Ms. ABIR ABDUL MALIK

PID NO: P36180007457
Age: 20 Year(s) Sex: Female

Reference:
Sample Collected At:
GILEAD MEDICAL & DENTAL CENTER HOUSE NO BALB NO C896/3,KANDA HIGHWAY NORTH RIDGE,ACCRA-14911.
014911

VID: 36180107742
Registered On:
02/07/2018 03:29 PM
Collected On:
02/07/2018
Reported On:
03/07/2018 10:39 AM

Investigation	Observed Value	Unit	Biological Reference Interval
FSH - Follicle Stimulating Hormone (Serum)	6.06	mIU/mL	Normal Menstruating Women Follicular Phase : 3.0 - 12.0 Mid Cycle Phase : 8.0 - 22.0 Luteal Phase : 2.0 - 12.0 Post Menopausal : 35.0 - 151.0
LH- Luteinizing hormone (Serum,CMIA)	2.88	mIU/mL	Follicular phase: 2.4-12.6 Midcycle peak: 14.0-95.66 Luteal phase: 1.0-11.4 Post menopausal: 7.7-58.5 Post Menopausal: 7.7-58.2

Interpretation :

Intact PTH has been demonstrated to be labile and is susceptible to fragmentation. This instability depends on both time and temperature . In room temperature EDTA sample stability is 8 hours and serum is for 4 hours. At 4degree C. EDTA sample stability is 72 hours and serum is for 48 hours.

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Bsc.Biomedical Scientists

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Investigation	Observed Value	Unit	Biological Reference Interval
Prolactin (Serum,CMIA)	15.75	ng/mL	5.18-26.53

Interpretation:

Prolactin secretion from pituitary shows significant diurnal, episodic and cyclical variations.
Following is a suggested approach to hyperprolactinaemia in females -

Serum Prolactin levels	**Interpretation**	**Remark** "
5.18 to 26.53 ng/ml	**Normal**	**Biological Reference Interval** "
26.53 to 50 ng/ml	Mild prolactin excess	Often seen with physiological conditions like physical/emotional stress, exercise, pregnancy, lactation, etc. This may not be associated with clinical hyperprolactinaemia & needs review after a month""
51 to 75 ng/ml	Moderate prolactin excess	Often associated with clinical hyperprolactinaemia(short luteal phase,oligomennorrhea), hypothyroidism (often subclinical), macroprolactinaemia.""
Above 100 ng/ml	Marked prolactin excess	Often associated with clinical hyperprolactinaemia- hypogonadism, amenorrhea, galactorrhea, hypothyroidism (often subclinical), macroprolactinaemia.""
Above 200 ng/ml	Marked prolactin excess	Often associated with pituitary adenoma requiring further workup. High levels may be repeated with tripooled sample.

References :

1. Diagnosis & Treatment of hyperprolactinaemia. The endocrine society clinical practice guideline, 2011
2. Diagnosis & Management of hyperprolactinemia. Canadian Medical Association CMAJ .Sept.16, 2003;169(6)

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Investigation	Observed Value	Unit	Biological Reference Interval
HCG Beta Subunit, Serum			
HCG Beta Subunit (Serum,CMIA)	< 2.0	mIU/mL	Less than 5.3
Post LMP Period	-		

Pregnant Woman - Weeks of gestation(Gest.)	Weeks post Last Menstrual Period (LMP)	Range(mIU/ml)
1.3 to 2	3.3 to 4	16 to 156
2 to 3	4 to 5	101 to 4,870
3 to 4	5 to 6	1,110 to 31,500
4 to 5	6 to 7	2,560 to 82,300
5 to 6	7 to 8	23,100 to 151,000
6 to 7	8 to 9	27,300 to 233,000
7 to 11	9 to 13	20,900 to 291,000
11 to 16	13 to 18	6,140 to 103,000
16 to 21	18 to 23	4,720 to 80,100
21 to 39	23 to 41	2,700 to 78,100

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Investigation	Observed Value	Unit	Biological Reference Interval
25 Hydroxy (OH) Vit D (Serum,CMIA)	**23.80**	ng/mL	Deficiency: < 10 Insufficiency: 10-30 Sufficiency: 30-100 Hypervitaminosis: > 100

Interpretation :

1. Vitamin D is a fat soluble vitamin and exists in two main forms as cholecalciferol(vitamin D3) which is synthesized in skin from 7-dehydrocholesterol in response to sunlight exposure & Ergocalciferol(vitamin D2) present mainly in dietary sources.Both cholecalciferol & Ergocalciferol are converted to 25(OH)vitamin D in liver.
2. Testing for 25(OH)vitamin D is recommended as it is the best indicator of vitamin D nutritional status as obtained from sunlight exposure & dietary intake. For diagnosis of vitamin D deficiency it is recommended to have clinical correlation with serum 25(OH)vitamin D, serum calcium, serum PTH & serum alkaline phosphatase.
3. During monitoring of oral vitamin D therapy- suggested testing of serum 25(OH)vitamin D is after 12 weeks or 3 mths of treatment. However, the required dosage of vitamin D supplements & time to achieve sufficient vitamin D levels show significant seasonal(especially winter) & individual variability depending on age, body fat, sun exposure, physical activity ,genetic factors(especially variable vitamin D receptor responses), associated liver or renal disease, malabsorption syndromes and calcium or magnesium deficiency influencing the vitamin D metabolism Vitamin D toxicity is known but very rare.kindly correlate clinically, repeat with fresh sample if indicated.

Associated Test Profile :

- For diagnosis of vitamin D deficiency it is recommended to have clinical correlation with serum 25(OH)vitamin D and serum PTH.An inverse relationship exists between PTH and 25(OH)D levels, Parathyroid hormone levels start to rise at 25(OH)D levels below 31 ng/mL & usually decrease after the correction of vitamin D insufficiency.Thus, restoration of PTH and 25(OH) D levels to normalcy after adequate vitamin D replacement therapy is a useful monitoring strategy.
- As a holistic & scientific approach for diagnosis and optimal treatment for vitamin D deficiency, Vitamin D plus profile (25 Hydroxy(OH) Vit D and PTH) is suggested.

-- End of Report --

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