



P K R JAIN HEALTHCARE INSTITUTE

NASIRPUR, Hissar Road, AMBALA CITY- (Haryana)

A PIONEER DIAGNOSTIC CENTRE

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

TEST PERFORMED AT KOS DIAGNOSTIC LAB, AMBALA CANTT.

NAME	: Mr. KUSUM	PATIENT ID	: 1823715
AGE/ GENDER	: 53 YRS/MALE	REG. NO./LAB NO.	: 122504090006
COLLECTED BY	:	REGISTRATION DATE	: 09/Apr/2025 08:55 AM
REFERRED BY	:	COLLECTION DATE	: 09/Apr/2025 09:45AM
BARCODE NO.	: 12507973	REPORTING DATE	: 09/Apr/2025 01:10PM
CLIENT CODE.	: P.K.R JAIN HEALTHCARE INSTITUTE		
CLIENT ADDRESS	: NASIRPUR, HISSAR ROAD, AMBALA CITY - HARYANA		

Test Name	Value	Unit	Biological Reference interval
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SWASTHYA WELLNESS PANEL: 1.0

COMPLETE BLOOD COUNT (CBC)

RED BLOOD CELLS (RBCS) COUNT AND INDICES

HAEMOGLOBIN (HB) <i>by CALORIMETRIC</i>	10.7 ^L	gm/dL	12.0 - 17.0
RED BLOOD CELL (RBC) COUNT <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	4.33	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	32.6 ^L	%	40.0 - 54.0
MEAN CORPUSCULAR VOLUME (MCV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	75.2 ^L	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	24.6 ^L	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	32.7	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) <i>by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER</i>	16.5 ^H	%	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>	17.37	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX <i>by CALCULATED</i>	87.2	RATIO	BETA THALASSEMIA TRAIT: <= 74.1 IRON DEFICIENCY ANEMIA: >= 74.1


WHITE BLOOD CELLS (WBCS)


TOTAL LEUCOCYTE COUNT (TLC) <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	2410 ^L	/cmm	4000 - 11000
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DIFFERENTIAL LEUCOCYTE COUNT (DLC)

NEUTROPHILS	58	%	50 - 70
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<i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>			
LYMPHOCYTES	27	%	20 - 40
<i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>			
EOSINOPHILS	3	%	1 - 6
<i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>			
MONOCYTES	12	%	2 - 12
<i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>			
BASOPHILS	0	%	0 - 1
<i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>			
<u>ABSOLUTE LEUKOCYTES (WBC) COUNT</u>			
ABSOLUTE NEUTROPHIL COUNT	1398 ^L	/cmm	2000 - 7500
<i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>			
ABSOLUTE LYMPHOCYTE COUNT	651 ^L	/cmm	800 - 4900
<i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>			
ABSOLUTE EOSINOPHIL COUNT	72	/cmm	40 - 440
<i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>			
ABSOLUTE MONOCYTE COUNT	289	/cmm	80 - 880
<i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>			
ABSOLUTE BASOPHIL COUNT	0	/cmm	0 - 110
<i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>			
<u>PLATELETS AND OTHER PLATELET PREDICTIVE MARKERS.</u>			
PLATELET COUNT (PLT)	109000 ^L	/cmm	150000 - 450000
<i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>			
PLATELETCRIT (PCT)	0.12	%	0.10 - 0.36
<i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>			
MEAN PLATELET VOLUME (MPV)	11	fL	6.50 - 12.0
<i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>			
PLATELET LARGE CELL COUNT (P-LCC)	40000	/cmm	30000 - 90000
<i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>			
PLATELET LARGE CELL RATIO (P-LCR)	36.6	%	11.0 - 45.0
<i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>			
PLATELET DISTRIBUTION WIDTH (PDW)	16	%	15.0 - 17.0
<i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>			

NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD



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ERYTHROCYTE SEDIMENTATION RATE (ESR)

ERYTHROCYTE SEDIMENTATION RATE (ESR)	38^H	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:

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, methyl dopa, oral contraceptives, penicillamine procainamide, theophylline, and vitamin A can increase ESR, while aspirin, cortisone, and quinine may decrease it



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PROTHROMBIN TIME STUDIES (PT/INR)

PT TEST (PATIENT) <i>by PHOTO OPTICAL CLOT DETECTION</i>	12.7	SECS	11.5 - 14.5
PT (CONTROL) <i>by PHOTO OPTICAL CLOT DETECTION</i>	12	SECS	
ISI <i>by PHOTO OPTICAL CLOT DETECTION</i>	1.1		
INTERNATIONAL NORMALISED RATIO (INR) <i>by PHOTO OPTICAL CLOT DETECTION</i>	1.06		0.80 - 1.20
PT INDEX <i>by PHOTO OPTICAL CLOT DETECTION</i>	94.49	%	

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	Low Intensity 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	
Recurrent embolism	High Intensity 2.5 - 3.5
Mechanical heart valve	
Antiphospholipid antibodies ⁺	

COMMENTS:




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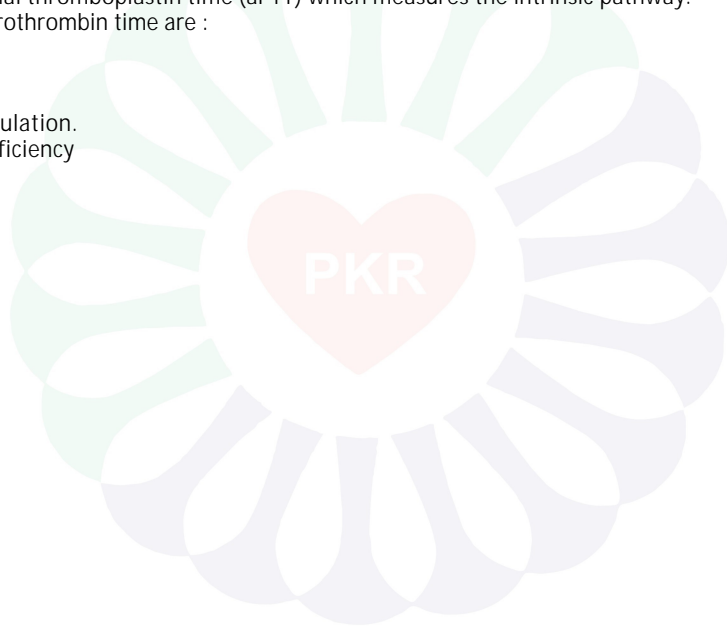
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The prothrombin time (PT) and its derived measures of prothrombin ratio (PR) and international normalized ratio (INR) are measures of the efficacy of the extrinsic pathway of coagulation. PT test reflects the adequacy of factors I (fibrinogen), II (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

GLUCOSE FASTING (F)

GLUCOSE FASTING (F): PLASMA by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)	93.44	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>	128.24	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>	83.94	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>	35.21	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>	76.24	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>	93.03	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>	16.79	mg/dL	0.00 - 45.00
TOTAL LIPIDS: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	340.42 ^L	mg/dL	350.00 - 700.00
CHOLESTEROL/HDL RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	3.64	RATIO	LOW RISK: 3.30 - 4.40 AVERAGE RISK: 4.50 - 7.0




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LDL/HDL RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	2.17	RATIO	MODERATE RISK: 7.10 - 11.0 HIGH RISK: > 11.0
TRIGLYCERIDES/HDL RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	2.38 ^L	RATIO	LOW RISK: 0.50 - 3.0 MODERATE RISK: 3.10 - 6.0 HIGH RISK: > 6.0

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 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.
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)

BILIRUBIN TOTAL: SERUM <i>by DIAZOTIZATION, SPECTROPHOTOMETRY</i>	2.09 ^H	mg/dL	INFANT: 0.20 - 8.00 ADULT: 0.00 - 1.20
BILIRUBIN DIRECT (CONJUGATED): SERUM <i>by DIAZO MODIFIED, SPECTROPHOTOMETRY</i>	0.77 ^H	mg/dL	0.00 - 0.40
BILIRUBIN INDIRECT (UNCONJUGATED): SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	1.32 ^H	mg/dL	0.10 - 1.00
SGOT/AST: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	34.15	U/L	7.00 - 45.00
SGPT/ALT: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	22.16	U/L	0.00 - 49.00
AST/ALT RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	1.54	RATIO	0.00 - 46.00
ALKALINE PHOSPHATASE: SERUM <i>by PARA NITROPHENYL PHOSPHATASE BY AMINO METHYL PROPANOL</i>	159 ^H	U/L	40.0 - 150.0
GAMMA GLUTAMYL TRANSFERASE (GGT): SERUM <i>by SZASZ, SPECTROPHOTOMETRY</i>	35	U/L	0.00 - 55.0
TOTAL PROTEINS: SERUM <i>by BIURET, SPECTROPHOTOMETRY</i>	6.44	gm/dL	6.20 - 8.00
ALBUMIN: SERUM <i>by BROMOCRESOL GREEN</i>	3.64	gm/dL	3.50 - 5.50
GLOBULIN: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	2.8	gm/dL	2.30 - 3.50
A : G RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	1.3	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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CLIENT CODE.	: P.K.R JAIN HEALTHCARE INSTITUTE		
CLIENT ADDRESS	: NASIRPUR, HISSAR ROAD, AMBALA CITY - HARYANA		

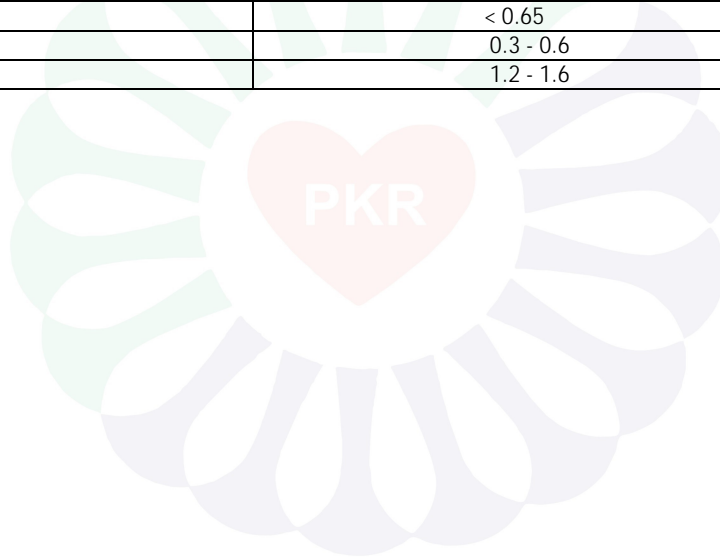
Test Name	Value	Unit	Biological Reference interval
HEPATOCELLULAR CARCINOMA & CHRONIC HEPATITIS		> 1.3 (Slightly Increased)	

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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TEST PERFORMED AT KOS DIAGNOSTIC LAB, AMBALA CANTT.

NAME	: Mr. KUSUM	PATIENT ID	: 1823715
AGE/ GENDER	: 53 YRS/MALE	REG. NO./LAB NO.	: 122504090006
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Test Name	Value	Unit	Biological Reference interval
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KIDNEY FUNCTION TEST (COMPLETE)

UREA: SERUM <i>by UREASE - GLUTAMATE DEHYDROGENASE (GLDH)</i>	24.68	mg/dL	10.00 - 50.00
CREATININE: SERUM <i>by ENZYMATIC, SPECTROPHOTOMETRY</i>	0.62	mg/dL	0.40 - 1.40
BLOOD UREA NITROGEN (BUN): SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	11.53	mg/dL	7.0 - 25.0
BLOOD UREA NITROGEN (BUN)/CREATININE RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	18.6	RATIO	10.0 - 20.0
UREA/CREATININE RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	39.81	RATIO	
URIC ACID: SERUM <i>by URICASE - OXIDASE PEROXIDASE</i>	3.66	mg/dL	3.60 - 7.70
CALCIUM: SERUM <i>by ARSENAZO III, SPECTROPHOTOMETRY</i>	8.46^L	mg/dL	8.50 - 10.60
PHOSPHOROUS: SERUM <i>by PHOSPHOMOLYBDATE, SPECTROPHOTOMETRY</i>	3.6	mg/dL	2.30 - 4.70

ELECTROLYTES

SODIUM: SERUM <i>by ISE (ION SELECTIVE ELECTRODE)</i>	142.5	mmol/L	135.0 - 150.0
POTASSIUM: SERUM <i>by ISE (ION SELECTIVE ELECTRODE)</i>	3.99	mmol/L	3.50 - 5.00
CHLORIDE: SERUM <i>by ISE (ION SELECTIVE ELECTRODE)</i>	106.88	mmol/L	90.0 - 110.0

ESTIMATED GLOMERULAR FILTRATION RATE

ESTIMATED GLOMERULAR FILTRATION RATE (eGFR): SERUM <i>by CALCULATED</i>	114.3
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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/1.73m ²)	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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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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TUMOUR MARKER

ALPHA FETO PROTEIN (AFP): TUMOR MARKER

ALPHA FETO PROTEIN (AFP) TUMOUR MARKER: SERUM <i>by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)</i>	0.5	IU/mL	SMOKERS: < 8.00 NON SMOKERS: < 8.00 HEPATO CELLULAR CARCINOMA:100.0->350.0
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INTERPRETATION:

1. Alpha-fetoprotein (AFP) is a glycoprotein that is produced in early fetal life by the liver, GIT & yolk sac and by a variety of tumors including hepatocellular carcinoma, hepatoblastoma, and nonseminomatous germ cell tumors of the ovary and testis (eg, yolk sac and embryonal carcinoma). Most studies report elevated AFP concentrations in approximately 70% of patients with hepatocellular carcinoma. Elevated AFP concentrations are found in 50% to 70% of patients with non seminomatous testicular tumors.
2. It is a major component of fetal plasma, reaching a peak concentration of 3mg/mL at 12 weeks of gestation. Following birth, it clears from circulation, falling to 100 ng/ mL by 150 days and reaching adult values by end of 1 year.
3. AFP is elevated during pregnancy. Persistence of AFP in the mother following birth is a rare hereditary condition.
3. Neonates have markedly elevated AFP levels (>100,000 ng/mL) that rapidly fall to below 100 ng/mL by 150 days and gradually return to normal over their first year.
4. Concentrations of AFP above the reference range also have been found in serum of patients with benign liver disease (eg, viral hepatitis, cirrhosis), gastrointestinal tract tumors and, along with carcinoembryonic antigen in ataxia telangiectasia.

CAUTION:

1. It is not recommended to use this assay for the initial diagnosis of the above mentioned malignancies.
2. It is best used for monitoring of therapy and to look for relapse of malignancies that have been surgically excised or cleared with chemo/radiotherapy.
3. Failure of the AFP value to return to normal by approximately 1 month after surgery suggests the presence of residual tumor.
4. Elevation of AFP after remission suggests tumor recurrence; however, tumors originally producing AFP may recur without an increase in AFP.

NOTE:

A difference of > 20% between two measurements is considered to be medically significant. The assay is used only as an adjunct to diagnosis and monitoring/ diagnosis should be confirmed by other tests/procedures.



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Test Name	Value	Unit	Biological Reference interval
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CLINICAL PATHOLOGY

URINE ROUTINE & MICROSCOPIC EXAMINATION

PHYSICAL EXAMINATION

QUANTITY RECIEVED <i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>	30	ml	
COLOUR <i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>	YELLOW		PALE YELLOW
TRANSPARANCY <i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>	HAZY		CLEAR
SPECIFIC GRAVITY <i>by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY</i>	1.02		1.002 - 1.030

CHEMICAL EXAMINATION

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

MICROSCOPIC EXAMINATION



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Test Name	Value	Unit	Biological Reference interval
RED BLOOD CELLS (RBCs) <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	NEGATIVE (-ve)	/HPF	0 - 3
PUS CELLS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	10-12	/HPF	0 - 5
EPITHELIAL CELLS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	8-10	/HPF	ABSENT
CRYSTALS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	NEGATIVE (-ve)		NEGATIVE (-ve)
CASTS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	NEGATIVE (-ve)		NEGATIVE (-ve)
BACTERIA <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	NEGATIVE (-ve)		NEGATIVE (-ve)
OTHERS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	NEGATIVE (-ve)		NEGATIVE (-ve)
TRICHOMONAS VAGINALIS (PROTOZOA) <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	ABSENT		ABSENT

*** End Of Report ***



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