MC-3003

PATIENT NAME : M NAGESHWAR RAO	**REF. DOCTOR :**	
CODE/NAME & ADDRESS : C000138482 RELEX HEALTHCARE SERVICES INDIA PVT LTD PLOT 63/A, GROUND FLOOR, RAGHAVENDRA NILAYAM, 7TH PHASE,KPHB COLONY,HYDERABAD HYDERABAD 500072 08047109222	ACCESSION NO : **0042WC005493** PATIENT ID : MNAGM29035142 CLIENT PATIENT ID: ABHA NO :	AGE/SEX : 72 Years Male DRAWN : 29/03/2023 00:00:00 RECEIVED : 29/03/2023 15:18:04 REPORTED : 29/03/2023 17:16:07

Test Report Status **Preliminary**	Results	Biological Reference Interval	Units

HAEMATOLOGY - CBC

CBC WITH ESR (CBC+PS+ESR) EDTA WHOLE BLOOD/SMEAR

BLOOD COUNTS,EDTA WHOLE BLOOD

	Results	Biological Reference Interval	Units
HEMOGLOBIN (HB) METHOD : CYANMETHEMOGLOBIN METHOD	**11.3 Low**	13.0 - 17.0	g/dL
RED BLOOD CELL (RBC) COUNT METHOD : ELECTRICAL IMPEDANCE	**4.44 Low**	4.5 - 5.5	mil/µL
WHITE BLOOD CELL (WBC) COUNT METHOD : ELECTRICAL IMPEDANCE	8.10	4.0 - 10.0	thou/µL
PLATELET COUNT METHOD : ELECTRICAL IMPEDANCE	311	150 - 410	thou/µL

RBC AND PLATELET INDICES

	Results	Biological Reference Interval	Units
HEMATOCRIT (PCV) METHOD : CALCULATED PARAMETER	**35.6 Low**	40 - 50	%
MEAN CORPUSCULAR VOLUME (MCV) METHOD : CALCULATED PARAMETER	**80.0 Low**	83 - 101	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH) METHOD : CALCULATED PARAMETER	**25.4 Low**	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC) METHOD : CALCULATED PARAMETER	31.7	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW) METHOD : CALCULATED PARAMETER	13.5	11.6 - 14.0	%
MENTZER INDEX	18.0		
MEAN PLATELET VOLUME (MPV) METHOD : CALCULATED PARAMETER	8.6	6.8 - 10.9	fL

WBC DIFFERENTIAL COUNT

	Results	Biological Reference Interval	Units
NEUTROPHILS METHOD : ACV TECHNOLOGY	61	40 - 80	%
LYMPHOCYTES METHOD : ACV TECHNOLOGY	21	20 - 40	%
MONOCYTES METHOD : ACV TECHNOLOGY	6	2 - 10	%
EOSINOPHILS METHOD : ACV TECHNOLOGY	**11 High**	1 - 6	%

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BASOPHILS METHOD : ACV TECHNOLOGY	1	0 - 2	%
ABSOLUTE NEUTROPHIL COUNT METHOD : CALCULATED PARAMETER	4.94	2.0 - 7.0	thou/µL
ABSOLUTE LYMPHOCYTE COUNT METHOD : CALCULATED PARAMETER	1.70	1.0 - 3.0	thou/µL
ABSOLUTE MONOCYTE COUNT METHOD : CALCULATED PARAMETER	0.49	0.2 - 1.0	thou/µL
ABSOLUTE EOSINOPHIL COUNT METHOD : CALCULATED PARAMETER	**0.89 High**	0.02 - 0.50	thou/µL
ABSOLUTE BASOPHIL COUNT METHOD : CALCULATED PARAMETER	0.08	0.02 - 0.10	thou/µL
NEUTROPHIL LYMPHOCYTE RATIO (NLR) METHOD : CALCULATED	2.9		

PERIPHERAL SMEAR EXAM, EDTA WHOLE BLOOD

RBC METHOD : MICROSCOPIC EXAMINATION	NORMOCYTIC NORMOCHROMIC WITH FEW MICROCYTES.
WBC METHOD : MICROSCOPIC EXAMINATION	EOSINOPHILIA.
PLATELETS METHOD : MICROSCOPIC EXAMINATION	ADEQUATE ON SMEAR.

Interpretation(s)
BLOOD COUNTS,EDTA WHOLE BLOOD-The cell morphology is well preserved for 24hrs. However after 24-48 hrs a progressive increase in MCV and HCT is observed leading to a decrease in MCHC. A direct smear is recommended for an accurate differential count and for examination of RBC morphology.
RBC AND PLATELET INDICES-Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia(>13) from Beta thalassaemia trait
(<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.
WBC DIFFERENTIAL COUNT-The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR < 3.3, COVID-19 patients tend to show mild disease.
(Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients A.-P. Yang, et al. International Immunopharmacology 84 (2020) 106504
This ratio element is a calculated parameter and out of NABL scope.

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HAEMATOLOGY

CBC WITH ESR (CBC+PS+ESR) EDTA WHOLE BLOOD/SMEAR	RESULT PENDING		
ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD	RESULT PENDING		

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BIOCHEMISTRY			
LIVER FUNCTION PROFILE, SERUM			
BILIRUBIN, TOTAL	0.38	0.2 - 1.0	mg/dL
BILIRUBIN, DIRECT	0.02	0.0 - 0.2	mg/dL
BILIRUBIN, INDIRECT	0.36	0.1 - 1.0	mg/dL
TOTAL PROTEIN	6.9	6.4 - 8.2	g/dL
ALBUMIN	4.0	3.4 - 5.0	g/dL
GLOBULIN	2.9	2.0 - 4.1	g/dL
ALBUMIN/GLOBULIN RATIO	1.4	1.0 - 2.1	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	36	15 - 37	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)	42	< 45.0	U/L
ALKALINE PHOSPHATASE	103	30 - 120	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)	30	15 - 85	U/L
LACTATE DEHYDROGENASE	**356 High**	110 - 210	U/L
KIDNEY PANEL - 1			
BLOOD UREA NITROGEN (BUN), SERUM			
BLOOD UREA NITROGEN	10	8 - 23	mg/dL
CREATININE, SERUM			
CREATININE	0.86	0.80 - 1.30	mg/dL
URIC ACID, SERUM			
URIC ACID	4.4	3.5 - 7.2	mg/dL
TOTAL PROTEIN, SERUM			
TOTAL PROTEIN	6.9	6.4 - 8.2	g/dL
ALBUMIN, SERUM			
ALBUMIN	4.0	3.4 - 5.0	g/dL
ELECTROLYTES (NA/K/CL), SERUM			
SODIUM, SERUM	140	136 - 145	mmol/L
POTASSIUM, SERUM	**5.46 High**	3.50 - 5.10	mmol/L
CHLORIDE, SERUM	101	98 - 107	mmol/L

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KIDNEY PANEL - 1			
BUN/CREAT RATIO			
BUN/CREAT RATIO	11.63	5.00 - 15.00	
GLOBULIN			
GLOBULIN	2.9	2.0 - 4.1	g/dL

Interpretation(s)
LIVER FUNCTION PROFILE, SERUM-LIVER FUNCTION PROFILE
Bilirubin is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. Bilirubin is excreted in bile and urine, and elevated levels may give yellow discoloration in jaundice.Elevated levels results from increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Conjugated (direct) bilirubin is elevated more than unconjugated (indirect) bilirubin in Viral hepatitis, Drug reactions, Alcoholic liver disease Conjugated (direct) bilirubin is also elevated more than unconjugated (indirect) bilirubin when there is some kind of blockage of the bile ducts like in Gallstones getting into the bile ducts, tumors &Scarring of the bile ducts. Increased unconjugated (indirect) bilirubin may be a result of Hemolytic or pernicious anemia, Transfusion reaction & a common metabolic condition termed Gilbert syndrome, due to low levels of the enzyme that attaches sugar molecules to bilirubin.
AST is an enzyme found in various parts of the body. AST is found in the liver, heart, skeletal muscle, kidneys, brain, and red blood cells, and it is commonly measured clinically as a marker for liver health. AST levels increase during chronic viral hepatitis, blockage of the bile duct, cirrhosis of the liver,liver cancer,kidney failure,hemolytic anemia,pancreatitis,hemochromatosis. AST levels may also increase after a heart attack or strenuous activity.ALT test measures the amount of this enzyme in the blood.ALT is found mainly in the liver, but also in smaller amounts in the kidneys,heart,muscles, and pancreas.It is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health.AST levels increase during acute hepatitis,sometimes due to a viral infection,ischemia to the liver,chronic hepatitis,obstruction of bile ducts,cirrhosis.
ALP is a protein found in almost all body tissues.Tissues with higher amounts of ALP include the liver,bile ducts and bone.Elevated ALP levels are seen in Biliary obstruction, Osteoblastic bone tumors, osteomalacia, hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, Paget''''''''s disease,Rickets,Sarcoidosis etc. Lower-than-normal ALP levels seen in Hypophosphatasia,Malnutrition,Protein deficiency,Wilson''''''''s disease.GGT is an enzyme found in cell membranes of many tissues mainly in the liver,kidney and pancreas.It is also found in other tissues including intestine,spleen,heart, brain and seminal vesicles.The highest concentration is in the kidney,but the liver is considered the source of normal enzyme activity.Serum GGT has been widely used as an index of liver dysfunction.Elevated serum GGT activity can be found in diseases of the liver,biliary system and pancreas.Conditions that increase serum GGT are obstructive liver disease,high alcohol consumption and use of enzyme-inducing drugs etc.Serum total protein,also known as total protein,is a biochemical test for measuring the total amount of protein in serum.Protein in the plasma is made up of albumin and globulin.Higher-than-normal levels may be due to:Chronic inflammation or infection,including HIV and hepatitis B or C,Multiple myeloma,Waldenstrom''''''''s disease.Lower-than-normal levels may be due to: Agammaglobulinemia,Bleeding (hemorrhage),Burns,Glomerulonephritis,Liver disease, Malabsorption,Malnutrition,Nephrotic syndrome,Protein-losing enteropathy etc.Human serum albumin is the most abundant protein in human blood plasma.It is produced in the liver.Albumin constitutes about half of the blood serum protein.Low blood albumin levels (hypoalbuminemia) can be caused by:Liver disease like cirrhosis of the liver, nephrotic syndrome,protein-losing enteropathy,Burns,hemodilution,increased vascular permeability or decreased lymphatic clearance,malnutrition and wasting etc
BLOOD UREA NITROGEN (BUN), SERUM-Causes of Increased levels include Pre renal (High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal), Renal Failure, Post Renal (Malignancy, Nephrolithiasis, Prostatism)
Causes of decreased level include Liver disease, SIADH.
CREATININE, SERUM-Higher than normal level may be due to:
• Blockage in the urinary tract
• Kidney problems, such as kidney damage or failure, infection, or reduced blood flow
• Loss of body fluid (dehydration)
• Muscle problems, such as breakdown of muscle fibers
• Problems during pregnancy, such as seizures (eclampsia)), or high blood pressure caused by pregnancy (preeclampsia)

Lower than normal level may be due to:
• Myasthenia Gravis
• Muscular dystrophy
URIC ACID, SERUM-**Causes of Increased levels:**-Dietary(High Protein Intake,Prolonged Fasting,Rapid weight loss),Gout,Lesch nyhan syndrome,Type 2 DM,Metabolic syndrome
Causes of decreased levels-Low Zinc intake,OCP,Multiple Sclerosis
TOTAL PROTEIN, SERUM-Serum total protein,also known as total protein, is a biochemical test for measuring the total amount of protein in serum..Protein in the plasma is made up of albumin and globulin

Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma, Waldenstrom''''''''''''''''''''''''''''''''s disease
Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage),Burns,Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome,Protein-losing enteropathy etc.
ALBUMIN, SERUM-Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. Low blood albumin levels (hypoalbuminemia) can be caused by: Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance,malnutrition and wasting etc.

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CLINICAL PATH - URINALYSIS

KIDNEY PANEL - 1

PHYSICAL EXAMINATION, URINE			
COLOR	PALE YELLOW		
APPEARANCE	CLEAR		
CHEMICAL EXAMINATION, URINE			
PH	7.0	4.7 - 7.5	
SPECIFIC GRAVITY	1.015	1.003 - 1.035	
PROTEIN	NOT DETECTED	NOT DETECTED	
GLUCOSE	NOT DETECTED	NOT DETECTED	
KETONES	NOT DETECTED	NOT DETECTED	
BLOOD	NOT DETECTED	NOT DETECTED	
BILIRUBIN	NOT DETECTED	NOT DETECTED	
UROBILINOGEN	NORMAL	NORMAL	
NITRITE	NOT DETECTED	NOT DETECTED	
LEUKOCYTE ESTERASE	NOT DETECTED	NOT DETECTED	
MICROSCOPIC EXAMINATION, URINE			
RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
PUS CELL (WBC'S)	2-3	0-5	/HPF
EPITHELIAL CELLS	2-3	0-5	/HPF
CASTS	NOT DETECTED		
CRYSTALS	NOT DETECTED		
BACTERIA	NOT DETECTED	NOT DETECTED	
YEAST	NOT DETECTED	NOT DETECTED	

Comments

NOTE : URINE MICROSCOPIC EXAMINATION IS CARRIED OUT ON CENTRIFUGED URINE SEDIMENT.

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