



P K R JAIN HEALTHCARE INSTITUTE

NASIRPUR, Hissar Road, AMBALA CITY- (Haryana)

A PIONEER DIAGNOSTIC CENTRE

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

NAME : Mrs. RAJBALA
AGE/ GENDER : 45 YRS/FEMALE
COLLECTED BY :
REFERRED BY :
BARCODE NO. : 12505264
CLIENT CODE. : P.K.R JAIN HEALTHCARE INSTITUTE
CLIENT ADDRESS : NASIRPUR, HISSAR ROAD, AMBALA CITY - HARYANA

PATIENT ID : 1648837
REG. NO./LAB NO. : 122410210008
REGISTRATION DATE : 21/Oct/2024 10:06 AM
COLLECTION DATE : 21/Oct/2024 10:13AM
REPORTING DATE : 21/Oct/2024 12:50PM

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	11.2 ^L	gm/dL	12.0 - 16.0
RED BLOOD CELL (RBC) COUNT by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	3.86	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	32.4 ^L	%	37.0 - 50.0
MEAN CORPUSCULAR VOLUME (MCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	84	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	28.9	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	34.5	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	14.3	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	46.4	fL	35.0 - 56.0
MENTZERS INDEX by CALCULATED	21.76	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX by CALCULATED	31	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	8440	/cmm	4000 - 11000
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DIFFERENTIAL LEUCOCYTE COUNT (DLC)

NEUTROPHILS by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	60	%	50 - 70
LYMPHOCYTES by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	30	%	20 - 40
EOSINOPHILS by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	4	%	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
ABSOLUTE LEUKOCYTES (WBC) COUNT			
ABSOLUTE NEUTROPHIL COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	5064	/cmm	2000 - 7500
ABSOLUTE LYMPHOCYTE COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	2532	/cmm	800 - 4900
ABSOLUTE EOSINOPHIL COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	338	/cmm	40 - 440
ABSOLUTE MONOCYTE COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	506	/cmm	80 - 880
ABSOLUTE BASOPHIL COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	0	/cmm	0 - 110
PLATELETS AND OTHER PLATELET PREDICTIVE MARKERS.			
PLATELET COUNT (PLT) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	283000	/cmm	150000 - 450000
PLATELETCRIT (PCT) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	0.32	%	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	105000 ^H	/cmm	30000 - 90000
PLATELET LARGE CELL RATIO (P-LCR) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	37.1	%	11.0 - 45.0
PLATELET DISTRIBUTION WIDTH (PDW) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	15.6	%	15.0 - 17.0
NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD			




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ERYTHROCYTE SEDIMENTATION RATE (ESR)

ERYTHROCYTE SEDIMENTATION RATE (ESR) 58^H 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 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.

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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PERIPHERAL BLOOD SMEAR

TEST NAME:

PERIPHERAL BLOOD FILM/SMEAR (PBF)

RED BLOOD CELLS (RBC'S):

Mild anisocytosis with a few microcytes. RBCs mostly appear normochromic. No polychromatic cells or normoblasts noted.

WHITE BLOOD CELLS (WBC'S):

No immature leucocytes seen.

PLATELETS:

Platelets are adequate.


HEMOPARASITES:


NOT SEEN.

IMPRESSION:

Mild microcytic normochromic picture.




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TEST PERFORMED AT KOS DIAGNOSTIC LAB, AMBALA CANTT.

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CLINICAL CHEMISTRY/BIOCHEMISTRY

LIVER FUNCTION TEST (COMPLETE)

BILIRUBIN TOTAL: SERUM <i>by DIAZOTIZATION, SPECTROPHOTOMETRY</i>	0.81	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>	0.65	mg/dL	0.10 - 1.00
SGOT/AST: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	16.69	U/L	7.00 - 45.00
SGPT/ALT: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	16.73	U/L	0.00 - 49.00
AST/ALT RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	1	RATIO	0.00 - 46.00
ALKALINE PHOSPHATASE: SERUM <i>by PARA NITROPHENYL PHOSPHATASE BY AMINO METHYL PROPANOL</i>	90.72	U/L	40.0 - 130.0
GAMMA GLUTAMYL TRANSFERASE (GGT): SERUM <i>by SZASZ, SPECTROPHOTOMETRY</i>	18.18	U/L	0.00 - 55.0
TOTAL PROTEINS: SERUM <i>by BIURET, SPECTROPHOTOMETRY</i>	7.75	gm/dL	6.20 - 8.00
ALBUMIN: SERUM <i>by BROMOCRESOL GREEN</i>	3.81	gm/dL	3.50 - 5.50
GLOBULIN: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	3.94 ^H	gm/dL	2.30 - 3.50
A : G RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	0.97 ^L	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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KIDNEY FUNCTION TEST (BASIC)

UREA: SERUM by UREASE - GLUTAMATE DEHYDROGENASE (GLDH)	32.61	mg/dL	10.00 - 50.00
CREATININE: SERUM by ENZYMATIC, SPECTROPHOTOMETRY	0.93	mg/dL	0.40 - 1.20
BLOOD UREA NITROGEN (BUN): SERUM by CALCULATED, SPECTROPHOTOMETRY	15.24	mg/dL	7.0 - 25.0
BLOOD UREA NITROGEN (BUN)/CREATININE RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	16.39	RATIO	10.0 - 20.0
UREA/CREATININE RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	35.06	RATIO	
URIC ACID: SERUM by URICASE - OXIDASE PEROXIDASE	5.4	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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AMYLASE

AMYLASE - SERUM	59.07	IU/L	0 - 90
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by CNPG 3, SPECTROPHOTOMETRY

INTERPRETATION

COMMENTS

- 1.Amylase is produced in the Pancreas and most of the elevation in serum is due to increased rate of Amylase entry into the blood stream / decreased rate of clearance or both.
- 2.Serum Amylase rises within 6 to 48 hours of onset of Acute pancreatitis in 80% of patients, but is not proportional to the severity of the disease.
- 3.Activity usually returns to normal in 3-5 days in patients with milder edematous form of the disease.
- 4.Values persisting longer than this period suggest continuing necrosis of pancreas or Pseudocyst formation.
- 5.Approximately 20% of patients with Pancreatitis have normal or near normal activity.
- 6.Hyperlipemic patients with Pancreatitis also show spuriously normal Amylase levels due to suppression of Amylase activity by triglyceride.
- 7.Low Amylase levels are seen in Chronic Pancreatitis, Congestive Heart failure, 2nd & 3rd trimesters of pregnancy, Gastrointestinal cancer & bone fractures.




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LIPASE

LIPASE - SERUM	58.91	U/L	0 - 60
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by METHYL RESORUFIN, SPECTROPHOTOMETRY

INTERPRETATION

1. Pancreas is the major and primary source of serum lipase though lipases are also present in liver, stomach, intestine, WBC, fat cells and milk.
2. In acute pancreatitis, serum lipase becomes elevated at the same time as amylase and remains high for 7-10 days.
3. Increased lipase activity rarely lasts longer than 14 days.
4. Prolonged increase suggests poor prognosis or presence of a cyst.
5. The combined use of serum lipase and serum amylase is effective in ruling out acute pancreatitis.

INCREASED LEVEL:

1. Acute & Chronic pancreatitis
2. Obstruction of pancreatic duct
3. Non pancreatic conditions like renal diseases, acute cholecystitis, intestinal obstruction, duodenal ulcer, alcoholism, diabetic ketoacidosis and following endoscopic retrograde cholangiopancreatography

NOTE:

1. Elevations 2 to 50 times the upper reference have been reported. The increase in serum lipase is not necessarily proportional to the severity of the attack. Normalization is not necessarily a sign of resolution.

ADVICE:

Concomitant testing of serum amylase and lipase is highly recommended to establish a diagnosis of pancreatic injury

*** End Of Report ***



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