P K R JAIN HEALTHCARE INSTITUTE

NASIRPUR, Hissar Road, AMBALA CITY- (Haryana)

A PIONEER DIAGNOSTIC CENTRE

0171-2532620, 8222896961 pkrjainhealthcare@gmail.com

NAME	**: Mr. DARSHAN CHAWLA**		
AGE/ GENDER	: 62 YRS/MALE	**PATIENT ID**	: 1600295
COLLECTED BY	:	**REG. NO./LAB NO.**	**: 122501080009**
REFERRED BY	:	**REGISTRATION DATE**	: 08/Jan/2025 11:46 AM
BARCODE NO.	: 12506446	**COLLECTION DATE**	: 08/Jan/2025 11:52AM
CLIENT CODE.	: P.K.R JAIN HEALTHCARE INSTITUTE	**REPORTING DATE**	: 08/Jan/2025 12:55PM
CLIENT ADDRESS	: NASIRPUR, HISSAR ROAD, AMBALA CITY - HARYANA		

HAEMATOLOGY

COMPLETE BLOOD COUNT (CBC)

Test Name	Value	Unit	Biological Reference interval
RED BLOOD CELLS (RBCS) COUNT AND INDICES			
HAEMOGLOBIN (HB) *by CALORIMETRIC*	14.5	gm/dL	12.0 - 17.0
RED BLOOD CELL (RBC) COUNT *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	4.58	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	44.1	%	40.0 - 54.0
MEAN CORPUSCULAR VOLUME (MCV) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	96.2	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	31.7	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	33	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	14.6	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	51.3	fL	35.0 - 56.0
MENTZERS INDEX *by CALCULATED*	21	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX *by CALCULATED*	30.71	RATIO	BETA THALASSEMIA TRAIT:<= 65.0 IRON DEFICIENCY ANEMIA: > 65.0
WHITE BLOOD CELLS (WBCS)			
TOTAL LEUCOCYTE COUNT (TLC) *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	8910	/cmm	4000 - 11000
DIFFERENTIAL LEUCOCYTE COUNT (DLC)			
NEUTROPHILS *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	55	%	50 - 70
LYMPHOCYTES	32	%	20 - 40

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Test Name	Value	Unit	Biological Reference interval
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
EOSINOPHILS *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	5	%	1 - 6
MONOCYTES *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	8	%	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*	4901	/cmm	2000 - 7500
ABSOLUTE LYMPHOCYTE COUNT *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	**2851^{L}**	/cmm	800 - 4900
ABSOLUTE EOSINOPHIL COUNT *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	**446^{H}**	/cmm	40 - 440
ABSOLUTE MONOCYTE COUNT *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	713	/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*	152000	/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*	12	fL	6.50 - 12.0
PLATELET LARGE CELL COUNT (P-LCC) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	60000	/cmm	30000 - 90000
PLATELET LARGE CELL RATIO (P-LCR) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	39.3	%	11.0 - 45.0
PLATELET DISTRIBUTION WIDTH (PDW) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	16.9	%	15.0 - 17.0

NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD

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TEST PERFORMED AT KOS DIAGNOSTIC LAB, AMBALA CANTT.

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Test Name	Value	Unit	Biological Reference interval

CLINICAL CHEMISTRY/BIOCHEMISTRY

CALCIUM

CALCIUM: SERUM *by ARSENAZO III, SPECTROPHOTOMETRY*	8.79	mg/dL	8.50 - 10.60

INTERPRETATION:-

1.Serum calcium (total) estimation is used for the diagnosis and monitoring of a wide range of disorders including diseases of bone, kidney, parathyroid gland, or gastrointestinal tract.
2. Calcium levels may also reflect abnormal vitamin D or protein levels.
3.The calcium content of an adult is somewhat over 1 kg (about 2% of the body weight).Of this, 99% is present as calcium hydroxyapatite in bones and <1% is present in the extra-osseous intracellular space or extracellular space (ECS).
4. In serum, calcium is bound to a considerable extent to proteins (approximately 40%), 10% is in the form of inorganic complexes, and 50% is present as free or ionized calcium.
NOTE:-Calcium ions affect the contractility of the heart and the skeletal musculature, and are essential for the function of the nervous system. In addition, calcium ions play an important role in blood clotting and bone mineralization.

HYPOCALCEMIA (LOW CALCIUM LEVELS) CAUSES :-

1.Due to the absence or impaired function of the parathyroid glands or impaired vitamin-D synthesis.
2. Chronic renal failure is also frequently associated with hypocalcemia due to decreased vitamin-D synthesis as well as hyperphosphatemia and skeletal resistance to the action of parathyroid hormone (PTH).
3.***NOTE:-*** A characteristic symptom of hypocalcemia is latent or manifest tetany and osteomalacia.

HYPERCALCEMIA (INCREASE CALCIUM LEVELS) CAUSES:-

1.Increased mobilization of calcium from the skeletal system or increased intestinal absorption.
2.Primary hyperparathyroidism (pHPT)
3.Bone metastasis of carcinoma of the breast, prostate, thyroid gland, or lung.
NOTE:-Severe hypercalcemia may result in cardiac arrhythmia.

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Test Name	Value	Unit	Biological Reference interval

PHOSPHOROUS

PHOSPHOROUS: SERUM *by PHOSPHOMOLYBDATE, SPECTROPHOTOMETRY*	2.88	mg/dL	2.5 - 4.5

INTERPREATION:-

1.Eighty-eight percent of the phosphorus contained in the body is localized in bone in the form of hydroxyapatite. The remainder is involved in intermediary carbohydrate metabolism and in physiologically important substances such as phospholipids, nucleic acids, and adenosine triphosphate (ATP).
2.Phosphorus occurs in blood in the form of inorganic phosphate and organically bound phosphoric acid. The small amount of extracellular organic phosphorus is found exclusively in the form of phospholipids.
3.Serum phosphate concentrations are dependent on meals and variation in the secretion of hormones such as parathyroid hormone (PTH) and may vary widely.

DECREASED (HYPOPHOSPHATEMIA):-

1.Shift of phosphate from extracellular to intracellular.
2.Renal phosphate wasting.
3.Loss from the gastrointestinal tract.
4.Loss from intracellular stores.

INCREASED (HYPERPHOPHATEMIA):-

1.Inability of the kidneys to excrete phosphate.
2.Increased intake or a shift of phosphate from the tissues into the extracellular fluid.

SIGNIFICANCE:-

1.Phosphate levels may be used in the diagnosis and management of a variety of disorders including bone, parathyroid and renal disease.
2.Hypophosphatemia is relatively common in hospitalized patients. Levels less than 1.5 mg/dL may result in muscle weakness, hemolysis of red cells, coma, and bone deformity and impaired bone growth.
3.The most acute problem associated with rapid elevations of serum phosphate levels is hypocalcemia with tetany, seizures, and hypotension. Soft tissue calcification is also an important long-term effect of high phosphorus levels.
4.Phosphorus levels less than 1.0 mg/dL are potentially life-threatening and are considered a critical value.

NOTE: Phosphorus has a very strong biphasic circadian rhythm. Values are lowest in the morning, peak first in the late afternoon and peak again in the late evening. The second peak is quite elevated and results may be outside the reference range

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Test Name	Value	Unit	Biological Reference interval
ELECTROLYTES COMPLETE PROFILE			
SODIUM: SERUM *by ISE (ION SELECTIVE ELECTRODE)*	136.7	mmol/L	135.0 - 150.0
POTASSIUM: SERUM *by ISE (ION SELECTIVE ELECTRODE)*	4.4	mmol/L	3.50 - 5.00
CHLORIDE: SERUM *by ISE (ION SELECTIVE ELECTRODE)*	102.53	mmol/L	90.0 - 110.0

INTERPRETATION:-

SODIUM:-

Sodium is the major cation of extra-cellular fluid. Its primary function in the body is to chemically maintain osmotic pressure & acid base balance & to transmit nerve impulse.

HYPONATREMIA (LOW SODIUM LEVEL) CAUSES:-

1. Low sodium intake.
2. Sodium loss due to diarrhea & vomiting with adequate water and iadequate salt replacement.
3. Diuretics abuses.
4. Salt loosing nephropathy.
5. Metabolic acidosis.
6. Adrenocortical issuficiency .
7. Hepatic failure.

HYPERNATREMIA (INCREASED SODIUM LEVEL) CAUSES:-

1. Hyperapnea (Prolonged)
2. Diabetes insipidus
3. Diabetic acidosis
4. Cushings syndrome
5. Dehydration

POTASSIUM:-

Potassium is the major cation in the intracellular fluid. 90% of potassium is concentrated within the cells. When cells are damaged, potassium is released in the blood.

HYPOKALEMIA (LOW POTASSIUM LEVELS):-

1. Diarrhoea, vomiting & malabsorption.
2. Severe Burns.
3. Increased Secretions of Aldosterone

HYPERKALEMIA (INCREASED POTASSIUM LEVELS):-

1. Oliguria
2. Renal failure or Shock
3. Respiratory acidosis

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Test Name	Value	Unit	Biological Reference interval
4.Hemolysis of blood			

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Test Name	Value	Unit	Biological Reference interval

CLINICAL PATHOLOGY

URINE ROUTINE & MICROSCOPIC EXAMINATION

PHYSICAL EXAMINATION

QUANTITY RECIEVED *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	30	ml	
COLOUR *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	PALE YELLOW		PALE YELLOW
TRANSPARANCY *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	HAZY		CLEAR
SPECIFIC GRAVITY *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	1.02		1.002 - 1.030

CHEMICAL EXAMINATION

REACTION *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	ACIDIC		
PROTEIN ***by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY***	**2+**		**NEGATIVE (-ve)**
SUGAR *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	NEGATIVE (-ve)		NEGATIVE (-ve)
pH *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	5.5		5.0 - 7.5
BILIRUBIN *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	NEGATIVE (-ve)		NEGATIVE (-ve)
NITRITE *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY.*	NEGATIVE (-ve)		NEGATIVE (-ve)
UROBILINOGEN *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	NOT DETECTED	EU/dL	0.2 - 1.0
KETONE BODIES *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	NEGATIVE (-ve)		NEGATIVE (-ve)
BLOOD *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	NEGATIVE (-ve)		NEGATIVE (-ve)
ASCORBIC ACID *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	NEGATIVE (-ve)		NEGATIVE (-ve)

MICROSCOPIC EXAMINATION

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

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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

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PROTEIN/CREATININE RATIO: RANDOM URINE

Test Name	Value	Unit	Biological Reference interval
PROTEINS: RANDOM URINE *by SPECTROPHOTOMETRY*	**170.17^{H}**	mg/dL	5 - 25
CREATININE: RANDOM URINE *by SPECTROPHOTOMETRY*	141.44	mg/dL	20 - 320
PROTEIN/CREATININE RATIO: RANDOM URINE *by SPECTROPHOTOMETRY*	**1.2^{H}**		< 0.20

INTERPRETATION:

PROTEIN/CREATININE RATIO	REMARKS
< 0.20	NORMAL
0.20 – 1.00	LOW GRADE PROTEINURIA
1.00 – 5.00	MODERATE PROTEINURIA
>5.00	NEPHROSIS

NOTE:
Urinary total proteins are nearly negligible in healthy adults. The Protein Creatinine ratio is a simple and convenient method to quantitate and monitor proteinuria in adults with chronic kidney disease. Patients with 2 or more positive results within a period of 1-2 weeks should be labeled as having persistent proteinuria and investigated further

*** End Of Report ***

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