



# 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.

<b>NAME</b>	: Mrs. RENU	<b>PATIENT ID</b>	: 1642030
<b>AGE/ GENDER</b>	: 53 YRS/FEMALE	<b>REG. NO./LAB NO.</b>	: 122410130004
<b>COLLECTED BY</b>	:	<b>REGISTRATION DATE</b>	: 13/Oct/2024 10:24 AM
<b>REFERRED BY</b>	:	<b>COLLECTION DATE</b>	: 13/Oct/2024 02:25PM
<b>BARCODE NO.</b>	: 12505153	<b>REPORTING DATE</b>	: 13/Oct/2024 01:03PM
<b>CLIENT CODE.</b>	: P.K.R JAIN HEALTHCARE INSTITUTE		
<b>CLIENT ADDRESS</b>	: NASIRPUR, HISSAR ROAD, AMBALA CITY - HARYANA		

Test Name	Value	Unit	Biological Reference interval
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## CLINICAL CHEMISTRY/BIOCHEMISTRY

### LIVER FUNCTION TEST (COMPLETE)

BILIRUBIN TOTAL: SERUM <i>by DIAZOTIZATION, SPECTROPHOTOMETRY</i>	0.88	mg/dL	INFANT: 0.20 - 8.00 ADULT: 0.00 - 1.20
BILIRUBIN DIRECT (CONJUGATED): SERUM <i>by DIAZO MODIFIED, SPECTROPHOTOMETRY</i>	0.16	mg/dL	0.00 - 0.40
BILIRUBIN INDIRECT (UNCONJUGATED): SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	0.72	mg/dL	0.10 - 1.00
SGOT/AST: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	21.53	U/L	7.00 - 45.00
SGPT/ALT: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	17.71	U/L	0.00 - 49.00
AST/ALT RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	1.22	RATIO	0.00 - 46.00
ALKALINE PHOSPHATASE: SERUM <i>by PARA NITROPHENYL PHOSPHATASE BY AMINO METHYL PROPANOL</i>	122.76	U/L	40.0 - 130.0
GAMMA GLUTAMYL TRANSFERASE (GGT): SERUM <i>by SZASZ, SPECTROPHOTOMETRY</i>	25.42	U/L	0.00 - 55.0
TOTAL PROTEINS: SERUM <i>by BIURET, SPECTROPHOTOMETRY</i>	6.81	gm/dL	6.20 - 8.00
ALBUMIN: SERUM <i>by BROMOCRESOL GREEN</i>	4.11	gm/dL	3.50 - 5.50
GLOBULIN: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	2.7	gm/dL	2.30 - 3.50
A : G RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	1.52	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



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INTRAHEPATIC CHOLESTATIS	> 1.5		
HEPATOCELLULAR CARCINOMA & CHRONIC HEPATITIS	> 1.3 (Slightly Increased)		

**DECREASED:**

- Acute Hepatitis due to virus, drugs, toxins (with AST increased 3 to 10 times upper limit of normal)
- 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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**REPORTING DATE** : 13/Oct/2024 03:09PM

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## KIDNEY FUNCTION TEST (BASIC)

UREA: SERUM by UREASE - GLUTAMATE DEHYDROGENASE (GLDH)	18.24	mg/dL	10.00 - 50.00
CREATININE: SERUM by ENZYMATIC, SPECTROPHOTOMETRY	0.76	mg/dL	0.40 - 1.20
BLOOD UREA NITROGEN (BUN): SERUM by CALCULATED, SPECTROPHOTOMETRY	8.52	mg/dL	7.0 - 25.0
BLOOD UREA NITROGEN (BUN)/CREATININE RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	11.21	RATIO	10.0 - 20.0
UREA/CREATININE RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	24	RATIO	
URIC ACID: SERUM by URICASE - OXIDASE PEROXIDASE	3.62	mg/dL	2.50 - 6.80



  
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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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## IMMUNOPATHOLOGY/SEROLOGY

### ANTI NUCLEAR ANTIBODY/FACTOR (ANA/ANF)

ANTI NUCLEUR ANTIBODIES (ANA): SERUM by ELISA (ENZYME LINKED IMMUNOASSAY)	0.67	INDEX VALUE	NEGATIVE: < 1.0 BORDERLINE: 1.0 - 1.20 POSITIVE: > 1.20
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#### INTERPRETATION:-

- 1.For diagnostic purposes, ANA value should be used as an adjuvant to other clinical and laboratory data available.
- 2.Measurement of antinuclear antibodies (ANAs) in serum is the most commonly performed screening test for patients suspected of having a systemic rheumatic disease, also referred to as connective tissue disease.
- 3.ANAs occur in patients with a variety of autoimmune diseases, both systemic and organ-specific. They are particularly common in the systemic rheumatic diseases, which include lupus erythematosus (LE), discoid LE, drug-induced LE, mixed connective tissue disease, Sjogren syndrome, scleroderma (systemic sclerosis), CREST (calcinosis, Raynaud's phenomenon, esophageal dysmotility, sclerodactyly, telangiectasia) syndrome, polymyositis/dermatomyositis, and rheumatoid arthritis.

#### NOTE:

- 1.The diagnosis of a systemic rheumatic disease is based primarily on the presence of compatible clinical signs and symptoms. The results of tests for autoantibodies including ANA and specific autoantibodies are ancillary. Additional diagnostic criteria include consistent histopathology or specific radiographic findings. Although individual systemic rheumatic diseases are relatively uncommon, a great many patients present with clinical findings that are compatible with a systemic rheumatic disease ANA screening may be useful for ruling out the disease.
- 2.Secondary, disease specific auto antibodies maybe ordered for patients who are screen positive as ancillary aids for the diagnosis of specific auto-immune disorders.

\*\*\* End Of Report \*\*\*



  
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