Pathkind Labs

Booked For
CGHS Arpit Hospital Limited Unit of Jeevan Jyoti Hospital, 163, Lowther Road, Bai Ka Bagh, Prayagraj, UP- 211003, - 211003
Contact No. -9532988809

Processed By
Jeevan Jyoti HLM, Pathkind Diagnostics Pvt. Ltd., 162, Lowther Road, Bai Ka Bagh, Prayagraj, Uttar Pradesh-211003, - 211003
Contact No. -7500075111

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Age/Gender	: 35 Yrs/Female	Sample Collected on	: 08/03/2024 11:25:23 AM
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Accession No	**: 121220243080005**	Report Released on	: 08/03/2024 12:00:15 PM
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Report Status -Preliminary

Test Name	Result	Biological Ref. Interval	Unit

KIDNEY PROFILE

BIOCHEMISTRY

Blood Urea Nitrogen *Sample :* Serum *Method :* Spectrophotometry	**5.26 L**	7.00 - 18.69	mg/dL
Blood Urea *Sample :* Serum *Method :* Spectrophotometry	**11.26 L**	15.00 - 40.00	mg/dL
Creatinine *Sample :* Serum *Method :* Spectrophotometry	**0.45 L**	0.50 - 1.10	mg/dL
BUN Creatinine Ratio *Sample :* Serum *Method :* Calculated	11.69	10.00 - 20.00	Ratio
Total Protein *Sample :* Serum *Method :* Spectrophotometry	7.75	6.40 - 8.30	gm/dL
Uric Acid *Sample :* Serum *Method :* Spectrophotometry	4.47	2.40 - 5.70	mg/dL
Sodium *Sample :* Serum *Method :* ISE	137.90	136.00 - 145.00	mmol/L
Potassium	4.36	3.50 - 5.10	mmol/L

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Sample : *Serum* *Method :* *ISE*			
Chloride *Sample :* *Serum* *Method :* *ISE*	**111.50 H**	98.00 - 107.00	mmol/L
Albumin *Sample :* *Serum* *Method :* *Spectrophotometry*	4.51	3.97 - 4.94	gm/dL
Globulin *Sample :* *Serum* *Method :* *Calculated*	3.24	1.90 - 3.70	gm/dL
Albumin Globulin A/G Ratio *Sample :* *Serum* *Method :* *Calculated*	1.39	1.00 - 2.10	Ratio

CLINICAL PATHOLOGY

Urine Routine & Microscopic Examination

Sample : *Urine, Random*

Colour, Urine *Method :* Manual	Pale Yellow	Pale Yellow	---
Appearance *Method :* Manual	**Slightly Hazy**	Clear	---
Specific Gravity *Method :* Ionic concentration method	1.015	1.00 - 1.04	---
pH *Method :* Double indicator principle	5.00	4.70 - 7.50	---

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Glucose *Method :* Bendict's Method	Not Detected	Not Detected	---
Protein *Method :* Sulphosalicyclic acid Method	**Detected (Trace)**	Not Detected	---
Ketones *Method :* Rothera's Method	Not Detected	Not Detected	---
Blood *Method :* Peroxidase	**Detected**	Not Detected	---
Bilirubin *Method :* Diazo-Reaction / Fouchets Test	Not Detected	Not Detected	---
Urobilinogen *Method :* Ehrlich's Reaction	Normal	Normal	---
Nitrite *Method :* Nitrite Test	Not Detected	Not Detected	---
Pus Cells *Method :* Microscopy	5-7	0-5	/hpf
RBC *Method :* Microscopy	**2-3**	Not Detected	/hpf
Epithelial Cells *Method :* Microscopy	**3-5**	0-5	/hpf
Casts *Method :* Microscopy	Not Detected	Not Detected	---
Crystals *Method :* Microscopy	Not Detected	Not Detected	---
Bacteria *Method :* Microscopy	Not Detected	Not Detected	---
Remarks *Method :* *Manual*	Microscopic examination has been performed on urine sediment.		

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HAEMATOLOGY

Complete Blood Count (CBC)

Sample : *Whole Blood, EDTA*

Haemoglobin (Hb) *Method :* *Photometric*	**10.90 L**	12.00 - 15.00	gm/dL
Total WBC Count / TLC *Method :* *Impedance*	**3.93 L**	4.00 - 10.00	thou/µL
RBC Count *Method :* *Impedance*	**3.19 L**	3.80 - 4.80	million/µL
PCV / Hematocrit *Method :* *Impedance*	**33.60 L**	36.00 - 46.00	%
MCV *Method :* *Calculated*	**105.50 H**	83.00 - 101.00	fL
MCH *Method :* *Calculated*	**34.40 H**	27.00 - 32.00	pg
MCHC *Method :* *Calculated*	32.60	31.50 - 34.50	gm/dL
RDW (Red Cell Distribution Width) *Method :* *Calculated*	**16.00 H**	11.90 - 15.50	%
Neutrophils *Method :* *VCS Technology & Microscopy*	47.00	40.00 - 80.00	%
Lymphocytes *Method :* *VCS Technology & Microscopy*	**46.00 H**	20.00 - 40.00	%
Eosinophils *Method :* *VCS Technology & Microscopy*	2.00	1.00 - 6.00	%
Monocytes *Method :* *VCS Technology & Microscopy*	5.00	2.00 - 10.00	%

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Basophils *Method :* *VCS Technology & Microscopy*	0.00	0.00 - 2.00	%
Absolute Neutrophil Count (ANC) *Method :* *Calculated*	**1847.10 L**	2000.00 - 7000.00	/µL
Absolute Lymphocyte Count *Method :* *Calculated*	1807.80	1000.00 - 3000.00	/µL
Absolute Eosinophil Count (AEC) *Method :* *Calculated*	78.60	20.00 - 500.00	/µL
Absolute Monocyte Count *Method :* *Calculated*	**196.50 L**	200.00 - 1000.00	/µL
Absolute Basophil Count *Method :* *Calculated*	**0.00 L**	20.00 - 100.00	/µL
Platelet Count *Method :* *Impedance*	150.00	150.00 - 410.00	thou/µL
MPV (Mean Platelet Volume) *Method :* *Calculated*	**12.50 H**	6.80 - 10.90	fL
Erythrocyte Sedimentation Rate (ESR) *Sample :* *Whole Blood, EDTA* *Method :* *Modified Westergren Method*	**16.00 H**	0.00 - 12.00	mm Ist Hour
Blood Group *Sample :* *Whole Blood, EDTA*			
Blood Grouping *Method :* *Slide and tube agglutination*	**O**		---
Rh (D) Typing *Method :* *Forward/Reverse by tube agglutination*	**Positive**		---
HbA1C (Glycosylated Hemoglobin) *Sample :* *Whole Blood, EDTA*			
HbA1c	**6.36 H**	Non Diabetic : <	%

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Method : High Performance Liquid Chromatography (HPLC)		5.7 Pre Diabetic Range: 5.7 - 6.4 Diabetic Range: > 6.5 Goal of Therapy: < 7.0 Action Suggested: > 8.0	
Mean Plasma Glucose *Method : Calculated*	**135.83 H**	0.00 - 116.00	mg/dL

BIOCHEMISTRY

Fasting Plasma Glucose
Sample : Plasma Fluoride - Fasting
Method : Hexokinase

Plasma Glucose, Fasting	**112.17 H**	Normal : 74 - 99 Impaired Fasting Glucose : 100 - 125 Diabetes : > 126	mg/dL

Thyroid Profile Total
Sample : Serum
Method : ECLIA

Total T3 (Triiodothyronine)	1.23	0.80 - 2.00	ng/mL
Total T4 (Thyroxine)	11.27	5.10 - 14.10	µg/dL
TSH 3rd Generation	3.460	0.27 - 4.20	µIU/mL

Lipid Profile
Sample : Serum

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Test Name	Result	Biological Ref. Interval	Unit
Total Cholesterol *Method :* *Spectrophotometry*	**230.89 H**	No Risk : < 200 Moderate Risk : 200 - 239 High Risk : > 240	mg/dL
Triglycerides *Method :* *Spectrophotometry*	144.42	Desirable : < 150 Boderline High : 150 - 199 High : 200 - 499 Very High : >= 500	mg/dL
LDL Cholesterol (Calculated) *Method :* *Calculated*	**164.83 H**	0.00 - 100.00	mg/dL
HDL Cholesterol *Method :* *Spectrophotometry*	**37.18 L**	Low : < 40 Optimal : 40 - 60 High > 60	mg/dL
VLDL Cholesterol *Method :* *Calculated*	28.88	Desirable : 10 - 35	mg/dL
Total Cholesterol / HDL Ratio *Method :* *Calculated*	**6.21 H**	Low Risk : 3.3 - 4.4 Average Risk : 4.5 - 7.0 Moderate Risk : 7.1 - 11.0 High Risk : > 11.0	Ratio
LDL / HDL Ratio *Method :* *Calculated*	**4.43 H**	Low Risk : 0.5 - 3.0 Moderate Risk : 3.1 - 6.0 High Risk : > 6.0	Ratio
Non HDL Cholesterol *Method :* *Manual*	**193.71 H**	0.00 - 130.00	mg/dL

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Test Name	Result	Biological Ref. Interval	Unit
Liver Function Test (LFT)			
Sample : Serum			
Bilirubin Total	0.38	0.00 - 1.20	mg/dL
Method : Spectrophotometry			
Bilirubin Direct	0.15	0.00 - 0.20	mg/dL
Method : Spectrophotometry			
Serum Bilirubin (Indirect)	0.23	0.00 - 0.90	mg/dL
Method : Calculated			
SGOT / AST	**35.90 H**	0.00 - 32.00	U/L
Method : Spectrophotometry			
SGPT / ALT	**50.18 H**	0.00 - 33.00	U/L
Method : Spectrophotometry			
AST / ALT Ratio	0.72	-	Ratio
Method : Calculated			
Alkaline Phosphatase	**154.89 H**	35.00 - 104.00	U/L
Method : Spectrophotometry			
Total Protein	7.75	6.40 - 8.30	gm/dL
Method : Spectrophotometry			
Albumin	4.51	3.97 - 4.94	gm/dL
Method : Spectrophotometry			
Globulin	3.24	1.90 - 3.70	gm/dL
Method : Calculated			
Albumin Globulin A/G Ratio	1.39	1.00 - 2.10	Ratio
Method : Calculated			

Sodium

Clinical Significance :
Serum Sodium estimation is performed to assess acid-base balance, water balance, water intoxication, and dehydration.

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Creatinine

Clinical Significance :

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

Potassium

Clinical Significance :

Potassium (K+) is the major intracellular cation. It regulates neuromuscular excitability, heart contractility, intracellular fluid volume, and hydrogen ion concentration. High levels of serum Potassium is seen in acute renal disease and end-stage renal failure due to decreased excretion.Levels are also high during the diuretic phase of acute tubular necrosis, during administration of non-potassium sparing diuretic therapy, and during states of excess mineralocorticoid or glucocorticoid.

Chloride

Chloride (Cl) is the major extracellular anion and it has an important role in maintaining proper body water distribution, osmotic pressure, and normalanion-cation balance in the extracellular fluid compartment. Chloride is increased in dehydration, renal tubular acidosis, acute renal failure, metabolic acidosis associated with prolonged diarrhea and loss of sodium bicarbonate, diabetes insipidus, adrenocortical hyperfuction,salicylate intoxication and with excessive infusion of isotonic saline or extremely high dietary intake of salt. Hyperchloremia acidosis may be a sign of severe renal tubular pathology. Chloride is decreased inoverhydration, chronic respiratory acidosis, salt-losing nephritis, metabolic alkalosis, congestive heart failure, Addisonian crisis, certain types of metabolic acidosis, persistent gastric secretion and prolonged vomiting, aldosteronism, bromide intoxication, syndrome of inappropriate antidiuretic hormone secretion,and conditions associated with expansion of extracellular fluid volume.

Thyroid Profile Total

- Patient preparation is particularly important for hormone studies, results of which may be markedly affected by many factors such as stress, position, fasting state, time of the day, preceding diet & drug therapy.
- T3 is one of the thyroid hormones derived due to peripheral conversion of T4. The levels of T3 helps in the diagnosis of T3 Thyrotoxicosis and monitoring the course of hypothyroidism. However, T3 is not recommended for diagnosis of hyperthyroidism as decreased values have minimal clinical significance. Values below the lower limits can be caused by a number of conditions including non-thyroidal illness, acute and chronic stress and hypothyroidism.
- Elevated level of T4 is seen in hyperthyroidism, pregnancy, euthyroid patients with increased serum TBG. Decreased levels are noted in hypothyroidism, hypoproteinemia, euthyroid sick syndrome, decrease in TBG.
- TSH controls biosynthesis and release of thyroid hormones T3 & T4. TSH levels are increased in primary hypothyroidism, insufficient thyroid hormone replacement therapy, Hashimotos thyroiditis, use of amphetamines, dopamine antagonists, iodine containing agents, lithium, and iodide induced or deficiency goiter.

Uric Acid

Clinical Significance :

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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.

Liver Function Test (LFT)

Indications for liver function assessment includes:

- Screen for liver infections, such as hepatitis
- Monitor the progression of a disease, such as viral or alcoholic hepatitis, and determine how well a treatment is working
- Measure the severity of a disease, particularly scarring of the liver (cirrhosis)
- Monitor possible side effects of medications

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

Albumin

"Hypoalbuminemia can be caused by impaired synthesis due to liver disease (primary) or due to diminished protein intake (secondary), increased catabolism due to tissue damage and inflammation; malabsorption of amino acids; and increased renal excretion (eg, nephrotic syndrome).Hyperalbuminemia is seen in dehydration."

Lipid Profile

COMMENTS / INTERPRETATION :
Lipid Profile consist of Triglycerides, Cholesterol and other lipoprotein fractions in serum. The levels reflect the status of Lipid metabolism in the body, collectively they aid in the diagnosis of various abnormal hyper lipidaemias. Analysis of Lipids has assumed greater importance due to increasing prevalence rates of Ischaemic Heart Diseases (IHD).

NCEP (ATP III) Guidelines.

Urine Routine & Microscopic Examination

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.

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Erythrocyte Sedimentation Rate (ESR)

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)

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.

Blood Group

Blood group ABO & Rh test identifies your blood group & type of Rh factor. There are four major blood groups- A, B, AB, and O. It is important to know your blood group as you may need a transfusion of blood or blood components; you may want to donate your blood ; before or during a woman's pregnancy to determine the risk of Rh mismatch with the fetus.

Complete Blood Count (CBC)

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.

** End of Report **

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Test Name	Result	Biological Ref. Interval	Unit

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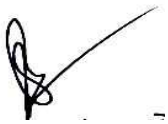

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