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	**: Baby. HARNAAZ KAUR**		
AGE/ GENDER	: 1 YRS/FEMALE	**PATIENT ID**	: 1747541
COLLECTED BY	:	**REG. NO./LAB NO.**	**: 122502060020**
REFERRED BY	:	**REGISTRATION DATE**	: 06/Feb/2025 12:54 PM
BARCODE NO.	: 12506871	**COLLECTION DATE**	: 06/Feb/2025 01:01PM
CLIENT CODE.	: P.K.R JAIN HEALTHCARE INSTITUTE	**REPORTING DATE**	: 06/Feb/2025 02:28PM
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*	**10^{L}**	gm/dL	12.0 - 16.0
RED BLOOD CELL (RBC) COUNT *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	4.8	Millions/cmm	3.50 - 5.50
PACKED CELL VOLUME (PCV) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	**30^{L}**	%	35.0 - 49.0
MEAN CORPUSCULAR VOLUME (MCV) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	**62.6^{L}**	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	**20.8^{L}**	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	33.3	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	**16.5^{H}**	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	39.3	fL	35.0 - 56.0
MENTZERS INDEX *by CALCULATED*	13.04	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX *by CALCULATED*	21.48	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*	8270	/cmm	6000 - 18000
DIFFERENTIAL LEUCOCYTE COUNT (DLC)			
NEUTROPHILS *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	**29^{L}**	%	50 - 70

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Test Name	Value	Unit	Biological Reference interval
LYMPHOCYTES *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	**63^{H}**	%	20 - 60
EOSINOPHILS *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	2	%	1 - 6
MONOCYTES *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	6	%	3 - 13
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*	2398	/cmm	2000 - 7500
ABSOLUTE LYMPHOCYTE COUNT *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	**5210^{H}**	/cmm	800 - 4900
ABSOLUTE EOSINOPHIL COUNT *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	165	/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*	382000	/cmm	150000 - 450000
PLATELETCRIT (PCT) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	0.32	%	0.10 - 0.36
MEAN PLATELET VOLUME (MPV) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	8	fL	6.50 - 12.0
PLATELET LARGE CELL COUNT (P-LCC) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	73000	/cmm	30000 - 90000
PLATELET LARGE CELL RATIO (P-LCR) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	19	%	11.0 - 45.0
PLATELET DISTRIBUTION WIDTH (PDW) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	15.5	%	15.0 - 17.0

NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD

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Test Name	Value	Unit	Biological Reference interval
BLEEDING TIME (BT)			
BLEEDING TIME (BT) *by DUKE METHOD*	3:24	MINS	1 - 5

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Test Name	Value	Unit	Biological Reference interval
CLOTTING TIME (CT)			
CLOTTING TIME (CT) *by CAPILLARY TUBE METHOD*	6:12	MINS	4 - 9

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PROTHROMBIN TIME STUDIES (PT/INR)

Test Name	Value	Unit	Biological Reference interval
PT TEST (PATIENT) *by PHOTO OPTICAL CLOT DETECTION*	12.3	SECS	11.5 - 15.3
PT (CONTROL) *by PHOTO OPTICAL CLOT DETECTION*	12.1	SECS	
ISI *by PHOTO OPTICAL CLOT DETECTION*	1.1		
INTERNATIONAL NORMALISED RATIO (INR) *by PHOTO OPTICAL CLOT DETECTION*	1.02		0.86 - 1.22
PT INDEX *by PHOTO OPTICAL CLOT DETECTION*	98.37	%	

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+		

COMMENTS:

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Test Name	Value	Unit	Biological Reference interval

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

ACTIVATED PARTIAL THROMBOPLASTIN TIME (APTT)

APTT (PATIENT VALUE) *by PHOTO OPTICAL CLOT DETECTION*	35.21	SECS	33.6 - 43.8

INTERPRETATION:-

The activated partial thromboplastin time (aPTT or APTT) is a performance indicator measuring the efficacy of both the **intrinsic** (now referred to as the contact activation pathway) and the common coagulation pathways. Apart from detecting abnormalities in blood clotting, it is also used to monitor the treatment effects with heparin, a major anticoagulant. It is used in conjunction with the prothrombin time (PT) which measures the extrinsic pathway.

COMMON CAUSES OF PROLONGED APTT :-

1. Disseminated intravascular coagulation.
2. Liver disease.
3. Massive transfusion with stored blood.
4. Heparin administration or contamination.
5. A circulating Anticogulant.
6. Deficiency of a coagulation Factor other than factor 7.

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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.

*** End Of Report ***

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