PATHKIND REFERENCE LAB
PATHKIND DIAGNOSTICS PVT. LTD.
Plot No. 55-56, Udyog Vihar, Phase IV, Sector-18, Gurugram-122015
E-Mail: care@pathkindlabs.com | Website: www.pathkindlabs.com
Customer Care: 75000 75111

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. RAJNIKANT SINGH REG-318242 ECHS**	Billing Date	:	08/04/202309:22:58
Age	:	33 Yrs	Sample Collected on	:	08/04/2023 13:09:59
Sex	:	Male	Sample Received on	:	08/04/2023 13:26:15
P. ID No.	:	P1212100011133	Report Released on	:	08/04/2023 13:43:54
Accession No	:	**1212230339**	Barcode No.	:	1212069754
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*	14.6	13.0 - 17.0	gm/dL
Total WBC Count / TLC *Sample: Whole Blood EDTA* *Method: Impedance*	8.1	4.0 - 10.0	thou/µL
RBC Count *Sample: Whole Blood EDTA* *Method: Impedance*	5.0	4.5 - 5.5	million/µL
PCV / Hematocrit *Sample: Whole Blood EDTA* *Method: Impedance*	44.6	40.0 - 50.0	%
MCV *Sample: Whole Blood EDTA* *Method: Calculated*	89.8	83.0 - 101.0	fL
MCH *Sample: Whole Blood EDTA* *Method: Calculated*	29.5	27.0 - 32.0	pg
MCHC *Sample: Whole Blood EDTA* *Method: Calculated*	32.8	31.5 - 34.5	g/dL
RDW (Red Cell Distribution Width) *Sample: Whole Blood EDTA* *Method: Calculated*	12.2	11.8 - 15.6	%
DLC (Differential Leucocyte Count) *Method: Flowcytometry/Microscopy*			
Neutrophils *Sample: Whole Blood EDTA* *Method: VCS Technology & Microscopy*	62	40 - 80	%
Lymphocytes *Sample: Whole Blood EDTA* *Method: VCS Technology & Microscopy*	27	20 - 40	%

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Test Name	Result	Biological Ref. Interval	Unit
Eosinophils *Sample: Whole Blood EDTA* *Method: VCS Technology & Microscopy*	**07 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*	5022	2000 - 7000	/µL
Absolute Lymphocyte Count *Sample: Whole Blood EDTA*	2187	1000 - 3000	/µL
Absolute Eosinophil Count *Sample: Whole Blood EDTA*	**567 H**	20 - 500	/µL
Absolute Monocyte Count *Sample: Whole Blood EDTA*	324	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*	206	150 - 410	thou/µL
MPV (Mean Platelet Volume) *Sample: Whole Blood EDTA* *Method: Calculated*	**11.2 H**	6.8 - 10.9	fL
Sample: Whole Blood EDTA **Erythrocyte Sedimentation Rate (ESR)** *Sample: Whole Blood EDTA* *Method: Modified Westergren Method*	06	<10	mm 1st Hour

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Report Status - Preliminary Report

Test Name	Result	Biological Ref. Interval	Unit
Blood Group			
Blood Grouping *Sample: Whole Blood EDTA*	"O'		
Rh (D) Typing *Sample: Whole Blood EDTA*	POSITIVE		
BIOCHEMISTRY			
HbA1C (Glycosylated Hemoglobin)			
HbA1c *Sample: Whole Blood EDTA* *Method: Turbidimetric inhibition immunoassay*	**6.1 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*	**128.4 H**	<116.0	mg/dL
Fasting Plasma Glucose *Sample: Fluoride Plasma - F*	**109 H**	74 - 106	mg/dl
Glucose Post-Prandial *Sample: Fluoride Plasma - PP* *Method: Hexokinase*	**207 H**	70 - 140	mg/dl
Thyroid Profile Total			
Total T3 (Triiodothyronine) *Sample: Serum* *Method: ECLIA*	0.91	0.80 - 2.00	ng/mL
Total T4 (Thyroxine) *Sample: Serum* *Method: ECLIA*	7.81	5.10 - 14.10	µg/dL
TSH 3rd Generation *Sample: Serum* *Method: ECLIA*	4.160	0.270 - 4.200	µIU/mL

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Report Status - Preliminary Report

Test Name	Result	Biological Ref. Interval	Unit
Liver Function Test (LFT)			
Bilirubin Total *Sample: Serum* *Method: Spectrophotometery*	**1.4 H**	<1.1	mg/dL
Bilirubin Direct *Sample: Serum* *Method: Spectrophotometery*	**0.4 H**	<0.2	mg/dL
Serum Bilirubin (Indirect) *Sample: Serum* *Method: Calculated*	**1.00 H**	<0.90	mg/dL
SGOT / AST *Sample: Serum* *Method: Spectrophotometery*	18	<37	U/L
SGPT / ALT *Sample: Serum* *Method: Spectrophotometery*	25	<41	U/L
AST / ALT Ratio *Sample: Serum* *Method: Calculated*	0.72		
Alkaline Phosphatase (ALP) *Sample: Serum* *Method: Spectrophotometery*	95	<128	U/L
Total Protein *Sample: Serum* *Method: Spectrophotometry*	7.2	6.4 - 8.3	g/dL
Albumin *Sample: Serum* *Method: Spectrophotometery*	**5.0 H**	4.0 - 4.9	g/dL
Globulin *Sample: Serum* *Method: Calculated*	2.2	1.9 - 3.7	g/dL
Albumin/Globulin (A/G) Ratio *Sample: Serum* *Method: Calculated*	**2.3 H**	1.0 - 2.1	g/dL

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Report Status - Preliminary Report

Test Name	Result	Biological Ref. Interval	Unit
Lipid Profile			
Total Cholesterol *Sample: Serum* *Method: Spectrophotometery*	167	No risk : < 200 Moderate risk : 200–239 High risk : =240	mg/dL
Triglycerides *Sample: Serum* *Method: Spectrophotometry*	**225 H**	Desirable : < 150 Borderline High : 150 - 199 High : 200 - 499 Very High : >/= 500	mg/dL
LDL Cholesterol (Calculated) *Sample: Serum* *Method: Calculated*	91	Optimal : <100 Near Optimal : 100 - 129 Borderline High : 130 - 160 High : 161 - 189 Very High : >/=190	mg/dL
HDL Cholesterol *Sample: Serum* *Method: Spectrophometry*	**31 L**	Low : < 40 Optimal : 40 - 60 High : > 60	mg/dl
Non HDL Cholesterol *Sample: Serum*	**136 H**	< 130	mg/dL
VLDL Cholesterol *Sample: Serum* *Method: Calculated*	**45.0 H**	Desirable 10 - 35	mg/dL
Total Cholesterol / HDL Ratio *Sample: Serum* *Method: Calculated*	**5.39 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*	2.9	0.5 - 3.0 Low Risk : 0.5 - 3.0 Moderate Risk : 3.1 - 6.0 High Risk : > 6.0	
Kidney Profile (KFT)			
Blood Urea			

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Report Status - Preliminary Report

Test Name	Result	Biological Ref. Interval	Unit
Blood Urea Nitrogen (BUN) *Sample: Serum* *Method: Spectrophotometry-Urease / GLDH*	9.02	8.87 - 20.50	mg/dL
Urea *Sample: Serum* *Method: Spectrophotometery*	19.30	17.00 - 43.00	mg/dL
Creatinine *Sample: Serum* *Method: Spectrophotometry*	0.83	0.70 - 1.30	mg/dL
BUN Creatinine Ratio *Sample: Serum* *Method: Calculated*	11	10 - 20	
Calcium *Sample: Serum* *Method: Spectrophotometery*	9.9	8.6 - 10.0	mg/dL
Uric Acid *Sample: Serum* *Method: Spectrophotometery*	**7.3 H**	3.4 - 7.0	mg/dL
Total Protein *Sample: Serum* *Method: Spectrophotometry*	7.2	6.4 - 8.3	g/dL
Albumin *Sample: Serum* *Method: Spectrophotometery*	**5.0 H**	4.0 - 4.9	g/dL
Globulin *Sample: Serum* *Method: Calculated*	2.2	1.9 - 3.7	g/dL
Albumin/Globulin (A/G) Ratio *Sample: Serum* *Method: Calculated*	**2.3 H**	1.0 - 2.1	g/dL

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Report Status - Preliminary Report

Test Name	Result	Biological Ref. Interval	Unit

CLINICAL PATHOLOGY

Urine Routine & Microscopic Examination

Method: Reflectance Photometry

Physical Examination

Colour *Sample: Urine* *Method: Physical Examination*	yellow	Pale Yellow	
Appearance *Sample: Urine* *Method: Physical Examination*	Clear	Clear	
Specific Gravity *Sample: Urine* *Method: pKa change of pretreated polyelectrolytes*	1.020	1.003 - 1.035	
pH *Sample: Urine* *Method: Double indicator principle*	5.0	4.7 - 7.5	

Chemical Examination

Glucose *Sample: Urine* *Method: Glucose oxidase/peroxidase*	Not Detected	Not Detected	
Protein *Sample: Urine* *Method: Protein-error-of-indicators principle*	Not Detected	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*	1 - 2	0 - 5	/hpf
RBC *Sample: Urine*	Not Detected	Not Detected	/hpf
Epithelial Cells *Sample: Urine*	1 - 2	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

BIOCHEMISTRY

Electrolytes (Na/K/Cl)

Sodium *Sample: Serum* *Method: ISE*	141	136 - 145	mmol/L

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Potassium *Sample: Serum* *Method: ISE*	4.4	3.5 - 5.1	mmol/L
Chloride *Sample: Serum* *Method: ISE*	**109 H**	97 - 107	mmol/L

Complete Blood Count (CBC)

Clinical Significance :

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

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not reflect glycemic control in these cases accurately.

Total T3 (Triiodothyronine)

Clinical Significance :

Thyroid hormones, T3 and T4, which are secreted by the thyroid gland, regulate a number of developmental, metabolic, and neural activities throughout the body. The thyroid gland synthesizes 2 hormones - T3 and T4. T3 production in the thyroid gland constitutes approximately 20% of the total circulating T3, 80% being produced by peripheral conversion from T4. T3 is more potent biologically. Total T3 comprises of Free T3 and bound T3. Bound T3 remains bound to carrier proteins like thyroid-binding globulin, prealbumin, and albumin). Only the free forms are metabolically active. In hyperthyroidism, both T4 and T3 levels are usually elevated, but in some rare cases, only T3 elevation is also seen. In hypothyroidism T4 and T3 levels are both low. T3 levels are frequently low in sick or hospitalized euthyroid patients.

Total T4 (Thyroxine)

Clinical Significance :

Total T4 is synthesized in the thyroid gland. About 0.05% of circulating T4 is in the free or biologically active form. The remainder is bound to thyroxine-binding globulin (TBG), prealbumin, and albumin. High levels of T4 (and FT4) causes hyperthroidism and low levels lead to hypothyroidism.

TSH 3rd Generation

Clinical Significance :

TSH levels are elevated in primary hyporthyroidism and low in primary hyperthyroidism. Evaluation of TSH is useful in the differential diagnosis of primary from secondary and tertiary hypothyroidism. In primary hypothyroidism, TSH levels are elevated, while in secondary and tertiary hypothyroidism, TSH levels are low or normal. High TSH level in the presence of normal FT4 is called subclinical hypothyroidism and low TSH with normal FT4 is called subclinical hyperthyroidism. Sick, hospitalized patients may have falsely low or transiently elevated TSH. Significant diurnal variation is also seen in TSH levels.

Bilirubin Total

Clinical Significance :

"Total Bilirubin is one of the most commonly used tests to assess liver function. A number of inherited and acquired diseases affect bilirubin production, metabolism, storage and excretion and causes hyperbilirubinemia resulting in jaundice.Hyperbilirubinemia may be due to increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Unconjugated hyperbilirubinemia is seen in newborn andd known as physiological jaundice.

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Name	:	**Mr. RAJNIKANT SINGH REG-318242 ECHS**	Billing Date	:	08/04/202309:22:58
Age	:	33 Yrs	Sample Collected on	:	08/04/2023 13:09:59
Sex	:	Male	Sample Received on	:	08/04/2023 13:26:15
P. ID No.	:	P1212100011133	Report Released on	:	08/04/2023 13:43:54
Accession No	:	**1212230339**	Barcode No.	:	1212069755, 1212068525, 1212069756, 1212068540, 1212069754
Referring Doctor	:	SELF			
Referred By	:		Ref no.	:	

Report Status - Preliminary Report

Test Name	Result	Biological Ref. Interval	Unit

Elevated unconjugated bilirubin in the neonatal period may result in brain damage (kernicterus).Crigler-Najjar syndromes type I and type II are also associated with elevated levels of indirect bilirubin.Both conjugated and unconjugated bilirubin are increased in hepatitis and space-occupying lesions of the liver; and obstructive lesions such as carcinoma of the head of the pancreas, common bile duct, or ampulla of Vater."

Bilirubin Direct

Clinical Significance :
"Direct bilirubin is a measurement of conjugated bilirubin.Jaundice can occur as a result of increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Inherited disorders in which direct bilirubin levels are increased are seen in Dubin-Johnson syndrome and Rotor syndrome,idiopathic neonatal hepatitis and biliary atresia. The most commonly occurring form of jaundice of the newborn called physiological jaundiceis due to increase in levels of indirect bilirubin.Both conjugated and unconjugated bilirubin are increased in hepatocellular diseases such as hepatitis and space-occupying lesions of the liver, bstructive lesions such as carcinoma of the head of the pancreas, common bile duct, or ampulla of Vater."

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 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.

Alkaline Phosphatase (ALP)

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Report Status - Preliminary Report

Test Name	Result	Biological Ref. Interval	Unit

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 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.

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

Clinical Significance :
"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

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	LDL-C goal of <50 mg/dl (recommended) LDL-C goal of ≤30 mg/dl (optional)	LDL-C goal of ≤30 mg/dl

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Test Name	Result	Biological Ref. Interval	Unit
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	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	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

Uric Acid

Clinical Significance :

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Test Name	Result	Biological Ref. Interval	Unit

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.

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. Ankit Singh
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Lab Head

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