



P K R JAIN HEALTHCARE INSTITUTE

NASIRPUR, Hissar Road, AMBALA CITY- (Haryana)

A PIONEER DIAGNOSTIC CENTRE

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

NAME	: Mr. SIMARDEEP SINGH	PATIENT ID	: 1749550
AGE/ GENDER	: 15 YRS/MALE	REG. NO./LAB NO.	: 122502080007
COLLECTED BY	:	REGISTRATION DATE	: 08/Feb/2025 09:17 AM
REFERRED BY	:	COLLECTION DATE	: 08/Feb/2025 12:33PM
BARCODE NO.	: 12506895	REPORTING DATE	: 08/Feb/2025 02:16PM
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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HAEMATOLOGY COMPLETE BLOOD COUNT (CBC)

RED BLOOD CELLS (RBCS) COUNT AND INDICES

HAEMOGLOBIN (HB) <i>by CALORIMETRIC</i>	14.6	gm/dL	12.0 - 17.0
RED BLOOD CELL (RBC) COUNT <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	4.81	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	43	%	35.0 - 49.0
MEAN CORPUSCULAR VOLUME (MCV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	89.5	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	30.5	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	34	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	12.5	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	43	fL	35.0 - 56.0
MENTZERS INDEX <i>by CALCULATED</i>	18.61	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX <i>by CALCULATED</i>	23.37	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>	7540	/cmm	4000 - 11000
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DIFFERENTIAL LEUCOCYTE COUNT (DLC)

NEUTROPHILS <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	53	%	50 - 70
LYMPHOCYTES	38	%	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	7	%	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	3996	/cmm	2000 - 7500
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
ABSOLUTE LYMPHOCYTE COUNT	2865	/cmm	800 - 4900
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
ABSOLUTE EOSINOPHIL COUNT	151	/cmm	40 - 440
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
ABSOLUTE MONOCYTE COUNT	528	/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)	155000	/cmm	150000 - 450000
by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE			
PLATELETCRIT (PCT)	0.24	%	0.10 - 0.36
by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE			
MEAN PLATELET VOLUME (MPV)	16 ^H	fL	6.50 - 12.0
by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE			
PLATELET LARGE CELL COUNT (P-LCC)	100000 ^H	/cmm	30000 - 90000
by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE			
PLATELET LARGE CELL RATIO (P-LCR)	64.2 ^H	%	11.0 - 45.0
by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE			
PLATELET DISTRIBUTION WIDTH (PDW)	16.1	%	15.0 - 17.0
by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE			
NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD			




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CLINICAL CHEMISTRY/BIOCHEMISTRY

GLUCOSE FASTING (F)

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

98.93

mg/dL


NORMAL: < 100.0
PREDIABETIC: 100.0 - 125.0
DIABETIC: > 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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CHOLESTEROL: SERUM

CHOLESTEROL TOTAL: SERUM
by CHOLESTEROL OXIDASE PAP

137.37

mg/dL

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

INTERPRETATION:

NATIONAL LIPID ASSOCIATION RECOMMENDATIONS (NLA-2014)	CHOLESTEROL IN ADULTS (mg/dL)	CHOLESTEROL IN ADULTS (mg/dL)
DESIRABLE	< 200.0	< 170.0
BORDERLINE HIGH	200.0 – 239.0	171.0 – 199.0
HIGH	>= 240.0	>= 200.0

NOTE:

- 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.
- As per National Lipid association - 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.




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LIVER FUNCTION TEST (COMPLETE)

BILIRUBIN TOTAL: SERUM <i>by DIAZOTIZATION, SPECTROPHOTOMETRY</i>	0.43	mg/dL	INFANT: 0.20 - 8.00 ADULT: 0.00 - 1.20
BILIRUBIN DIRECT (CONJUGATED): SERUM <i>by DIAZO MODIFIED, SPECTROPHOTOMETRY</i>	0.19	mg/dL	0.00 - 0.40
BILIRUBIN INDIRECT (UNCONJUGATED): SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	0.24	mg/dL	0.10 - 1.00
SGOT/AST: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	31.58	U/L	7.00 - 45.00
SGPT/ALT: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	30.95	U/L	0.00 - 49.00
AST/ALT RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	1.02	RATIO	0.00 - 46.00
ALKALINE PHOSPHATASE: SERUM <i>by PARA NITROPHENYL PHOSPHATASE BY AMINO METHYL PROPANOL</i>	521.91 ^H	U/L	50.00 - 370.00
GAMMA GLUTAMYL TRANSFERASE (GGT): SERUM <i>by SZASZ, SPECTROPHOTOMETRY</i>	15.03	U/L	0.00 - 55.0
TOTAL PROTEINS: SERUM <i>by BIURET, SPECTROPHOTOMETRY</i>	6.49	gm/dL	6.20 - 8.00
ALBUMIN: SERUM <i>by BROMOCRESOL GREEN</i>	4.35	gm/dL	3.50 - 5.50
GLOBULIN: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	2.14 ^L	gm/dL	2.30 - 3.50
A : G RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	2.03 ^H	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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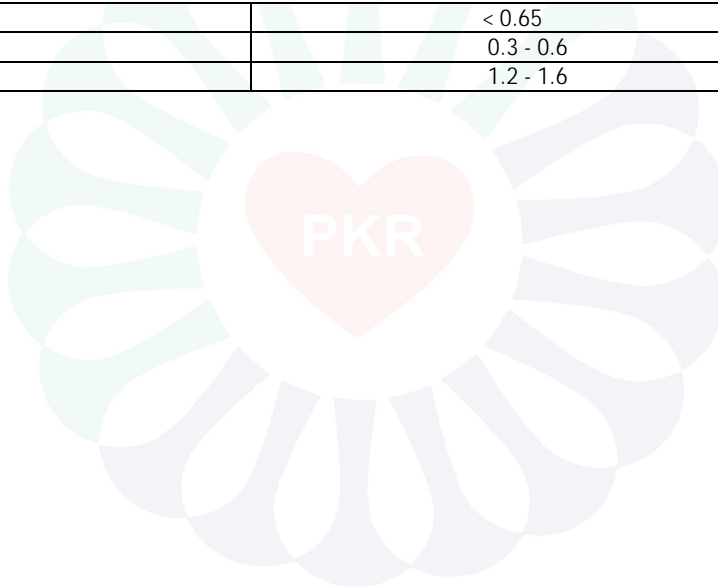
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DECREASED:

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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ENDOCRINOLOGY

THYROID FUNCTION TEST: TOTAL

TRIIODOTHYRONINE (T3): SERUM by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)	1.28	ng/mL	0.35 - 1.93
THYROXINE (T4): SERUM by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)	8.87	µgm/dL	4.87 - 13.20
THYROID STIMULATING HORMONE (TSH): SERUM by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)	1.75	µIU/mL	0.50 - 5.50

3rd GENERATION, ULTRASENSITIVE

INTERPRETATION:

TSH levels are subject to circadian variation, reaching peak levels between 2-4 a.m and at a minimum between 6-10 pm. The variation is of the order of 50%. Hence time of the day has influence on the measured serum TSH concentrations. TSH stimulates the production and secretion of the metabolically active hormones, thyroxine (T4) and triiodothyronine (T3). Failure at any level of regulation of the hypothalamic-pituitary-thyroid axis will result in either underproduction (hypothyroidism) or overproduction (hyperthyroidism) of T4 and/or T3.

CLINICAL CONDITION	T3	T4	TSH
Primary Hypothyroidism:	Reduced	Reduced	Increased (Significantly)
Subclinical Hypothyroidism:	Normal or Low Normal	Normal or Low Normal	High
Primary Hyperthyroidism:	Increased	Increased	Reduced (at times undetectable)
Subclinical Hyperthyroidism:	Normal or High Normal	Normal or High Normal	Reduced

LIMITATIONS:-

1. T3 and T4 circulates in reversibly bound form with Thyroid binding globulins (TBG), and to a lesser extent albumin and Thyroid binding Pre Albumin so conditions in which TBG and protein levels alter such as pregnancy, excess estrogens, androgens, anabolic steroids and glucocorticoids may falsely affect the T3 and T4 levels and may cause false thyroid values for thyroid function tests.
2. Normal levels of T4 can also be seen in Hyperthyroid patients with : T3 Thyrotoxicosis, Decreased binding capacity due to hypoproteinemia or ingestion of certain drugs (e.g.: phenytoin, salicylates).
3. Serum T4 levels in neonates and infants are higher than values in the normal adult, due to the increased concentration of TBG in neonate serum.
4. TSH may be normal in central hypothyroidism, recent rapid correction of hyperthyroidism or hypothyroidism, pregnancy, phenytoin therapy.

TRIIODOTHYRONINE (T3)		THYROXINE (T4)		THYROID STIMULATING HORMONE (TSH)	
Age	Refferance Range (ng/mL)	Age	Refferance Range (µg/dL)	Age	Reference Range (µIU/mL)
0 - 7 Days	0.20 - 2.65	0 - 7 Days	5.90 - 18.58	0 - 7 Days	2.43 - 24.3
7 Days - 3 Months	0.36 - 2.59	7 Days - 3 Months	6.39 - 17.66	7 Days - 3 Months	0.58 - 11.00
3 - 6 Months	0.51 - 2.52	3 - 6 Months	6.75 - 17.04	3 Days - 6 Months	0.70 - 8.40
6 - 12 Months	0.74 - 2.40	6 - 12 Months	7.10 - 16.16	6 - 12 Months	0.70 - 7.00




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1 - 10 Years	0.92 - 2.28	1 - 10 Years	6.00 - 13.80
11- 19 Years	0.35 - 1.93	11 - 19 Years	4.87- 13.20
> 20 years (Adults)	0.35 - 1.93	> 20 Years (Adults)	4.87 - 12.60
RECOMMENDATIONS OF TSH LEVELS DURING PREGNANCY (μ U/mL)			
1st Trimester			0.10 - 2.50
2nd Trimester			0.20 - 3.00
3rd Trimester			0.30 - 4.10

INCREASED TSH LEVELS:

- 1.Primary or untreated hypothyroidism may vary from 3 times to more than 100 times normal depending upon degree of hypofunction.
- 2.Hypothyroid patients receiving insufficient thyroid replacement therapy.
- 3.Hashimotos thyroiditis
- 4.DRUGS: Amphetamines, iodine containing agents & dopamine antagonist.
- 5.Neonatal period, increase in 1st 2-3 days of life due to post-natal surge


DECREASED TSH LEVELS:

- 1.Toxic multi-nodular goiter & Thyroiditis.
- 2.Over replacement of thyroid hormone in treatment of hypothyroidism.
- 3.Autonomously functioning Thyroid adenoma
- 4.Secondary pituitary or hypothalamic hypothyroidism
- 5.Acute psychiatric illness
- 6.Severe dehydration.
- 7.DRUGS: Glucocorticoids, Dopamine, Levodopa, T4 replacement therapy, Anti-thyroid drugs for thyrotoxicosis.
- 8.Pregnancy: 1st and 2nd Trimester

*** End Of Report ***




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