



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. PRINCE JAIN	PATIENT ID	: 1679127
AGE/ GENDER	: 59 YRS/MALE	REG. NO./LAB NO.	: 122411220020
COLLECTED BY	:	REGISTRATION DATE	: 22/Nov/2024 02:10 PM
REFERRED BY	:	COLLECTION DATE	: 22/Nov/2024 08:48PM
BARCODE NO.	: 12505791	REPORTING DATE	: 22/Nov/2024 10:24PM
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

GLYCOSYLATED HAEMOGLOBIN (HBA1C)

GLYCOSYLATED HAEMOGLOBIN (HbA1c): WHOLE BLOOD <i>by HPLC (HIGH PERFORMANCE LIQUID CHROMATOGRAPHY)</i>	7.8^H	%	4.0 - 6.4
ESTIMATED AVERAGE PLASMA GLUCOSE <i>by HPLC (HIGH PERFORMANCE LIQUID CHROMATOGRAPHY)</i>	177.16^H	mg/dL	60.00 - 140.00

INTERPRETATION:

AS PER AMERICAN DIABETES ASSOCIATION (ADA):

REFERENCE GROUP	GLYCOSYLATED HEMOGLOBIN (HBA1C) in %	
Non diabetic Adults >= 18 years	<5.7	
At Risk (Prediabetes)	5.7 – 6.4	
Diagnosing Diabetes	>= 6.5	
Age > 19 Years		
Therapeutic goals for glycemic control	Goals of Therapy:	< 7.0
	Actions Suggested:	>8.0
	Age < 19 Years	
	Goal of therapy:	<7.5

COMMENTS:

- Glycosylated hemoglobin (HbA1c) test is three monthly monitoring done to assess compliance with therapeutic regimen in diabetic patients.
- Since Hb1c reflects long term fluctuations in blood glucose concentration, a diabetic patient who has recently under good control may still have high concentration of HbA1c. Converse is true for a diabetic previously under good control but now poorly controlled.
- Target goals of < 7.0 % may be beneficial in patients with short duration of diabetes, long life expectancy and no significant cardiovascular disease. In patients with significant complications of diabetes, limited life expectancy or extensive co-morbid conditions, targeting a goal of < 7.0% may not be appropriate.
- High HbA1c (>9.0 -9.5 %) is strongly associated with risk of development and rapid progression of microvascular and nerve complications
- Any condition that shorten RBC life span like acute blood loss, hemolytic anemia falsely lower HbA1c results.
- HbA1c results from patients with HbSS, HbSC and HbD must be interpreted with caution, given the pathological processes including anemia, increased red cell turnover, and transfusion requirement that adversely impact HbA1c as a marker of long-term glycemic control.
- Specimens from patients with polycythemia or post-splenectomy may exhibit increase in HbA1c values due to a somewhat longer life span of the red cells.



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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>	0.21	mg/dL	0.00 - 0.40
BILIRUBIN INDIRECT (UNCONJUGATED): SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	0.6	mg/dL	0.10 - 1.00
SGOT/AST: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	21.83	U/L	7.00 - 45.00
SGPT/ALT: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	31.26	U/L	0.00 - 49.00
AST/ALT RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	0.7	RATIO	0.00 - 46.00
ALKALINE PHOSPHATASE: SERUM <i>by PARA NITROPHENYL PHOSPHATASE BY AMINO METHYL PROPANOL</i>	75.55	U/L	40.0 - 130.0
GAMMA GLUTAMYL TRANSFERASE (GGT): SERUM <i>by SZASZ, SPECTROPHOTOMETRY</i>	12.51	U/L	0.00 - 55.0
TOTAL PROTEINS: SERUM <i>by BIURET, SPECTROPHOTOMETRY</i>	7.11	gm/dL	6.20 - 8.00
ALBUMIN: SERUM <i>by BROMOCRESOL GREEN</i>	4.76	gm/dL	3.50 - 5.50
GLOBULIN: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	2.35	gm/dL	2.30 - 3.50
A : G RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	2.03^H	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



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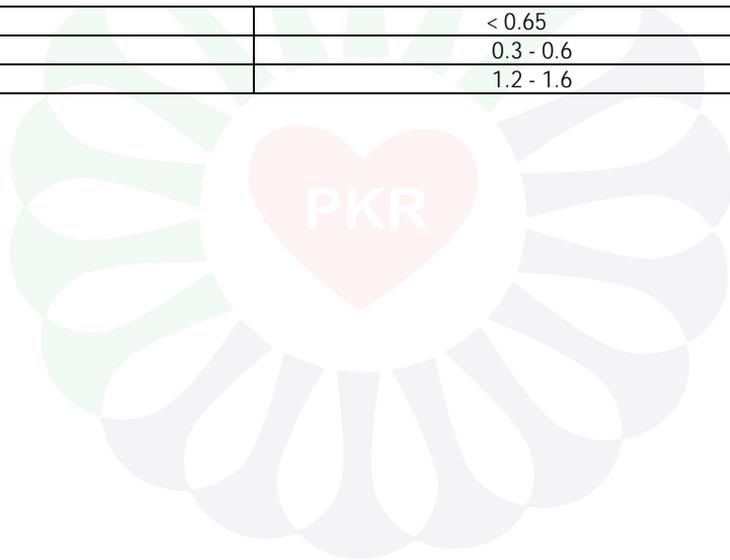
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HEPATOCELLULAR CARCINOMA & CHRONIC HEPATITIS			> 1.3 (Slightly Increased)
DECREASED:			
1. Acute Hepatitis due to virus, drugs, toxins (with AST increased 3 to 10 times upper limit of normal)			
2. Extra Hepatic cholestasis: 0.8 (normal or slightly decreased).			
PROGNOSTIC SIGNIFICANCE:			
NORMAL			< 0.65
GOOD PROGNOSTIC SIGN			0.3 - 0.6
POOR PROGNOSTIC SIGN			1.2 - 1.6



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KIDNEY FUNCTION TEST (BASIC)

UREA: SERUM <i>by UREASE - GLUTAMATE DEHYDROGENASE (GLDH)</i>	29.8	mg/dL	10.00 - 50.00
CREATININE: SERUM <i>by ENZYMATIC, SPECTROPHOTOMETRY</i>	0.96	mg/dL	0.40 - 1.40
BLOOD UREA NITROGEN (BUN): SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	13.93	mg/dL	7.0 - 25.0
BLOOD UREA NITROGEN (BUN)/CREATININE RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	14.51	RATIO	10.0 - 20.0
UREA/CREATININE RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	31.04	RATIO	
URIC ACID: SERUM <i>by URICASE - OXIDASE PEROXIDASE</i>	4.21	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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TUMOUR MARKER

PROSTATE SPECIFIC ANTIGEN (PSA) - TOTAL

PROSTATE SPECIFIC ANTIGEN (PSA) - TOTAL:	0.67	ng/mL	0.0 - 4.0
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SERUM

by CLIA (CHEMILUMINESCENCE IMMUNOASSAY)

INTERPRETATION:

NOTE:

1. This is a recommended test for detection of prostate cancer along with Digital Rectal Examination (DRE) in males above 50 years of age.
2. False negative / positive results are observed in patients receiving mouse monoclonal antibodies for diagnosis or therapy
3. PSA levels may appear consistently elevated / depressed due to the interference by heterophilic antibodies & nonspecific protein binding
4. Immediate PSA testing following digital rectal examination, ejaculation, prostatic massage, indwelling catheterization, ultrasonography and needle biopsy of prostate is not recommended as they falsely elevate levels
5. PSA values regardless of levels should not be interpreted as absolute evidence of the presence or absence of disease. All values should be correlated with clinical findings and results of other investigations
6. Sites of Non-prostatic PSA production are breast epithelium, salivary glands, peri-urethral & anal glands, cells of male urethra & breast milk
7. Physiological decrease in PSA level by 18% has been observed in hospitalized / sedentary patients either due to supine position or suspended sexual activity
8. The concentration of PSA in a given specimen, determined with assays from different manufacturers, may not be comparable due to differences in assay methods, calibration, and reagent specificity.

RECOMMENDED TESTING INTERVALS

1. Preoperatively (Baseline)
2. 2-4 Days Post operatively
3. Prior to discharge from hospital
4. Monthly Follow Up if levels are high and showing a rising trend

POST SURGERY	FREQUENCY OF TESTING
1st Year	Every 3 Months
2 nd Year	Every 4 Months
3 rd Year Onwards	Every 6 Months

CLINICAL USE:

1. An aid in the early detection of Prostate cancer when used in conjunction with Digital rectal examination in males more than 50 years of age and in those with two or more affected first degree relatives.
2. Followup and management of Prostate cancer patients.
3. Detect metastatic or persistent disease in patients following surgical or medical treatment of Prostate cancer

INCREASED LEVEL:

1. Prostate cancer
2. Benign Prostatic Hyperplasia
3. Prostatitis
4. Genitourinary infections



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