



P K R JAIN HEALTHCARE INSTITUTE

NASIRPUR, Hissar Road, AMBALA CITY- (Haryana)

A PIONEER DIAGNOSTIC CENTRE

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

NAME : Mrs. POOJA JAIN
AGE/ GENDER : 44 YRS/FEMALE
COLLECTED BY :
REFERRED BY :
BARCODE NO. : 12507921
CLIENT CODE. : P.K.R JAIN HEALTHCARE INSTITUTE
CLIENT ADDRESS : NASIRPUR, HISSAR ROAD, AMBALA CITY - HARYANA

PATIENT ID : 1674751
REG. NO./LAB NO. : 122504060004
REGISTRATION DATE : 06/Apr/2025 09:17 AM
COLLECTION DATE : 06/Apr/2025 09:24 AM
REPORTING DATE : 06/Apr/2025 11:35 AM

Test Name	Value	Unit	Biological Reference interval
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SWASTHYA WELLNESS PANEL: 1.2

COMPLETE BLOOD COUNT (CBC)

RED BLOOD CELLS (RBCS) COUNT AND INDICES

HAEMOGLOBIN (HB) by CALORIMETRIC	12.8	gm/dL	12.0 - 16.0
RED BLOOD CELL (RBC) COUNT by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	4.64	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	37	%	37.0 - 50.0
MEAN CORPUSCULAR VOLUME (MCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	79..7	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	27.6	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	34.6	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	14.5	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	43.5	fL	35.0 - 56.0
MENTZERS INDEX by CALCULATED	17.03	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0

WHITE BLOOD CELLS (WBCS)

TOTAL LEUCOCYTE COUNT (TLC) by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	6030	/cmm	4000 - 11000
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DIFFERENTIAL LEUCOCYTE COUNT (DLC)

NEUTROPHILS by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	58	%	50 - 70
LYMPHOCYTES by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	35	%	20 - 40
EOSINOPHILS by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	0L	%	1 - 6




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MONOCYTES <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	7	%	2 - 12
BASOPHILS <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	0	%	0 - 1
<u>ABSOLUTE LEUKOCYTES (WBC) COUNT</u>			
<u>PLATELETS AND OTHER PLATELET PREDICTIVE MARKERS.</u>			
PLATELET COUNT (PLT) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	213000	/cmm	150000 - 450000
PLATELETCRIT (PCT) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	0.3	%	0.10 - 0.36
PLATELET LARGE CELL COUNT (P-LCC) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	71000	/cmm	30000 - 90000
NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD			




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ERYTHROCYTE SEDIMENTATION RATE (ESR)

ERYTHROCYTE SEDIMENTATION RATE (ESR)	10	mm/1st hr	0 - 20
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by RED CELL AGGREGATION BY CAPILLARY PHOTOMETRY

INTERPRETATION:

1. ESR is a non-specific test because an elevated result often indicates the presence of inflammation associated with infection, cancer and autoimmune 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:

- ESR and C - reactive protein (C-RP) are both markers of inflammation.
- Generally, ESR does not change as rapidly as does CRP, either at the start of inflammation or as it resolves.
- CRP is not affected by as many other factors as is ESR, making it a better marker of inflammation.**
- If the ESR is elevated, it is typically a result of two types of proteins, globulins or fibrinogen.
- Women tend to have a higher ESR, and menstruation and pregnancy can cause temporary elevations.
- 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 PERFORMED AT KOS DIAGNOSTIC LAB, AMBALA CANTT.

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CLINICAL CHEMISTRY/BIOCHEMISTRY

GLUCOSE FASTING (F)

GLUCOSE FASTING (F): PLASMA by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)	77.72	mg/dL	NORMAL: < 100.0 PREDIABETIC: 100.0 - 125.0 DIABETIC: > OR = 126.0
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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			
CHOLESTEROL TOTAL: SERUM <i>by CHOLESTEROL OXIDASE PAP</i>	187.5	mg/dL	OPTIMAL: < 200.0 BORDERLINE HIGH: 200.0 - 239.0 HIGH CHOLESTEROL: > OR = 240.0
TRIGLYCERIDES: SERUM <i>by GLYCEROL PHOSPHATE OXIDASE (ENZYMATIC)</i>	111.55	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 <i>by SELECTIVE INHIBITION</i>	48.99	mg/dL	LOW HDL: < 30.0 BORDERLINE HIGH HDL: 30.0 - 60.0 HIGH HDL: > OR = 60.0
LDL CHOLESTEROL: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	116.2	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 <i>by CALCULATED, SPECTROPHOTOMETRY</i>	138.51 ^H	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 <i>by CALCULATED, SPECTROPHOTOMETRY</i>	22.31	mg/dL	0.00 - 45.00
TOTAL LIPIDS: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	486.55	mg/dL	350.00 - 700.00
CHOLESTEROL/HDL RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	3.83	RATIO	LOW RISK: 3.30 - 4.40 AVERAGE RISK: 4.50 - 7.0




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Test Name	Value	Unit	Biological Reference interval
LDL/HDL RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	2.37	RATIO	MODERATE RISK: 7.10 - 11.0 HIGH RISK: > 11.0 LOW RISK: 0.50 - 3.0 MODERATE RISK: 3.10 - 6.0 HIGH RISK: > 6.0
TRIGLYCERIDES/HDL RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	2.28 ^L	RATIO	3.00 - 5.00

INTERPRETATION:

- 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 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.
- 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.
- NLA-2014 identifies Non HDL Cholesterol (an indicator of all atherogenic lipoproteins such as LDL, VLDL, IDL, Lp(a), 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.
- 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)

BILIRUBIN TOTAL: SERUM <i>by DIAZOTIZATION, SPECTROPHOTOMETRY</i>	0.49	mg/dL	INFANT: 0.20 - 8.00 ADULT: 0.00 - 1.20
BILIRUBIN DIRECT (CONJUGATED): SERUM <i>by DIAZO MODIFIED, SPECTROPHOTOMETRY</i>	0.17	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>	17.46	U/L	7.00 - 45.00
SGPT/ALT: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	9.5	U/L	0.00 - 49.00
AST/ALT RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	1.84	RATIO	0.00 - 46.00
ALKALINE PHOSPHATASE: SERUM <i>by PARA NITROPHENYL PHOSPHATASE BY AMINO METHYL PROPANOL</i>	72.53	U/L	40.0 - 130.0
GAMMA GLUTAMYL TRANSFERASE (GGT): SERUM <i>by SZASZ, SPECTROPHOTOMETRY</i>	19.91	U/L	0.00 - 55.0
TOTAL PROTEINS: SERUM <i>by BIURET, SPECTROPHOTOMETRY</i>	5.21 ^L	gm/dL	6.20 - 8.00
ALBUMIN: SERUM <i>by BROMOCRESOL GREEN</i>	3.73	gm/dL	3.50 - 5.50
GLOBULIN: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	1.48 ^L	gm/dL	2.30 - 3.50
A : G RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	2.52 ^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 CHOLESTATIS	> 1.5




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Test Name	Value	Unit	Biological Reference interval
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 (COMPLETE)

UREA: SERUM by UREASE - GLUTAMATE DEHYDROGENASE (GLDH)	13.58	mg/dL	10.00 - 50.00
CREATININE: SERUM by ENZYMATIC, SPECTROPHOTOMETRY	0.69	mg/dL	0.40 - 1.20
BLOOD UREA NITROGEN (BUN): SERUM by CALCULATED, SPECTROPHOTOMETRY	6.35 ^L	mg/dL	7.0 - 25.0
BLOOD UREA NITROGEN (BUN)/CREATININE RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	9.2 ^L	RATIO	10.0 - 20.0
UREA/CREATININE RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	19.68	RATIO	
URIC ACID: SERUM by URICASE - OXIDASE PEROXIDASE	2.91	mg/dL	2.50 - 6.80
CALCIUM: SERUM by ARSENAZO III, SPECTROPHOTOMETRY	8.87	mg/dL	8.50 - 10.60
PHOSPHOROUS: SERUM by PHOSPHOMOLYBDATE, SPECTROPHOTOMETRY	3.3	mg/dL	2.30 - 4.70

ELECTROLYTES

SODIUM: SERUM by ISE (ION SELECTIVE ELECTRODE)	140.2	mmol/L	135.0 - 150.0
POTASSIUM: SERUM by ISE (ION SELECTIVE ELECTRODE)	3.99	mmol/L	3.50 - 5.00
CHLORIDE: SERUM by ISE (ION SELECTIVE ELECTRODE)	105.15	mmol/L	90.0 - 110.0

ESTIMATED GLOMERULAR FILTRATION RATE

ESTIMATED GLOMERULAR FILTRATION RATE (eGFR): SERUM by CALCULATED	109.7
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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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- Catabolic states with increased tissue breakdown.
- GI haemorrhage.
- High protein intake.
- Impaired renal function plus
- 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).
- Urine reabsorption (e.g. ureter colostomy)
- Reduced muscle mass (subnormal creatinine production)
- Certain drugs (e.g. tetracycline, glucocorticoids)

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

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

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

- Acute tubular necrosis.
- Low protein diet and starvation.
- Severe liver disease.
- Other causes of decreased urea synthesis.
- Repeated dialysis (urea rather than creatinine diffuses out of extracellular fluid).
- Inherited hyperammonemias (urea is virtually absent in blood).
- SIADH (syndrome of inappropriate antidiuretic hormone) due to tubular secretion of urea.
- Pregnancy.

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

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

INAPPROPRIATE RATIO:

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

ESTIMATED GLOMERULAR FILTRATION 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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A PIONEER DIAGNOSTIC CENTRE

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

NAME	: Mrs. POOJA JAIN	PATIENT ID	: 1674751
AGE/ GENDER	: 44 YRS/FEMALE	REG. NO./LAB NO.	: 122504060004
COLLECTED BY	:	REGISTRATION DATE	: 06/Apr/2025 09:17 AM
REFERRED BY	:	COLLECTION DATE	: 06/Apr/2025 09:24AM
BARCODE NO.	: 12507921	REPORTING DATE	: 06/Apr/2025 05:07PM
CLIENT CODE.	: P.K.R JAIN HEALTHCARE INSTITUTE		
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Test Name	Value	Unit	Biological Reference interval
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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 fulfill 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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Test Name	Value	Unit	Biological Reference interval
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ENDOCRINOLOGY

THYROID FUNCTION TEST: TOTAL

TRIODOOTHYRONINE (T3): SERUM by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)	1.23	ng/mL	0.35 - 1.93
THYROXINE (T4): SERUM by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)	7.87	µgm/dL	4.87 - 12.60
THYROID STIMULATING HORMONE (TSH): SERUM by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY) 3rd GENERATION, ULTRA SENSITIVE	14.7 ^H	µIU/mL	0.35 - 5.50

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:-

- 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.
- 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).
- 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.
- TSH may be normal in central hypothyroidism, recent rapid correction of hyperthyroidism or hypothyroidism, pregnancy, phenytoin therapy.

TRIODOOTHYRONINE (T3)		THYROXINE (T4)		THYROID STIMULATING HORMONE (TSH)	
Age	Reference Range (ng/mL)	Age	Reference 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




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Test Name		Value		Unit	Biological Reference interval
6 - 12 Months	0.74 - 2.40	6 - 12 Months	7.10 - 16.16	6 - 12 Months	0.70 - 7.00
1 - 10 Years	0.92 - 2.28	1 - 10 Years	6.00 - 13.80	1 - 10 Years	0.60 - 5.50
11- 19 Years	0.35 - 1.93	11 - 19 Years	4.87- 13.20	11 - 19 Years	0.50 - 5.50
> 20 years (Adults)	0.35 - 1.93	> 20 Years (Adults)	4.87 - 12.60	> 20 Years (Adults)	0.35- 5.50
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




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TEST PERFORMED AT KOS DIAGNOSTIC LAB, AMBALA CANTT.

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TUMOUR MARKER

CANCER ANTIGEN 125 (CA 125): OVARIAN CANCER MARKER

CANCER ANTIGEN (CA) -125: SERUM	23.6	U/mL	0.0 - 35.0
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by CMIA (CHEMILUMINESCENCE MICROPARTICLE IMMUNOASSAY)

INTERPRETATION:

1. Cancer antigen 125 (CA 125) is a glycoprotein antigen normally expressed in tissues derived from coelomic epithelia (ovary, fallopian tube, peritoneum, pleura, pericardium, colon, kidney, stomach).
2. Serum CA 125 is elevated in approximately 80% of women with advanced epithelial ovarian cancer, but assay sensitivity is suboptimal in early disease stages. The average reported sensitivities are 50% for stage I and 90% for stage II or greater.
3. Elevated serum CA 125 levels have been reported in individuals with a variety of nonovarian malignancies including cervical, liver, pancreatic, lung, colon, stomach, biliary tract, uterine, fallopian tube, breast, and endometrial carcinomas.

SIGNIFICANCE:

1. Evaluating patients' response to cancer therapy, especially for ovarian carcinoma
2. Predicting recurrent ovarian cancer or intra-peritoneal tumor. In monitoring studies, elevations of cancer antigen 125 (CA 125) >35 U/mL after de-bulking surgery and chemotherapy indicate that residual disease is likely (>95% accuracy). However, normal levels do not rule-out recurrence.
3. A persistently rising CA 125 value suggests progressive malignant disease and poor therapeutic response.
4. Physiologic half-life of CA 125 is approximately 5 days.
5. In patients with advanced disease who have undergone cyto-reductive surgery and are on chemotherapy, a prolonged half-life (>20 days) may be associated with a shortened disease-free survival.

NOTE:

1. CA 125 levels. Hence this assay, regardless of level, should not be interpreted as absolute evidence for the presence or absence of malignant disease. The assay value should be used in conjunction with findings from clinical evaluation and other diagnostic procedures. It is not recommended to use this test for the initial diagnosis of ovarian cancer.
2. Falsely Elevated serum CA 125 levels have been reported in individuals with a variety of nonmalignant conditions including: cirrhosis, hepatitis, endometriosis, first trimester pregnancy, ovarian cysts, and pelvic inflammatory disease. Elevated levels during the menstrual cycle also have been reported.



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CLINICAL PATHOLOGY

URINE ROUTINE & MICROSCOPIC EXAMINATION

PHYSICAL EXAMINATION

QUANTITY RECIEVED	10	ml	
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
COLOUR	PALE YELLOW		PALE YELLOW
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
TRANSPARANCY	TURBID		CLEAR
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
SPECIFIC GRAVITY	1.01		1.002 - 1.030
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			


CHEMICAL EXAMINATION

REACTION	ACIDIC		
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
PROTEIN	NEGATIVE (-ve)		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
SUGAR	NEGATIVE (-ve)		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
pH	6		5.0 - 7.5
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
BILIRUBIN	NEGATIVE (-ve)		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
NITRITE	NEGATIVE (-ve)		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY.			
UROBILINOGEN	NOT DETECTED	EU/dL	0.2 - 1.0
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
KETONE BODIES	NEGATIVE (-ve)		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
BLOOD	3+		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
ASCORBIC ACID	NEGATIVE (-ve)		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			

MICROSCOPIC EXAMINATION




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Test Name	Value	Unit	Biological Reference interval
RED BLOOD CELLS (RBCs) by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT	25 - 30	/HPF	0 - 3
PUS CELLS by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT	4-5	/HPF	0 - 5
EPITHELIAL CELLS by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT	2-3	/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

*** End Of Report ***




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