



# P K R JAIN HEALTHCARE INSTITUTE

NASIRPUR, Hissar Road, AMBALA CITY- (Haryana)

**A PIONEER DIAGNOSTIC CENTRE**

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

**NAME** : Mr. SUBHASH SHARMA  
**AGE/ GENDER** : 68 YRS/MALE  
**COLLECTED BY** :  
**REFERRED BY** :  
**BARCODE NO.** : 12506158  
**CLIENT CODE.** : P.K.R JAIN HEALTHCARE INSTITUTE  
**CLIENT ADDRESS** : NASIRPUR, HISSAR ROAD, AMBALA CITY - HARYANA

**PATIENT ID** : 1327434  
**REG. NO./LAB NO.** : 122412160002  
**REGISTRATION DATE** : 16/Dec/2024 09:34 AM  
**COLLECTION DATE** : 16/Dec/2024 09:41AM  
**REPORTING DATE** : 16/Dec/2024 04:12PM

Test Name	Value	Unit	Biological Reference interval
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## HAEMATOLOGY

### GLYCOSYLATED HAEMOGLOBIN (HbA1C)

GLYCOSYLATED HAEMOGLOBIN (HbA1c): **10.8<sup>H</sup>** % 4.0 - 6.4  
WHOLE BLOOD  
by HPLC (HIGH PERFORMANCE LIQUID CHROMATOGRAPHY)  
ESTIMATED AVERAGE PLASMA GLUCOSE **263.26<sup>H</sup>** mg/dL 60.00 - 140.00  
by HPLC (HIGH PERFORMANCE LIQUID CHROMATOGRAPHY)

#### 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	
Therapeutic goals for glycemic control	Age > 19 Years	
	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 shortens RBC life span like acute blood loss, hemolytic anemia falsely lowers 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

### GLUCOSE FASTING (F) AND POST PRANDIAL (PP)


GLUCOSE FASTING (F): PLASMA by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)	246.99 <sup>H</sup>	mg/dL	NORMAL: < 100.0 PREDIABETIC: 100.0 - 125.0 DIABETIC: > OR = 126.0
GLUCOSE POST PRANDIAL (PP): PLASMA by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)	293.44 <sup>H</sup>	mg/dL	NORMAL: < 140.00 PREDIABETIC: 140.0 - 200.0 DIABETIC: > OR = 200.0


#### INTERPRETATION:

#### IN ACCORDANCE WITH AMERICAN DIABETES ASSOCIATION GUIDELINES:

1. A fasting plasma glucose below 100 mg/dL and post-prandial plasma glucose level below 140 mg/dl is considered normal.
2. A fasting plasma glucose level between 100 - 125 mg/dl and post-prandial plasma glucose level between 140 – 200 mg/dL is considered as glucose intolerant or pre diabetic. 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 and post-prandial plasma glucose level 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>	0.41	mg/dL	INFANT: 0.20 - 8.00 ADULT: 0.00 - 1.20
BILIRUBIN DIRECT (CONJUGATED): SERUM <i>by DIAZO MODIFIED, SPECTROPHOTOMETRY</i>	0.15	mg/dL	0.00 - 0.40
BILIRUBIN INDIRECT (UNCONJUGATED): SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	0.26	mg/dL	0.10 - 1.00
SGOT/AST: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	23.31	U/L	7.00 - 45.00
SGPT/ALT: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	26.94	U/L	0.00 - 49.00
AST/ALT RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	0.87	RATIO	0.00 - 46.00
ALKALINE PHOSPHATASE: SERUM <i>by PARA NITROPHENYL PHOSPHATASE BY AMINO METHYL PROPANOL</i>	81.95	U/L	40.0 - 130.0
GAMMA GLUTAMYL TRANSFERASE (GGT): SERUM <i>by SZASZ, SPECTROPHOTOMETRY</i>	14.23	U/L	0.00 - 55.0
TOTAL PROTEINS: SERUM <i>by BIURET, SPECTROPHOTOMETRY</i>	6.61	gm/dL	6.20 - 8.00
ALBUMIN: SERUM <i>by BROMOCRESOL GREEN</i>	3.83	gm/dL	3.50 - 5.50
GLOBULIN: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	2.78	gm/dL	2.30 - 3.50
A : G RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	1.38	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 CHOLESTATIS	> 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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BARCODE NO.	: 12506158	REPORTING DATE	: 16/Dec/2024 11:06AM
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Test Name	Value	Unit	Biological Reference interval
<b>KIDNEY FUNCTION TEST (BASIC)</b>			
UREA: SERUM <i>by UREASE - GLUTAMATE DEHYDROGENASE (GLDH)</i>	43.39	mg/dL	10.00 - 50.00
CREATININE: SERUM <i>by ENZYMATIC, SPECTROPHOTOMETRY</i>	<b>1.58<sup>H</sup></b>	mg/dL	0.40 - 1.40
BLOOD UREA NITROGEN (BUN): SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	20.28	mg/dL	7.0 - 25.0
BLOOD UREA NITROGEN (BUN)/CREATININE RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	12.84	RATIO	10.0 - 20.0
UREA/CREATININE RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	27.46	RATIO	
URIC ACID: SERUM <i>by URICASE - OXIDASE PEROXIDASE</i>	3.64	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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## CLINICAL PATHOLOGY

### URINE ROUTINE & MICROSCOPIC EXAMINATION

#### PHYSICAL EXAMINATION

QUANTITY RECIEVED	30	ml	
<small>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</small>			
COLOUR	PALE YELLOW		PALE YELLOW
<small>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</small>			
TRANSPARANCY	TURBID		CLEAR
<small>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</small>			
SPECIFIC GRAVITY	1.02		1.002 - 1.030
<small>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</small>			


#### CHEMICAL EXAMINATION


REACTION	ACIDIC		
<small>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</small>			
PROTEIN	1+		NEGATIVE (-ve)
<small>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</small>			
SUGAR	1+		NEGATIVE (-ve)
<small>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</small>			
pH	5.5		5.0 - 7.5
<small>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</small>			
BILIRUBIN	NEGATIVE (-ve)		NEGATIVE (-ve)
<small>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</small>			
NITRITE	NEGATIVE (-ve)		NEGATIVE (-ve)
<small>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY.</small>			
UROBILINOGEN	NOT DETECTED	EU/dL	0.2 - 1.0
<small>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</small>			
KETONE BODIES	NEGATIVE (-ve)		NEGATIVE (-ve)
<small>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</small>			
BLOOD	TRACE		NEGATIVE (-ve)
<small>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</small>			
ASCORBIC ACID	NEGATIVE (-ve)		NEGATIVE (-ve)
<small>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</small>			

#### MICROSCOPIC EXAMINATION

RED BLOOD CELLS (RBCs)	3-4	/HPF	0 - 3
<small>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</small>			



  
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PUS CELLS by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT	2-3	/HPF	0 - 5
EPITHELIAL CELLS by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT	1-2	/HPF	ABSENT
CRYSTALS by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT	NEGATIVE (-ve)		NEGATIVE (-ve)
CASTS by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT	NEGATIVE (-ve)		NEGATIVE (-ve)
BACTERIA by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT	NEGATIVE (-ve)		NEGATIVE (-ve)
OTHERS by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT	NEGATIVE (-ve)		NEGATIVE (-ve)
TRICHOMONAS VAGINALIS (PROTOZOA) by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT	ABSENT		ABSENT

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



  
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