P K R JAIN HEALTHCARE INSTITUTE

NASIRPUR, Hissar Road, AMBALA CITY- (Haryana)

A PIONEER DIAGNOSTIC CENTRE

0171-2532620, 8222896961 pkrjainhealthcare@gmail.com

NAME	**: Mrs. KULDEEP KAUR**		
AGE/ GENDER	: 65 YRS/FEMALE	**PATIENT ID**	: 1732633
COLLECTED BY	:	**REG. NO./LAB NO.**	**: 122501230014**
REFERRED BY	:	**REGISTRATION DATE**	: 23/Jan/2025 02:27 PM
BARCODE NO.	: 12506646	**COLLECTION DATE**	: 23/Jan/2025 02:35PM
CLIENT CODE.	: P.K.R JAIN HEALTHCARE INSTITUTE	**REPORTING DATE**	: 23/Jan/2025 03:04PM
CLIENT ADDRESS	: NASIRPUR, HISSAR ROAD, AMBALA CITY - HARYANA		

SWASTHYA WELLNESS PANEL: 1.0

COMPLETE BLOOD COUNT (CBC)

Test Name	Value	Unit	Biological Reference interval
RED BLOOD CELLS (RBCS) COUNT AND INDICES			
HAEMOGLOBIN (HB) *by CALORIMETRIC*	**11.7[L]**	gm/dL	12.0 - 16.0
RED BLOOD CELL (RBC) COUNT *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	3.94	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	**34.5[L]**	%	37.0 - 50.0
MEAN CORPUSCULAR VOLUME (MCV) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	87.4	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	29.7	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	34	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	14	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	45.8	fL	35.0 - 56.0
MENTZERS INDEX *by CALCULATED*	22.18	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX *by CALCULATED*	31.06	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*	7080	/cmm	4000 - 11000
NUCLEATED RED BLOOD CELLS (nRBCS) *by AUTOMATED 6 PART HEMATOLOGY ANALYZER*	NIL		0.00 - 20.00
NUCLEATED RED BLOOD CELLS (nRBCS) % *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	NIL	%	< 10 %

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Test Name	Value	Unit	Biological Reference interval
DIFFERENTIAL LEUCOCYTE COUNT (DLC)			
NEUTROPHILS *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	62	%	50 - 70
LYMPHOCYTES *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	29	%	20 - 40
EOSINOPHILS *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	2	%	1 - 6
MONOCYTES *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	7	%	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*	4390	/cmm	2000 - 7500
ABSOLUTE LYMPHOCYTE COUNT *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	2053	/cmm	800 - 4900
ABSOLUTE EOSINOPHIL COUNT *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	142	/cmm	40 - 440
ABSOLUTE MONOCYTE COUNT *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	496	/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*	265000	/cmm	150000 - 450000
PLATELETCRIT (PCT) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	0.34	%	0.10 - 0.36
MEAN PLATELET VOLUME (MPV) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	**13^{H}**	fL	6.50 - 12.0
PLATELET LARGE CELL COUNT (P-LCC) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	**126000^{H}**	/cmm	30000 - 90000
PLATELET LARGE CELL RATIO (P-LCR) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	**47.5^{H}**	%	11.0 - 45.0
PLATELET DISTRIBUTION WIDTH (PDW) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	15.9	%	15.0 - 17.0

NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD

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Test Name	Value	Unit	Biological Reference interval

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Test Name	Value	Unit	Biological Reference interval

ERYTHROCYTE SEDIMENTATION RATE (ESR)

ERYTHROCYTE SEDIMENTATION RATE (ESR) *by RED CELL AGGREGATION BY CAPILLARY PHOTOMETRY*	**32^{H}**	mm/1st hr	0 - 20

INTERPRETATION:

1. ESR is a non-specific test because an elevated result often indicates the presence of inflammation associated with infection, cancer and auto-immune 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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PROTHROMBIN TIME STUDIES (PT/INR)

Test Name	Value	Unit	Biological Reference interval
PT TEST (PATIENT) *by PHOTO OPTICAL CLOT DETECTION*	**14.7^{H}**	SECS	11.5 - 14.5
PT (CONTROL) *by PHOTO OPTICAL CLOT DETECTION*	12	SECS	
ISI *by PHOTO OPTICAL CLOT DETECTION*	1.1		
INTERNATIONAL NORMALISED RATIO (INR) *by PHOTO OPTICAL CLOT DETECTION*	**1.25^{H}**		0.80 - 1.20
PT INDEX *by PHOTO OPTICAL CLOT DETECTION*	81.63	%	
ADVICE	**KINDLY CORRELATE CLINICALLY**		

INTERPRETATION:-

1.INR is the parameter of choice in monitoring adequacy of oral anti-coagulant therapy. Appropiate therapeutic range varies with the disease and treatment intensity.
2. Prolonged INR suggests potential bleeding disorder /bleeding complications
3. Results should be clinically correlated.
4. *Test conducted on Citrated Plasma*

RECOMMENDED THERAPEUTIC RANGE FOR ORAL ANTI-COAGULANT THERAPY (INR)		
INDICATION		**INTERNATIONAL NORMALIZED RATIO (INR)**
Treatment of venous thrombosis	Low Intensity	2.0 - 3.0
Treatment of pulmonary embolism		
Prevention of systemic embolism in tissue heart valves		
Valvular heart disease		
Acute myocardial infarction		
Atrial fibrillation		
Bileaflet mechanical valve in aortic position		
Recurrent embolism	High Intensity	2.5 - 3.5
Mechanical heart valve		
Antiphospholipid antibodies^{+}		

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Test Name	Value	Unit	Biological Reference interval

COMMENTS:

The prothrombin time (PT) and its derived measures of prothrombin ratio (PR) and international normalized ratio (INR) are measures of the efficacy of the extrinsic pathway of coagulation. PT test reflects the adequacy of factors I (fibrinogen), II (prothrombin), V, VII, and X. It is used in conjunction with the activated partial thromboplastin time (aPTT) which measures the intrinsic pathway.

The common causes of prolonged prothrombin time are :

1.Oral Anticoagulant therapy.
2.Liver disease.
3.Vit K. deficiency.
4.Disseminated intra vascular coagulation.
5.Factor 5, 7 , 10 or Prothrombin dificiency

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Test Name	Value	Unit	Biological Reference interval

CLINICAL CHEMISTRY/BIOCHEMISTRY

GLUCOSE FASTING (F)

GLUCOSE FASTING (F): PLASMA *by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)*	89.2	mg/dL	NORMAL: < 100.0 PREDIABETIC: 100.0 - 125.0 DIABETIC: > 0R = 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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LIPID PROFILE : BASIC

Test Name	Value	Unit	Biological Reference interval
CHOLESTEROL TOTAL: SERUM *by CHOLESTEROL OXIDASE PAP*	171.06	mg/dL	OPTIMAL: < 200.0 BORDERLINE HIGH: 200.0 - 239.0 HIGH CHOLESTEROL: > OR = 240.0
TRIGLYCERIDES: SERUM *by GLYCEROL PHOSPHATE OXIDASE (ENZYMATIC)*	110.56	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 *by SELECTIVE INHIBITION*	69.36	mg/dL	LOW HDL: < 30.0 BORDERLINE HIGH HDL: 30.0 - 60.0 HIGH HDL: > OR = 60.0
LDL CHOLESTEROL: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	79.59	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 *by CALCULATED, SPECTROPHOTOMETRY*	101.7	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 *by CALCULATED, SPECTROPHOTOMETRY*	22.11	mg/dL	0.00 - 45.00
TOTAL LIPIDS: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	452.68	mg/dL	350.00 - 700.00
CHOLESTEROL/HDL RATIO: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	2.47	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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Test Name	Value	Unit	Biological Reference interval
LDL/HDL RATIO: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	1.15	RATIO	LOW RISK: 0.50 - 3.0 MODERATE RISK: 3.10 - 6.0 HIGH RISK: > 6.0
TRIGLYCERIDES/HDL RATIO: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	**1.59**^{L}	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 atherogeniclipoproteins such as LDL , VLDL, IDL, Lpa, 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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TEST PERFORMED AT KOS DIAGNOSTIC LAB, AMBALA CANTT.

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LIVER FUNCTION TEST (COMPLETE)

Test Name	Value	Unit	Biological Reference interval
BILIRUBIN TOTAL: SERUM *by DIAZOTIZATION, SPECTROPHOTOMETRY*	0.49	mg/dL	INFANT: 0.20 - 8.00 ADULT: 0.00 - 1.20
BILIRUBIN DIRECT (CONJUGATED): SERUM *by DIAZO MODIFIED, SPECTROPHOTOMETRY*	0.23	mg/dL	0.00 - 0.40
BILIRUBIN INDIRECT (UNCONJUGATED): SERUM *by CALCULATED, SPECTROPHOTOMETRY*	0.26	mg/dL	0.10 - 1.00
SGOT/AST: SERUM *by IFCC, WITHOUT PYRIDOXAL PHOSPHATE*	21.8	U/L	7.00 - 45.00
SGPT/ALT: SERUM *by IFCC, WITHOUT PYRIDOXAL PHOSPHATE*	23	U/L	0.00 - 49.00
AST/ALT RATIO: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	0.95	RATIO	0.00 - 46.00
ALKALINE PHOSPHATASE: SERUM *by PARA NITROPHENYL PHOSPHATASE BY AMINO METHYL PROPANOL*	**155.95^{H}**	U/L	40.0 - 130.0
GAMMA GLUTAMYL TRANSFERASE (GGT): SERUM *by SZASZ, SPECTROPHTOMETRY*	**304.84^{H}**	U/L	0.00 - 55.0
TOTAL PROTEINS: SERUM *by BIURET, SPECTROPHOTOMETRY*	7.36	gm/dL	6.20 - 8.00
ALBUMIN: SERUM *by BROMOCRESOL GREEN*	4.16	gm/dL	3.50 - 5.50
GLOBULIN: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	3.2	gm/dL	2.30 - 3.50
A : G RATIO: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	1.3	RATIO	1.00 - 2.00

INTERPRETATION

NOTE:- **To be correlated in individuals having SGOT and SGPT values higher than Normal Referance 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)

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Test Name	Value	Unit	Biological Reference interval

DECREASED:

1. Acute Hepatitis due to virus, drugs, toxins (with AST increased 3 to 10 times upper limit of normal)
2. Extra Hepatic cholestatis: 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 Name	Value	Unit	Biological Reference interval
KIDNEY FUNCTION TEST (COMPLETE)			
UREA: SERUM *by UREASE - GLUTAMATE DEHYDROGENASE (GLDH)*	31.8	mg/dL	10.00 - 50.00
CREATININE: SERUM *by ENZYMATIC, SPECTROPHOTOMETERY*	0.97	mg/dL	0.40 - 1.20
BLOOD UREA NITROGEN (BUN): SERUM *by CALCULATED, SPECTROPHOTOMETRY*	14.86	mg/dL	7.0 - 25.0
BLOOD UREA NITROGEN (BUN)/CREATININE RATIO: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	15.32	RATIO	10.0 - 20.0
UREA/CREATININE RATIO: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	32.78	RATIO	
URIC ACID: SERUM *by URICASE - OXIDASE PEROXIDASE*	**2.15**^{L}	mg/dL	2.50 - 6.80
CALCIUM: SERUM *by ARSENAZO III, SPECTROPHOTOMETRY*	9.44	mg/dL	8.50 - 10.60
PHOSPHOROUS: SERUM *by PHOSPHOMOLYBDATE, SPECTROPHOTOMETRY*	4.67	mg/dL	2.30 - 4.70
ELECTROLYTES			
SODIUM: SERUM *by ISE (ION SELECTIVE ELECTRODE)*	139.63	mmol/L	135.0 - 150.0
POTASSIUM: SERUM *by ISE (ION SELECTIVE ELECTRODE)*	4.65	mmol/L	3.50 - 5.00
CHLORIDE: SERUM *by ISE (ION SELECTIVE ELECTRODE)*	104.72	mmol/L	90.0 - 110.0
ESTIMATED GLOMERULAR FILTERATION RATE			
ESTIMATED GLOMERULAR FILTERATION RATE (eGFR): SERUM *by CALCULATED*	64.8		

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.
2. Catabolic states with increased tissue breakdown.
3. GI haemorrhage.

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Test Name	Value	Unit	Biological Reference interval

4. High protein intake.
5. Impaired renal function plus
6. 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).
7. Urine reabsorption (e.g. ureter colostomy)
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 inappropiate antidiuretic harmone) 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.

INAPPROPIATE 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).

ESTIMATED GLOMERULAR FILTERATION 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 m2 (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 fullfill 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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Test Name	Value	Unit	Biological Reference interval
MAGNESIUM			
MAGNESIUM: SERUM *by XYLIDYL BLUE, SPECTROPHOTMETRY*	2.33	mg/dL	1.6 - 2.6

INTERPRETATION:-

1.Magnesium along with potassium is a major intracellular cation.
2.Magnesium is a cofactor of many enzyme systems. All adenosine triphosphate (ATP)-dependent enzymatic reactions require magnesium as a cofactor. 3.Approximately 70% of magnesium ions are stored in bone. The remainder is involved in intermediary metabolic processes; about 70% is present in free form while the other 30% is bound to proteins (especially albumin), citrates, phosphate, and other complex formers. The serum magnesium level is kept constant within very narrow limits. Regulation takes place mainly via the kidneys, primarily via the ascending loop of Henle.

INCREASD (HYPERMAGNESIA):-Conditions that interfere with glomerular filtration result in retention of magnesium and hence elevation of serum concentrations.
1.Acute and chronic renal failure.
2.magnesium overload.
3.Magnesium release from the intracellular space.
4.Mild-to-moderate hypermagnesemia may prolong atrioventricular conduction time. Magnesium toxicity may result in central nervous system (CNS) depression, cardiac arrest, and respiratory arrest.

DECREASED (HYPOMAGNESIA):-
1.Chronic alcoholism.
2.Childhood malnutrition.
3.Malabsorption.
4.Acute pancreatitis.
5.Hypothyroidism.
6.Chronic glomerulonephritis.
7.Aldosteronism.
8.Prolonged intravenous feeding.

NOTE:-
Numerous studies have shown a correlation between magnesium deficiency and changes in calcium-, potassium-, and phosphate-homeostasis which are associated with cardiac disorders such as ventricular arrhythmias that cannot be treated by conventional therapy, increased sensitivity to digoxin, coronary artery spasms, and sudden death. Additional concurrent symptoms include neuromuscular and neuropsychiatric disorders.

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Test Name	Value	Unit	Biological Reference interval

IMMUNOPATHOLOGY/SEROLOGY

HEPATITIS C VIRUS (HCV) ANTIBODIES SCREENING

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

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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Test Name	Value	Unit	Biological Reference interval

ANTI HUMAN IMMUNODEFICIENCY VIRUS (HIV) ANTIBODIES HIV (1 & 2) SCREENING

HIV 1/2 AND P24 ANTIGEN RESULT — NON - REACTIVE

by IMMUNOCHROMATOGRAPHY

INTERPRETATION:-

1.AIDS is caused by at least 2 known types of HIV viruses, HIV-1 and HIV HIV-2.
2.This NACO approved immuno-chromatographic solid phase ELISA assay detects antibodies against both HIV-1 and HIV-2 viruses.
3.The test is used for routine serologic screening of patients at risk for HIV-1 or HIV-2 infection.
4.All screening ELISA assays for HIV antibody detection have high sensitivity but have low specificity.
5.At this laboratory, all positive samples are cross checked for positivity with two alternate assays prior to reporting.

NOTE:-

1.Confirmatory testing by Western blot is recommended for patients who are reactive for HIV by this assay.
2.Antibodies against HIV-1 and HIV-2 are usually not detectable until 6 to 12 weeks following exposure (window period) and are almost always detectable by 12 months.
3.The test is not recommended for children born to HIV infected mothers till the child turns two years old (as HIV antibodies may be transmitted passively to the child trans-placentally).

FALSE NEGATIVE RESULT SEEN IN:

1.Window period
2.Severe immuno-suppression including advanced AIDS.

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Test Name	Value	Unit	Biological Reference interval

HEPATITIS B SURFACE ANTIGEN (HBsAg) SCREENING

HEPATITIS B SURFACE ANTIGEN (HBsAg) RESULT *by IMMUNOCHROMATOGRAPHY*	NON REACTIVE		

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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Test Name	Value	Unit	Biological Reference interval

TUMOUR MARKER

CANCER ANTIGEN 125 (CA 125): OVARIAN CANCER MARKER

CANCER ANTIGEN (CA) -125: SERUM *by CMIA (CHEMILUMINESCENCE MICROPARTICLE IMMUNOASSAY)*	16.4	U/mL	0.0 - 35.0

INTERPRETATION:

1. Cancer antigen 125 (CA 125) is a glycoprotein antigen normally expressed in tissues derived from coelomic epithelia (ovary, fallopian tube, peritoneum, pleura, pericardium, colon, kidney, stomach).
2. Serum CA 125 is elevated in approximately 80% of women with advanced epithelial ovarian cancer, but assay sensitivity is suboptimal in early disease stages. The average reported sensitivities are 50% for stage I and 90% for stage II or greater.
3. Elevated serum CA 125 levels have been reported in individuals with a variety of nonovarian malignancies including cervical, liver, pancreatic, lung, colon, stomach, biliary tract, uterine, fallopian tube, breast, and endometrial carcinomas.

SIGNIFICANCE:

1. Evaluating patients' response to cancer therapy, especially for ovarian carcinoma
2. Predicting recurrent ovarian cancer or intra-peritoneal tumor.In monitoring studies, elevations of cancer antigen 125 (CA 125) >35 U/mL after de-bulking surgery and chemotherapy indicate that residual disease is likely (>95% accuracy). However, normal levels do not rule-out recurrence.
3. A persistently rising CA 125 value suggests progressive malignant disease and poor therapeutic response.
4. Physiologic half-life of CA 125 is approximately 5 days.
5. In patients with advanced disease who have undergone cyto-reductive surgery and are on chemotherapy, a prolonged half-life (>20 days) may be associated with a shortened disease-free survival.

NOTE:

1. CA 125 levels. Hence this assay, regardless of level, should not be interpreted as absolute evidence for the presence or absence of malignant disease. The assay value should be used in conjunction with findings from clinical evaluation and other diagnostic procedures It is not recommended to use this test for the initial diagnosis of ovarian cancer.

2. Falsely Elevated serum CA 125 levels have been reported in individuals with a variety of nonmalignant conditions including: cirrhosis, hepatitis, endometriosis, first trimester pregnancy, ovarian cysts, and pelvic inflammatory disease. Elevated levels during the menstrual cycle also have been reported.

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CLINICAL PATHOLOGY

URINE ROUTINE & MICROSCOPIC EXAMINATION

Test Name	Value	Unit	Biological Reference interval
PHYSICAL EXAMINATION			
QUANTITY RECIEVED *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	10	ml	
COLOUR *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	PALE YELLOW		PALE YELLOW
TRANSPARANCY *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	CLEAR		CLEAR
SPECIFIC GRAVITY *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	>=1.030		1.002 - 1.030
CHEMICAL EXAMINATION			
REACTION *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	ACIDIC		
PROTEIN *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	Negative		NEGATIVE (-ve)
SUGAR *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	Negative		NEGATIVE (-ve)
pH *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	<=5.0		5.0 - 7.5
BILIRUBIN *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	Negative		NEGATIVE (-ve)
NITRITE *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY.*	Negative		NEGATIVE (-ve)
UROBILINOGEN *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	Normal	EU/dL	0.2 - 1.0
KETONE BODIES *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	Negative		NEGATIVE (-ve)
BLOOD *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	Negative		NEGATIVE (-ve)
ASCORBIC ACID *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	NEGATIVE (-ve)		NEGATIVE (-ve)
MICROSCOPIC EXAMINATION			
RED BLOOD CELLS (RBCs)	NEGATIVE (-ve)	/HPF	0 - 3

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Test Name	Value	Unit	Biological Reference interval
by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT			
PUS CELLS	2-3	/HPF	0 - 5
by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT			
EPITHELIAL CELLS	1-4	/HPF	ABSENT
by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT			
CRYSTALS	NEGATIVE (-ve)		NEGATIVE (-ve)
by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT			
CASTS	NEGATIVE (-ve)		NEGATIVE (-ve)
by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT			
BACTERIA	NEGATIVE (-ve)		NEGATIVE (-ve)
by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT			
OTHERS	NEGATIVE (-ve)		NEGATIVE (-ve)
by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT			
TRICHOMONAS VAGINALIS (PROTOZOA)	ABSENT		ABSENT
by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT			

*** End Of Report ***

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