



# P K R JAIN HEALTHCARE INSTITUTE

NASIRPUR, Hissar Road, AMBALA CITY- (Haryana)

## A PIONEER DIAGNOSTIC CENTRE

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

**NAME** : Mrs. RITU  
**AGE/ GENDER** : 50 YRS/FEMALE  
**COLLECTED BY** :  
**REFERRED BY** :  
**BARCODE NO.** : 12506326  
**CLIENT CODE.** : P.K.R JAIN HEALTHCARE INSTITUTE  
**CLIENT ADDRESS** : NASIRPUR, HISSAR ROAD, AMBALA CITY - HARYANA

**PATIENT ID** : 1710691  
**REG. NO./LAB NO.** : 122412280007  
**REGISTRATION DATE** : 28/Dec/2024 12:19 PM  
**COLLECTION DATE** : 28/Dec/2024 12:23PM  
**REPORTING DATE** : 28/Dec/2024 01:58PM

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) <i>by CALORIMETRIC</i>	13.7	gm/dL	12.0 - 16.0
RED BLOOD CELL (RBC) COUNT <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	4.71	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	40.1	%	37.0 - 50.0
MEAN CORPUSCULAR VOLUME (MCV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	85.1	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	29.1	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	34.2	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	13.2	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	42.7	fL	35.0 - 56.0
MENTZERS INDEX <i>by CALCULATED</i>	18.07	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX <i>by CALCULATED</i>	23.86	RATIO	BETA THALASSEMIA TRAIT:<= 65.0 IRON DEFICIENCY ANEMIA: > 65.0

#### WHITE BLOOD CELLS (WBCS)

TOTAL LEUCOCYTE COUNT (TLC) <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	8290	/cmm	4000 - 11000
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#### DIFFERENTIAL LEUCOCYTE COUNT (DLC)

NEUTROPHILS <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	41 <sup>L</sup>	%	50 - 70
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LYMPHOCYTES by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	53 <sup>H</sup>	%	20 - 40
EOSINOPHILS by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	2	%	1 - 6
MONOCYTES by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	4	%	2 - 12
BASOPHILS by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	0	%	0 - 1
<b><u>ABSOLUTE LEUKOCYTES (WBC) COUNT</u></b>			
ABSOLUTE NEUTROPHIL COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	3399	/cmm	2000 - 7500
ABSOLUTE LYMPHOCYTE COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	4394 <sup>L</sup>	/cmm	800 - 4900
ABSOLUTE EOSINOPHIL COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	166	/cmm	40 - 440
ABSOLUTE MONOCYTE COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	332	/cmm	80 - 880
ABSOLUTE BASOPHIL COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	0	/cmm	0 - 110
<b><u>PLATELETS AND OTHER PLATELET PREDICTIVE MARKERS.</u></b>			
PLATELET COUNT (PLT) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	172000	/cmm	150000 - 450000
PLATELETCRIT (PCT) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	0.16	%	0.10 - 0.36
MEAN PLATELET VOLUME (MPV) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	10	fL	6.50 - 12.0
PLATELET LARGE CELL COUNT (P-LCC) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	42000	/cmm	30000 - 90000
PLATELET LARGE CELL RATIO (P-LCR) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	24.4	%	11.0 - 45.0
PLATELET DISTRIBUTION WIDTH (PDW) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	16.1	%	15.0 - 17.0

NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD



  
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BARCODE NO.	: 12506326	REPORTING DATE	: 28/Dec/2024 01:59PM
CLIENT CODE.	: P.K.R JAIN HEALTHCARE INSTITUTE		
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## ERYTHROCYTE SEDIMENTATION RATE (ESR)

ERYTHROCYTE SEDIMENTATION RATE (ESR) **65<sup>H</sup>** 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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## CLINICAL CHEMISTRY/BIOCHEMISTRY

### URIC ACID

URIC ACID: SERUM by URICASE - OXIDASE PEROXIDASE	2.53	mg/dL	2.50 - 6.80
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#### INTERPRETATION:-

1. GOUT occurs when high levels of Uric Acid in the blood cause crystals to form & accumulate around a joint.  
2. Uric Acid is the end product of purine metabolism. Uric acid is excreted to a large degree by the kidneys and to a smaller degree in the intestinal tract by microbial degradation.

#### INCREASED:-

##### (A).DUE TO INCREASED PRODUCTION:-

1. Idiopathic primary gout.
2. Excessive dietary purines (organ meats, legumes, anchovies, etc).
3. Cytolytic treatment of malignancies especially leukemias & lymphomas.
4. Polycythemia vera & myeloid metaplasia.
5. Psoriasis.
6. Sickle cell anaemia etc.

##### (B).DUE TO DECREASED EXCRETION (BY KIDNEYS)

1. Alcohol ingestion.
2. Thiazide diuretics.
3. Lactic acidosis.
4. Aspirin ingestion (less than 2 grams per day).
5. Diabetic ketoacidosis or starvation.
6. Renal failure due to any cause etc.

#### DECREASED:-


##### (A).DUE TO DIETARY DEFICIENCY


1. Dietary deficiency of Zinc, Iron and molybdenum.
2. Fanconi syndrome & Wilson's disease.
3. Multiple sclerosis.
4. Syndrome of inappropriate antidiuretic hormone (SIADH) secretion & low purine diet etc.

##### (B).DUE TO INCREASED EXCRETION

1. Drugs:- Probenecid, sulphinpyrazone, aspirin doses (more than 4 grams per day), corticosteroids and ACTH, anti-coagulants and estrogens etc.



  
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## IMMUNOPATHOLOGY/SEROLOGY

### C-REACTIVE PROTEIN (CRP)

C-REACTIVE PROTEIN (CRP) QUANTITATIVE: **88.89<sup>H</sup>** mg/L 0.0 - 6.0

SERUM

by NEPHLOMETRY

#### INTERPRETATION:

1. C-reactive protein (CRP) is one of the most sensitive acute-phase reactants for inflammation.
2. CRP levels can increase dramatically (100-fold or more) after severe trauma, bacterial infection, inflammation, surgery, or neoplastic proliferation.
3. CRP levels (Quantitative) has been used to assess activity of inflammatory disease, to detect infections after surgery, to detect transplant rejection, and to monitor these inflammatory processes.
4. As compared to ESR, CRP shows an earlier rise in inflammatory disorders which begins in 4-6 hrs, the intensity of the rise being higher than ESR and the recovery being earlier than ESR. Unlike ESR, CRP levels are not influenced by hematologic conditions like Anemia, Polycythemia etc.,
5. Elevated values are consistent with an acute inflammatory process.

#### NOTE:

1. Elevated C-reactive protein (CRP) values are nonspecific and should not be interpreted without a complete clinical history.
2. Oral contraceptives may increase CRP levels.

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



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