varies with the disease and treatment intensity.
2. Prolonged INR suggests potential bleeding disorder /bleeding complications
3. Results should be clinically correlated.
4. Test conducted on Citrated Plasma


RECOMMENDED THERAPEUTIC RANGE FOR ORAL ANTI-COAGULANT THERAPY (INR)

INDICATION		INTERNATIONAL NORMALIZED RATIO (INR)
Treatment of venous thrombosis	Low Intensity	2.0 - 3.0
Treatment of pulmonary embolism		
Prevention of systemic embolism in tissue heart valves		
Valvular heart disease		
Acute myocardial infarction		
Atrial fibrillation		
Bileaflet mechanical valve in aortic position	High Intensity	2.5 - 3.5
Recurrent embolism		
Mechanical heart valve		
Antiphospholipid antibodies ⁺		

COMMENTS:




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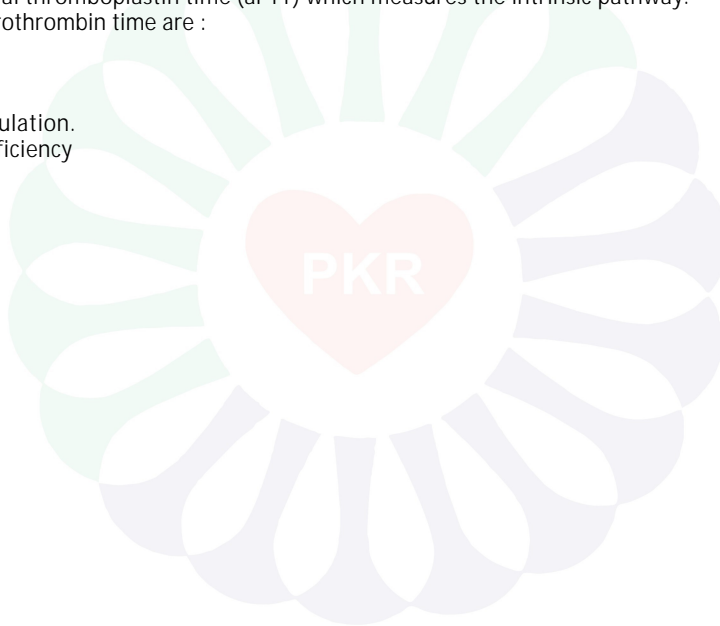
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The prothrombin time (PT) and its derived measures of prothrombin ratio (PR) and international normalized ratio (INR) are measures of the efficacy of the extrinsic pathway of coagulation. PT test reflects the adequacy of factors I (fibrinogen), II (prothrombin), V, VII, and X. It is used in conjunction with the activated partial thromboplastin time (aPTT) which measures the intrinsic pathway.

The common causes of prolonged prothrombin time are :

- 1.Oral Anticoagulant therapy.
- 2.Liver disease.
- 3.Vit K. deficiency.
- 4.Disseminated intra vascular coagulation.
- 5.Factor 5, 7 , 10 or Prothrombin deficiency




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CLINICAL CHEMISTRY/BIOCHEMISTRY

GLUCOSE RANDOM (R)

GLUCOSE RANDOM (R): PLASMA
by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)

359.61^H mg/dL

NORMAL: < 140.00
PREDIABETIC: 140.0 - 200.0
DIABETIC: > OR = 200.0

INTERPRETATION

IN ACCORDANCE WITH AMERICAN DIABETES ASSOCIATION GUIDELINES:

1. A random plasma glucose level below 140 mg/dl is considered normal.
2. A random glucose level between 140 - 200 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 random glucose level of above 200 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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LIVER FUNCTION TEST (COMPLETE)

BILIRUBIN TOTAL: SERUM <i>by DIAZOTIZATION, SPECTROPHOTOMETRY</i>	1.43 ^H	mg/dL	INFANT: 0.20 - 8.00 ADULT: 0.00 - 1.20
BILIRUBIN DIRECT (CONJUGATED): SERUM <i>by DIAZO MODIFIED, SPECTROPHOTOMETRY</i>	0.46 ^H	mg/dL	0.00 - 0.40
BILIRUBIN INDIRECT (UNCONJUGATED): SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	0.97	mg/dL	0.10 - 1.00
SGOT/AST: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	36.7	U/L	7.00 - 45.00
SGPT/ALT: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	82.1 ^H	U/L	0.00 - 49.00
AST/ALT RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	0.45	RATIO	0.00 - 46.00
ALKALINE PHOSPHATASE: SERUM <i>by PARA NITROPHENYL PHOSPHATASE BY AMINO METHYL PROPANOL</i>	106.8	U/L	40.0 - 130.0
GAMMA GLUTAMYL TRANSFERASE (GGT): SERUM <i>by SZASZ, SPECTROPHOTOMETRY</i>	77.13 ^H	U/L	0.00 - 55.0
TOTAL PROTEINS: SERUM <i>by BIURET, SPECTROPHOTOMETRY</i>	6.82	gm/dL	6.20 - 8.00
ALBUMIN: SERUM <i>by BROMOCRESOL GREEN</i>	4.33	gm/dL	3.50 - 5.50
GLOBULIN: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	2.49	gm/dL	2.30 - 3.50
A : G RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	1.74	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 CHOLESTASIS	> 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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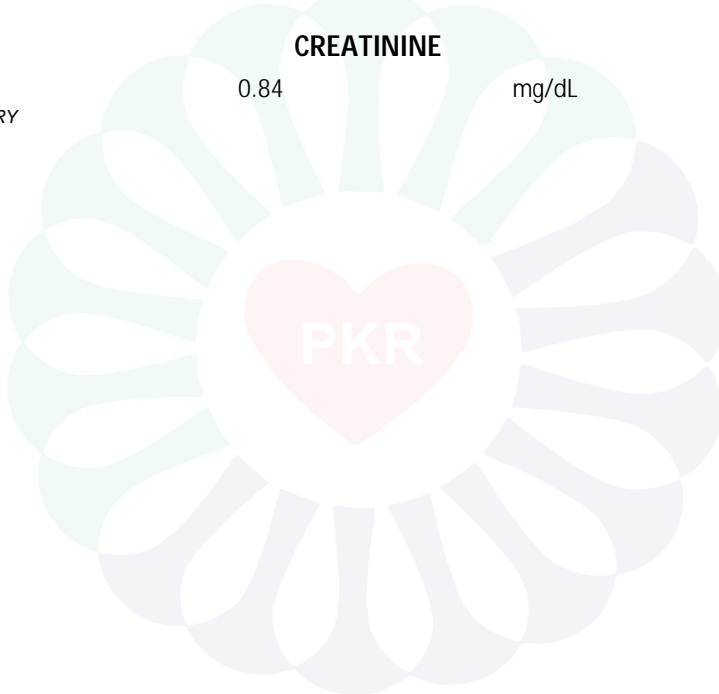
CREATININE: SERUM by ENZYMATIC, SPECTROPHOTOMETRY	0.84	mg/dL	0.40 - 1.40
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CREATININE


0.84

mg/dL

0.40 - 1.40




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IMMUNOPATHOLOGY/SEROLOGY HEPATITIS C VIRUS (HCV) ANTIBODIES SCREENING

HEPATITIS C ANTIBODY (HCV) TOTAL
RESULT

NON - REACTIVE

by IMMUNOCHROMATOGRAPHY

INTERPRETATION:


1.Anti HCV total antibody assay identifies presence IgG antibodies in the serum . It is a useful screening test with a specificity of nearly 99%.
2.It becomes positive approximately 24 weeks after exposure. The test can not isolate an active ongoing HCV infection from an old infection that has been cleared. All positive results must be confirmed for active disease by an HCV PCR test .

FALSE NEGATIVE RESULTS SEEN IN:

- 1.Window period
- 2.Immunocompromised states.




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ANTI HUMAN IMMUNODEFICIENCY VIRUS (HIV) ANTIBODIES HIV (1 & 2) SCREENING

HIV 1/2 AND P24 ANTIGEN RESULT NON - REACTIVE
by IMMUNOCHROMATOGRAPHY

INTERPRETATION:-

- 1.AIDS is caused by at least 2 known types of HIV viruses, HIV-1 and HIV HIV-2.
- 2.This NACO approved immuno-chromatographic solid phase ELISA assay detects antibodies against both HIV-1 and HIV-2 viruses.
- 3.The test is used for routine serologic screening of patients at risk for HIV-1 or HIV-2 infection.
- 4.All screening ELISA assays for HIV antibody detection have high sensitivity but have low specificity.
- 5.At this laboratory, all positive samples are cross checked for positivity with two alternate assays prior to reporting.

NOTE:-

- 1.Confirmatory testing by Western blot is recommended for patients who are reactive for HIV by this assay.
- 2.Antibodies against HIV-1 and HIV-2 are usually not detectable until 6 to 12 weeks following exposure (window period) and are almost always detectable by 12 months.
- 3.The test is not recommended for children born to HIV infected mothers till the child turns two years old (as HIV antibodies may be transmitted passively to the child trans-placentally).

FALSE NEGATIVE RESULT SEEN IN:

- 1.Window period
- 2.Severe immuno-suppression including advanced AIDS.




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NAME	: Mr. SHANKAR	PATIENT ID	: 1630855
AGE/ GENDER	: 45 YRS/MALE	REG. NO./LAB NO.	: 122410010004
COLLECTED BY	:	REGISTRATION DATE	: 01/Oct/2024 08:59 AM
REFERRED BY	:	COLLECTION DATE	: 01/Oct/2024 09:02AM
BARCODE NO.	: 12505006	REPORTING DATE	: 01/Oct/2024 11:40AM
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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HEPATITIS B SURFACE ANTIGEN (HBsAg) SCREENING

HEPATITIS B SURFACE ANTIGEN (HBsAg) NON - REACTIVE
RESULT

by IMMUNOCHROMATOGRAPHY

INTERPRETATION:-

1.HBsAG is the first serological marker of HBV infection to appear in the blood (approximately 30-60 days after infection and prior to the onset of clinical disease). It is also the last viral protein to disappear from blood and usually disappears by three months after infection in self limiting acute Hepatitis B viral infection.

2.Persistence of HBsAg in blood for more than six months implies chronic infection. It is the most common marker used for diagnosis of an acute Hepatitis B infection but has very limited role in assessing patients suffering from chronic hepatitis.

FALSE NEGATIVE RESULT SEEN IN:

- 1.Window period.
- 2.Infection with HBsAg mutant strains
- 3.Hepatitis B Surface antigen (HBsAg) is the earliest indicator of HBV infection. Usually it appears in 27 - 41 days (as early as 14 days).
- 4.Appears 7 - 26 days before biochemical abnormalities. Peaks as ALT rises. Persists during the acute illness. Usually disappears 12- 20 weeks after the onset of symptoms / laboratory abnormalities in 90% of cases.
- 5.Is the most reliable serologic marker of HBV infection. Persistence > 6 months defines carrier state. May also be found in chronic infection.Hepatitis B vaccination does not cause a positive HBsAg. Titers are not of clinical value.

NOTE:-

- 1.All reactive HBsAG Should be reconfirmed with neutralization test(HBsAg confirmatory test).
- 2.Anti - HAV IgM appears at the same time as symptoms in > 99% of cases, peaks within the first month, becomes nondetectable in 12 months (usually 6 months). Presence confirms diagnosis of recent acute infection.

*** End Of Report ***




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