



P K R JAIN HEALTHCARE INSTITUTE

NASIRPUR, Hissar Road, AMBALA CITY- (Haryana)

A PIONEER DIAGNOSTIC CENTRE

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

NAME	: Mr. RAVINDER SINGH	PATIENT ID	: 1733451
AGE/ GENDER	: 78 YRS/MALE	REG. NO./LAB NO.	: 122501240019
COLLECTED BY	:	REGISTRATION DATE	: 24/Jan/2025 11:43 AM
REFERRED BY	:	COLLECTION DATE	: 24/Jan/2025 11:44AM
BARCODE NO.	: 12506666	REPORTING DATE	: 24/Jan/2025 01:36PM
CLIENT CODE.	: P.K.R JAIN HEALTHCARE INSTITUTE		
CLIENT ADDRESS	: NASIRPUR, HISSAR ROAD, AMBALA CITY - HARYANA		

Test Name	Value	Unit	Biological Reference interval
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SWASTHYA WELLNESS PANEL: 1.0

COMPLETE BLOOD COUNT (CBC)

RED BLOOD CELLS (RBCS) COUNT AND INDICES

HAEMOGLOBIN (HB) <i>by CALORIMETRIC</i>	12.4	gm/dL	12.0 - 17.0
RED BLOOD CELL (RBC) COUNT <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	4.24	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	36.9^L	%	40.0 - 54.0
MEAN CORPUSCULAR VOLUME (MCV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	87.1	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	29.2	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	33.5	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	13	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	42	fL	35.0 - 56.0
MENTZERS INDEX <i>by CALCULATED</i>	20.54	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX <i>by CALCULATED</i>	26.66	RATIO	BETA THALASSEMIA TRAIT:<= 65.0 IRON DEFICIENCY ANEMIA: > 65.0

WHITE BLOOD CELLS (WBCS)

TOTAL LEUCOCYTE COUNT (TLC) <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	6540	/cmm	4000 - 11000
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DIFFERENTIAL LEUCOCYTE COUNT (DLC)

NEUTROPHILS <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	67	%	50 - 70
LYMPHOCYTES	26	%	20 - 40




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by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
EOSINOPHILS	2	%	1 - 6
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
MONOCYTES	5	%	2 - 12
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
BASOPHILS	0	%	0 - 1
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
<u>ABSOLUTE LEUKOCYTES (WBC) COUNT</u>			
ABSOLUTE NEUTROPHIL COUNT	4382	/cmm	2000 - 7500
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
ABSOLUTE LYMPHOCYTE COUNT	1700 ^L	/cmm	800 - 4900
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
ABSOLUTE EOSINOPHIL COUNT	131	/cmm	40 - 440
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
ABSOLUTE MONOCYTE COUNT	327	/cmm	80 - 880
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
ABSOLUTE BASOPHIL COUNT	0	/cmm	0 - 110
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
<u>PLATELETS AND OTHER PLATELET PREDICTIVE MARKERS.</u>			
PLATELET COUNT (PLT)	219000	/cmm	150000 - 450000
by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE			
PLATELETCRIT (PCT)	0.22	%	0.10 - 0.36
by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE			
MEAN PLATELET VOLUME (MPV)	10	fL	6.50 - 12.0
by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE			
PLATELET LARGE CELL COUNT (P-LCC)	65000	/cmm	30000 - 90000
by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE			
PLATELET LARGE CELL RATIO (P-LCR)	29.8	%	11.0 - 45.0
by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE			
PLATELET DISTRIBUTION WIDTH (PDW)	16.3	%	15.0 - 17.0
by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE			
NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD			




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ERYTHROCYTE SEDIMENTATION RATE (ESR)

ERYTHROCYTE SEDIMENTATION RATE (ESR)	20	mm/1st hr	0 - 20
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by RED CELL AGGREGATION BY CAPILLARY PHOTOMETRY

INTERPRETATION:

1. ESR is a non-specific test because an elevated result often indicates the presence of inflammation associated with infection, cancer and 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)

PT TEST (PATIENT) by PHOTO OPTICAL CLOT DETECTION	13.7	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	1.16		0.80 - 1.20
PT INDEX by PHOTO OPTICAL CLOT DETECTION	87.59	%	

INTERPRETATION:-

1. INR is the parameter of choice in monitoring adequacy of oral anti-coagulant therapy. Appropriate 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	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	2.5 - 3.5
Recurrent embolism	
Mechanical heart valve	
Antiphospholipid antibodies ⁺	

COMMENTS:




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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 deficiency




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CLINICAL CHEMISTRY/BIOCHEMISTRY

GLUCOSE FASTING (F)

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

129.4^H

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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LIPID PROFILE : BASIC

CHOLESTEROL TOTAL: SERUM
by CHOLESTEROL OXIDASE PAP

190.06

mg/dL

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

TRIGLYCERIDES: SERUM
by GLYCEROL PHOSPHATE OXIDASE (ENZYMATIC)

222.34^H

mg/dL

OPTIMAL: < 150.0
BORDERLINE HIGH: 150.0 - 199.0

HDL CHOLESTEROL (DIRECT): SERUM
by SELECTIVE INHIBITION

39.18

mg/dL

HIGH: 200.0 - 499.0
VERY HIGH: > OR = 500.0
LOW HDL: < 30.0
BORDERLINE HIGH HDL: 30.0 - 60.0

LDL CHOLESTEROL: SERUM
by CALCULATED, SPECTROPHOTOMETRY

106.41

mg/dL

HIGH HDL: > OR = 60.0
OPTIMAL: < 100.0
ABOVE OPTIMAL: 100.0 - 129.0
BORDERLINE HIGH: 130.0 - 159.0

NON HDL CHOLESTEROL: SERUM
by CALCULATED, SPECTROPHOTOMETRY

150.88^H

mg/dL

HIGH: 160.0 - 189.0
VERY HIGH: > OR = 190.0
OPTIMAL: < 130.0
ABOVE OPTIMAL: 130.0 - 159.0
BORDERLINE HIGH: 160.0 - 189.0

VLDL CHOLESTEROL: SERUM
by CALCULATED, SPECTROPHOTOMETRY

44.47

mg/dL

HIGH: 190.0 - 219.0
VERY HIGH: > OR = 220.0
0.00 - 45.00

TOTAL LIPIDS: SERUM
by CALCULATED, SPECTROPHOTOMETRY

602.46

mg/dL

350.00 - 700.00


CHOLESTEROL/HDL RATIO: SERUM
by CALCULATED, SPECTROPHOTOMETRY


4.85^H

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>	2.72	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>	5.67 ^H	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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LIVER FUNCTION TEST (COMPLETE)

BILIRUBIN TOTAL: SERUM <i>by DIAZOTIZATION, SPECTROPHOTOMETRY</i>	1.04	mg/dL	INFANT: 0.20 - 8.00 ADULT: 0.00 - 1.20
BILIRUBIN DIRECT (CONJUGATED): SERUM <i>by DIAZO MODIFIED, SPECTROPHOTOMETRY</i>	0.37	mg/dL	0.00 - 0.40
BILIRUBIN INDIRECT (UNCONJUGATED): SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	0.67	mg/dL	0.10 - 1.00
SGOT/AST: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	28.4	U/L	7.00 - 45.00
SGPT/ALT: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	17.32	U/L	0.00 - 49.00
AST/ALT RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	1.64	RATIO	0.00 - 46.00
ALKALINE PHOSPHATASE: SERUM <i>by PARA NITROPHENYL PHOSPHATASE BY AMINO METHYL PROPANOL</i>	99.46	U/L	40.0 - 130.0
GAMMA GLUTAMYL TRANSFERASE (GGT): SERUM <i>by SZASZ, SPECTROPHOTOMETRY</i>	26.11	U/L	0.00 - 55.0
TOTAL PROTEINS: SERUM <i>by BIURET, SPECTROPHOTOMETRY</i>	6.43	gm/dL	6.20 - 8.00
ALBUMIN: SERUM <i>by BROMOCRESOL GREEN</i>	3.96	gm/dL	3.50 - 5.50
GLOBULIN: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	2.47	gm/dL	2.30 - 3.50
A : G RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	1.6	RATIO	1.00 - 2.00

INTERPRETATION

NOTE:- To be correlated in individuals having SGOT and SGPT values higher than Normal Reference Range.


USE:- Differential diagnosis of diseases of hepatobiliary system and pancreas.

INCREASED:

DRUG HEPATOTOXICITY	> 2
ALCOHOLIC HEPATITIS	> 2 (Highly Suggestive)
CIRRHOSIS	1.4 - 2.0
INTRAHEPATIC CHOLESTASIS	> 1.5
HEPATOCELLULAR CARCINOMA & CHRONIC HEPATITIS	> 1.3 (Slightly Increased)




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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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P K R JAIN HEALTHCARE INSTITUTE

NASIRPUR, Hissar Road, AMBALA CITY- (Haryana)

A PIONEER DIAGNOSTIC CENTRE

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

TEST PERFORMED AT KOS DIAGNOSTIC LAB, AMBALA CANTT.

NAME	: Mr. RAVINDER SINGH	PATIENT ID	: 1733451
AGE/ GENDER	: 78 YRS/MALE	REG. NO./LAB NO.	: 122501240019
COLLECTED BY	:	REGISTRATION DATE	: 24/Jan/2025 11:43 AM
REFERRED BY	:	COLLECTION DATE	: 24/Jan/2025 11:44AM
BARCODE NO.	: 12506666	REPORTING DATE	: 24/Jan/2025 04:21PM
CLIENT CODE.	: P.K.R JAIN HEALTHCARE INSTITUTE		
CLIENT ADDRESS	: NASIRPUR, HISSAR ROAD, AMBALA CITY - HARYANA		

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

UREA: SERUM by UREASE - GLUTAMATE DEHYDROGENASE (GLDH)	25.8	mg/dL	10.00 - 50.00
CREATININE: SERUM by ENZYMATIC, SPECTROPHOTOMETRY	1.21	mg/dL	0.40 - 1.40
BLOOD UREA NITROGEN (BUN): SERUM by CALCULATED, SPECTROPHOTOMETRY	12.06	mg/dL	7.0 - 25.0
BLOOD UREA NITROGEN (BUN)/CREATININE RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	9.97 ^L	RATIO	10.0 - 20.0
UREA/CREATININE RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	21.32	RATIO	
URIC ACID: SERUM by URICASE - OXIDASE PEROXIDASE	5.83	mg/dL	3.60 - 7.70
CALCIUM: SERUM by ARSENAZO III, SPECTROPHOTOMETRY	9.58	mg/dL	8.50 - 10.60
PHOSPHOROUS: SERUM by PHOSPHOMOLYBDATE, SPECTROPHOTOMETRY	2.76	mg/dL	2.30 - 4.70

ELECTROLYTES

SODIUM: SERUM by ISE (ION SELECTIVE ELECTRODE)	139.2	mmol/L	135.0 - 150.0
POTASSIUM: SERUM by ISE (ION SELECTIVE ELECTRODE)	4.82	mmol/L	3.50 - 5.00
CHLORIDE: SERUM by ISE (ION SELECTIVE ELECTRODE)	104.4	mmol/L	90.0 - 110.0

ESTIMATED GLOMERULAR FILTRATION RATE

ESTIMATED GLOMERULAR FILTRATION RATE (eGFR): SERUM by CALCULATED	61.3
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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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- 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 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 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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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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Test Name	Value	Unit	Biological Reference interval
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C-REACTIVE PROTEIN (CRP)

C-REACTIVE PROTEIN (CRP) QUANTITATIVE: SERUM	4.39	mg/L	0.0 - 6.0
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by NEPHLOMETRY

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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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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CLINICAL PATHOLOGY

URINE ROUTINE & MICROSCOPIC EXAMINATION

PHYSICAL EXAMINATION

QUANTITY RECEIVED	30	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	NEGATIVE (-ve)		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
SUGAR	NEGATIVE (-ve)		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
pH	5.5		5.0 - 7.5
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
BILIRUBIN	NEGATIVE (-ve)		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
NITRITE	NEGATIVE (-ve)		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
UROBILINOGEN	NOT DETECTED	EU/dL	0.2 - 1.0
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
KETONE BODIES	NEGATIVE (-ve)		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
BLOOD	NEGATIVE (-ve)		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
ASCORBIC ACID	NEGATIVE (-ve)		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			

MICROSCOPIC EXAMINATION

RED BLOOD CELLS (RBCs)	NEGATIVE (-ve)	/HPF	0 - 3
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by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT			
PUS CELLS	3-4	/HPF	0 - 5
by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT			
EPITHELIAL CELLS	4-5	/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	FEW SPERMS SEEN		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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