Pathkind Labs

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NATIONAL REFERENCE LAB
PATHKIND DIAGNOSTICS PVT. LTD.
Plot No. 55 - 56, Udyog Vihar, Phase 4, Gurugram - 122015
E-Mail: care@pathkindlabs.com | Website: www.pathkindlabs.com
Customer Care: 782-784-4444

Client

Anuradha Diagnostic (Chhattarpur)
H.No.B-317, Shop No.1, Ground Floor
Chhattarpur Extn., New Delhi, Delhi-110074

Processed By

Pathkind Diagnostic Pvt. Ltd.
Plot No. 55-56, Udhyog Vihar Ph-IV, Gurugram - 122015

Name	:	**Mr. SAURABH BANSAL**	Billing Date	:	06/02/2021 10:06:06
Age	:	36 Yrs	Sample Collected on	:	06/02/2021 10:27:50
Sex	:	Male	Sample Received on	:	06/02/2021 10:58:48
P. ID No.	:	P10001269337	Report Released on	:	06/02/2021 13:57:38
Accession No	:	**1000201113304**	Barcode No.	:	11591296
Referring Doctor	:	Dr. Self			
Referred By	:		Ref no.	:	

Report Status - Final

Test Name	Result	Biological Ref. Interval	Unit
	BIOCHEMISTRY		
Homocysteine *Sample: Serum* *Method: CMIA*	11.78	5.46 - 16.20	µmol/L
# Immunoglobulin A (IgA) *Sample: Serum* *Method: Immunoturbidimetric*	139.0	82.0 - 453.0	mg/dL
IgE Total *Sample: Serum* *Method: ECLIA*	18.41	0.00 - 100.00	U/mL
# Immunoglobulin G (IgG) *Sample: Serum* *Method: Immunoturbidimetric*	1210.0	751.0 - 1560.0	mg/dL
# Immunoglobulin M (IgM) *Sample: Serum* *Method: Immunoturbidimetric*	67.0	46.0 - 304.0	mg/dL

HEALTHKIND COMPLETE

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Report Status - Final

Test Name	Result	Biological Ref. Interval	Unit
	HAEMATOLOGY		
Complete Blood Count (CBC)			
Haemoglobin (Hb) *Sample: Whole Blood EDTA* *Method: Photometric measurement*	16.7	13.0 - 17.0	gm/dL
Total WBC Count / TLC *Sample: Whole Blood EDTA* *Method: Impedance*	10.0	4.0 - 10.0	thou/µL
RBC Count *Sample: Whole Blood EDTA* *Method: Impedance*	**6.0 H**	4.5 - 5.5	million/µL
PCV / Hematocrit *Sample: Whole Blood EDTA* *Method: Impedance*	**51.4 H**	40.0 - 50.0	%
MCV *Sample: Whole Blood EDTA* *Method: Calculated*	86.4	83.0 - 101.0	fL
MCH *Sample: Whole Blood EDTA* *Method: Calculated*	28.1	27.0 - 32.0	pg
MCHC *Sample: Whole Blood EDTA* *Method: Calculated*	32.5	31.5 - 34.5	g/dL
RDW (Red Cell Distribution Width) *Sample: Whole Blood EDTA* *Method: Calculated*	15.2	11.8 - 15.6	%
DLC (Differential Leucocyte Count) *Method: Flowcytometry/Microscopy*			
Neutrophils *Sample: Whole Blood EDTA* *Method: VCS Technology & Microscopy*	53	40 - 80	%

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Lymphocytes *Sample: Whole Blood EDTA* *Method: VCS Technology & Microscopy*	35	20 - 40	%
Eosinophils *Sample: Whole Blood EDTA* *Method: VCS Technology & Microscopy*	04	01 - 06	%
Monocytes *Sample: Whole Blood EDTA* *Method: VCS Technology & Microscopy*	08	02 - 10	%
Basophils *Sample: Whole Blood EDTA* *Method: VCS Technology & Microscopy*	00	00 - 02	%
Absolute Neutrophil Count *Sample: Whole Blood EDTA*	5300	2000 - 7000	/µL
Absolute Lymphocyte Count *Sample: Whole Blood EDTA*	**3500 H**	1000 - 3000	/µL
Absolute Eosinophil Count *Sample: Whole Blood EDTA*	400	20 - 500	/µL
Absolute Monocyte Count *Sample: Whole Blood EDTA*	800	200 - 1000	/µL
Platelet Count *Sample: Whole Blood EDTA* *Method: Impedance*	264	150 - 410	thou/µL
MPV (Mean Platelet Volume) *Sample: Whole Blood EDTA* *Method: Calculated*	8.8	6.8 - 10.9	fL
Erythrocyte Sedimentation Rate (ESR) *Sample: Whole Blood EDTA* *Method: Modified Westergren Method*	**26 H**	<10	mm 1st Hour

BIOCHEMISTRY

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Test Name	Result	Biological Ref. Interval	Unit
Fasting Plasma Glucose *Sample: Fluoride Plasma - F* *Method: Hexokinase*	98	Normal : 74 - 99 Impaired Fasting Glucose :100 - 125 Diabetes : > 126	mg/dL
HbA1C (Glycosylated Hemoglobin)			
HbA1c *Sample: Whole Blood EDTA* *Method: High Perfomance Liquid Chromatography (HPLC)*	5.5	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*	111.2	<116.0	mg/dL
Lipid Profile			
Total Cholesterol *Sample: Serum* *Method: Spectrophometry-Esterase/CO/Peroxidase*	**202 H**	Desirable Level : < 200 Borderline : 200 - 239 High Risk : >/= 240	mg/dL
Triglycerides *Sample: Serum* *Method: Spectrophotometry-Enzymatic*	**196 H**	Desirable : < 150 Borderline High : 150 - 199 High : 200 - 499 Very High : >/= 500	mg/dL
LDL Cholesterol (Calculated) *Sample: Serum* *Method: Calculated*	**112 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-Esterase/CO/Peroxidase*	51	Low : < 40 Optimal : 40 - 60 High : > 60	mg/dL
VLDL Cholesterol *Sample: Serum* *Method: Calculated*	**39.2 H**	Desirable 10 - 35	mg/dL
Total Cholesterol / HDL Ratio *Sample: Serum* *Method: Calculated*	3.96		

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Report Status - Final

Test Name	Result	Biological Ref. Interval	Unit
		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*	2.2	0.5 - 3.0 Low Risk : 0.5 - 3.0 Moderate Risk : 3.1 - 6.0 High Risk : > 6.0	

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Test Name	Result	Biological Ref. Interval	Unit
Liver Function Test (LFT)			
Bilirubin Total *Sample: Serum* *Method: Spectrophotometry-Diazo*	0.5	<1.1	mg/dL
Bilirubin Direct *Sample: Serum* *Method: Spectrophotometry-Diazo*	0.2	<0.2	mg/dL
Serum Bilirubin (Indirect) *Sample: Serum* *Method: Calculated*	0.3	<0.90	mg/dL
SGOT / AST *Sample: Serum* *Method: Spectrophotometry-IFCC Without Pyridoxal PO4*	28	<33	U/L
SGPT / ALT *Sample: Serum* *Method: Spectrophotometry-IFCC Without Pyridoxal PO4*	**52 H**	0 - 41	U/L
AST / ALT Ratio *Sample: Serum*	0.54		
Alkaline Phosphatase (ALP) *Sample: Serum* *Method: IFCC*	49	40 - 129	U/L
Total Protein *Sample: Serum* *Method: Spectrophotometry Biuret*	7.7	6.4 - 8.3	g/dL
Albumin *Sample: Serum* *Method: Spectrophotometry-Bromocresol Purple*	4.6	3.5 - 4.8	g/dL
Globulin *Sample: Serum* *Method: Calculated*	3.1	1.9 - 3.7	g/dL
Albumin/Globulin (A/G) Ratio *Sample: Serum* *Method: Calculated*	1.5	1.0 - 2.1	g/dL

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Test Name	Result	Biological Ref. Interval	Unit
SEROLOGY			
Hepatitis B Surface Antigen (HBsAg) Rapid Card *Sample: Serum* *Method: Immunochromatography*	Non Reactive	Non Reactive	
BIOCHEMISTRY			
Blood Urea			
Blood Urea Nitrogen (BUN) *Sample: Serum* *Method: Spectrophotometry-Urease / GLDH*	10.90	8.87 - 20.50	mg/dL
Urea *Sample: Serum* *Method: Urease/GLDH*	23.33	19.00 - 44.00	mg/dL
Creatinine *Sample: Serum* *Method: Spectrophotometry Alkaline Picrate*	0.77	0.70 - 1.30	mg/dL
BUN Creatinine Ratio *Sample: Serum* *Method: Calculated*	14	10 - 20	
Uric Acid *Sample: Serum* *Method: Uricase-Peroxidase*	5.2	3.4 - 7.0	mg/dL
Electrolytes (Na/K/Cl)			
Sodium *Sample: Serum* *Method: ISE*	138	136 - 145	mmol/L
Potassium *Sample: Serum* *Method: ISE*	**5.4 H**	3.5 - 5.1	mmol/L
Chloride *Sample: Serum* *Method: ISE*	**96 L**	97 - 107	mmol/L

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Test Name	Result	Biological Ref. Interval	Unit
Calcium *Method: Spectrophotometry - OCC*	9.6	8.6 - 10.0	mg/dL
Iron Studies **Sample: Serum** *Method: Method: Spectrophotometry-Ferrozine*			
Iron *Sample: Serum*	96	59 - 158	µg/dL
(UIBC) **Unsaturated Iron Binding Capacity** *Sample: Serum*	317	110 - 370	µg/dL
Total Iron Binding Capacity (TIBC) *Sample: Serum* *Method: Calculated*	413	228 - 428	µg/dL
% Saturation *Sample: Serum*	23	20 - 50	%
Thyroid Profile Total			
Total T3 (Triiodothyronine) *Sample: Serum* *Method: ECLIA*	1.82	0.80 - 2.00	ng/mL
Total T4 (Thyroxine) *Sample: Serum* *Method: ECLIA*	9.07	5.10 - 14.10	µg/dL
TSH 3rd Generation *Sample: Serum* *Method: ECLIA*	2.280	0.270 - 4.200	µIU/mL
Vitamin D 25 - Hydroxy *Sample: Serum* *Method: ECLIA*	**22.7** L	Deficiency < 20 Insufficiency 20 - 30 Sufficiency 30 - 100 Toxicity > 100	ng/mL
Vitamin B12 *Sample: Serum* *Method: ECLIA*	424	191 - 663	pg/mL

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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*	1.020	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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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	0 - 3	/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

Homocysteine

Homocysteine is a sulphur containing amino acid. There is an association between elevated levels of circulating homocysteine and various vascular

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and cardiovascular disorders. Clinically the measurement of homocysteine is considered important to diagnose homocystinuria, to identify individuals with or at risk of 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 A (IgA)

The human imunoglobulins (IgG, IgA, IgM, IgE and IgD) are a group of functinally and structurally closely related glycoproteins. Serum IgA is produced by plasma cells (B-Cells) and represent about 15% of all soluble immunoglobulins. IgA is the predominant immunglobulin in body secretions like saliva, sweat, colostrums gastrointestinal and bronchial secretions and protects the skin and
mucosa againstmicro-organism.
Polyclonal IgA increase is observed in severe infections, autoimmune disease, chronic liver disease and sarcoidosis. Monoclonal IgA increase is seen in IgA myeloma.
Decreased IgA levels are seen in protein losing enteropathies, skin burns, congenital and acquired immunodefiency diseases.

Haemoglobin (Hb)

Clinical Significance :
Hemoglobin is the iron containing protein molecule in red blood cells that carries oxygen from the lungs to the body's tissues and returns carbon dioxide from the tissues back to the lungs. Decrease in Hemoglobin levels results in anaemia and very high Hemoglobin levels results in hemochromatosis.

PCV / Hematocrit

Clinical Significance :
Hemoglobin is the iron containing protein molecule in red blood cells that carries oxygen from the lungs to the body's tissues and returns carbon dioxide from the tissues back to the lungs. Decrease in Hemoglobin levels results in anaemia and very high Hemoglobin levels results in hemochromatosis.

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Plot No. 55-56, Udhyog Vihar Ph-IV, Gurugram - 122015

Name	:	**Mr. SAURABH BANSAL**	Billing Date	:	06/02/202110:06:06
Age	:	36 Yrs	Sample Collected on	:	06/02/2021 10:27:50
Sex	:	Male	Sample Received on	:	06/02/2021 10:58:48
P. ID No.	:	P10001269337	Report Released on	:	06/02/2021 13:57:38
Accession No	:	**1000201113304**	Barcode No.	:	11591294, 11591296, 11591293, 11591295
Referring Doctor	:	Dr. Self			
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Report Status - Final

Test Name	Result	Biological Ref. Interval	Unit

Hematocrit or Packed cell volume (PCV) is the proportion of blood volume occupied by red blood cells and is typically about three times the hemoglobin concentration.

Platelet Count

Clinical Significance :
Platelets or thrombocytes are a cellular component of blood whose function is to stop bleeding by clumping or clotting blood vessel injuries. Low platelet count, also known as Thrombocytopenia, can be either due to less production or increased destruction of platelets. High platelet count or Thrombocytosis can be due to unregulated production, secondary to congenital, reactive or neoplastic conditions.

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.

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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

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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.

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.

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

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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. 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

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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.

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 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."

Hepatitis B Surface Antigen (HBsAg)

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Clinical Significance :
Hepatitis B surface antigen (HBsAg) is the first serologic marker appearing in the serum at 6 to 16 weeks following exposure to HBV. In acute infection, HBsAg usually disappears in 1 to 2 months after the onset of symptoms. Persistence of HBsAg for more than 6 months in duration indicates development of either a chronic carrier state or chronic HBV infection.

In case of negative results:
Please note that while rapid test is a sensitive and reliable screening test, it should not be used as a sole criterion for diagnosis. It is recommended to use molecular testing (PCR) for confirmation.

In case of positive results:
The test has been performed on two different rapid technologies. Please note that while rapid test is a sensitive and reliable screening test, it should not be used as a sole criterion for diagnosis. It is recommended to use molecular testing (PCR) for confirmation.

Blood Urea Nitrogen (BUN)

Clinical Significance :
Increased blood urea nitrogen (BUN) may be due to prerenal causes (cardiac decompensation, water depletion due to decreased intake and excessive loss, increased protein catabolism, and high protein diet), renal causes (acute glomerulonephritis, chronic nephritis, polycystic kidney disease, nephrosclerosis, and tubular necrosis) and postrenal causes (eg, all types of obstruction of the urinary tract, such as stones, enlarged prostate gland, tumors).

Creatinine

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

Sodium

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

Potassium

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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

Clinical Significance :
"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."

Calcium

Serum Calcium levels are used to monitor and diagnose a wide range of diseases of bone, kidney, parathyroid gland, or gastrointestinal tract. Calcium levels may also reflect abnormal vitamin D or protein levels. Hypocalcemia or low serum calcium levels is associated with absent or decreased function of the parathyroid glands, impaired vitamin-D synthesis, low dietary intake and chronic renal failure. Hypercalcemia is due to increased mobilization of calcium from the skeletal system or increased intestinal absorption.It is usually seen in case of primary hyperparathyroidism (pHPT) or bone metastasis of carcinoma of the breast, prostate, thyroid gland, or lung.

Iron

Clinical Significance :
Serum Iron is normal or low in iron deficient anaemia, pregnancy, patients taking oral contraceptive medications,in chronic inflammatory and malignancies. Serum Iron is high in hereditary hemochromatosis and in iron overload states.

Total Iron Binding Capacity (TIBC)

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Clinical Significance :
Transferrin is the primary plasma iron transport protein but accounts for 25% to 30% saturation with iron. The additional amount of iron that can be bound is the unsaturated iron-binding capacity (UIBC). The total iron-binding capacity (TIBC) can be indirectly determined using the sum of the serum iron and UIBC. TIBC levels are usually low when serum Iron levels are high and vice versa.

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 hypothyroidism 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, whil secondary and tertiary hypothyroidism, TSH levels are low or normal. High TSH level in the presence of normal FT4 is 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.

Guidelines for TSH levels in pregnancy, as per American Thyroid Association, are as follows:

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PREGNANCY TRIMESTER	BIOLOGICAL REFERENCE INTERVAL	UNIT
FIRST TRIMESTER	0.100 - 2.500	µIU/mL
SECOND TRIMESTER	0.200 - 3.000	µIU/mL
THIRD TRIMESTER	0.300 - 3.000	µIU/mL

Vitamin D 25 - Hydroxy

Clinical Significance :

The 25-hydroxy vitamin D test is used to detect bone weakness or other bone malfunctions or disorders that occur as a result of a vitamin D deficiency.Those who are at high risk of having low levels of vitamin D include people who don't get much exposure to the sun, older adult, people with obesity, babies who are breastfed only, post gastric bypass surgery, Crohn's disease and other intestinal malabsorption conditions. Hypervitaminosis D usually occurs due to over intake of Vitamin D supplementation.

Vitamin B12

Clinical Significance :

Vitamin B12 is necessary for hematopoiesis and normal neuronal function. It requires intrinsic factor (IF) for absorption. Vitamin B12 deficiency may be due to lack of IF secretion by gastric mucosa (eg, gastrectomy, gastric atrophy) or intestinal malabsorption (eg, ileal resection, small intestinal diseases). Vitamin B12 deficiency results in macrocytic anemia, glossitis, peripheral neuropathy, weakness, hyperreflexia, ataxia, loss of proprioception, poor coordination, and affective behavioral changes.

-

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. Maneesh Bagai
MD (Pathology)
Head - Reference Lab

Dr. Arpeeta Mazumdar
Microbiologist

Dr. Shweta Paul
Consultant-Biochemist

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KIDNEY	BUN, Creatinine, Bun/Creatinine Ratio, Electrolytes, Uric Acid, Urine R/E	BUN, Creatinine, BUN/Creatinine Ratio, Electrolytes, Uric Acid, Urine R/E	BUN, Creatinine, BUN/Creatinine Ratio, Electrolytes, Uric Acid, Urine R/E
BONES	Vitamin D, Calcium	Vitamin D, Calcium, Phosphorus	Vitamin D, Calcium, Phosphorus, Rheumatoid Factor
THYROID	T3, T4, TSH	T3, T4, TSH	FT3, FT4, TSH
NERVES	Vitamin B12	Vitamin B12	Vitamin B12
LIVER	Bilirubin (Total, Direct, Indirect), SGOT, SGPT, ALP, Protein, Albumin, Globulin, A:G Ratio, HBsAg	Bilirubin (Total, Direct, Indirect), SGOT, SGPT, ALP, GGT, LDH, Protein, Albumin, Globulin, A:G Ratio, HBsAg	Bilirubin (Total, Direct, Indirect), SGOT, SGPT, ALP, GGT, LDH, Protein, Albumin, Globulin, A:G Ratio, HBsAg
ANAEMIA	Iron, TIBC, UIBC, % Saturation	Iron, TIBC, UIBC, % Saturation, Ferritin	Iron, TIBC, UIBC, % Saturation, Ferritin, Folic Acid
INFECTION	CBC, ESR	CBC, ESR	CBC, ESR

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