P K R JAIN HEALTHCARE INSTITUTE

NASIRPUR, Hissar Road, AMBALA CITY- (Haryana)

A PIONEER DIAGNOSTIC CENTRE

0171-2532620, 8222896961 pkrjainhealthcare@gmail.com

NAME	**: Master. SHIVAAY**		
AGE/ GENDER	: 8 YRS/MALE	**PATIENT ID**	: 1751471
COLLECTED BY	:	**REG. NO./LAB NO.**	**: 122502100019**
REFERRED BY	:	**REGISTRATION DATE**	: 10/Feb/2025 12:56 PM
BARCODE NO.	: 12506933	**COLLECTION DATE**	: 10/Feb/2025 12:59PM
CLIENT CODE.	: P.K.R JAIN HEALTHCARE INSTITUTE	**REPORTING DATE**	: 10/Feb/2025 01:40PM
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*	13.2	gm/dL	12.0 - 16.0
RED BLOOD CELL (RBC) COUNT *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	4.73	Millions/cmm	3.50 - 5.50
PACKED CELL VOLUME (PCV) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	37.5	%	35.0 - 49.0
MEAN CORPUSCULAR VOLUME (MCV) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	**79.4**^{L}	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	28	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	35.3	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	13.2	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	41.1	fL	35.0 - 56.0
MENTZERS INDEX *by CALCULATED*	16.79	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX *by CALCULATED*	22.23	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*	11600	/cmm	4000 - 12000
DIFFERENTIAL LEUCOCYTE COUNT (DLC)			
NEUTROPHILS *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	57	%	50 - 70
LYMPHOCYTES	34	%	20 - 45

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Test Name	Value	Unit	Biological Reference interval
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
EOSINOPHILS *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	**0^{L}**	%	1 - 6
MONOCYTES *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	9	%	3 - 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*	6612	/cmm	2000 - 7500
ABSOLUTE LYMPHOCYTE COUNT *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	**3944^{L}**	/cmm	800 - 4900
ABSOLUTE EOSINOPHIL COUNT *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	**0^{L}**	/cmm	40 - 440
ABSOLUTE MONOCYTE COUNT *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	**1044^{H}**	/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*	291000	/cmm	150000 - 450000
PLATELETCRIT (PCT) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	0.31	%	0.10 - 0.36
MEAN PLATELET VOLUME (MPV) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	11	fL	6.50 - 12.0
PLATELET LARGE CELL COUNT (P-LCC) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	**94000^{H}**	/cmm	30000 - 90000
PLATELET LARGE CELL RATIO (P-LCR) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	32.3	%	11.0 - 45.0
PLATELET DISTRIBUTION WIDTH (PDW) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	16.2	%	15.0 - 17.0

NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD

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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*	**36^{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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Test Name	Value	Unit	Biological Reference interval

IMMUNOPATHOLOGY/SEROLOGY

TYPHOID COMBO SCREEN (TYPHOID ANTIGEN, IgG AND IgM): SERUM

TYPHOID ANTIGEN - SERUM *by ICT (IMMUNOCHROMATOGRAPHY)*	NEGATIVE (-ve)		NEGATIVE (-ve)
TYPHI DOT ANTIBODY IgG *by ICT (IMMUNOCHROMATOGRAPHY)*	NEGATIVE (-ve)		NEGATIVE (-ve)
TYPHI DOT ANTIBODY IgM *by ICT (IMMUNOCHROMATOGRAPHY)*	NEGATIVE (-ve)		NEGATIVE (-ve)

INTERPRETATION:

Typhoid fever is a life threatening illness caused by the bacterium Salmonella typhus.The infection is acquired typically by ingestion. On reaching the gut, the bacilli attach themselves to the epithelial cells of the intestinal villi and penetrate the lamina and submucosa. They are then phagocytosed there by polymorphs and mesenteric lymph nodes, where they multiply and, via the thoracic duct, enter the blood stream. A transient bacteremia follows, during which the bacilli are seeded in the liver, gall bladder, spleen, bone marrow, lymph nodes, and kidneys, where further multiplication takes place. Towards the end of the incubation period, there occurs a massive bacteremia from these sites, heralding the onset of the clinical symptoms.

The diagnosis of typhoid consists of isolation of the bacilli and the demonstration of antibodies. The isolation of the bacilli is very time consuming and antibody detection is not very specific. Other tests include the Widal reaction. The advantage of this test is that it takes only 10-20 minutes and requires only a small amount of stool/serum/plasma to perform. It is the easiest and most specific method for detecting S. typhi infection.

RELATIVE SENSTIVITY OF TYPHOID ANTIGEN DETECTION: 98.7%
RELATIVE SPECIFICITY OF TYPHOID ANTIGEN DETECTION: 97.4%

DETECTABLE IgM RESPONSE:

ONSET OF FEVER	PERCENT POSITIVE
4 - 6 DAYS	43.5
6 - 9 DAYS	92.9
> 9 DAYS	99.5

1.This is a solid phase, immunochromatographic ELISA assay that detects specific IgM and IgG Antibodies against the OUTER MEMBRAN PROTEIN(OMP) of theSalmonella species. IgM antibodies appear in the serum 2-3 days post infection and are indicative of a recent infection while the IgG antibodies appear later and are useful for presumptive diagnosis of Enteric fever if the patient presents more than a week after onset of symptoms.

2.This is a useful screening assay for the early detection of Enteric fever and has a high sensitivity. However the test has moderate specificity and false positive results may be obtained in the following situations:

- Antibodies against Salmonella may cross react with other antibodies.
- Unrelated infections may lead to production of specific Salmonella antibodies if the patient has previously been exposed to

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Test Name	Value	Unit	Biological Reference interval

Salmonella infection **(ANAMNESTIC RESPONSE)**.

NOTE:-Rapid blood culture performed during 1st week of infection is highly recommended for confirmation of all IgM positive results. In case the patient has presented after the first week of infection, a thorough clinical correlation and confirmatory Widal test must be performed to establish the diagnosis.

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Test Name	Value	Unit	Biological Reference interval

C-REACTIVE PROTEIN (CRP)

C-REACTIVE PROTEIN (CRP) QUANTITATIVE: SERUM *by NEPHLOMETRY*	**46.99H**	mg/L	0.0 - 6.0

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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CLINICAL PATHOLOGY

URINE ROUTINE & MICROSCOPIC EXAMINATION

Test Name	Value	Unit	Biological Reference interval
PHYSICAL EXAMINATION			
QUANTITY RECIEVED *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	30	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*	1.01		1.002 - 1.030
CHEMICAL EXAMINATION			
REACTION *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	ALKALINE		
PROTEIN *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	NEGATIVE (-ve)		NEGATIVE (-ve)
SUGAR *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	NEGATIVE (-ve)		NEGATIVE (-ve)
pH *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	7.5		5.0 - 7.5
BILIRUBIN *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	NEGATIVE (-ve)		NEGATIVE (-ve)
NITRITE *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY.*	NEGATIVE (-ve)		NEGATIVE (-ve)
UROBILINOGEN *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	NOT DETECTED	EU/dL	0.2 - 1.0
KETONE BODIES *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	NEGATIVE (-ve)		NEGATIVE (-ve)
BLOOD *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	NEGATIVE (-ve)		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	3-4	/HPF	0 - 5
by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT			
EPITHELIAL CELLS	2-3	/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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