



# P K R JAIN HEALTHCARE INSTITUTE

NASIRPUR, Hissar Road, AMBALA CITY- (Haryana)

## A PIONEER DIAGNOSTIC CENTRE

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

**NAME** : Mrs. SANTOSH  
**AGE/ GENDER** : 59 YRS/FEMALE  
**COLLECTED BY** :  
**REFERRED BY** :  
**BARCODE NO.** : 12506716  
**CLIENT CODE.** : P.K.R JAIN HEALTHCARE INSTITUTE  
**CLIENT ADDRESS** : NASIRPUR, HISSAR ROAD, AMBALA CITY - HARYANA

**PATIENT ID** : 1737453  
**REG. NO./LAB NO.** : 122501280001  
**REGISTRATION DATE** : 28/Jan/2025 08:49 AM  
**COLLECTION DATE** : 28/Jan/2025 09:02AM  
**REPORTING DATE** : 28/Jan/2025 12:51PM

Test Name	Value	Unit	Biological Reference interval
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### HAEMATOLOGY COMPLETE BLOOD COUNT (CBC)

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

HAEMOGLOBIN (HB) <i>by CALORIMETRIC</i>	12.9	gm/dL	12.0 - 16.0
RED BLOOD CELL (RBC) COUNT <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	5.02 <sup>H</sup>	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	38.9	%	37.0 - 50.0
MEAN CORPUSCULAR VOLUME (MCV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	77.4 <sup>L</sup>	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	25.7 <sup>L</sup>	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	33.2	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	13.9	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	39.6	fL	35.0 - 56.0
MENTZERS INDEX <i>by CALCULATED</i>	15.42	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX <i>by CALCULATED</i>	21.43	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>	9830	/cmm	4000 - 11000
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#### DIFFERENTIAL LEUCOCYTE COUNT (DLC)

NEUTROPHILS <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	66	%	50 - 70
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DR.VINAY CHOPRA  
CONSULTANT PATHOLOGIST  
MBBS, MD (PATHOLOGY & MICROBIOLOGY)

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





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LYMPHOCYTES <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	18 <sup>L</sup>	%	20 - 40
EOSINOPHILS <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	11 <sup>H</sup>	%	1 - 6
MONOCYTES <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	5	%	2 - 12
BASOPHILS <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	0	%	0 - 1
<b><u>ABSOLUTE LEUKOCYTES (WBC) COUNT</u></b>			
ABSOLUTE NEUTROPHIL COUNT <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	6488	/cmm	2000 - 7500
ABSOLUTE LYMPHOCYTE COUNT <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	1769	/cmm	800 - 4900
ABSOLUTE EOSINOPHIL COUNT <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	1081 <sup>H</sup>	/cmm	40 - 440
ABSOLUTE MONOCYTE COUNT <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	492	/cmm	80 - 880
ABSOLUTE BASOPHIL COUNT <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	0	/cmm	0 - 110
<b><u>PLATELETS AND OTHER PLATELET PREDICTIVE MARKERS.</u></b>			
PLATELET COUNT (PLT) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	480000 <sup>H</sup>	/cmm	150000 - 450000
PLATELETCRIT (PCT) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	0.43 <sup>H</sup>	%	0.10 - 0.36
MEAN PLATELET VOLUME (MPV) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	9	fL	6.50 - 12.0
PLATELET LARGE CELL COUNT (P-LCC) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	98000 <sup>H</sup>	/cmm	30000 - 90000
PLATELET LARGE CELL RATIO (P-LCR) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	20.4	%	11.0 - 45.0
PLATELET DISTRIBUTION WIDTH (PDW) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	15.7	%	15.0 - 17.0

NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD



  
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## ERYTHROCYTE SEDIMENTATION RATE (ESR)

ERYTHROCYTE SEDIMENTATION RATE (ESR) **60<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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## CLINICAL CHEMISTRY/BIOCHEMISTRY

### ELECTROLYTES COMPLETE PROFILE

SODIUM: SERUM <i>by ISE (ION SELECTIVE ELECTRODE)</i>	137.9	mmol/L	135.0 - 150.0
POTASSIUM: SERUM <i>by ISE (ION SELECTIVE ELECTRODE)</i>	4.37	mmol/L	3.50 - 5.00
CHLORIDE: SERUM <i>by ISE (ION SELECTIVE ELECTRODE)</i>	103.43	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 inadequate salt replacement.
3. Diuretics abuses.
4. Salt loosing nephropathy.
5. Metabolic acidosis.
6. Adrenocortical insufficiency .
7. Hepatic failure.

##### HYPERNATREMIA (INCREASED SODIUM LEVEL) CAUSES:-

1. Hyperapnea (Prolonged)
2. Diabetes insipidus
3. Diabetic acidosis
4. Cushing's 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



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2.Renal failure or Shock  
3.Respiratory acidosis  
4.Hemolysis of blood

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



  
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