



# P K R JAIN HEALTHCARE INSTITUTE

NASIRPUR, Hissar Road, AMBALA CITY- (Haryana)

## A PIONEER DIAGNOSTIC CENTRE

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

**NAME** : Mrs. HARJINDER KAUR  
**AGE/ GENDER** : 45 YRS/FEMALE  
**COLLECTED BY** :  
**REFERRED BY** :  
**BARCODE NO.** : 12507156  
**CLIENT CODE.** : P.K.R JAIN HEALTHCARE INSTITUTE  
**CLIENT ADDRESS** : NASIRPUR, HISSAR ROAD, AMBALA CITY - HARYANA

**PATIENT ID** : 1765298  
**REG. NO./LAB NO.** : 122502210018  
**REGISTRATION DATE** : 21/Feb/2025 02:14 PM  
**COLLECTION DATE** : 21/Feb/2025 03:49PM  
**REPORTING DATE** : 22/Feb/2025 11:38AM

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>	4.14	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	38.8	%	37.0 - 50.0
MEAN CORPUSCULAR VOLUME (MCV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	93.8	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	31.3	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	33.3	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	13.4	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	47.2	fL	35.0 - 56.0
MENTZERS INDEX <i>by CALCULATED</i>	22.66	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX <i>by CALCULATED</i>	30.5	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>	7600	/cmm	4000 - 11000
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#### DIFFERENTIAL LEUCOCYTE COUNT (DLC)

NEUTROPHILS <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	64	%	50 - 70
LYMPHOCYTES	29	%	20 - 40



  
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by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
EOSINOPHILS	3	%	1 - 6
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
MONOCYTES	4	%	2 - 12
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
BASOPHILS	0	%	0 - 1
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
<b><u>ABSOLUTE LEUKOCYTES (WBC) COUNT</u></b>			
ABSOLUTE NEUTROPHIL COUNT	4864	/cmm	2000 - 7500
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
ABSOLUTE LYMPHOCYTE COUNT	2204 <sup>L</sup>	/cmm	800 - 4900
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
ABSOLUTE EOSINOPHIL COUNT	228	/cmm	40 - 440
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
ABSOLUTE MONOCYTE COUNT	304	/cmm	80 - 880
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
ABSOLUTE BASOPHIL COUNT	0	/cmm	0 - 110
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
<b><u>PLATELETS AND OTHER PLATELET PREDICTIVE MARKERS.</u></b>			
PLATELET COUNT (PLT)	250000	/cmm	150000 - 450000
by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE			
PLATELETCRIT (PCT)	0.23	%	0.10 - 0.36
by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE			
MEAN PLATELET VOLUME (MPV)	9	fL	6.50 - 12.0
by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE			
PLATELET LARGE CELL COUNT (P-LCC)	56000	/cmm	30000 - 90000
by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE			
PLATELET LARGE CELL RATIO (P-LCR)	22.2	%	11.0 - 45.0
by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE			
PLATELET DISTRIBUTION WIDTH (PDW)	15.7	%	15.0 - 17.0
by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE			
NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD			



  
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<b>BARCODE NO.</b>	: 12507156	<b>REPORTING DATE</b>	: 22/Feb/2025 05:04PM
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## PERIPHERAL BLOOD SMEAR

### TEST NAME:

**PERIPHERAL BLOOD FILM/SMEAR (PBF)**

### RED BLOOD CELLS (RBC'S):

RBCs mostly appear normocytic & normochromic.No polychromatic cells or normoblastic activity evident.

### WHITE BLOOD CELLS (WBC'S):

No immature leucocytes seen.

### PLATELETS:

Platelets are adequate.


### HEMOPARASITES:


NOT SEEN.

### IMPRESSION:

Normocytic normochromic picture.



  
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## PROTHROMBIN TIME STUDIES (PT/INR)

PT TEST (PATIENT) by PHOTO OPTICAL CLOT DETECTION	13.8	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	1.17		0.80 - 1.20
PT INDEX by PHOTO OPTICAL CLOT DETECTION	86.96	%	

### 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 <sup>+</sup>	

### 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

### CALCIUM

CALCIUM: SERUM by ARSENAZO III, SPECTROPHOTOMETRY	9.74	mg/dL	8.50 - 10.60
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#### INTERPRETATION:-

1. Serum calcium (total) estimation is used for the diagnosis and monitoring of a wide range of disorders including diseases of bone, kidney, parathyroid gland, or gastrointestinal tract.
2. Calcium levels may also reflect abnormal vitamin D or protein levels.
3. The calcium content of an adult is somewhat over 1 kg (about 2% of the body weight). Of this, 99% is present as calcium hydroxyapatite in bones and <1% is present in the extra-osseous intracellular space or extracellular space (ECS).
4. In serum, calcium is bound to a considerable extent to proteins (approximately 40%), 10% is in the form of inorganic complexes, and 50% is present as free or ionized calcium.

**NOTE:-** Calcium ions affect the contractility of the heart and the skeletal musculature, and are essential for the function of the nervous system. In addition, calcium ions play an important role in blood clotting and bone mineralization.

#### HYPOCALCEMIA (LOW CALCIUM LEVELS) CAUSES :-

1. Due to the absence or impaired function of the parathyroid glands or impaired vitamin-D synthesis.
2. Chronic renal failure is also frequently associated with hypocalcemia due to decreased vitamin-D synthesis as well as hyperphosphatemia and skeletal resistance to the action of parathyroid hormone (PTH).
3. **NOTE:-** A characteristic symptom of hypocalcemia is latent or manifest tetany and osteomalacia.

#### HYPERCALCEMIA (INCREASE CALCIUM LEVELS) CAUSES:-

1. Increased mobilization of calcium from the skeletal system or increased intestinal absorption.
  2. Primary hyperparathyroidism (pHPT)
  3. Bone metastasis of carcinoma of the breast, prostate, thyroid gland, or lung.
- NOTE:-** Severe hypercalcemia may result in cardiac arrhythmia.



  
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## ELECTROLYTES PROFILE: SODIUM AND POTASSIUM

SODIUM: SERUM by ISE (ION SELECTIVE ELECTRODE)	139.7	mmol/L	135.0 - 150.0
POTASSIUM: SERUM by ISE (ION SELECTIVE ELECTRODE)	3.6	mmol/L	3.50 - 5.00

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

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



  
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