



P K R JAIN HEALTHCARE INSTITUTE

NASIRPUR, Hissar Road, AMBALA CITY- (Haryana)

A PIONEER DIAGNOSTIC CENTRE

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

NAME : Mrs. KAILASH RANI JAIN
AGE/ GENDER : 86 YRS/FEMALE
COLLECTED BY :
REFERRED BY :
BARCODE NO. : 12506643
CLIENT CODE. : P.K.R JAIN HEALTHCARE INSTITUTE
CLIENT ADDRESS : NASIRPUR, HISSAR ROAD, AMBALA CITY - HARYANA

PATIENT ID : 1732337
REG. NO./LAB NO. : 122501230011
REGISTRATION DATE : 23/Jan/2025 11:37 AM
COLLECTION DATE : 23/Jan/2025 01:52PM
REPORTING DATE : 23/Jan/2025 12:54PM

Test Name	Value	Unit	Biological Reference interval
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HAEMATOLOGY HAEMOGLOBIN (HB)

HAEMOGLOBIN (HB) **10.8^L** gm/dL 12.0 - 16.0
by CALORIMETRIC

INTERPRETATION:-

Hemoglobin is the protein molecule in red blood cells that carries oxygen from the lungs to the body's tissues and returns carbon dioxide from the tissues back to the lungs.

A low hemoglobin level is referred to as ANEMIA or low red blood count.

ANEMIA (DECREASED HAEMOGLOBIN):

- 1) Loss of blood (traumatic injury, surgery, bleeding, colon cancer or stomach ulcer)
- 2) Nutritional deficiency (iron, vitamin B12, folate)
- 3) Bone marrow problems (replacement of bone marrow by cancer)
- 4) Suppression by red blood cell synthesis by chemotherapy drugs
- 5) Kidney failure
- 6) Abnormal hemoglobin structure (sickle cell anemia or thalassemia).


POLYCYTHEMIA (INCREASED HAEMOGLOBIN):

- 1) People in higher altitudes (Physiological)
- 2) Smoking (Secondary Polycythemia)
- 3) Dehydration produces a falsely rise in hemoglobin due to increased haemoconcentration
- 4) Advanced lung disease (for example, emphysema)
- 5) Certain tumors
- 6) A disorder of the bone marrow known as polycythemia rubra vera,
- 7) Abuse of the drug erythropoietin (Epogen) by athletes for blood doping purposes (increasing the amount of oxygen available to the body by chemically raising the production of red blood cells).

NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD




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CLINICAL CHEMISTRY/BIOCHEMISTRY

KIDNEY FUNCTION TEST (BASIC)

UREA: SERUM <i>by UREASE - GLUTAMATE DEHYDROGENASE (GLDH)</i>	29.28	mg/dL	10.00 - 50.00
CREATININE: SERUM <i>by ENZYMATIC, SPECTROPHOTOMETRY</i>	0.85	mg/dL	0.40 - 1.20
BLOOD UREA NITROGEN (BUN): SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	13.68	mg/dL	7.0 - 25.0
BLOOD UREA NITROGEN (BUN)/CREATININE RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	16.09	RATIO	10.0 - 20.0
UREA/CREATININE RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	34.45	RATIO	
URIC ACID: SERUM <i>by URICASE - OXIDASE PEROXIDASE</i>	4.2	mg/dL	2.50 - 6.80




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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).

*** End Of Report ***



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