



P K R JAIN HEALTHCARE INSTITUTE

NASIRPUR, Hissar Road, AMBALA CITY- (Haryana)

A PIONEER DIAGNOSTIC CENTRE

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

NAME : Miss. KRITIKA SHARMA
AGE/ GENDER : 20 YRS/FEMALE
COLLECTED BY :
REFERRED BY :
BARCODE NO. : 12507475
CLIENT CODE. : P.K.R JAIN HEALTHCARE INSTITUTE
CLIENT ADDRESS : NASIRPUR, HISSAR ROAD, AMBALA CITY - HARYANA

PATIENT ID : 1788614
REG. NO./LAB NO. : 122503120005
REGISTRATION DATE : 12/Mar/2025 10:24 AM
COLLECTION DATE : 12/Mar/2025 11:00AM
REPORTING DATE : 12/Mar/2025 11:46AM

| Test Name | Value | Unit | Biological Reference interval |
|-----------|-------|------|-------------------------------|
|-----------|-------|------|-------------------------------|

HAEMATOLOGY COMPLETE BLOOD COUNT (CBC)

RED BLOOD CELLS (RBCS) COUNT AND INDICES

| | | | |
|---|-------------------|--------------|--|
| HAEMOGLOBIN (HB) <i>by CALORIMETRIC</i> | 12.2 | 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> | 35.8 ^L | % | 37.0 - 50.0 |
| MEAN CORPUSCULAR VOLUME (MCV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i> | 86.3 | fL | 80.0 - 100.0 |
| MEAN CORPUSCULAR HAEMOGLOBIN (MCH) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i> | 29.3 | 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> | 13.2 | % | 11.00 - 16.00 |
| RED CELL DISTRIBUTION WIDTH (RDW-SD) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i> | 43.4 | fL | 35.0 - 56.0 |
| MENTZERS INDEX <i>by CALCULATED</i> | 20.85 | RATIO | BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0 |
| GREEN & KING INDEX <i>by CALCULATED</i> | 27.36 | 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> | 6340 | /cmm | 4000 - 11000 |
|---|------|------|--------------|

DIFFERENTIAL LEUCOCYTE COUNT (DLC)

| | | | |
|---|----|---|---------|
| NEUTROPHILS <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i> | 61 | % | 50 - 70 |
| LYMPHOCYTES | 26 | % | 20 - 40 |




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| by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY | | | |
| EOSINOPHILS | 5 | % | 1 - 6 |
| by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY | | | |
| MONOCYTES | 8 | % | 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 | 3867 | /cmm | 2000 - 7500 |
| by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY | | | |
| ABSOLUTE LYMPHOCYTE COUNT | 1648 ^L | /cmm | 800 - 4900 |
| by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY | | | |
| ABSOLUTE EOSINOPHIL COUNT | 317 | /cmm | 40 - 440 |
| by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY | | | |
| ABSOLUTE MONOCYTE COUNT | 507 | /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) | 102000 ^L | /cmm | 150000 - 450000 |
| by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE | | | |
| PLATELETCRIT (PCT) | 0.17 | % | 0.10 - 0.36 |
| by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE | | | |
| MEAN PLATELET VOLUME (MPV) | 17 ^H | fL | 6.50 - 12.0 |
| by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE | | | |
| PLATELET LARGE CELL COUNT (P-LCC) | 69000 | /cmm | 30000 - 90000 |
| by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE | | | |
| PLATELET LARGE CELL RATIO (P-LCR) | 67.6 ^H | % | 11.0 - 45.0 |
| by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE | | | |
| PLATELET DISTRIBUTION WIDTH (PDW) | 16.4 | % | 15.0 - 17.0 |
| by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE | | | |
| NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD | | | |




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CLINICAL CHEMISTRY/BIOCHEMISTRY

LIVER FUNCTION TEST (COMPLETE)

| | | | |
|--|---------------------|-------|---|
| BILIRUBIN TOTAL: SERUM <i>by DIAZOTIZATION, SPECTROPHOTOMETRY</i> | 0.53 | mg/dL | INFANT: 0.20 - 8.00 ADULT: 0.00 - 1.20 |
| BILIRUBIN DIRECT (CONJUGATED): SERUM <i>by DIAZO MODIFIED, SPECTROPHOTOMETRY</i> | 0.21 | mg/dL | 0.00 - 0.40 |
| BILIRUBIN INDIRECT (UNCONJUGATED): SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i> | 0.32 | mg/dL | 0.10 - 1.00 |
| SGOT/AST: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i> | 26.78 | U/L | 7.00 - 45.00 |
| SGPT/ALT: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i> | 23.78 | U/L | 0.00 - 49.00 |
| AST/ALT RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i> | 1.13 | RATIO | 0.00 - 46.00 |
| ALKALINE PHOSPHATASE: SERUM <i>by PARA NITROPHENYL PHOSPHATASE BY AMINO METHYL PROPANOL</i> | 137.82 ^H | U/L | 40.0 - 130.0 |
| GAMMA GLUTAMYL TRANSFERASE (GGT): SERUM <i>by SZASZ, SPECTROPHOTOMETRY</i> | 10.68 | U/L | 0.00 - 55.0 |
| TOTAL PROTEINS: SERUM <i>by BIURET, SPECTROPHOTOMETRY</i> | 6.28 | gm/dL | 6.20 - 8.00 |
| ALBUMIN: SERUM <i>by BROMOCRESOL GREEN</i> | 4.1 | gm/dL | 3.50 - 5.50 |
| GLOBULIN: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i> | 2.18 ^L | gm/dL | 2.30 - 3.50 |
| A : G RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i> | 1.88 | 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 CHOLESTATIS | > 1.5 |




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| HEPATOCELLULAR CARCINOMA & CHRONIC HEPATITIS | | > 1.3 (Slightly Increased) | |


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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KIDNEY FUNCTION TEST (BASIC)

| | | | |
|--|-------|-------|---------------|
| UREA: SERUM by UREASE - GLUTAMATE DEHYDROGENASE (GLDH) | 29.96 | mg/dL | 10.00 - 50.00 |
| CREATININE: SERUM by ENZYMATIC, SPECTROPHOTOMETRY | 0.89 | mg/dL | 0.40 - 1.20 |
| BLOOD UREA NITROGEN (BUN): SERUM by CALCULATED, SPECTROPHOTOMETRY | 14 | mg/dL | 7.0 - 25.0 |
| BLOOD UREA NITROGEN (BUN)/CREATININE RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY | 15.73 | RATIO | 10.0 - 20.0 |
| UREA/CREATININE RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY | 33.66 | RATIO | |
| URIC ACID: SERUM by URICASE - OXIDASE PEROXIDASE | 2.61 | mg/dL | 2.50 - 6.80 |




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INTERPRETATION:

Normal range for a healthy person on normal diet: 12 - 20

To Differentiate between pre- and postrenal 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.
2. Catabolic states with increased tissue breakdown.
3. GI hemorrhage.
4. High protein intake.
5. Impaired renal function plus .
6. Excess protein intake or production or tissue breakdown (e.g. infection, GI bleeding, thyrotoxicosis, Cushings syndrome, high protein diet, burns, surgery, cachexia, high fever).
7. Urine reabsorption (e.g. ureterocolostomy)
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 inappropriate antidiuretic hormone) 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.

INAPPROPRIATE 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).



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IMMUNOPATHOLOGY/SEROLOGY

ANTI TISSUE TRANSGLUTAMINASE (tTG) ANTIBODY IgA

| | | | |
|---|------|-------|--------------------------------------|
| ANTI TISSUE TRANSGLUTAMINASE ANTIBODY IgA by ELISA (ENZYME LINKED IMMUNOASSAY) | 3.43 | IU/mL | NEGATIVE: < 20.0 POSITIVE: > 20.0 |
|---|------|-------|--------------------------------------|

INTERPRETATION:

1. Anti-transglutaminase antibodies (ATA) are autoantibodies against the transglutaminase protein.
2. Antibodies to tissue transglutaminase are found in patients with several conditions, including coeliac disease, juvenile diabetes, inflammatory bowel disease, and various forms of arthritis.
3. In coeliac disease, ATA are involved in the destruction of the villous extracellular matrix and target the destruction of intestinal villous epithelial cells by killer cells.
4. Deposits of anti-tTG in the intestinal epithelium predict coeliac disease.
5. Celiac disease (gluten-sensitive enteropathy, celiac sprue) results from an immune-mediated inflammatory process following ingestion of wheat, rye, or barley proteins that occurs in genetically susceptible individuals. The inflammation in celiac disease occurs primarily in the mucosa of the small intestine, which leads to villous atrophy.

CLINICAL MANIFESTATIONS RELATED TO GASTROINTESTINAL TRACT:

1. Abdominal pain
2. Malabsorption
3. Diarrhea and Constipation.

CLINICAL MANIFESTATION OF CELIAC DISEASE NOT RESTRICTED TO GIT:

1. Failure to grow (delayed puberty and short stature)
2. Iron deficiency anemia
3. Recurrent fetal loss
4. Osteoporosis and chronic fatigue
5. Recurrent aphthous stomatitis (canker sores)
6. Dental enamel hypoplasia, and dermatitis herpetiformis.
7. Patients with celiac disease may also present with neuropsychiatric manifestations including ataxia and peripheral neuropathy, and are at increased risk for development of non-Hodgkin lymphoma.
8. The disease is also associated with other clinical disorders including thyroiditis, type I diabetes mellitus, Down syndrome, and IgA deficiency.


NOTE:


1. The finding of tissue transglutaminase (tTG)-IgA antibodies is specific for celiac disease and possibly for dermatitis herpetiformis. For individuals with moderately to strongly positive results, a diagnosis of celiac disease is likely and the patient should undergo biopsy to confirm the diagnosis.
2. If patients strictly adhere to a gluten-free diet, the unit value of IgA-anti-tTG should begin to decrease within 6 to 12 months of onset of dietary therapy.

CAUTION:

1. This test should not be solely relied upon to establish a diagnosis of celiac disease. It should be used to identify patients who have an increased probability of having celiac disease and in whom a small intestinal biopsy is recommended.




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- Affected individuals who have been on a gluten-free diet prior to testing may have a negative result.
- For individuals who test negative, IgA deficiency should be considered. If total IgA is normal and tissue transglutaminase (tTG)-IgA is negative there is a low probability of the patient having celiac disease and a biopsy may not be necessary.
- If serology is negative or there is substantial clinical doubt remaining, then further investigation should be performed with endoscopy and bowel biopsy. This is especially important in patients with frank malabsorptive symptoms since many syndromes can mimic celiac disease. For the patient with frank malabsorptive symptoms, bowel biopsy should be performed regardless of serologic test results.
- The antibody pattern in dermatitis herpetiformis may be more variable than in celiac disease; therefore, both endomysial and tTG antibody determinations are recommended to maximize the sensitivity of the serologic tests.




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C-REACTIVE PROTEIN (CRP)

C-REACTIVE PROTEIN (CRP) QUANTITATIVE: 1.56 mg/L 0.0 - 6.0
SERUM
by NEPHLOMETRY

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.

*** End Of Report ***




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