



PKR 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	: Mr. VIKAS	PATIENT ID	: 1716404
AGE/ GENDER	: 41 YRS/MALE	REG. NO./LAB NO.	: 122501050001
COLLECTED BY	:	REGISTRATION DATE	: 05/Jan/2025 09:21 AM
REFERRED BY	:	COLLECTION DATE	: 05/Jan/2025 09:32AM
BARCODE NO.	: 12506396	REPORTING DATE	: 05/Jan/2025 11:51AM
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 COMPLETE BLOOD COUNT (CBC)

RED BLOOD CELLS (RBCS) COUNT AND INDICES

HAEMOGLOBIN (HB) <i>by CALORIMETRIC</i>	15	gm/dL	12.0 - 17.0
RED BLOOD CELL (RBC) COUNT <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDEANCE</i>	4.61	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	43	%	40.0 - 54.0
MEAN CORPUSCULAR VOLUME (MCV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	93.3	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	32.5	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	34.8	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	12.8	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	45	fL	35.0 - 56.0
MENTZERS INDEX <i>by CALCULATED</i>	20.24	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX <i>by CALCULATED</i>	25.88	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 & MICROSCOPY</i>	5420	/cmm	4000 - 11000
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DIFFERENTIAL LEUCOCYTE COUNT (DLC)

NEUTROPHILS <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	39 ^L	%	50 - 70
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LYMPHOCYTES <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	54 ^H	%	20 - 40
EOSINOPHILS <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	3	%	1 - 6
MONOCYTES <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	4	%	2 - 12
BASOPHILS <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	0	%	0 - 1
<u>ABSOLUTE LEUKOCYTES (WBC) COUNT</u>			
ABSOLUTE NEUTROPHIL COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	2114	/cmm	2000 - 7500
ABSOLUTE LYMPHOCYTE COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	2927	/cmm	800 - 4900
ABSOLUTE EOSINOPHIL COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	163	/cmm	40 - 440
ABSOLUTE MONOCYTE COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	217	/cmm	80 - 880
ABSOLUTE BASOPHIL COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	0	/cmm	0 - 110
<u>PLATELETS AND OTHER PLATELET PREDICTIVE MARKERS.</u>			
PLATELET COUNT (PLT) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	194000	/cmm	150000 - 450000
PLATELETCRIT (PCT) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	0.23	%	0.10 - 0.36
MEAN PLATELET VOLUME (MPV) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	12	fL	6.50 - 12.0
PLATELET LARGE CELL COUNT (P-LCC) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	79000	/cmm	30000 - 90000
PLATELET LARGE CELL RATIO (P-LCR) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	40.7	%	11.0 - 45.0
PLATELET DISTRIBUTION WIDTH (PDW) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	16.6	%	15.0 - 17.0
NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD			



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ERYTHROCYTE SEDIMENTATION RATE (ESR)

ERYTHROCYTE SEDIMENTATION RATE (ESR)	8	mm/1st hr	0 - 20
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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):

RBCs are normocytic & normochromic.No polychromatic cells or normoblasts seen.

WHITE BLOOD CELLS (WBC'S):

No immature leucocytes seen.

PLATELETS:

Platelets are adequate.

HEMOPARASITES:

NOT SEEN.

IMPRESSION:

Normocytic normochromic picture.



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CLINICAL CHEMISTRY/BIOCHEMISTRY

GLUCOSE RANDOM (R)

GLUCOSE RANDOM (R): PLASMA <i>by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)</i>	112.71	mg/dL	NORMAL: < 140.00 PREDIABETIC: 140.0 - 200.0 DIABETIC: > OR = 200.0
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INTERPRETATION

IN ACCORDANCE WITH AMERICAN DIABETES ASSOCIATION GUIDELINES:

1. A random plasma glucose level below 140 mg/dl is considered normal.
2. A random glucose level between 140 - 200 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 random glucose level of 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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CHOLESTEROL: SERUM

CHOLESTEROL TOTAL: SERUM
by CHOLESTEROL OXIDASE PAP

215.35^H

mg/dL

OPTIMAL: < 200.0
BORDERLINE HIGH: 200.0 - 239.0
HIGH CHOLESTEROL: > OR = 240.0

INTERPRETATION:

NATIONAL LIPID ASSOCIATION RECOMMENDATIONS (NLA-2014)	CHOLESTEROL IN ADULTS (mg/dL)	CHOLESTEROL IN ADULTS (mg/dL)
DESIRABLE	< 200.0	< 170.0
BORDERLINE HIGH	200.0 – 239.0	171.0 – 199.0
HIGH	>= 240.0	>= 200.0

NOTE:

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 National Lipid association - 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.



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LIVER FUNCTION TEST (COMPLETE)

BILIRUBIN TOTAL: SERUM <i>by DIAZOTIZATION, SPECTROPHOTOMETRY</i>	1.06	mg/dL	INFANT: 0.20 - 8.00 ADULT: 0.00 - 1.20
BILIRUBIN DIRECT (CONJUGATED): SERUM <i>by DIAZO MODIFIED, SPECTROPHOTOMETRY</i>	0.35	mg/dL	0.00 - 0.40
BILIRUBIN INDIRECT (UNCONJUGATED): SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	0.71	mg/dL	0.10 - 1.00
SGOT/AST: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	24.58	U/L	7.00 - 45.00
SGPT/ALT: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	31.2	U/L	0.00 - 49.00
AST/ALT RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	0.79	RATIO	0.00 - 46.00
ALKALINE PHOSPHATASE: SERUM <i>by PARA NITROPHENYL PHOSPHATASE BY AMINO METHYL PROPANOL</i>	87.19	U/L	40.0 - 130.0
GAMMA GLUTAMYL TRANSFERASE (GGT): SERUM <i>by SZASZ, SPECTROPHOTOMETRY</i>	28.84	U/L	0.00 - 55.0
TOTAL PROTEINS: SERUM <i>by BIURET, SPECTROPHOTOMETRY</i>	6.79	gm/dL	6.20 - 8.00
ALBUMIN: SERUM <i>by BROMOCRESOL GREEN</i>	4.31	gm/dL	3.50 - 5.50
GLOBULIN: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	2.48	gm/dL	2.30 - 3.50
A : G RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	1.74	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
HEPATOCELLULAR CARCINOMA & CHRONIC HEPATITIS	> 1.3 (Slightly Increased)



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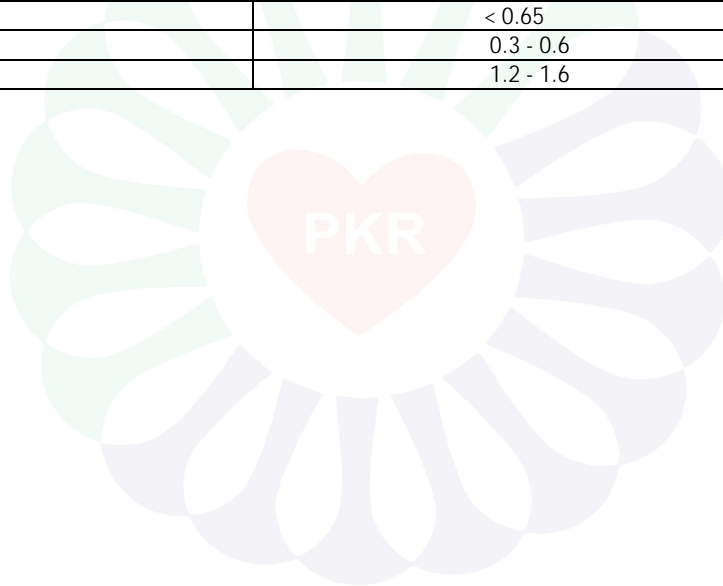
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DECREASED:

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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URIC ACID

URIC ACID: SERUM <i>by URICASE - OXIDASE PEROXIDASE</i>	4.24	mg/dL	3.60 - 7.70
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INTERPRETATION:-

- GOUT occurs when high levels of Uric Acid in the blood cause crystals to form & accumulate around a joint.
- 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:-

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

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

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

DECREASED:-

(A).DUE TO DIETARY DEFICIENCY

- Dietary deficiency of Zinc, Iron and molybdenum.
- Fanconi syndrome & Wilsons disease.
- Multiple sclerosis .
- Syndrome of inappropriate antidiuretic hormone (SIADH) secretion & low purine diet etc.

(B).DUE TO INCREASED EXCRETION

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



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AMYLASE

AMYLASE - SERUM <i>by CNPG 3, SPECTROPHOTOMETRY</i>	35.08	IU/L	0 - 90
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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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AGE/ GENDER	: 41 YRS/MALE	REG. NO./LAB NO.	: 122501050001
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REFERRED BY	:	COLLECTION DATE	: 05/Jan/2025 09:32AM
BARCODE NO.	: 12506396	REPORTING DATE	: 05/Jan/2025 05:31PM
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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LIPASE

LIPASE - SERUM <i>by METHYL RESORUFIN, SPECTROPHOTOMETRY</i>	22.72	U/L	0 - 60
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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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