A28 - MR. MANINDAR SINGH - ANVI
COLLECTION CENTRE, SIRSA
SANJEEV MARKET, SIRSA, NEAR HANUMAN TEMPLE, G.B. NAGAR, UP

Name	: Mr. SUDHIR JAIN			**Collected**	: 6/4/2021 10:16:00AM
Lab No.	: 300837902	**Age:** 60 Years	**Gender:** Male	**Received**	: 6/4/2021 3:35:52PM
				Reported	: 7/4/2021 2:10:29PM
A/c Status	: P	**Ref By :** SELF		**Report Status**	: Final

SwasthFit Super 4

Test Name	Results	Units	Bio. Ref. Interval
COMPLETE BLOOD COUNT;CBC (Electrical Impedence & Flow)			
Hemoglobin	13.80	g/dL	13.00 - 17.00
Packed Cell Volume (PCV)	43.30	%	40.00 - 50.00
RBC Count	4.95	mill/mm3	4.50 - 5.50
MCV	87.50	fL	83.00 - 101.00
MCH	27.90	pg	27.00 - 32.00
MCHC	31.90	g/dL	31.50 - 34.50
Red Cell Distribution Width (RDW)	**14.90**	%	11.60 - 14.00
Total Leukocyte Count (TLC)	7.03	thou/mm3	4.00 - 10.00
Differential Leucocyte Count (DLC)			
Segmented Neutrophils	56.70	%	40.00 - 80.00
Lymphocytes	35.00	%	20.00 - 40.00
Monocytes	4.60	%	2.00 - 10.00
Eosinophils	3.10	%	1.00 - 6.00
Basophils	0.60	%	<2.00
Absolute Leucocyte Count			
Neutrophils	3.99	thou/mm3	2.00 - 7.00
Lymphocytes	2.46	thou/mm3	1.00 - 3.00
Monocytes	0.32	thou/mm3	0.20 - 1.00
Eosinophils	0.22	thou/mm3	0.02 - 0.50
Basophils	0.04	thou/mm3	0.02 - 0.10

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Test Name	Results	Units	Bio. Ref. Interval
Platelet Count	269.0	thou/mm3	150.00 - 410.00
Mean Platelet Volume	9.0	fL	6.5 - 12.0

Note

1. As per the recommendation of International council for Standardization in Hematology, the differential leucocyte counts are additionally being reported as absolute numbers of each cell in per unit volume of blood

2. Test conducted on EDTA whole blood

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Test Name	Results	Units	Bio. Ref. Interval
LIVER & KIDNEY PANEL, SERUM (Spectrophotometry, Indirect ISE)			
Bilirubin Total	0.65	mg/dL	0.30 - 1.20
Bilirubin Direct	0.20	mg/dL	<0.30
Bilirubin Indirect	0.45	mg/dL	<1.10
AST (SGOT)	26	U/L	<50
ALT (SGPT)	36	U/L	<50
GGTP	42	U/L	<55
Alkaline Phosphatase (ALP)	75	U/L	30 - 120
Total Protein	6.60	g/dL	6.40 - 8.30
Albumin	4.60	g/dL	3.50 - 5.20
A : G Ratio	**2.30**		0.90 - 2.00
Urea	26.00	mg/dL	17.00 - 43.00
Creatinine	0.87	mg/dL	0.67 - 1.17

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Test Name	Results	Units	Bio. Ref. Interval
Uric Acid	5.50	mg/dL	3.50 - 7.20
Calcium, Total	9.00	mg/dL	8.80 - 10.60
Phosphorus	2.90	mg/dL	2.30 - 3.70
Sodium	138.00	mEq/L	136.00 - 146.00
Potassium	3.95	mEq/L	3.50 - 5.10
Chloride	103.00	mEq/L	101.00 - 109.00

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Test Name	Results	Units	Bio. Ref. Interval
HbA1c (GLYCOSYLATED HEMOGLOBIN), BLOOD (HPLC)			
HbA1c	**10.9**	%	4.00 - 5.60
Estimated average glucose (eAG)	266	mg/dL	

Interpretation
HbA1c result is suggestive of Diabetes/ Higher than glycemic goal in a known Diabetic patient.

Please note, Glycemic goal should be individualized based on duration of diabetes, age/life expectancy, comorbid conditions, known CVD or advanced microvascular complications, hypoglycaemia unawareness, and individual patient considerations

Result Rechecked,
Please Correlate Clinically.

Note: Presence of Hemoglobin variants and/or conditions that affect red cell turnover must be considered, particularly when the HbA1C result does not correlate with the patient's blood glucose levels.

FACTORS THAT INTERFERE WITH HbA1C MEASUREMENT	FACTORS THAT AFFECT INTERPRETATION OF HBA1C RESULTS
Hemoglobin variants,elevated fetal hemoglobin (HbF) and chemically modified derivatives of hemoglobin (e.g. carbamylated Hb in patients with renal failure) can affect the accuracy of HbA1c measurements	Any condition that shortens erythrocyte survival or decreases mean erythrocyte age (e.g.,recovery from acute blood loss, hemolytic anemia, HbSS, HbCC, and HbSC) will falsely lower HbA1c test results regardless of the assay method used.Iron deficiency anemia is associated with higher HbA1c

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Test Name	Results	Units	Bio. Ref. Interval
GLUCOSE, FASTING (F), PLASMA (Hexokinase)	**280.00**	mg/dL	70.00 - 100.00
VITAMIN B12; CYANOCOBALAMIN, SERUM (CLIA)	344.00	pg/mL	211.00 - 911.00

Notes

1. Interpretation of the result should be considered in relation to clinical circumstances.
2. It is recommended to consider supplementary testing with plasma Methylmalonic acid (MMA) or plasma homocysteine levels to determine biochemical cobalamin deficiency in presence of clinical suspicion of deficiency but indeterminate levels. Homocysteine levels are more sensitive but MMA is more specific
3. False increase in Vitamin B12 levels may be observed in patients with intrinsic factor blocking antibodies, MMA measurement should be considered in such patients
4. The concentration of Vitamin B12 obtained with different assay methods cannot be used interchangeably due to differences in assay methods and reagent specificity

VITAMIN D, 25 - HYDROXY, SERUM (Chemiluminescence)	62.27	nmol/L

Interpretation

LEVEL	REFERENCE RANGE IN nmol/L	COMMENTS
Deficient	< 50	High risk for developing bone disease
Insufficient	50-74	Vitamin D concentration which normalizes Parathyroid hormone concentration
Sufficient	75-250	Optimal concentration for maximal health benefit
Potential intoxication	>250	High risk for toxic effects

Note

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Test Name	Results	Units	Bio. Ref. Interval

- The assay measures both D2 (Ergocalciferol) and D3 (Cholecalciferol) metabolites of vitamin D.
- 25 (OH)D is influenced by sunlight, latitude, skin pigmentation, sunscreen use and hepatic function.
- Optimal calcium absorption requires vitamin D 25 (OH) levels exceeding 75 nmol/L.
- It shows seasonal variation, with values being 40-50% lower in winter than in summer.
- Levels vary with age and are increased in pregnancy.
- A new test Vitamin D, Ultrasensitive by LC-MS/MS is also available

Comments

Vitamin D promotes absorption of calcium and phosphorus and mineralization of bones and teeth. Deficiency in children causes Rickets and in adults leads to Osteomalacia. It can also lead to Hypocalcemia and Tetany. Vitamin D status is best determined by measurement of 25 hydroxy vitamin D, as it is the major circulating form and has longer half life (2-3 weeks) than 1,25 Dihydroxy vitamin D (5-8 hrs).

Decreased Levels

- Inadequate exposure to sunlight
- Dietary deficiency
- Vitamin D malabsorption
- Severe Hepatocellular disease
- Drugs like Anticonvulsants
- Nephrotic syndrome

Increased levels

Vitamin D intoxication

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Test Name	Results	Units	Bio. Ref. Interval
THYROID PROFILE,TOTAL, SERUM (Chemiluminescent Immunoassay)			
T3, Total	0.87	ng/mL	0.60 - 1.81
T4, Total	8.30	µg/dL	5.01 - 12.45
TSH	1.25	µIU/mL	0.35 - 5.50

Note

1. 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.
2. Alteration in concentration of Thyroid hormone binding protein can profoundly affect Total T3 and/or Total T4 levels especially in pregnancy and in patients on steroid therapy.
3. Unbound fraction (Free,T4 /Free,T3) of thyroid hormone is biologically active form and correlate more closely with clinical status of the patient than total T4/T3 concentration
4. Values <0.03 uIU/mL need to be clinically correlated due to presence of a rare TSH variant in some individuals

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Test Name	Results	Units	Bio. Ref. Interval
LIPID SCREEN, SERUM (Enzymatic Spectrophotometry)			
Cholesterol, Total	151.00	mg/dL	<200.00
Triglycerides	**171.00**	mg/dL	<150.00
HDL Cholesterol	43.80	mg/dL	>40.00
LDL Cholesterol, Calculated	73.00	mg/dL	<100.00
VLDL Cholesterol,Calculated	**34.20**	mg/dL	<30.00
Non-HDL Cholesterol	107	mg/dL	<130

Interpretation

REMARKS	TOTAL CHOLESTEROL in mg/dL	TRIGLYCERIDE in mg/dL	LDL CHOLESTEROL in mg/dL	NON HDL CHOLESTEROL in mg/dL
Optimal	<200	<150	<100	<130
Above Optimal	-	-	100-129	130 - 159
Borderline High	200-239	150-199	130-159	160 - 189
High	>=240	200-499	160-189	190 - 219
Very High	-	>=500	>=190	>=220

Note

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. NLA-2014 recommends a complete lipoprotein profile as the initial test for evaluating cholesterol.

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3. Friedewald equation to calculate LDL cholesterol is most accurate when Triglyceride level is < 400 mg/dL. Measurement of Direct LDL cholesterol is recommended when Triglyceride level is > 400 mg/dL
4. NLA-2014 identifies Non HDL Cholesterol(an indicator of all atherogeniclipoproteins such as LDL , VLDL, IDL, Lpa, 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. Apolipoprotein B is an optional, secondary lipid target for treatment once LDL & Non HDL goals have been achieved
6. Additional testing for Apolipoprotein B, hsCRP,Lp(a) & LP-PLA2 should be considered among patients with moderate risk for ASCVD for risk refinement

Treatment Goals as per Lipid Association of India 2016

RISK CATEGORY	TREATMENT GOAL		CONSIDER THERAPY	
	LDL CHOLESTEROL (LDL-C)(mg/dL)	NON HDL CHLOESTEROL (NON HDL-C) (mg/dL)	LDL CHOLESTEROL (LDL-C)(mg/dL)	NON HDL CHLOESTEROL (NON HDL-C) (mg/dL)
Very High	<50	<80	>=50	>=80
High	<70	<100	>=70	>=100
Moderate	<100	<130	>=100	>=130
Low	<100	<130	>=130*	>=160*

*In low risk patient, consider therapy after an initial non-pharmacological intervention for at least 3 months

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High	<70	<100	>=70	>=100
Moderate	<100	<130	>=100	>=130
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Test Name	Results	Units	Bio. Ref. Interval
IRON STUDIES MONITORING PANEL			
Iron	68.00	ug/dL	65.00 - 175.00
Total Iron Binding Capacity (TIBC)	370.69	µg/dL	250 - 425
Transferrin Saturation	**18.34**	%	20.00 - 50.00
Ferritin	27.60	ng/mL	22.00 - 322.00

Comment

Iron is an essential trace mineral element which forms an important component of hemoglobin, metallocompounds and Vitamin A. Deficiency of iron, leads to microcytic hypochromic anemia. The toxic effects of iron are deposition of iron in various organs of the body and hemochromatosis.

Total Iron Binding capacity (TIBC) is a direct measure of the protein Transferrin which transports iron from the gut to storage sites in the bone marrow. In iron deficiency anemia, serum iron is reduced and TIBC increases.

Transferrin Saturation occurs in Idiopathic hemochromatosis and Transfusional hemosiderosis where no unsaturated iron binding capacity is available for iron mobilization. Similar condition is seen in congenital deficiency of Transferrin.

Ferritin appears to be in equilibrium with tissue ferritin and is a good indicator of storage iron in normal subjects and in most disorders. In patients with some hepatocellular diseases, malignancies and inflammatory diseases, serum ferritin is a disproportionately high estimate of storage iron because serum ferritin is an acute phase reactant. In such disorders iron deficiency anemia may exist with a normal serum ferritin concentration. In the presence of inflammation, persons with low serum ferritin are likely to respond to iron therapy.

HERPES SIMPLEX VIRUS (HSV) 1 + 2 ANTIBODIES PANEL, IgG & IgM, SERUM @ (CLIA)			
Herpes simplex virus 1+2, IgG	**4.59**	Index	<0.90
Herpes simplex virus 1+2, IgM	<0.500	Index	<0.90

Interpretation

HSV 1 + 2 IgG RESULT	HSV 1 + 2 IgM RESULT	REMARKS

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Test Name	Results	Units	Bio. Ref. Interval
IN INDEX	IN INDEX		
<0.90	<0.90	Negative	
0.90-<1.10	0.90-<1.10	Equivocal	
≥1.10	≥1.10	Positive	

HSV 1 + 2 IgG

Note

1. This assay is used for qualitative detection of specific IgG antibodies to Herpes Simplex virus (1+2) in serum samples only. However in interpreting CSF HSV IgG levels it should be done in conjunction with serum IgG levels and ratio of 4:1 is considered significant indicating HSV encephalitis.
2. Positive result indicates past infection with Herpes Simplex virus or administration of HSV immunoglobulins. Pregnant females with positive HSV specific IgG antibodies are considered to be immune and hence risk of transmission of infection to fetus is minimal.
3. Equivocal results should be re-tested in 10-14 days.
4. Negative result indicates person has not been exposed to Herpes Simplex virus in the past. Patients with negative results in suspected disease should be re-tested after 10-14 days. False negative results can be due to immunosuppression or due to low/undetectable level of IgG antibodies.
5. HSV serology cannot distinguish genital from nongenital infections.
6. The result should be interpreted in conjunction with clinical finding and other diagnostic tests.
7. The magnitude of the measured result is not indicative of the amount of antibody present.

HSV 1 + 2 IgM

Note

1. This assay is used for qualitative detection of specific IgM antibodies to Herpes Simplex virus (1&2) in serum samples only.
2. Positive result for Herpes Simplex virus IgM may indicate acute infection, reinfection or reactivation of latent virus. Persistence of low level HSV IgM antibodies following post infection over a long period is not uncommon. False positive reaction may occur due to high levels of rheumatoid factor or during the course of other viral illnesses due to cross reactivity.
3. An equivocal result requires repeat testing in 10-14 days.
4. Negative result for Herpes Simplex virus IgM indicates no Herpes Simplex virus infection. False negative reaction may be due to processing of sample collected early in the course of disease or absence of immune response.
5. HSV serology cannot distinguish genital from nongenital infections.
6. The result should be interpreted in conjunction with clinical finding and other diagnostic tests.

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7. The magnitude of the measured result is not indicative of the amount of antibody present.

Comment

Herpes simplex virus (HSV) types 1 and 2 are members of the Herpesviridae family, and produce infections that may range from mild stomatitis to disseminated and fatal disease. Infections with HSV types 1 and 2 can differ significantly in their clinical manifestations and severity which can range from gingivostomatitis, keratitis, encephalitis, vesicular skin eruptions, aseptic meningitis, neonatal herpes, genital tract infections, and disseminated primary infection.

HSV type 2 primarily causes urogenital infections and is found almost exclusively in adults. HSV type 1 is closely associated with orolabial infection, although genital infection with this virus can be common in certain populations. Once infection occurs, HSV persists in a latent state in sensory ganglia from where it may re-emerge to cause periodic recurrence of infection induced by many stimuli, which may or may not result in clinical lesions.

Asymptomatic infections may occur in healthy individuals and during pregnancy. Once infection occurs, HSV persists in a latent state in sensory ganglia from where it may re-emerge to cause periodic recurrence of infection induced by many stimuli, which may or may not result in clinical lesions. In immunocompromised patients the disease is more severe and they are more likely to have frequent HSV recurrences. This suggests that serum antibody and virus-specific cell-mediated immunity contribute to recovery. Pregnant women who develop genital herpes are two to three times more likely to have spontaneous abortions or deliver a premature infant than are pregnant non-infected women. Infection in neonates occur during passage through birth canal and may result in neurological damage.

HSV (1+2) IgM	HSV (1+2) IgG	Remarks
Negative	Negative	No infection or very early infection; no previous exposure
Positive	Negative	Acute infection
Positive	Positive	Acute infection; Chronic infection; could indicate re-activation; IgM may be positive for several months after the infection resolves.
Negative	Positive	Past infection

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Test Name	Results	Units	Bio. Ref. Interval
NT- ProBNP (N-TERMINAL PRO B TYPE NATRIURETIC PEPTIDE) @ (ECLIA)	89.00	pg/mL	<263.00

Note

1. NT-pro-BNP value increases with age , elevated levels can be seen in apparently healthy individual with increasing age
2. NT-pro-BNP values need to be interpreted in conjunction with the medical history, clinical findings and other information
3. NT pro-BNP value <125 pg/mL exclude cardiac dysfunction with a high level of certainty in patients presenting with dyspnea
4. Lack **of** NT-ProBNP elevation has been reported if Congestive Heart Failure (CHF) is very acute (first hour) or if there is Ventricular inflow obstruction

Comments

NT-ProBNP is a marker of atrial & ventricular distension due to increased intracardiac pressure, hence it is used as an aid in the diagnosis of CHF. The diagnostic strength of NT-ProBNP is their high sensitivity for ruling out heart failure; however, as the value increases heart failure becomes more likely. NT-ProBNP levels are correlated with New York Heart Association (NYHA) functional classes for CHF.

NYHA functional classification for CHF

CLASSES	5th - 95th PERCENTILE	PERCENT >125 pg/mL
I	33-3410	78.6
II	103-6567	94.0
III	126-10449	95.3
IV	148-12188	97.1

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Test Name	Results	Units	Bio. Ref. Interval

Interpretation in patients presenting with acute dyspnea

Category	Optimal Cut-off (pg/mL)	Sensitivity (%)	Specificity (%)	PPV (%)	NPV (%)	Accuracy
Rule in cut-off						
<50 years	450	97	93	79	99	94
50-75 years	900	90	82	83	88	85
>75 years	1800	85	73	92	55	83
Rule out cut-off						
All Patients	300	99	60	77	98	83

Clinical Uses

- As an aid in the diagnosis of suspected cases of CHF
- Detection of mild forms of cardiac dysfunction
- To assess severity of heart failure in already diagnosed cases of CHF
- For risk stratification of patients with Acute Coronary Syndrome (ACS) & CHF
- For monitoring therapy in patients with Left Ventricular dysfunction

Limitations of NT-ProBNP

Higher levels than expected	Lower levels than expected
Increasing age	Obesity
ACS	Pulomanary edema
Renal insufficiency	Pericarditis/tamponade
RV Dysfunction	Genetic polymorphism
Atrial fibrillation	
Pulmonary hypertension	
Pulmonary embolism	
Anemia	
Sepsis	
Mitral Regurgitation	

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Test Name	Results	Units	Bio. Ref. Interval
TROPONIN- T, HIGH SENSITIVE, SERUM @ (ECLIA)	11.22	pg/mL	<14.00

Interpretation

INITIAL RESULT IN pg/mL	REMARKS
<14	The upper reference limit (99th percentile) for high sensitive Troponin T(hsTn)
> 14 - < 53	Repeat sampling after 3 hours.50% change in initial value is diagnostic of Myocardial infarction (MI)
>53 - 100	Repeat sampling after 3 hours.20% change in initial value is diagnostic of Myocardial infarction (MI)
>100	WHO cut-off value diagnostic for MI

Note

1. False positive results can be seen in the presence of Rheumatoid factor and heterophile antibodies.
2. Due to the release kinetics of cardiac troponin T, an initial test result < 99th percentile within the initial hours of onset of symptoms does not rule out Myocardial Infarction with certainty. If MI is still suspected, repeat the test 3 hours after initial assessment.

Comments

Cardiac Troponin is a cardiospecific, highly sensitive marker of myocardial damage , but is also expressed by diseased skeletal muscle. Troponin T levels rise in serum about 3-4 hours after appearance of cardiac symptoms and remain elevated upto 14 days. It is an independent prognostic marker which can predict near, mid and long term outcome in patients with Acute Coronary Syndrome (ACS). It is also a useful tool in guiding anti-thrombotic therapy. Patients with ischemic symptoms who have elevated Troponin T levels receive greater benefit from Antiplatelet and Antithrombotic therapies.

Increased Levels

- **Cardiac causes**: Congestive Heart Failure, Cardiomyopathy, Myocarditis, Heart contusion, Interventional therapy like cardiac surgery and drug induced cardiotoxicity
- **Non cardiac causes**: Renal Failure, Lung embolism, Non-cardiac surgery , Rhabdomyolysis, Polymyositis, Stroke & Left Ventricular dysfunction in Septic shock

Uses

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- Exclusion diagnosis of Acute Myocardial Infarction
- Monitoring Acute Coronary syndromes and estimating prognosis
- Monitoring patients with non-ischemic causes of cardiac injury

IMMUNOGLOBULIN IgE, SERUM @ (ImmunoCAP,FEIA)	**79.30**	kUA/L	<64.00

Note: 1. Normal levels of IgE do not rule out possibility of IgE dependent allergies as the diagnostic sensitivity of the test depends upon elapsed time between exposure to an allergen and testing, patient age and affected target organs.
2. No close correlation has been demonstrated between severity of allergic reaction and IgE levels.

Comments

Immunoglobulin E (IgE) is the most important trigger molecule for allergic information. The level of IgE is low during the first year of life, gradually increases with age and reaches adult levels after 10 years. As IgE is a mediator of allergic response, quantitative measurement can provide useful information for differential diagnosis of atopic and non-atopic disease. Patients with atopic diseases like Allergic asthma, Allergic rhinitis & Atopic dermatitis have moderately elevated IgE levels.

Increased Levels - Atopic/Non-atopic allergy, Hyper IgE syndrome, Parasitic infections, IgE Myeloma, Pulmonary Aspergillosis, Immunodeficiency states & Autoimmune diseases

Uses

- Evaluation of children with strong family history of allergies and early clinical signs of disease
- Evaluation of children and adults suspected of having allergic respiratory disease to establish the diagnosis and define the allergens
- To confirm clinical expression of sensitivity to foods in patients with Anaphylactic sensitivity or with Asthma, Angioedema or Cutaneous disease
- To evaluate sensitivity to insect venom allergens particularly as an aid in defining venom specificity in those cases in which skin tests are equivocal
- To confirm the presence of IgE antibodies to certain occupational allergens

ERYTHROCYTE SEDIMENTATION RATE (ESR) (Capillary photometry)	**32**	mm/hr	0.00 - 20.00

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Test Name	Results	Units	Bio. Ref. Interval

Note

1. C-Reactive Protein (CRP) is the recommended test in acute inflammatory conditions.
2. Test conducted on EDTA whole blood at 37°C.
3. ESR readings are auto- corrected with respect to Hematocrit (PCV) values.

CORTISOL, MORNING, SERUM @ (CLIA)	10.10	µg/dL	4.30 - 22.40

Note: Cortisol is best measured in the morning when evaluating for possible Adrenal Insufficiency and best measured in the afternoon or evening to differentiate normal and Cushings Syndrome subjects. Diurnal rhythmicity of cortisol is increased by systemic disease and stress.

Clinical Use

* Direct assessment of Adrenal function

Increased levels: Cushings Syndrome, Ectopic ACTH syndrome, Ectopic CRH syndrome, Adrenal adenoma / carcinoma, Adrenal micronodular dysplasia, Adrenal macronodular hyperplasia, Stress

Decreased Levels - Addisons disease, Pituitary dysfunction

C-REACTIVE PROTEIN; CRP, SERUM (Immunoturbidimetry)	2.30	mg/L	<6.00

Comments

CRP is an acute phase reactant which is used in inflammatory disorders for monitoring course and effect of therapy. It is most useful as an indicator of activity in Rheumatoid arthritis, Rheumatic fever, tissue injury or necrosis and infections. As compared to ESR, CRP shows an earlier rise in inflammatory disorders which begins in 4-6 hrs, the intensity of the rise being higher than ESR and the recovery being earlier than ESR. Unlike ESR, CRP levels are not influenced by hematologic conditions like Anemia, Polycythemia etc.

HOMOCYSTEINE, QUANTITATIVE, SERUM * (Chemiluminescent Microparticle Immunoassay)	**17.22**	umol/L	3.70 - 13.90

Comments

Homocysteine is a sulphur containing amino acid. There is an association between elevated levels of circulating homocysteine and various vascular and cardiovascular disorders. Clinically the measurement of homocysteine is considered important to diagnose homocystinuria, to identify individuals with or at risk of

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developing cobalamin or folate deficiency & to assess risk factor for Cardiovascular Disease (CVD) for which the recommendations are:

- Specially useful in young CVD patients (< 40 yrs)
- In known cases of CVD, high homocysteine levels should be used as a prognostic marker for CVD events and mortality
- CVD patients with homocysteine levels > 15 umol/L belong to a high risk group
- Increased homocysteine levels with low vitamin concentrations should be handled as a potential vitamin deficiency case.

IMMUNOGLOBULIN PROFILE, SERUM @ (Immunoturbidimetry)			
Immunogloublin IgG, Serum	904.00	mg/dL	700.00 - 1600.00
Immunogloublin IgM, Serum	55.80	mg/dL	40.00 - 230.00
Immunogloublin IgA, Serum	253.20	mg/dL	70.00 - 400.00

Comments:

Approximately 80% of serum immunoglobulin is IgG, 6% is IgM and 13% is IgA. High levels of IgM signify acute infections whereas IgG predominates in chronic infections. IgA is the predominant immunoglobulin in body secretions like saliva, sweat and colostrums.

Polyclonal increases are seen in:

IgG: SLE, Chronic liver diseases, Infectious diseases and Cystic fibrosis
IgM: Viral, bacterial and parasitic infections, Liver diseases, Rheumatoid arthritis, Scleroderma, Cystic fibrosis & heroin addiction
IgA: Chronic liver diseases, Chronic infections, Autoimmune disorders, Sarcoidosis and Wiscott-Aldrich syndrome.

Monoclonal increases are seen in IgG & IgA Myelomas and IgM increases in cases of Waldenstroms macroglobulinemia

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Decreased synthesis of IgG, IgM & IgA is seen in Congenital and Acquired Immunodeficiency diseases.

Decreased levels are seen in Protein losing enteropathies, Nephrotic syndrome and skin burns.

PROLACTIN, SERUM (Chemiluminescent Immunoassay)	6.00	ng/mL	2.10 - 17.70

Note: 1. Since prolactin is secreted in a pulsatile manner and is also influenced by a variety of physiologic stimuli, it is recommended to test 3 specimens at 20-30 minute intervals after pooling.
2. Major circulating form of Prolactin is a nonglycosylated monomer, but several forms of Prolactin linked with immunoglobulin occur which can give falsely high Prolactin results.
3. Macroprolactin assay is recommended if prolactin levels are elevated, but signs and symptoms of hyperprolactinemia are absent or pituitary imaging studies are normal

Clinical Use

- Diagnosis & management of pituitary adenomas
- Differential diagnosis of male & female hypogonadism

Increased Levels

- **Physiologic:** Sleep, stress, postprandially, pain, coitus
- **Systemic disorders:** Chest wall or thoracic spinal cord lesions, Primary / Secondary hypothyroidism, Adrenal insufficiency, Chronic renal failure, Cirrhosis
- **Medications:**
  - **Psychiatric medications** like Phenothiazine, Haloperidol, Risperidone, Domperidone, Fluoexetine, Amitriptylene, MAO inhibitors etc.,
  - **Antihypertensives:** Alphamethyldopa, Reserpine, Verapamil
  - **Opiates:** Heroin, Methadone, Morphine, Apomorphine
  - **Cimetidine / Ranitidine**
- **Prolactin secreting pituitary tumors:** Prolactinoma, Acromegaly
- **Miscellaneous**: Epileptic seizures, Ectopic secretion of prolactin by non-pituitary tumors, pressure / transaction of pituitary stalk, macroprolactinemia
- **Idiopathic**

Decreased levels

- Pituitary deficiency: Pituitary necrosis / infarction
- Bromocriptine administration

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Test Name	Results	Units	Bio. Ref. Interval
• Pseudohypoparathyroidism			
PSA (PROSTATE SPECIFIC ANTIGEN), FREE, SERUM @ (CMIA)	0.139	ng/mL	

Interpretation

REFERENCE GROUP	FREE PSA 0-0.5 ng/mL	FREE PSA >0.5-2.5 ng/mL	FREE PSA >2.5-5.0 ng/mL	FREE PSA >5.0-10 ng/mL	FREE PSA >10.0 ng/mL
Healthy males	87.2%	12.8%	0%	0%	0%
BPH	51.9%	42.9%	4.2%	0.5%	0.5%
Stage A Prostate Cancer	38.5%	42.3%	11.5%	3.8%	3.8%
Stage B Prostate Cancer	23.9%	68.7%	7.5%	0%	0%

Note

1. Free PSA values regardless of levels should not be interpreted as absolute evidence for the presence or absence of disease. All values should be correlated with clinical findings and results of other investigations
2. False negative / positive results are observed in patients receiving mouse monoclonal antibodies for diagnosis or therapy
3. Free PSA levels may appear consistently elevated / depressed due to the interference by heterophilic antibodies & nonspecific protein binding
4. Immediate Free PSA testing following digital rectal examination, ejaculation, prostatic massage, ultrasonography and needle biopsy of prostate is not recommended as they falsely elevate levels
5. Hormone therapy affects Free PSA expression

Clinical Use

- An aid in the early detection of Prostate cancer in males 50 years or older with Total PSA values between 4.0 and 10.0 ng/mL and nonsuspicious digital rectal examination.
- An aid in discriminating between Prostate cancer and Benign Prostatic disease. Free PSA level is not used alone, but is mostly useful when expressed in a ratio with Total PSA. Hence PSA profile (Total + Free PSA) is the recommended test. Patients with benign conditions have a higher proportion of

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Test Name	Results	Units	Bio. Ref. Interval
Free PSA compared with Prostate cancer			
PSA (PROSTATE SPECIFIC ANTIGEN), TOTAL, SERUM * (CMIA)	0.490	ng/mL	<4.00

Note

1. False low / high results may be observed in patients receiving mouse monoclonal antibodies for diagnosis/therapy or due to interference by heterophilic antibodies & nonspecific protein binding or on high dose Biotin therapy.
2. Immediate PSA testing following digital rectal examination, ejaculation, prostatic massage, indwelling catheterization, ultrasonography and needle biopsy of prostate is not recommended as they falsely elevate levels. Elevated levels of PSA can also be seen in Benign Prostatic disease, Prostatis and/or Urinary tract infection.
3. PSA values regardless of levels should not be interpreted as absolute evidence of the presence or absence of disease. All values should be correlated with clinical findings and results of other investigations.
4. Physiological decrease in PSA level by 18% has been observed in hospitalized / sedentary patients either due to supine position or suspended sexual activity.
5. Prostate Health Index , OncoPro Prostate Screen are other recommended assay for PSA levels between 4-10 ng/mL (gray zone). It helps physicians to decide if biopsy is necessary.

TESTOSTERONE, TOTAL, SERUM * (Chemiluminescent Immunoassay)	504.83	ng/dL	86.49 - 788.22
TROPONIN I, SERUM @ HIGH SENSITIVE (CMIA)	10.000	pg/mL	<26.20

Interpretation

INITIAL RESULT in pg/mL	REMARKS
<26.2	The upper reference limit (99th percentile) for high sensitive Troponin I (hsTnI)
<26.2 & pain <6hrs	Repeat sampling after 3 hrs, a 50% change from initial value is diagnostic of Myocardial infarction (MI)
>26.2-262	Repeat sampling after 3 hrs, 50% change from initial value is

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	diagnostic of Myocardial infarction (MI)		
>262	MI may be ruled in as appropriate with 98% specificity		

Note:

1. Serial sampling to detect the temporal rise and fall of cTnI levels is recommended for the differentiation of acute cardiac events from chronic cardiac disease
2. Any condition resulting in myocardial injury can potentially increase hsTnI levels thus the results should be used in conjunction with other information such as ECG, clinical observations & symptoms, etc. to diagnose MI
3. A single hsTnI result may not be sufficient to evaluate MI. Serial blood draws are recommended for evaluation of Acute Coronary Syndrome (ACS)
4. False positive results can be seen in the presence of Rheumatoid factor and heterophile antibodies

Comment

Troponins are a group of proteins - C, I & T found in cardiac and skeletal muscle as a complex which regulates calcium dependent interaction of actin and myosin. The cardiac forms of Troponin I (cTnI) & Troponin T (cTnT) are distrinct from skeletal muscle forms. Cardiac Troponin is a cardiospecific, highly sensitive marker of myocardial damage and has never shown to be expressed in normal, regenerating or diseased skeletal muscle. In cases of acute myocardial damage, Troponin I levels rise in serum about 4-6 hours after appearance of cardiac symptoms and remain elevated upto 7-12 days of cardiac injury. It is an independent prognostic marker which can predict near, mid and long term outcome in patients with Acute Coronary Syndrome (ACS).

Increased Levels

Congestive Heart Failure, Cardiomyopathy, Myocarditis, Heart contusion, Interventional therapy like cardiac surgery and drug induced cardiotoxicity

Uses

- To differentiate patients with Non ST elevation Myocardial Infarction (NSTMI) from Unstable angina - patients with ACS with elevated Troponin I and / or CK-MB are considered to have NSTMI whereas the diagnosis of Unstable angina is established if Troponin I and CK-MB are within the normal range. Ideally Troponin I should be measured at presentation (0 hour) and repeated after 6-9 hours & 12-24 hours if earlier specimens are normal and the clinical suspicion is high.

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- Risk stratification of patients presenting with ACS and for cardiac risk in patients with Chronic Renal Failure. As it offers powerful risk assessment, in ACS, Troponin I monitoring should be included in practice guidelines.
- For selection of more intensive therapy and intervention in patients with elevated Troponin I.

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Test Name	Results	Units	Bio. Ref. Interval
Physical			
Chemical			
URINE EXAMINATION, ROUTINE; URINE, R/E	Please Repeat Sample		
Microscopy			

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Dr Parul Joshi
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----------End of report ----------

IMPORTANT INSTRUCTIONS

*Test results released pertain to the specimen submitted.*All test results are dependent on the quality of the sample received by the Laboratory. *Laboratory investigations are only a tool to facilitate in arriving at a diagnosis and should be clinically correlated by the Referring Physician .*Sample repeats are accepted on request of Referring Physician within 7 days post reporting.*Report delivery may be delayed due to unforeseen circumstances. Inconvenience is regretted.*Certain tests may require further testing at additional cost for derivation of exact value. Kindly submit request within 72 hours post reporting.*Test results may show interlaboratory variations.*The Courts/Forum at Delhi shall have exclusive jurisdiction in all disputes/claims concerning the test(s) & or results of test(s).*Test results are not valid for medico legal purposes. *Contact customer care Tel No. +91-11-39885050 for all queries related to test results.
(#) Sample drawn from outside source.