Pathkind Labs

Jeevan Jyoti Hospital
Multispeciality Hospital & Infertility Research Center
NABH Accredited Hospital

Client
Jeevan Jyoti HLM
Pathkind Diagnostics Pvt. Ltd.
162, Lowther Road, Bai Ka Bagh, Prayagraj

Processed By
Pathkind Diagnostics Pvt. Ltd.
162, Lowther Road, Bai Ka Bagh, Prayagraj
Uttar Pradesh-211003

Name	:	**Mr. MISRA VINAY KUMAR REG - 323738**	Billing Date	:	26/08/2023 12:02:31
Age	:	43 Yrs	Sample Collected on	:	26/08/2023 15:07:09
Sex	:	Male	Sample Received on	:	26/08/2023 15:30:19
P. ID No.	:	P1212100017847	Report Released on	:	26/08/2023 15:59:16
Accession No	:	**12122307305**	Barcode No.	:	1212050361
Referring Doctor	:	SELF			
Referred By	:		Ref no.	:	

Report Status - Preliminary Report

Test Name	Result	Biological Ref. Interval	Unit
HAEMATOLOGY			
Complete Blood Count (CBC)			
Haemoglobin (Hb) *Sample: Whole Blood EDTA* *Method: Photometric measurement*	15.7	13.0 - 17.0	gm/dL
Total WBC Count / TLC *Sample: Whole Blood EDTA* *Method: Impedance*	6.7	4.0 - 10.0	thou/µL
RBC Count *Sample: Whole Blood EDTA* *Method: Impedance*	5.4	4.5 - 5.5	million/µL
PCV / Hematocrit *Sample: Whole Blood EDTA* *Method: Impedance*	47.6	40.0 - 50.0	%
MCV *Sample: Whole Blood EDTA* *Method: Calculated*	88.3	83.0 - 101.0	fL
MCH *Sample: Whole Blood EDTA* *Method: Calculated*	29.2	27.0 - 32.0	pg
MCHC *Sample: Whole Blood EDTA* *Method: Calculated*	33.0	31.5 - 34.5	g/dL
RDW (Red Cell Distribution Width) *Sample: Whole Blood EDTA* *Method: Calculated*	13.4	11.8 - 15.6	%
DLC (Differential Leucocyte Count) *Method: Flowcytometry/Microscopy*			
Neutrophils *Sample: Whole Blood EDTA* *Method: VCS Technology & Microscopy*	65	40 - 80	%

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Test Name	Result	Biological Ref. Interval	Unit
Lymphocytes *Sample: Whole Blood EDTA* *Method: VCS Technology & Microscopy*	22	20 - 40	%
Eosinophils *Sample: Whole Blood EDTA* *Method: VCS Technology & Microscopy*	**09 H**	01 - 06	%
Monocytes *Sample: Whole Blood EDTA* *Method: VCS Technology & Microscopy*	04	02 - 10	%
Basophils *Sample: Whole Blood EDTA* *Method: VCS Technology & Microscopy*	00	00 - 02	%
Absolute Neutrophil Count *Sample: Whole Blood EDTA*	4355	2000 - 7000	/µL
Absolute Lymphocyte Count *Sample: Whole Blood EDTA*	1474	1000 - 3000	/µL
Absolute Eosinophil Count *Sample: Whole Blood EDTA*	**603 H**	20 - 500	/µL
Absolute Monocyte Count *Sample: Whole Blood EDTA*	268	200 - 1000	/µL
Absolute Basophil Count *Sample: Whole Blood EDTA*	**00 L**	20 - 100	/µL
DLC Performed By *Sample: Whole Blood EDTA*	EDTA Smear		
Platelet Count *Sample: Whole Blood EDTA* *Method: Impedance*	175	150 - 410	thou/µL
MPV (Mean Platelet Volume) *Sample: Whole Blood EDTA* *Method: Calculated*	10.1	6.8 - 10.9	fL

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Test Name	Result	Biological Ref. Interval	Unit
Sample: Whole Blood EDTA			
Erythrocyte Sedimentation Rate (ESR) *Sample: Whole Blood EDTA* *Method: Modified Westergren Method*	02	<10	mm 1st Hour
Blood Group			
Blood Grouping *Sample: Whole Blood EDTA* *Method: Column Agglutination*	"B"		
Rh (D) Typing *Sample: Whole Blood EDTA* *Method: Column agglutination*	POSITIVE		
BIOCHEMISTRY			
HbA1C (Glycosylated Hemoglobin)			
HbA1c *Sample: Whole Blood EDTA* *Method: Turbidimetric inhibition immunoassay*	**13.4 H**	Non Diabetic : < 5.7 % Prediabetic Range : 5.7 - 6.4 % Diabetic Range : >= 6.5 % Goal of Therapy :<7.0 % Action suggested :>8.0 %	%
Mean Plasma Glucose *Sample: Whole Blood EDTA* *Method: Calculated*	**337.9 H**	<116.0	mg/dL
Alkaline Phosphatase (ALP) *Sample: Serum* *Method: Spectrophotometery*	**135 H**	<128	U/L
Bilirubin (Total, Direct & Indirect)			
Bilirubin Total *Sample: Serum* *Method: Spectrophotometry-Diazo*	0.5	0.0 - 1.2	mg/dL
Bilirubin Direct *Sample: Serum* *Method: Spectrophotometry-Diazo*	0.2	0.0 - 0.2	mg/dL

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Test Name	Result	Biological Ref. Interval	Unit
Bilirubin (Total, Direct & Indirect)			
Serum Bilirubin (Indirect) *Sample: Serum* *Method: Calculated*	0.30	0.00 - 0.90	mg/dL
Creatinine *Sample: Serum* *Method: Spectrophotometry*	**0.63 L**	0.70 - 1.30	mg/dL
Glucose Post-Prandial *Sample: Fluoride Plasma - PP* *Method: Hexokinase*	**659 H**	70 - 140	mg/dl
Total Protein *Sample: Serum* *Method: Spectrophotometry*	7.8	6.4 - 8.3	g/dL
Prostate Specific Antigen (PSA) Total *Sample: Serum* *Method: ECLIA*	1.07	0.00 - 2.00	ng/mL
SGOT / AST *Sample: Serum* *Method: Spectrophotometery*	18	<37	U/L
SGPT / ALT *Sample: Serum* *Method: Spectrophotometery*	14	<41	U/L
Uric Acid *Sample: Serum* *Method: Spectrophotometery*	4.8	3.4 - 7.0	mg/dL
Lipid Profile *Method: Sample: Seurm*			
Total Cholesterol *Sample: Serum* *Method: Spectrophotometery*	192	No risk : < 200 Moderate risk : 200–239 High risk : =240	mg/dL
Triglycerides *Sample: Serum* *Method: Spectrophotometry*	**207 H**		mg/dL

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Test Name	Result	Biological Ref. Interval	Unit
		Desirable : < 150 Borderline High : 150 - 199 High : 200 - 499 Very High : >/= 500	
LDL Cholesterol (Calculated) *Sample: Serum* *Method: Calculated*	**116 H**	Optimal : <100 Near Optimal : 100 - 129 Borderline High : 130 - 160 High : 161 - 189 Very High : >/=190	mg/dL
HDL Cholesterol *Sample: Serum* *Method: Spectrophometry*	**35 L**	Low : < 40 Optimal : 40 - 60 High : > 60	mg/dl
VLDL Cholesterol *Sample: Serum* *Method: Calculated*	**41.4 H**	Desirable 10 - 35	mg/dL
Total Cholesterol / HDL Ratio *Sample: Serum* *Method: Calculated*	**5.49 H**	Low Risk : 3.3 - 4.4 Average Risk : 4.5 - 7.0 Moderate Risk : 7.1 - 11.0 High Risk : > 11.0	
LDL / HDL Ratio *Sample: Serum* *Method: Calculated*	**3.3 H**	0.5 - 3.0 Low Risk : 0.5 - 3.0 Moderate Risk : 3.1 - 6.0 High Risk : > 6.0	

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CLINICAL PATHOLOGY

Urine Routine & Microscopic Examination

Method: Reflectance Photometry

Physical Examination

Colour *Sample: Urine* *Method: Physical Examination*	Pale Yellow	Pale Yellow	
Appearance *Sample: Urine* *Method: Physical Examination*	Clear	Clear	
Specific Gravity *Sample: Urine* *Method: pKa change of pretreated polyelectrolytes*	1.010	1.003 - 1.035	
pH *Sample: Urine* *Method: Double indicator principle*	6.5	4.7 - 7.5	

Chemical Examination

Glucose *Sample: Urine* *Method: Glucose oxidase/peroxidase*	**Detected (++++)**	Not Detected	
Protein *Sample: Urine* *Method: Protein-error-of-indicators principle*	**Trace**	Not Detected	
Ketones *Sample: Urine* *Method: Sodium nitroprusside reaction*	Not Detected	Not Detected	
Blood *Sample: Urine* *Method: Peroxidase*	Not Detected	Not Detected	
Bilirubin *Sample: Urine* *Method: Diazo reaction*	Not Detected	Not Detected	

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Test Name	Result	Biological Ref. Interval	Unit
Urobilinogen *Sample: Urine* *Method: Ehrlich's reaction*	Normal	Normal	
Nitrite *Sample: Urine* *Method: Nitrite Test*	Not Detected	Not Detected	
Microscopic Examination *Method: Microscopy*			
Pus Cells *Sample: Urine*	2 - 3	0 - 5	/hpf
RBC *Sample: Urine*	Not Detected	Not Detected	/hpf
Epithelial Cells *Sample: Urine*	2 - 3	0 - 5	/hpf
Casts *Sample: Urine*	Not Detected	Not Detected	/hpf
Crystals *Sample: Urine*	Not Detected	Not Detected	/hpf
Bacteria *Sample: Urine*	Not Detected	Not Detected	/hpf
Remarks *Sample: Urine*			

Remarks : Microscopic Examination is performed on urine sediment
Complete Blood Count (CBC)

Clinical Significance :

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CBC comprises of estimation of the cellular componenets of blood including RBCs, WBCs and Platelets. Mean corpuscular volume (MCV) is a measure of the size of the average RBC, MCH is a measure of the hemoglobin cointent of the average RBC and MCHC is the hemoglobin concentration per RBC. The red cell distribution width (RDW) is a measure of the degree of variation in RBC size (anisocytosis) and is helpful in distinguishing between some anemias. CBC examination is used as a screening tool to confirm a hematologic disorder, to establish or rule out a diagnosis, to detect an unsuspected hematologic disorder, or to monitor effects of radiation or chemotherapy. Abnormal results may be due to a primary disorder of the cell-producing organs or an underlying disease. Results should be interpreted in conjunction with the patient's clinical picture and appropriate additional testing performed.

Erythrocyte Sedimentation Rate (ESR)

Clinical Significance :
The erythrocyte sedimentation rate (ESR) is a simple but non-specific test that helps to detect inflammation associated with conditions such as infections, cancers, and autoimmune diseases.

HbA1C (Glycosylated Hemoglobin)

Clinical Significance :
Hemoglobin A1c (HbA1c) level reflects the mean glucose concentration over the previous period (approximately 8-12 weeks) and provides a much better indication of long-term glycemic control than blood and urinary glucose determinations. American Diabetes Association (ADA) include the use of HbA1c to diagnose diabetes, using a cutpoint of 6.5%. The ADA recommends measurement of HbA1c 3-4 times per year for type 1 and poorly controlled type 2 diabetic patients, and 2 times per year for well-controlled type 2 diabetic patients) to assess whether a patient's metabolic control has remained continuously within the target range. Falsely low HbA1c results may be seen in conditions that shorten erythrocyte life span. and may not reflect glycemic control in these cases accurately.

Alkaline Phosphatase (ALP)

Clinical Significance :
Alkaline Phosphatase levels can be elevated in both liver related as well as bone related conditions. ALP levels are raised (more than 3 fold) in extrahepatic biliary obstruction (eg, by stone or by cancer of the head of the pancreas) than in intrahepatic obstruction, and is directly proportional to the level of obstruction. Levels may rise up to 10 to 12 times the upper limit of normal range and returns to

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normal on surgical removal of the obstruction. ALP levels rise together with GGT levels and If both GGT and ALP are elevated, a liver source of the ALP is likely. Among bone diseases, ALP levels rise in Paget disease (up to 25 fold),osteomalacia,rickets,primary and secondary hyperparathyroidism and osteogenic bone cancer. Elevated ALP is seen in children following accelerated bone growth. Also, a 2 to 3fold elevation may be observed in women in the third trimester of pregnancy, although the interval is very wide and levels may not exceed the upper limit of the reference interval in some cases.

Bilirubin (Total, Direct & Indirect)

Clinical Significance :
The most commonly occurring form of unconjugated hyperbilirubinemia is that seen in newborns and referred to as physiological jaundice. Elevated unconjugated bilirubin in the neonatal period may result in brain damage (kernicterus).

Creatinine

Clinical Significance :
Serum creatinine is inversely correlated with glomerular filtration rate (GFR). Increased levels of Serum Creatinine is associated with renal dysfunction.

Glucose Post-Prandial

COMMENTS / INTERPRETATION:

Any of the following results, confirmed on a subsequent day, can be considered diagnostic for diabetes:
-Fasting plasma or serum glucose > or =126 mg/dL after an 8-hour fast
-2-Hour plasma or serum glucose > or =200 mg/ dL during a 75-gram oral glucose tolerance test (OGTT)
-Random glucose >200 mg/dL, plus typical symptoms

Patients with "impaired" glucose regulation are those whose fasting serum or plasma glucose fall between 101 and 126 mg/dL, or whose 2-hour value on oral glucose tolerance test fall between 140 and 199 mg/dL. These patients have a markedly increased risk of developing type 2 diabetes and should be counseled for lifestyle changes and followed up with more testing.

Total Protein

Clinical Significance :
High levels of Serum Total Protein is seen in increased acute phase reactants in inflammation, late-stage liver disease, infections,multiple myeloma and

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other malignant paraproteinemias.n. Hypoproteinemia is seen in hypogammaglobulinemia, nephrotic syndrome and protein-losing enteropathy.

Prostate Specific Antigen (PSA) Total

Prostate specific antigen (PSA Total) is a blood test that helps in the screening of prostate cancer. PSA is a protein produced by b cancerous and noncancerous tissue in the prostate. This test is also used to monitor recurrence & response to treatment in known cases of prostate cancer. Many other conditions, such as an enlarged or inflamed prostate can also increase PSA levels. recommended test for detection of prostate cancer along with Digital Rectal Examination (DRE) in males above 50 years of age. Fa negative / positive results are observed in patients receiving mouse monoclonal antibodies for diagnosis or therapy. PSA levels m appear consistently elevated / depressed due to the interference by heterophilic antibodies & nonspecific protein binding Immediate PSA testing following digital rectal examination, ejaculation, prostatic massage, indwelling catheterization, ultrasonography and nee biopsy of prostate is not recommended as they falsely elevate levels. PSA values regardless of levels should not be interpret absolute evidence of the presence or absence of disease. All values should be correlated with clinical findings and results of o investigations.

SGOT / AST

Clinical Significance :

"Elevated aspartate aminotransferase (AST) values are seen most commonly in parenchymal liver diseases. Values can be elevated from 10 to 100 times the normal range, though commonly 20 to 50 times elevations are seen. AST levels are raised in infectious hepatitis and other inflammatory conditions affecting the liver along with ALT, though ALT levels are higher. The ALT:AST ratio which is normally <1 is reversed in these conditions and becomes >1. AST levels are usually raised before clinical signs and symptoms of disease appear. AST and ALT also rise in primary or metastatic carcinoma of the liver, with AST usually being higher than ALT.Elevated AST values may also be seen in disorders affecting the heart, skeletal muscle and kidney, such as myocardial infarction, muscular dystrophy, dermatomyositis, acute pancreatitis and crushed muscle injuries."

SGPT / ALT

Clinical Significance :

Elevated alanine aminotransferase (ALT) values are seen in parenchymal liver diseases characterized by a destruction of hepatocytes. Values are at least 10 times higher the normal range and may reach up to 100 times the upper reference limit. Commonly, values are seen

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to be 20 - 50 times higher than normal. In infectious hepatitis and other inflammatory conditions affecting the liver, ALT levels rise more than aspartate aminotransferase (AST), and the ALT/AST ratio, which is normally <1, is reversed and becomes >1. ALT levels usually rise before clinical signs and symptoms of disease appear.

Uric Acid

Clinical Significance :
Uric acid is the final product of purine metabolism. Serum uric acid levels are raised in case of increased purine synthesis, inherited metabolic disorder, excess dietary purine intake, increased nucleic acid turnover, malignancy and cytotoxic drugs. Decreased levels are seen in chronic renal failure, severe hepatocellular disease with reduced purine synthesis, defective renal tubular reabsorption, overtreatment of hyperuricemia with allopurinol, as well as some cancer therapies.

Total Cholesterol

Clinical Significance :
Serum cholesterol is elevated in hereditary hyperlipoproteinemias and in other metabolic diseases. Moderate-to-markedly elevated values are also seen in cholestatic liver disease. Increased levels are a risk factor for cardiovascular disease. Low levels of cholesterol may be seen in disorders like hyperthyroidism, malabsorption, and deficiencies of apolipoproteins.

Triglycerides

Clinical Significance :
Triglycerides are partly synthesized in the liver and partly derived from the diet. Increased serum triglyceride levels are a risk factor for atherosclerosis. Hyperlipidemia may be inherited or may be due to conditions like biliary obstruction, diabetes mellitus, nephrotic syndrome, renal failure,certain metabolic disorders or drug induced.

HDL Cholesterol

Clinical Significance :
High-density lipoprotein (HDL) is an important tool used to assess risk of developing coronary heart disease.Increased levels are seen in persons with more physical activity. Very high levels are seen in case of metabolic response to medications like hormone replacement therapy.Raised levels are also seen in case of chronic intoxication with alcohol, heavy metals or industrial chemicals.Low HDL cholesterol correlates with increased risk for coronary heart disease (CHD). Very low levels are seen in Tangier disease, cholestatic liver disease and in association with decreased hepatocyte function.

Lipid Profile

Client
Jeevan Jyoti HLM
Pathkind Diagnostics Pvt. Ltd.
162, Lowther Road, Bai Ka Bagh, Prayagraj

Processed By
Pathkind Diagnostics Pvt. Ltd.
162, Lowther Road, Bai Ka Bagh, Prayagraj
Uttar Pradesh-211003

Name	:	**Mr. MISRA VINAY KUMAR REG - 323738**	Billing Date	:	26/08/2023 12:02:31
Age	:	43 Yrs	Sample Collected on	:	26/08/2023 15:07:09
Sex	:	Male	Sample Received on	:	26/08/2023 15:30:19
P. ID No.	:	P1212100017847	Report Released on	:	26/08/2023 15:59:16
Accession No	:	**12122307305**	Barcode No.	:	1212031787, 1212031849, 1212031893, 1212050361
Referring Doctor	:	SELF			
Referred By	:		Ref no.	:	

Report Status - Preliminary Report

Test Name	Result	Biological Ref. Interval	Unit

Proposed LDL-C goals in very high risk and extreme risk group patients by the Lipid Association of India.

Very High Risk group(VHRG)	Extreme Risk group	
	Category A	Category B
LDL-C goal of <50 mg/dl High-risk conditions Any one of following: 1. ASCVD (CAD/PAD/TIA or stroke) 2. Homozygous familial 3. hypercholesterolemia 4. Diabetes with ≥2 major ASCVD risk factors∗/target organ damage	LDL-C goal of <50 mg/dl (recommended) LDL-C goal of ≤30 mg/dl (optional) CAD with ≥1 of following: 1. Diabetes without target organ damage/≤1 major 2. ASCVD risk factors 3. Familial hypercholesterolemia 4. ≥3 major ASCVD risk factors 5. CKD stage 3B and 4 6. ≥2 major ASCVD risk factors with ≥1 moderate 7. non-conventional risk factor# 8. Lp(a) ≥50 mg/dl 9. Coronary calcium score ≥300 HU 10. Extreme of a single risk factor 11. PAD 12. H/o TIA or stroke 13. Non-stenotic carotid plaque	LDL-C goal of ≤30 mg/dl CAD with ≥1 of following: 1. Diabetes + polyvascular disease/≥2 2. major ASCVD risk factors∗/target organ 3. damage 4. Recurrent ACS (within 12 months) 5. despite on LDL-C goal 6. Homozygous familial 7. Hypercholesterolemia

The LDL-C goal of ≤30 mg/dl must be pursued after detailed risk-benefit discussion between physician and patient.

Clinical judgment to be used in decision making if the patient has disease/risk factors not covered in the table, eg. peripheral arterial disease or cerebrovascular disease.

∗Major ASCVD risk factors: 1. Age- male ≥45 years, female ≥55 years, 2. Family h/o premature CAD- male <55 years, female <65 years, 3. Smoking/tobacco use, 4. Systemic hypertension, 5.Low HDL (males <40 mg/dl and females <50 mg/dl).

#Moderate non-conventional risk factors: 1. Coronary calcium score 100-299 HU, 2. Increased carotid intima-media thickness, 3. Lp(a) ≥20-49 mg/dl, 4. Impaired fasting glucose, 5. Increased waist circumference, 6. Apolipoprotein B ≥ 110 mg/dl, 7. hsCRP ≥2 mg/L.

Pathkind Labs

Jeevan Jyoti Hospital
Multispeciality Hospital & Infertility Research Center
NABH Accredited Hospital

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Referred By	:		Ref no.	:	

Report Status - Preliminary Report

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Urine Routine & Microscopic Examination

Clinical Significance :

Urine routine examination and microscopy comprises of a set of screening tests that can detect some common diseases like urinary tract infections, kidney disorders, liver problems, diabetes or other metabolic conditions. Physical characteristics (colour and appearance), chemical composition (glucose, protein, ketone, blood, bilirubin and urobilinogen) and microscopic content (pus cells, epithelial cells, RBCs, casts and crystals) are analyzed and reported.

** End of Report**

Dr Aparajita singh chauhan
Lab head - Prayagraj (JJH)