



P K R JAIN HEALTHCARE INSTITUTE

NASIRPUR, Hissar Road, AMBALA CITY- (Haryana)

A PIONEER DIAGNOSTIC CENTRE

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

TEST PERFORMED AT KOS DIAGNOSTIC LAB, AMBALA CANTT.

| | | | |
|----------------|--|-------------------|------------------------|
| NAME | : Mrs. RENU | PATIENT ID | : 1642030 |
| AGE/ GENDER | : 53 YRS/FEMALE | REG. NO./LAB NO. | : 122411180012 |
| COLLECTED BY | : | REGISTRATION DATE | : 18/Nov/2024 12:14 PM |
| REFERRED BY | : | COLLECTION DATE | : 18/Nov/2024 12:18PM |
| BARCODE NO. | : 12505711 | REPORTING DATE | : 18/Nov/2024 01:10PM |
| 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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CLINICAL CHEMISTRY/BIOCHEMISTRY

GLUCOSE FASTING (F)

GLUCOSE FASTING (F): PLASMA
by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)

80.38

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> | 160.09 | 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> | 75.61 | 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> | 54.06 | 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> | 90.91 | 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> | 106.03 | 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> | 15.12 | mg/dL | 0.00 - 45.00 |
| TOTAL LIPIDS: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i> | 395.79 | mg/dL | 350.00 - 700.00 |
| CHOLESTEROL/HDL RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i> | 2.96 | RATIO | LOW RISK: 3.30 - 4.40 AVERAGE RISK: 4.50 - 7.0 MODERATE RISK: 7.10 - 11.0 HIGH RISK: > 11.0 |




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| LDL/HDL RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i> | 1.68 | RATIO | LOW RISK: 0.50 - 3.0 MODERATE RISK: 3.10 - 6.0 HIGH RISK: > 6.0 |
| TRIGLYCERIDES/HDL RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i> | 1.4 ^L | RATIO | 3.00 - 5.00 |

INTERPRETATION:

1. 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.
2. 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.
3. 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.
4. 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.
5. 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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IMMUNOPATHOLOGY/SEROLOGY

HEPATITIS C VIRUS (HCV) ANTIBODIES SCREENING

HEPATITIS C ANTIBODY (HCV) TOTAL
RESULT
by IMMUNOCHROMATOGRAPHY

NON - REACTIVE

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-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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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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