P K R JAIN HEALTHCARE INSTITUTE

NASIRPUR, Hissar Road, AMBALA CITY- (Haryana)

A PIONEER DIAGNOSTIC CENTRE

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NAME	**: Mr. GURDEV SINGH**		
AGE/ GENDER	: 63 YRS/MALE	**PATIENT ID**	: 1776154
COLLECTED BY	:	**REG. NO./LAB NO.**	**: 122503030004**
REFERRED BY	:	**REGISTRATION DATE**	: 03/Mar/2025 10:12 AM
BARCODE NO.	: 12507305	**COLLECTION DATE**	: 03/Mar/2025 10:19AM
CLIENT CODE.	: P.K.R JAIN HEALTHCARE INSTITUTE	**REPORTING DATE**	: 03/Mar/2025 12:58PM
CLIENT ADDRESS	: NASIRPUR, HISSAR ROAD, AMBALA CITY - HARYANA		

SWASTHYA WELLNESS PANEL: 1.0

COMPLETE BLOOD COUNT (CBC)

Test Name	Value	Unit	Biological Reference interval
RED BLOOD CELLS (RBCS) COUNT AND INDICES			
HAEMOGLOBIN (HB) *by CALORIMETRIC*	13	gm/dL	12.0 - 17.0
RED BLOOD CELL (RBC) COUNT *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	4.63	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	**38.1^{L}**	%	40.0 - 54.0
MEAN CORPUSCULAR VOLUME (MCV) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	82.3	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*	34.1	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	13.8	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) *by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER*	42.2	fL	35.0 - 56.0
MENTZERS INDEX *by CALCULATED*	17.78	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX *by CALCULATED*	24.46	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*	8700	/cmm	4000 - 11000
DIFFERENTIAL LEUCOCYTE COUNT (DLC)			
NEUTROPHILS *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	**74^{H}**	%	50 - 70

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Test Name	Value	Unit	Biological Reference interval
LYMPHOCYTES *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	**16^{L}**	%	20 - 40
EOSINOPHILS *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	3	%	1 - 6
MONOCYTES *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	7	%	2 - 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*	6438	/cmm	2000 - 7500
ABSOLUTE LYMPHOCYTE COUNT *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	**1392^{L}**	/cmm	800 - 4900
ABSOLUTE EOSINOPHIL COUNT *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	261	/cmm	40 - 440
ABSOLUTE MONOCYTE COUNT *by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY*	609	/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*	**69000^{L}**	/cmm	150000 - 450000
PLATELETCRIT (PCT) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	0.1	%	0.10 - 0.36
MEAN PLATELET VOLUME (MPV) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	**14^{H}**	fL	6.50 - 12.0
PLATELET LARGE CELL COUNT (P-LCC) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	41000	/cmm	30000 - 90000
PLATELET LARGE CELL RATIO (P-LCR) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	**59.5^{H}**	%	11.0 - 45.0
PLATELET DISTRIBUTION WIDTH (PDW) *by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE*	16.4	%	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*	**21 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

CLINICAL CHEMISTRY/BIOCHEMISTRY

GLUCOSE FASTING (F)

GLUCOSE FASTING (F): PLASMA *by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)*	**116.23^{H}**	mg/dL	NORMAL: < 100.0 PREDIABETIC: 100.0 - 125.0 DIABETIC: > 0R = 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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LIPID PROFILE : BASIC

Test Name	Value	Unit	Biological Reference interval
CHOLESTEROL TOTAL: SERUM *by CHOLESTEROL OXIDASE PAP*	141.27	mg/dL	OPTIMAL: < 200.0 BORDERLINE HIGH: 200.0 - 239.0 HIGH CHOLESTEROL: > OR = 240.0
TRIGLYCERIDES: SERUM *by GLYCEROL PHOSPHATE OXIDASE (ENZYMATIC)*	**170.11^{H}**	mg/dL	OPTIMAL: < 150.0 BORDERLINE HIGH: 150.0 - 199.0 HIGH: 200.0 - 499.0 VERY HIGH: > OR = 500.0
HDL CHOLESTEROL (DIRECT): SERUM *by SELECTIVE INHIBITION*	46.51	mg/dL	LOW HDL: < 30.0 BORDERLINE HIGH HDL: 30.0 - 60.0 HIGH HDL: > OR = 60.0
LDL CHOLESTEROL: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	60.74	mg/dL	OPTIMAL: < 100.0 ABOVE OPTIMAL: 100.0 - 129.0 BORDERLINE HIGH: 130.0 - 159.0 HIGH: 160.0 - 189.0 VERY HIGH: > OR = 190.0
NON HDL CHOLESTEROL: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	94.76	mg/dL	OPTIMAL: < 130.0 ABOVE OPTIMAL: 130.0 - 159.0 BORDERLINE HIGH: 160.0 - 189.0 HIGH: 190.0 - 219.0 VERY HIGH: > OR = 220.0
VLDL CHOLESTEROL: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	34.02	mg/dL	0.00 - 45.00
TOTAL LIPIDS: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	452.65	mg/dL	350.00 - 700.00
CHOLESTEROL/HDL RATIO: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	3.04	RATIO	LOW RISK: 3.30 - 4.40 AVERAGE RISK: 4.50 - 7.0 MODERATE RISK: 7.10 - 11.0 HIGH RISK: > 11.0

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Test Name	Value	Unit	Biological Reference interval
LDL/HDL RATIO: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	1.31	RATIO	LOW RISK: 0.50 - 3.0 MODERATE RISK: 3.10 - 6.0 HIGH RISK: > 6.0
TRIGLYCERIDES/HDL RATIO: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	3.66	RATIO	3.00 - 5.00

INTERPRETATION:

1.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.

2. As per NLA-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.

3. Low HDL levels are associated with increased risk for Atherosclerotic Cardiovascular disease (ASCVD) due to insufficient HDL being available to participate in reverse cholesterol transport, the process by which cholesterol is eliminated from peripheral tissues.

4. NLA-2014 identifies Non HDL Cholesterol (an indicator of all atherogeniclipoproteins such as LDL , VLDL, IDL, Lpa, Chylomicron remnants) along with LDL-cholesterol as co- primary target for cholesterol lowering therapy. Note that major risk factors can modify treatment goals for LDL &Non HDL.

5. Additional testing for Apolipoprotein B, hsCRP,Lp(a) & LP-PLA2 should be considered among patients with moderate risk for ASCVD for risk refinement

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LIVER FUNCTION TEST (COMPLETE)

Test Name	Value	Unit	Biological Reference interval
BILIRUBIN TOTAL: SERUM *by DIAZOTIZATION, SPECTROPHOTOMETRY*	0.54	mg/dL	INFANT: 0.20 - 8.00 ADULT: 0.00 - 1.20
BILIRUBIN DIRECT (CONJUGATED): SERUM *by DIAZO MODIFIED, SPECTROPHOTOMETRY*	0.23	mg/dL	0.00 - 0.40
BILIRUBIN INDIRECT (UNCONJUGATED): SERUM *by CALCULATED, SPECTROPHOTOMETRY*	0.31	mg/dL	0.10 - 1.00
SGOT/AST: SERUM *by IFCC, WITHOUT PYRIDOXAL PHOSPHATE*	20.35	U/L	7.00 - 45.00
SGPT/ALT: SERUM *by IFCC, WITHOUT PYRIDOXAL PHOSPHATE*	18.51	U/L	0.00 - 49.00
AST/ALT RATIO: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	1.1	RATIO	0.00 - 46.00
ALKALINE PHOSPHATASE: SERUM *by PARA NITROPHENYL PHOSPHATASE BY AMINO METHYL PROPANOL*	74.23	U/L	40.0 - 130.0
GAMMA GLUTAMYL TRANSFERASE (GGT): SERUM *by SZASZ, SPECTROPHTOMETRY*	10.94	U/L	0.00 - 55.0
TOTAL PROTEINS: SERUM *by BIURET, SPECTROPHOTOMETRY*	**6.11^{L}**	gm/dL	6.20 - 8.00
ALBUMIN: SERUM *by BROMOCRESOL GREEN*	4.21	gm/dL	3.50 - 5.50
GLOBULIN: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	**1.9^{L}**	gm/dL	2.30 - 3.50
A : G RATIO: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	**2.22^{H}**	RATIO	1.00 - 2.00

INTERPRETATION

NOTE:- **To be correlated in individuals having SGOT and SGPT values higher than Normal Referance 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 CHOLESTATIS	> 1.5
HEPATOCELLULAR CARCINOMA & CHRONIC HEPATITIS	> 1.3 (Slightly Increased)

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Test Name	Value	Unit	Biological Reference interval

DECREASED:

1. Acute Hepatitis due to virus, drugs, toxins (with AST increased 3 to 10 times upper limit of normal)
2. Extra Hepatic cholestatis: 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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KIDNEY FUNCTION TEST (COMPLETE)

Test Name	Value	Unit	Biological Reference interval
UREA: SERUM *by UREASE - GLUTAMATE DEHYDROGENASE (GLDH)*	**66.05^{H}**	mg/dL	10.00 - 50.00
CREATININE: SERUM *by ENZYMATIC, SPECTROPHOTOMETERY*	1.07	mg/dL	0.40 - 1.40
BLOOD UREA NITROGEN (BUN): SERUM *by CALCULATED, SPECTROPHOTOMETRY*	**30.86^{H}**	mg/dL	7.0 - 25.0
BLOOD UREA NITROGEN (BUN)/CREATININE RATIO: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	**28.84^{H}**	RATIO	10.0 - 20.0
UREA/CREATININE RATIO: SERUM *by CALCULATED, SPECTROPHOTOMETRY*	61.73	RATIO	
URIC ACID: SERUM *by URICASE - OXIDASE PEROXIDASE*	5.03	mg/dL	3.60 - 7.70
CALCIUM: SERUM *by ARSENAZO III, SPECTROPHOTOMETRY*	9.12	mg/dL	8.50 - 10.60
PHOSPHOROUS: SERUM *by PHOSPHOMOLYBDATE, SPECTROPHOTOMETRY*	3.33	mg/dL	2.30 - 4.70
ELECTROLYTES			
SODIUM: SERUM *by ISE (ION SELECTIVE ELECTRODE)*	140.6	mmol/L	135.0 - 150.0
POTASSIUM: SERUM *by ISE (ION SELECTIVE ELECTRODE)*	4.12	mmol/L	3.50 - 5.00
CHLORIDE: SERUM *by ISE (ION SELECTIVE ELECTRODE)*	105.45	mmol/L	90.0 - 110.0
ESTIMATED GLOMERULAR FILTERATION RATE			
ESTIMATED GLOMERULAR FILTERATION RATE (eGFR): SERUM *by CALCULATED*	78		
ADVICE	**KINDLY CORRELATE CLINICALLY**		

INTERPRETATION:

To differentiate between pre- and post renal azotemia.

INCREASED RATIO (>20:1) WITH NORMAL CREATININE:

1. Prerenal azotemia (BUN rises without increase in creatinine) e.g. heart failure, salt depletion,dehydration, blood loss) due to decreased glomerular filtration rate.

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Test Name	Value	Unit	Biological Reference interval

2. Catabolic states with increased tissue breakdown.
3. GI haemorrhage.
4. High protein intake.
5. Impaired renal function plus
6. Excess protein intake or production or tissue breakdown (e.g. infection, GI bleeding, thyrotoxicosis, Cushing's syndrome, high protein diet, burns, surgery, cachexia, high fever).
7. Urine reabsorption (e.g. ureter colostomy)
8. Reduced muscle mass (subnormal creatinine production)
9. Certain drugs (e.g. tetracycline, glucocorticoids)

INCREASED RATIO (>20:1) WITH ELEVATED CREATININE LEVELS:

1. Postrenal azotemia (BUN rises disproportionately more than creatinine) (e.g. obstructive uropathy).
2. Prerenal azotemia superimposed on renal disease.

DECREASED RATIO (<10:1) WITH DECREASED BUN :

1. Acute tubular necrosis.
2. Low protein diet and starvation.
3. Severe liver disease.
4. Other causes of decreased urea synthesis.
5. Repeated dialysis (urea rather than creatinine diffuses out of extracellular fluid).
6. Inherited hyperammonemias (urea is virtually absent in blood).
7. SIADH (syndrome of inappropiate antidiuretic harmone) due to tubular secretion of urea.
8. Pregnancy.

DECREASED RATIO (<10:1) WITH INCREASED CREATININE:

1. Phenacimide therapy (accelerates conversion of creatine to creatinine).
2. Rhabdomyolysis (releases muscle creatinine).
3. Muscular patients who develop renal failure.

INAPPROPIATE RATIO:

1. Diabetic ketoacidosis (acetoacetate causes false increase in creatinine with certain methodologies,resulting in normal ratio when dehydration should produce an increased BUN/creatinine ratio).
2. Cephalosporin therapy (interferes with creatinine measurement).

ESTIMATED GLOMERULAR FILTERATION RATE:

CKD STAGE	DESCRIPTION	GFR (mL/min/1.73m2)	ASSOCIATED FINDINGS
G1	Normal kidney function	>90	No proteinuria
G2	Kidney damage with normal or high GFR	>90	Presence of Protein , Albumin or cast in urine
G3a	Mild decrease in GFR	60 -89	
G3b	Moderate decrease in GFR	30-59	
G4	Severe decrease in GFR	15-29	
G5	Kidney failure	<15	

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REFERRED BY	:	**REGISTRATION DATE**	: 03/Mar/2025 10:12 AM
BARCODE NO.	: 12507305	**COLLECTION DATE**	: 03/Mar/2025 10:19AM
CLIENT CODE.	: P.K.R JAIN HEALTHCARE INSTITUTE	**REPORTING DATE**	: 03/Mar/2025 07:00PM
CLIENT ADDRESS	: NASIRPUR, HISSAR ROAD, AMBALA CITY - HARYANA		

Test Name	Value	Unit	Biological Reference interval

COMMENTS:

1. Estimated Glomerular filtration rate (eGFR) is the sum of filtration rates in all functioning nephrons and so an estimation of the GFR provides a measure of functioning nephrons of the kidney.
2. eGFR calculated using the 2009 CKD-EPI creatinine equation and GFR category reported as per KDIGO guideline 2012
3. In patients, with eGFR creatinine between 45-59 ml/min/1.73 m2 (G3) and without any marker of Kidney damage, It is recommended to measure eGFR with Cystatin C for confirmation of CKD
4. eGFR category G1 OR G2 does not fullfill the criteria for CKD, in the absence of evidence of Kidney Damage
5. In a suspected case of Acute Kidney Injury (AKI), measurement of eGFR should be done after 48-96 hours of any Intervention or procedure
6. eGFR calculated by Serum Creatinine may be less accurate due to certain factors like Race, Muscle Mass, Diet, Certain Drugs. In such cases, eGFR should be calculated using Serum Cystatin C
7. A decrease in eGFR implies either progressive renal disease, or a reversible process causing decreased nephron function (eg, severe dehydration).

ADVICE:

KDIGO guideline, 2012 recommends Chronic Kidney Disease (CKD) should be classified based on cause, eGFR category and Albuminuria (ACR) category. GFR & ACR category combined together reflect risk of progression and helps Clinician to identify the individual who are progressing at more rapid rate than anticipated

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ENDOCRINOLOGY

INTACT PARATHYROID HORMONE (PTH)

INTACT PARATHROID HORMONE (PTH): SERUM *by CLIA (CHEMILUMINESCENCE IMMUNOASSAY)*	59.8	pg/mL	9.5 - 65.0

Intrepretation:-

Parathyroid hormone (PTH) is produced and secreted by the parathyroid glands, which are located along the posterior aspect of the thyroid gland. The serum calcium level regulates PTH secretion via negative feedback through the parathyroid calcium sensing receptor (CASR). Decreased calcium levels stimulate PTH release. Secreted PTH interacts with its specific type II G-protein receptor, causing rapid increases in renal tubular reabsorption of calcium and decreased phosphorus reabsorption. It also participates in long-term calciostatic functions by enhancing mobilization of calcium from bone and increasing renal synthesis of 1,25-dihydroxy vitamin D, which, in turn, increases intestinal calcium absorption.

The assay is useful for:

- Differential diagnosis of hypercalcemia
- Diagnosis of primary, secondary, and tertiary hyperparathyroidism
- Diagnosis of hypoparathyroidism
- Monitoring end-stage renal failure patients for possible renal osteodystrophy

Interpretation of results:

- An (appropriately) low PTH level and high phosphorus level in a hypercalcemic patient suggests that the hypercalcemia is not caused by PTH or PTH-like substances.
- An (appropriately) low PTH level with a low phosphorus level in a hypercalcemic patient suggests the diagnosis of paraneoplastic hypercalcemia.
- A low or normal PTH in a patient with hypocalcemia suggests hypoparathyroidism.

Low serum calcium and high PTH levels in a patient with normal renal function suggest resistance to PTH action (pseudohypoparathyroidism type 1a, 1b, 1c, or 2) or, very rarely, bio-ineffective PTH.

Elevated PTH value with a normal serum calcium in many cases in India is due to secondary hyperparathyroidism, primary cause being Vitamin D deficiency.

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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*	10	ml	
COLOUR *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	PALE YELLOW		PALE YELLOW
TRANSPARANCY *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	HAZY		CLEAR
SPECIFIC GRAVITY *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	1.02		1.002 - 1.030
CHEMICAL EXAMINATION			
REACTION *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	ACIDIC		
PROTEIN ***by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY***	**3+**		**NEGATIVE (-ve)**
SUGAR ***by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY***	**2+**		**NEGATIVE (-ve)**
pH *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	<=5.0		5.0 - 7.5
BILIRUBIN *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	Negative		NEGATIVE (-ve)
NITRITE *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY.*	Negative		NEGATIVE (-ve)
UROBILINOGEN *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	Normal	EU/dL	0.2 - 1.0
KETONE BODIES *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	Negative		NEGATIVE (-ve)
BLOOD ***by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY***	**1+**		**NEGATIVE (-ve)**
ASCORBIC ACID *by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY*	NEGATIVE (-ve)		NEGATIVE (-ve)
MICROSCOPIC EXAMINATION			
RED BLOOD CELLS (RBCs) *by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT*	5-6	/HPF	0 - 3

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Test Name	Value	Unit	Biological Reference interval
PUS CELLS *by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT*	1-3	/HPF	0 - 5
EPITHELIAL CELLS *by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT*	0-2	/HPF	ABSENT
CRYSTALS *by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT*	NEGATIVE (-ve)		NEGATIVE (-ve)
CASTS *by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT*	NEGATIVE (-ve)		NEGATIVE (-ve)
BACTERIA *by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT*	NEGATIVE (-ve)		NEGATIVE (-ve)
OTHERS *by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT*	NEGATIVE (-ve)		NEGATIVE (-ve)
TRICHOMONAS VAGINALIS (PROTOZOA) *by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT*	ABSENT		ABSENT

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Test Name	Value	Unit	Biological Reference interval

PROTEINS: 24 HOURS URINE

URINE VOLUME: 24 HOUR *by SPECTROPHOTOMETRY*	1850	mL	
PROTEINS: 24 HOURS URINE *by BIURET, SPECTROPHOTOMETRY*	**554.26^{H}**	mg/ 24 HOURS	25 -160

INTERPRETATION:

TYPES OF PROTEINURIA	*TOTAL PROTEINS IN mg/24 HOURS*	*CONDITIONS*
MINIMAL PROTEINURIA:	150 - 500 mg/24 hours	Chronic pyelonephritis, Chronic Interstial Nephritis, Renal Tubular disease, Postural
MODERATE PROTEINURIA:	500 - 1000 mg/24 hours	Nephrosclerosis, Multiple Myeloma, Toxic Nephropathy, Renal Calculi
HEAVY PROTEINURIA:	1000 - 3000 mg/24 hours	Nephrotic Syndrome, Acute Rapidly Progressive & Chronic Glomerulonephritis, Diabetes mellitus, Lupus erythematosus, Druga like Pencillamine, Heavy metals like Gold & Mercury.

NOTE:
1.Excreation of total protein in individuals is highly variable with or without kidney disease.
2.Conditions affecting protein excreation other than kidney didease are urinary tract infection, diet, mensturation & physical activity.

COMMENT:
1.Diagnosis of kidney disease and response to therapy is usually obtained by quatitattively analyzing the amount of protein excreated in urine over a 24 hour period.

*** End Of Report ***

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