



# 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** : 29 YRS/FEMALE  
**COLLECTED BY** :  
**REFERRED BY** :  
**BARCODE NO.** : 12506436  
**CLIENT CODE.** : P.K.R JAIN HEALTHCARE INSTITUTE  
**CLIENT ADDRESS** : NASIRPUR, HISSAR ROAD, AMBALA CITY - HARYANA

**PATIENT ID** : 1718424  
**REG. NO./LAB NO.** : 122501070017  
**REGISTRATION DATE** : 07/Jan/2025 03:32 PM  
**COLLECTION DATE** : 07/Jan/2025 03:37PM  
**REPORTING DATE** : 07/Jan/2025 08:45PM

Test Name	Value	Unit	Biological Reference interval
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## SWASTHYA WELLNESS PANEL: 1.0 COMPLETE BLOOD COUNT (CBC)

### RED BLOOD CELLS (RBCS) COUNT AND INDICES

HAEMOGLOBIN (HB) <i>by CALORIMETRIC</i>	8.1 <sup>L</sup>	gm/dL	12.0 - 16.0
RED BLOOD CELL (RBC) COUNT <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	3.24 <sup>L</sup>	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	24.6 <sup>L</sup>	%	37.0 - 50.0
MEAN CORPUSCULAR VOLUME (MCV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	76.1 <sup>L</sup>	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	24.9 <sup>L</sup>	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	32.8	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	16.9 <sup>H</sup>	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	48.5	fL	35.0 - 56.0
MENTZERS INDEX <i>by CALCULATED</i>	23.49	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX <i>by CALCULATED</i>	39.54	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>	8140	/cmm	4000 - 11000
NUCLEATED RED BLOOD CELLS (nRBCS) <i>by AUTOMATED 6 PART HEMATOLOGY ANALYZER</i>	NIL		0.00 - 20.00
NUCLEATED RED BLOOD CELLS (nRBCS) % <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	NIL	%	< 10 %



  
DR.VINAY CHOPRA  
CONSULTANT PATHOLOGIST  
MBBS, MD (PATHOLOGY & MICROBIOLOGY)

  
DR.YUGAM CHOPRA  
CONSULTANT PATHOLOGIST  
MBBS, MD (PATHOLOGY)





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## DIFFERENTIAL LEUCOCYTE COUNT (DLC)

NEUTROPHILS by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	63	%	50 - 70
LYMPHOCYTES by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	28	%	20 - 40
EOSINOPHILS by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	3	%	1 - 6
MONOCYTES by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	6	%	2 - 12
BASOPHILS by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	0	%	0 - 1

## ABSOLUTE LEUKOCYTES (WBC) COUNT

ABSOLUTE NEUTROPHIL COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	5128	/cmm	2000 - 7500
ABSOLUTE LYMPHOCYTE COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	2279 <sup>L</sup>	/cmm	800 - 4900
ABSOLUTE EOSINOPHIL COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	244	/cmm	40 - 440
ABSOLUTE MONOCYTE COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	488	/cmm	80 - 880
ABSOLUTE BASOPHIL COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	0	/cmm	0 - 110


## PLATELETS AND OTHER PLATELET PREDICTIVE MARKERS.

PLATELET COUNT (PLT) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	161000	/cmm	150000 - 450000
PLATELETCRIT (PCT) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	0.18	%	0.10 - 0.36
MEAN PLATELET VOLUME (MPV) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	11	fL	6.50 - 12.0
PLATELET LARGE CELL COUNT (P-LCC) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	64000	/cmm	30000 - 90000
PLATELET LARGE CELL RATIO (P-LCR) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	39.5	%	11.0 - 45.0
PLATELET DISTRIBUTION WIDTH (PDW) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	16	%	15.0 - 17.0

NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD



  
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## ERYTHROCYTE SEDIMENTATION RATE (ESR)

ERYTHROCYTE SEDIMENTATION RATE (ESR) **88<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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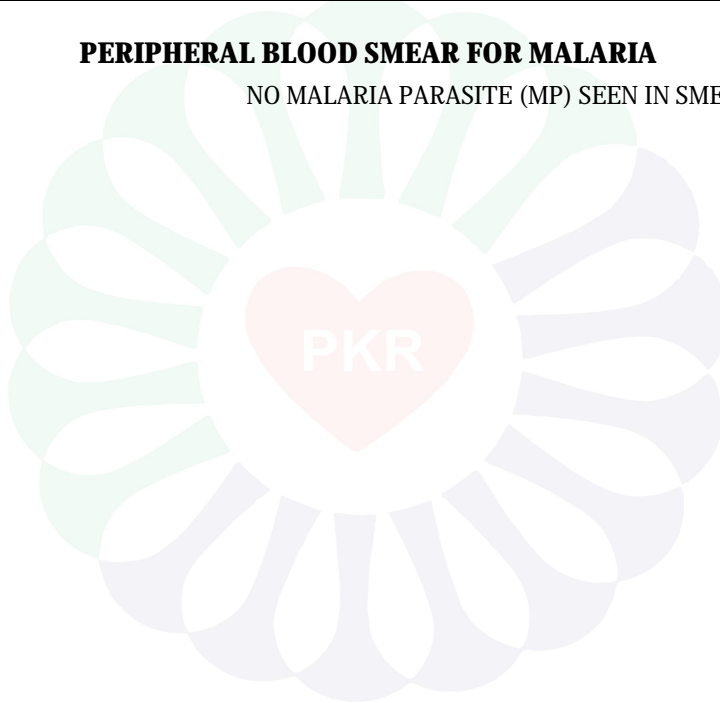
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## PERIPHERAL BLOOD SMEAR FOR MALARIA

PERIPHERAL BLOOD SMEAR  
FOR MALARIAL PARASITE (MP)  
by MICROSCOPY

NO MALARIA PARASITE (MP) SEEN IN SMEAR EXAMINED



  
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## COMPLEMENT COMPONENT - C3

COMPLEMENT COMPONENT - C3 95.63 mg/dL 90.0 - 180.0  
by NEPHLOMETRY

### INTERPRETATION:-

C3 plays a central role in the activation of complement system. Its activation is required for both classical and alternative complement activation pathways. People with C3 deficiency are susceptible to bacterial infections.

Low levels indicate activation by one or both pathways.

Complement C3 levels may be useful in following the activity of immune complex diseases as most of them show decreased C3 levels.

In the classical pathway, C3-convertase, known as C4b2a, catalyzes the proteolytic cleavage of C3 into C3a and C3b. While in the alternative pathway this effect is induced by C3bBb. C3a is an anaphylotoxin and the precursor of some cytokines such as ASP, and C3b serves as an opsonizing agent. Factor I can cleave C3b into C3c and C3d, the latter of which plays a role in enhancing B cell responses.

Measurement of serum C3 levels are used in the assessment of children suffering from repeated severe bacterial infections and in the work up of some types of kidney disease such as post-infectious glomerulonephritis and shunt nephritis.

**INCREASED IN** - many inflammatory conditions as an acute-phase reactant, active phase of rheumatic diseases (eg, rheumatoid arthritis, SLE), acute viral hepatitis, myocardial infarction, cancer, diabetes mellitus, pregnancy, sarcoidosis, amyloidosis, thyroiditis.

**DECREASED BY** - decreased synthesis (protein malnutrition, congenital deficiency, severe liver disease), increased catabolism (immune complex disease, membranoproliferative glomerulonephritis [75%], SLE, SjAgren syndrome, rheumatoid arthritis, DIC, paroxysmal nocturnal hemoglobinuria, autoimmune hemolytic anemia, gram-negative bacteremia), increased loss (burns, gastroenteropathies).



  
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## COMPLEMENT COMPONENT - C4

COMPLEMENT COMPONENT - C4 15.2 mg/dL 9.0 - 36.0  
by NEPHLOMETRY

### INTERPRETATION

C4 is a component of the classic complement pathway. Depressed levels usually indicate classic pathway activation. Low C4 accompanies acute attacks of hereditary angioedema (HAE), and C4 is used as a first-line test for the disease. C1 esterase inhibitor levels are not indicated for the evaluation of hereditary HAE unless C4 is low.

#### INCREASED:


1. Various malignancies (not clinically useful).

#### DECREASED:

1. Decreased synthesis (congenital deficiency),
2. Increased catabolism (SLE, rheumatoid arthritis, proliferative glomerulonephritis, HAE
3. Increased loss (burns, protein-losing enteropathies).



  
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TEST PERFORMED AT KOS DIAGNOSTIC LAB, AMBALA CANTT.

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## CLINICAL CHEMISTRY/BIOCHEMISTRY

### GLUCOSE FASTING (F)

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

85.8

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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<b>LIPID PROFILE : BASIC</b>			
CHOLESTEROL TOTAL: SERUM <i>by CHOLESTEROL OXIDASE PAP</i>	188.42	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>	209.54 <sup>H</sup>	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>	30.39	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>	116.12	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>	158.03 <sup>H</sup>	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>	41.91	mg/dL	0.00 - 45.00
TOTAL LIPIDS: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	586.38	mg/dL	350.00 - 700.00
CHOLESTEROL/HDL RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	6.2 <sup>H</sup>	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>	3.82 <sup>H</sup>	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>	6.9 <sup>H</sup>	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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**A PIONEER DIAGNOSTIC CENTRE**

☎ 0171-2532620, 8222896961

✉ pkrjainhealthcare@gmail.com

**NAME** : Mrs. RITU  
**AGE/ GENDER** : 29 YRS/FEMALE  
**COLLECTED BY** :  
**REFERRED BY** :  
**BARCODE NO.** : 12506436  
**CLIENT CODE.** : P.K.R JAIN HEALTHCARE INSTITUTE  
**CLIENT ADDRESS** : NASIRPUR, HISSAR ROAD, AMBALA CITY - HARYANA

**PATIENT ID** : 1718424  
**REG. NO./LAB NO.** : 122501070017  
**REGISTRATION DATE** : 07/Jan/2025 03:32 PM  
**COLLECTION DATE** : 07/Jan/2025 03:37PM  
**REPORTING DATE** : 07/Jan/2025 09:42PM

Test Name	Value	Unit	Biological Reference interval
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## LIVER FUNCTION TEST (COMPLETE)

BILIRUBIN TOTAL: SERUM <i>by DIAZOTIZATION, SPECTROPHOTOMETRY</i>	0.33	mg/dL	INFANT: 0.20 - 8.00 ADULT: 0.00 - 1.20
BILIRUBIN DIRECT (CONJUGATED): SERUM <i>by DIAZO MODIFIED, SPECTROPHOTOMETRY</i>	0.11	mg/dL	0.00 - 0.40
BILIRUBIN INDIRECT (UNCONJUGATED): SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	0.22	mg/dL	0.10 - 1.00
SGOT/AST: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	16.8	U/L	7.00 - 45.00
SGPT/ALT: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	12.3	U/L	0.00 - 49.00
AST/ALT RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	1.37	RATIO	0.00 - 46.00
ALKALINE PHOSPHATASE: SERUM <i>by PARA NITROPHENYL PHOSPHATASE BY AMINO METHYL PROPANOL</i>	98.42	U/L	40.0 - 130.0
GAMMA GLUTAMYL TRANSFERASE (GGT): SERUM <i>by SZASZ, SPECTROPHOTOMETRY</i>	18.44	U/L	0.00 - 55.0
TOTAL PROTEINS: SERUM <i>by BIURET, SPECTROPHOTOMETRY</i>	<b>5.94<sup>L</sup></b>	gm/dL	6.20 - 8.00
ALBUMIN: SERUM <i>by BROMOCRESOL GREEN</i>	<b>2.55<sup>L</sup></b>	gm/dL	3.50 - 5.50
GLOBULIN: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	3.39	gm/dL	2.30 - 3.50
A : G RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	<b>0.75<sup>L</sup></b>	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)



  
DR.VINAY CHOPRA  
CONSULTANT PATHOLOGIST  
MBBS, MD (PATHOLOGY & MICROBIOLOGY)

  
DR.YUGAM CHOPRA  
CONSULTANT PATHOLOGIST  
MBBS, MD (PATHOLOGY)





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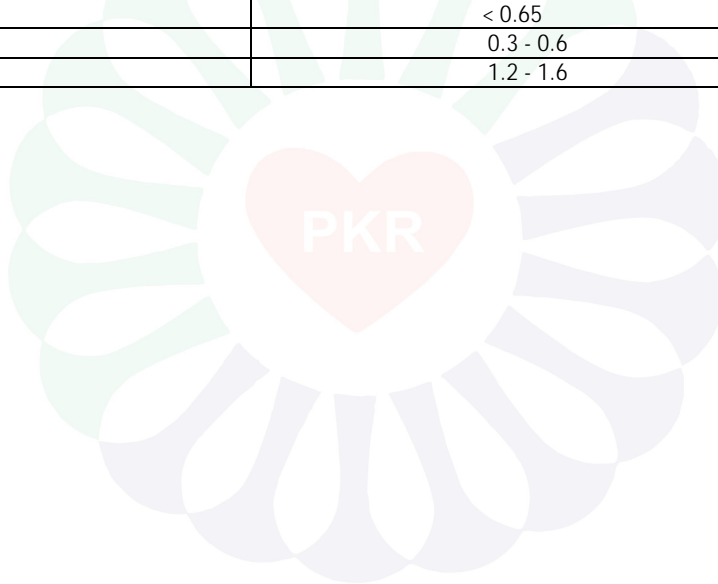
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**DECREASED:**

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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TEST PERFORMED AT KOS DIAGNOSTIC LAB, AMBALA CANTT.

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## KIDNEY FUNCTION TEST (COMPLETE)

UREA: SERUM by UREASE - GLUTAMATE DEHYDROGENASE (GLDH)	35.44	mg/dL	10.00 - 50.00
CREATININE: SERUM by ENZYMATIC, SPECTROPHOTOMETRY	<b>1.26<sup>H</sup></b>	mg/dL	0.40 - 1.20
BLOOD UREA NITROGEN (BUN): SERUM by CALCULATED, SPECTROPHOTOMETRY	16.56	mg/dL	7.0 - 25.0
BLOOD UREA NITROGEN (BUN)/CREATININE RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	13.14	RATIO	10.0 - 20.0
UREA/CREATININE RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	28.13	RATIO	
URIC ACID: SERUM by URICASE - OXIDASE PEROXIDASE	6.31	mg/dL	2.50 - 6.80
CALCIUM: SERUM by ARSENAZO III, SPECTROPHOTOMETRY	8.91	mg/dL	8.50 - 10.60
PHOSPHOROUS: SERUM by PHOSPHOMOLYBDATE, SPECTROPHOTOMETRY	3.35	mg/dL	2.30 - 4.70

## ELECTROLYTES

SODIUM: SERUM by ISE (ION SELECTIVE ELECTRODE)	144.4	mmol/L	135.0 - 150.0
POTASSIUM: SERUM by ISE (ION SELECTIVE ELECTRODE)	4.84	mmol/L	3.50 - 5.00
CHLORIDE: SERUM by ISE (ION SELECTIVE ELECTRODE)	108.3	mmol/L	90.0 - 110.0

## ESTIMATED GLOMERULAR FILTRATION RATE

ESTIMATED GLOMERULAR FILTRATION RATE (eGFR): SERUM by CALCULATED	59.3
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## ADVICE

### INTERPRETATION:


To differentiate between pre- and post renal 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.

## KINDLY CORRELATE CLINICALLY



  
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- Catabolic states with increased tissue breakdown.
- GI haemorrhage.
- High protein intake.
- Impaired renal function plus
- Excess protein intake or production or tissue breakdown (e.g. infection, GI bleeding, thyrotoxicosis, Cushing's syndrome, high protein diet, burns, surgery, cachexia, high fever).
- Urine reabsorption (e.g. ureter colostomy)
- Reduced muscle mass (subnormal creatinine production)
- Certain drugs (e.g. tetracycline, glucocorticoids)

#### INCREASED RATIO (>20:1) WITH ELEVATED CREATININE LEVELS:

- Postrenal azotemia (BUN rises disproportionately more than creatinine) (e.g. obstructive uropathy).
- Prerenal azotemia superimposed on renal disease.

#### DECREASED RATIO (<10:1) WITH DECREASED BUN :

- Acute tubular necrosis.
- Low protein diet and starvation.
- Severe liver disease.
- Other causes of decreased urea synthesis.
- Repeated dialysis (urea rather than creatinine diffuses out of extracellular fluid).
- Inherited hyperammonemias (urea is virtually absent in blood).
- SIADH (syndrome of inappropriate antidiuretic hormone) due to tubular secretion of urea.
- Pregnancy.

#### DECREASED RATIO (<10:1) WITH INCREASED CREATININE:

- Phenacimide therapy (accelerates conversion of creatine to creatinine).
- Rhabdomyolysis (releases muscle creatinine).
- Muscular patients who develop renal failure.

#### INAPPROPRIATE RATIO:

- Diabetic ketoacidosis (acetoacetate causes false increase in creatinine with certain methodologies, resulting in normal ratio when dehydration should produce an increased BUN/creatinine ratio).
- Cephalosporin therapy (interferes with creatinine measurement).

#### ESTIMATED GLOMERULAR FILTRATION RATE:

CKD STAGE	DESCRIPTION	GFR ( mL/min/1.73m2 )	ASSOCIATED FINDINGS
G1	Normal kidney function	>90	No proteinuria
G2	Kidney damage with normal or high GFR	>90	Presence of Protein , Albumin or cast in urine
G3a	Mild decrease in GFR	60 -89	
G3b	Moderate decrease in GFR	30-59	
G4	Severe decrease in GFR	15-29	
G5	Kidney failure	<15	



  
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#### COMMENTS:

1. Estimated Glomerular filtration rate (eGFR) is the sum of filtration rates in all functioning nephrons and so an estimation of the GFR provides a measure of functioning nephrons of the kidney.
2. eGFR calculated using the 2009 CKD-EPI creatinine equation and GFR category reported as per KDIGO guideline 2012
3. In patients, with eGFR creatinine between 45-59 ml/min/1.73 m<sup>2</sup> (G3) and without any marker of Kidney damage, It is recommended to measure eGFR with Cystatin C for confirmation of CKD
4. eGFR category G1 OR G2 does not fulfill the criteria for CKD, in the absence of evidence of Kidney Damage
5. In a suspected case of Acute Kidney Injury (AKI), measurement of eGFR should be done after 48-96 hours of any Intervention or procedure
6. eGFR calculated by Serum Creatinine may be less accurate due to certain factors like Race, Muscle Mass, Diet, Certain Drugs. In such cases, eGFR should be calculated using Serum Cystatin C
7. **A decrease in eGFR implies either progressive renal disease, or a reversible process causing decreased nephron function (eg, severe dehydration).**

#### ADVICE:

KDIGO guideline, 2012 recommends Chronic Kidney Disease (CKD) should be classified based on cause, eGFR category and Albuminuria (ACR) category. GFR & ACR category combined together reflect risk of progression and helps Clinician to identify the individual who are progressing at more rapid rate than anticipated



  
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## CREATININE PHOSPHOKINASE (CPK-NAC) TOTAL

CREATININE PHOSPHO KINASE (CPK-NAC) 24.43 IU/L 24 - 190  
by SPECTROPHOTOMETRY

### Interpretation:-

- 1.Serum creatine kinase (CK) activity is greatly elevated, at some time during the course of the disease, in all types of muscular dystrophy, and especially so in Duchenne type, in which levels up to 50 times the upper limit of normal may be encountered.
- 2.In progressive muscular dystrophy, enzyme activity in serum is highest in infancy and childhood (7-10 years of age) and may be elevated long before the disease is clinically apparent.
- 3.Quite high values of CK are noted in viral myositis, polymyositis, and similar muscle diseases.
- 4.However, in neurogenic Parkinsonism, serum enzyme activity is normal. Very high activity is also encountered in malignant hyperthermia.


### Significance:-

- 1.An early rise in CK is also seen after an acute MI, with values peaking at 12 to 24 hours and falling back to normal in 3 to 4 days.
- 2.Although total CK activity has been used as a diagnostic test for MI, it has been replaced by the troponin T and I immunoassays, and is no longer the laboratory test choice for diagnosing and monitoring acute infarctions.
- 3.Serum CK activity may increase in patients with acute cerebrovascular disease or neurosurgical intervention and with cerebral ischemia.
- 4.Serum CK activity also demonstrates an inverse relationship with thyroid activity. About 60% of hypothyroid subjects show an average elevation of CK activity 5-fold over the upper reference limit; elevation of as high as 50-fold may also be found.

**Note:** Exercise and muscle trauma (contact sports, traffic accidents, intramuscular injections, surgery, convulsions, wasp or bee stings, and burns) can elevate serum creatine kinase values.



  
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## LACTATE DEHYDROGENASE (LDH): SERUM

LACTATE DEHYDROGENASE (LDH): SERUM **486.9<sup>H</sup>** U/L 225.0 - 450.0  
by BASED ON SCE, SPECTROPHOTOMETRY

### INTERPRETATION:-

- 1.Lactate dehydrogenase (LDH) activity is present in all cells of the body with highest concentrations in heart, liver, muscle, kidney, lung, and erythrocytes.
- 2.The test can be used for monitoring changes in tumor burden after chemotherapy, although, lactate dehydrogenase elevations in patients with cancer are too erratic to be of use in the diagnosis of cancer

### INCREASED (MARKED) :-

- 1.Megaloblastic anemia.
- 2.Untreated pernicious anemia.
- 3.Hodgkins disease.
- 4.Abdominal and lung cancers.
- 5.Severe shock.
- 6.Hypoxia.

### INCREASED (MODERATE):-

- 1.Myocardial infarction (MI).
- 2.Pulmonary infarction and pulmonary embolism.
- 3.Leukemia.
- 4.Hemolytic anemia.
- 5.Infectious mononucleosis.
- 6.Progressive muscular dystrophy (especially in the early and middle stages of the disease)
- 7.Liver disease and renal disease.

### NOTE:-

- 1.In liver disease, elevations of LDH are not as great as the increases in aspartate amino transferase (AST) and alanine aminotransferase (ALT).
- 2.Serum LDH may be falsely elevated in otherwise healthy individuals which can be due to mechanical destruction of RBCs. Therefore, Possibility of mechanical errors (Transportation or vigorous shaking) should always be ruled out.



  
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## IMMUNOPATHOLOGY/SEROLOGY

### HEPATITIS C VIRUS (HCV) ANTIBODIES SCREENING

HEPATITIS C ANTIBODY (HCV) TOTAL  
RESULT NON - REACTIVE  
by IMMUNOCHROMATOGRAPHY

#### 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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## C-REACTIVE PROTEIN (CRP)

C-REACTIVE PROTEIN (CRP) QUANTITATIVE: SERUM by NEPHLOMETRY	24 <sup>H</sup>	mg/L	0.0 - 6.0
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### 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.



  
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## DENGUE FEVER COMBO SCREENING - (NS1 ANTIGEN, IgG AND IgM)

DENGUE NS1 ANTIGEN - SCREENING by ICT (IMMUNOCHROMATOGRAPHY)	NEGATIVE (-ve)		NEGATIVE (-ve)
DENGUE ANTIBODY IgG - SCREENING by ICT (IMMUNOCHROMATOGRAPHY)	NEGATIVE (-ve)		NEGATIVE (-ve)
DENGUE ANTIBODY IgM - SCREENING by ICT (IMMUNOCHROMATOGRAPHY)	NEGATIVE (-ve)		NEGATIVE (-ve)

### INTERPRETATION:-

- 1.This is a solid phase immunochromatographic ELISA test for the qualitative detection of the specific IgG and IgM antibodies against the Dengue virus.
- 2.The IgM antibodies take a minimum of 5-10 days in primary infection and 4-5 days in secondary infections to test positive and hence are suitable for the diagnosis of dengue fever only when the fever is approximately one week old.
- 3.The IgG antibodies develop at least two weeks after exposure to primary infection and subsequently remain positive for the rest of the life. A positive result is incapable of differentiating a current infection from a past infection.
- 4.The Dengue NS-1 antigen test is most suited for early diagnosis (within the first week of exposure).



  
DR.VINAY CHOPRA  
CONSULTANT PATHOLOGIST  
MBBS, MD (PATHOLOGY & MICROBIOLOGY)

  
DR.YUGAM CHOPRA  
CONSULTANT PATHOLOGIST  
MBBS, MD (PATHOLOGY)







# 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** : 29 YRS/FEMALE  
**COLLECTED BY** :  
**REFERRED BY** :  
**BARCODE NO.** : 12506436  
**CLIENT CODE.** : P.K.R JAIN HEALTHCARE INSTITUTE  
**CLIENT ADDRESS** : NASIRPUR, HISSAR ROAD, AMBALA CITY - HARYANA

**PATIENT ID** : 1718424  
**REG. NO./LAB NO.** : 122501070017  
**REGISTRATION DATE** : 07/Jan/2025 03:32 PM  
**COLLECTION DATE** : 07/Jan/2025 03:37PM  
**REPORTING DATE** : 07/Jan/2025 09:49PM

Test Name	Value	Unit	Biological Reference interval
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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.



  
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CONSULTANT PATHOLOGIST  
MBBS, MD (PATHOLOGY & MICROBIOLOGY)

  
DR.YUGAM CHOPRA

CONSULTANT PATHOLOGIST  
MBBS, MD (PATHOLOGY)





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**REPORTING DATE** : 09/Jan/2025 11:05AM

Test Name	Value	Unit	Biological Reference interval
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## ANTI dsDNA ANTIBODIES (QUANTITATIVE)

ANTI dsDNA ANTIBODIES (QUANTITATIVE)  
by ELISA (ENZYME-LINKED IMMUNOSORBENT ASSAY)

4.98<sup>H</sup>

AI

NEGATIVE: < 0.9  
POSITIVE: > 0.9


### INTERPRETATION: NOTE


1. Autoimmune reactivities are not by themselves diagnostic, but must be correlated with other laboratory & clinical findings

### COMMENTS

1. Anti ds-DNA antibodies are detected more frequently and at higher titres in Systemic lupus erythematosus (SLE) patients with Lupus nephritis.
2. Presence of these antibodies or an increase in titre correlate with an increased risk of Lupus nephritis flare. Hence it is useful to monitor Anti ds -DNA antibody levels and initiate appropriate therapy when titres increase.



  
DR.VINAY CHOPRA  
CONSULTANT PATHOLOGIST  
MBBS, MD (PATHOLOGY & MICROBIOLOGY)

  
DR.YUGAM CHOPRA  
CONSULTANT PATHOLOGIST  
MBBS, MD (PATHOLOGY)





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## TROPONIN T (QUALITATIVE)

TROPONIN T: BLOOD  
by IMMUNOCHROMATOGRAPHY

NEGATIVE (-ve)

### INTERPRETATION:

#### NOTE:

- 1.False positive results can be seen in the presence of Rheumatoid factor and heterophile antibodies.
2. Due to the release kinetics of cardiac troponin T, an initial test result < 99<sup>th</sup> percentile within the initial hours of onset of symptoms does not rule out Myocardial Infarction with certainty. If MI is still suspected, repeat the test 3 hours after initial assessment.

#### COMMENTS:

- 1.Cardiac Troponin is a cardiospecific, highly sensitive marker of myocardial damage, but is also expressed by diseased skeletal muscle.
- 2.The most common cause of cardiac injury is myocardial ischemia, ie, acute myocardial infarction. Troponin T becomes elevated 2 to 4 hours after the onset of myocardial necrosis, and can remain elevated for up to 14 days.
- 3.Elevations in troponin T are also seen in patients with unstable angina. The finding of unstable angina and an elevated troponin T are known to have adverse short- and long-term prognosis, as well as a unique beneficial response to an invasive interventional strategy and treatment with the newer antiplatelet agents and low-molecular-weight heparin.

#### CARDIAC CAUSES LEADING TO INCREASED LEVELS:

- 1.Congestive Heart Failure
- 2.Cardiomyopathy
- 3.Myocarditis,
- 4.Heart contusion
- 5.Interventional therapy like cardiac surgery and drug induced cardiotoxicity

#### NON CARDIAC CAUSES LEADING TO INCREASED LEVELS:

- 1.Renal Failure
- 2.Lung embolism
- 3.Non-cardiac surgery
- 4.Rhabdomyolysis
- 5.Polymyositis
- 6.Stroke & Left Ventricular dysfunction in Septic shock

#### THE TEST IS USEFUL IN FOLLOWING CONDITIONS:

- 1.Exclusion diagnosis of acute myocardial infarction
- 2.Monitoring acute coronary syndromes and estimating prognosis
- 3.Possible utility in monitoring patients with non-ischemic causes of cardiac injury.



DR.VINAY CHOPRA  
CONSULTANT PATHOLOGIST  
MBBS, MD (PATHOLOGY & MICROBIOLOGY)

DR.YUGAM CHOPRA  
CONSULTANT PATHOLOGIST  
MBBS, MD (PATHOLOGY)





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Test Name	Value	Unit	Biological Reference interval
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## CLINICAL PATHOLOGY

### URINE ROUTINE & MICROSCOPIC EXAMINATION

#### PHYSICAL EXAMINATION

QUANTITY RECEIVED	10	ml	
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
COLOUR	PALE YELLOW		PALE YELLOW
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
TRANSPARANCY	HAZY		CLEAR
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
SPECIFIC GRAVITY	1.02		1.002 - 1.030
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			

#### CHEMICAL EXAMINATION


REACTION	ACIDIC		
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
PROTEIN	3+		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
SUGAR	Negative		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
pH	6		5.0 - 7.5
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
BILIRUBIN	Negative		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
NITRITE	Negative		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
UROBILINOGEN	Normal	EU/dL	0.2 - 1.0
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
KETONE BODIES	Negative		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
BLOOD	1+		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
ASCORBIC ACID	NEGATIVE (-ve)		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			

#### MICROSCOPIC EXAMINATION

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



  
DR.VINAY CHOPRA  
CONSULTANT PATHOLOGIST  
MBBS, MD (PATHOLOGY & MICROBIOLOGY)

  
DR.YUGAM CHOPRA  
CONSULTANT PATHOLOGIST  
MBBS, MD (PATHOLOGY)







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Test Name	Value	Unit	Biological Reference interval
PUS CELLS by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT	5-7	/HPF	0 - 5
EPITHELIAL CELLS by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT	4-6	/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



  
DR.VINAY CHOPRA  
CONSULTANT PATHOLOGIST  
MBBS, MD (PATHOLOGY & MICROBIOLOGY)

  
DR.YUGAM CHOPRA  
CONSULTANT PATHOLOGIST  
MBBS, MD (PATHOLOGY)





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**REPORTING DATE** : 10/Jan/2025 10:59PM

Test Name	Value	Unit	Biological Reference interval
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## PROTEINS: 24 HOURS URINE

URINE VOLUME: 24 HOUR  
by SPECTROPHOTOMETRY  
2000 mL

PROTEINS: 24 HOURS URINE  
by BIURET, SPECTROPHOTOMETRY  
5234.2<sup>H</sup> mg/ 24 HOURS 25 -160

### INTERPRETATION:


TYPES OF PROTEINURIA	TOTAL PROTEINS IN mg/24 HOURS	CONDITIONS
MINIMAL PROTEINURIA:	150 - 500 mg/24 hours	Chronic pyelonephritis, Chronic Interstitial Nephritis, Renal Tubular disease, Postural
MODERATE PROTEINURIA:	500 - 1000 mg/24 hours	Nephrosclerosis, Multiple Myeloma, Toxic Nephropathy, Renal Calculi
HEAVY PROTEINURIA:	1000 - 3000 mg/24 hours	Nephrotic Syndrome, Acute Rapidly Progressive & Chronic Glomerulonephritis, Diabetes mellitus, Lupus erythematosus, Drugs like Pencillamine, Heavy metals like Gold & Mercury.

**NOTE:**  
1.Excretion of total protein in individuals is highly variable with or without kidney disease.  
2.Conditions affecting protein excretion other than kidney disease are urinary tract infection, diet, menstruation & physical activity.

**COMMENT:**  
1.Diagnosis of kidney disease and response to therapy is usually obtained by quantitatively analyzing the amount of protein excreted in urine over a 24 hour period.



  
DR.VINAY CHOPRA  
CONSULTANT PATHOLOGIST  
MBBS, MD (PATHOLOGY & MICROBIOLOGY)

  
DR.YUGAM CHOPRA  
CONSULTANT PATHOLOGIST  
MBBS, MD (PATHOLOGY)





# P K R JAIN HEALTHCARE INSTITUTE

NASIRPUR, Hissar Road, AMBALA CITY- (Haryana)

**A PIONEER DIAGNOSTIC CENTRE**

☎ 0171-2532620, 8222896961 ✉ [pkrajainhealthcare@gmail.com](mailto:pkrajainhealthcare@gmail.com)

NAME	: Mrs. RITU	PATIENT ID	: 1718424
AGE/ GENDER	: 29 YRS/FEMALE	REG. NO./LAB NO.	: 122501070017
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## MICROBIOLOGY

### CULTURE AEROBIC BACTERIA AND ANTIBIOTIC SENSITIVITY: URINE

#### CULTURE AND SUSCEPTIBILITY: URINE

DATE OF SAMPLE	07-01-2025
SPECIMEN SOURCE	URINE
INCUBATION PERIOD	48 HOURS
by AUTOMATED BROTH CULTURE	
CULTURE	STERILE
by AUTOMATED BROTH CULTURE	
ORGANISM	NO AEROBIC PYOGENIC ORGANISM GROWN AFTER 48 HOURS OF
by AUTOMATED BROTH CULTURE	INCUBATION AT 37°C

#### AEROBIC SUSCEPTIBILITY: URINE

##### INTERPRETATION:

1. In urine culture and sensitivity, presence of more than 100,000 organism per mL in midstream sample of urine is considered clinically significant. However in symptomatic patients, a smaller number of bacteria (100 to 10000/mL) may signify infection.

2. Colony count of 100 to 10000/ mL indicate infection, if isolate from specimen obtained by suprapubic aspiration or "in-and-out" catheterization or from patients with indwelling catheters.

##### SUSCEPTIBILITY:

1. A test interpreted as **SENSITIVE** implies that infection due to isolate may be appropriately treated with the dosage of an antimicrobial agent recommended for that type of infection and infecting species, unless otherwise indicated..

2. A test interpreted as **INTERMEDIATE** implies that the "infection due to the isolate may be appropriately treated in body sites where the drugs are physiologically concentrated or when a high dosage of drug can be used".


3. A test interpreted as **RESISTANT** implies that the "isolates are not inhibited by the usually achievable concentration of the agents with normal dosage, schedule and/or fall in the range where specific microbial resistance mechanism are likely (e.g. beta-lactamases), and clinical efficacy has not been reliable in treatment studies.


##### CAUTION:

Conditions which can cause a false Negative culture:

1. Patient is on antibiotics. Please repeat culture post therapy.
2. Anaerobic bacterial infection.
3. Fastidious aerobic bacteria which are not able to grow on routine culture media.
4. Besides all these factors, at least in 25-40 % of cases there is no direct correlation between in vivo clinical picture.
5. Renal tuberculosis to be confirmed by AFB studies.



  
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CONSULTANT PATHOLOGIST  
MBBS, MD (PATHOLOGY & MICROBIOLOGY)

  
DR.YUGAM CHOPRA  
CONSULTANT PATHOLOGIST  
MBBS, MD (PATHOLOGY)





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Test Name	Value	Unit	Biological Reference interval
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## CULTURE AEROBIC BACTERIA AND ANTIBIOTIC SENSITIVITY (CONVENTIONAL): BLOOD

### BLOOD CULTURE AND SUSCEPTIBILITY

DATE OF SAMPLE	07-01-2025
SPECIMEN SOURCE	BLOOD
INCUBATION PERIOD	5 DAYS
CULTURE	STERILE

by AUTOMATED BROTH CULTURE

ORGANISM

by AUTOMATED BROTH CULTURE

NO AEROBIC PYOGENIC ORGANISM GROWN AFTER 5 DAYS OF INCUBATION AT 37°C

### AEROBIC SUSCEPTIBILITY BLOOD

#### INTERPRETATION

#### SUSCEPTIBILITY:

1. A test interpreted as **SENSITIVE** implies that infection due to isolate may be appropriately treated with the dosage of an antimicrobial agent recommended for that type of infection and infecting species, unless otherwise indicated.
2. A test interpreted as **INTERMEDIATE** implies that the "Infection due to the isolate may be appropriately treated in body sites where the drugs are physiologically concentrated or when a high dosage of drug can be used".
3. A test interpreted as **RESISTANT** implies that the "isolates are not inhibited by the usually achievable concentration of the agents with normal dosage, schedule and/or fall in the range where specific microbial resistance mechanism are likely (e.g. beta-lactamases), and clinical efficacy has not been reliable in treatment studies.

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CONSULTANT PATHOLOGIST  
MBBS, MD (PATHOLOGY & MICROBIOLOGY)

DR.YUGAM CHOPRA  
CONSULTANT PATHOLOGIST  
MBBS, MD (PATHOLOGY)







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Test Name	Value	Unit	Biological Reference interval
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## SPECIAL INVESTIGATIONS

### N-TERMINAL PRO B TYPE NATRIURETIC PEPTIDE (NT-PRO BNP)

N-TERMINAL PRO B TYPE NATRIURETIC PEPTIDE (NT-PRO BNP) 283 pg/mL < 300

by ELFA (ENZYME LINKED FLOURESCENT ASSAY)

#### INTERPRETATION:

#### AGE AND CONDITION RELATED CUT OFF VALUES FOR NT-PRO BNP

IN ACUTE HEART FAILURE		
AGE (Years)	UNITS (pg/mL)	OPTIMAL CUT OFF VALUE
< 50	pg/mL	450
50 - 75	pg/mL	900
>75	pg/mL	1800
IN CHRONIC HEART FAILURE		
< 75	pg/mL	125
>75	pg/mL	450
NEGATIVE PREDICTIVE VALUE CUT OFF FOR NT-PRO BNP: < 300 pg/ml (HEART FAILURE UNLIKELY)		

The N-terminal of the prohormone brain natriuretic peptide (NT-proBNP), is a 76 amino acid terminal inactive protein that is cleaved from proBNP to release brain natriuretic peptide.

The main physiological function of NP is homeostasis and protection of among others the cardiovascular (CV) system from the effects of volume overload. They play an important role in regulating blood pressure (BP) and body fluid volume by their natriuretic and diuretic actions, arterial dilatation, and inhibition of the renin angiotensin system.


Concentrations of NP increase in patients with congestive heart failure (CHF) and other CV diseases owing to pressure and volume overload, whereas levels below cutoff are a strong negative predictor for CHF.

Both BNP and NT-proBNP levels in the blood are used for screening, diagnosis of acute congestive heart failure (CHF) and may be useful to establish prognosis in heart failure, as both markers are typically higher in patients with worse outcome. The plasma concentrations of both BNP and NT-proBNP are also typically increased in patients with asymptomatic or symptomatic left ventricular dysfunction and is associated with coronary artery disease and myocardial ischemia

*It can be used, along with other cardiac biomarkers test, to detect heart stress and damage and/or along with lung function tests to distinguish between causes of shortness of breath. Heart failure can be confused with other conditions, and it may co-exist with them. BNP and NT-proBNP*



  
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CONSULTANT PATHOLOGIST  
MBBS, MD (PATHOLOGY & MICROBIOLOGY)

  
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MBBS, MD (PATHOLOGY)





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levels can help doctors differentiate between heart failure and other problems, such as lung disease. An accurate diagnosis is important because the treatments are often different and must be started as soon as possible.

A BNP or NT-proBNP test may be ordered when a person has signs and symptoms that could be due to heart failure. These may include:

1. Difficulty breathing, shortness of breath
2. Fatigue
3. Swelling in the feet, ankles, legs, abdomen

#### NOTE:

1. Lack of NT-ProBNP elevation has been reported if Congestive Heart Failure (CHF) is very acute (first hour) or if there is Ventricular inflow obstruction
2. As per a number of studies, threshold for NT-ProBNP is 125 pg/mL
3. BNP and NT-proBNP levels decrease in most people who are taking drug therapies for heart failure, such as angiotensin-converting enzyme (ACE) inhibitors, beta blockers and diuretics.
4. Levels of both BNP and NT-proBNP tend to increase with age.
5. Levels of NT-proBNP and BNP may be increased in persons with kidney disease due to reduced clearance.
6. While both BNP and NT-proBNP will rise with left ventricle dysfunction and either can be measured for diagnosis or monitoring therapy, they are not interchangeable and the results cannot be directly compared.
7. Results to be clinically correlated.

#### CLINICAL USE:

1. As an aid in the diagnosis of suspected cases of CHF
2. Detection of mild forms of cardiac dysfunction
3. To assess severity of heart failure in already diagnosed cases of CHF
4. For risk stratification of patients with Acute Coronary Syndrome & CHF For monitoring therapy in patients with Left Ventricular dysfunction

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



DR. VINAY CHOPRA  
CONSULTANT PATHOLOGIST  
MBBS, MD (PATHOLOGY & MICROBIOLOGY)

DR. YUGAM CHOPRA  
CONSULTANT PATHOLOGIST  
MBBS, MD (PATHOLOGY)

