



## LABORATORY REPORT

Name : SAIFEE HUSENIBHAI HOTELWALA	Sex/Age : Male / 53 Years	Case ID : 51000201390
Ref. By : Dr. KAMLESH PARIKH	Dis. At : hospital	Pt. ID :
Bill. Loc. : Labcore spec lab baroda		Pt. Loc : OPD Collection
Reg Date and Time : 06-Oct-2025 17:13	Sample Type : Serum	Mobile No. : 8200055742
Sample Date and Time : 06-Oct-2025 17:14	Sample Coll. By : non	Ref Id1 : -
Report Date and Time : 06-Oct-2025 18:52	Acc. Remarks	Ref Id2 :

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
Uric Acid <i>Uricase</i>	6.96	mg/dL	3.4 - 7.0	
Calcium <i>BAPTA</i>	9.7	mg/dL	8.6 - 10.0	
Para Thyroid Hormone Intact <i>CMIA</i>	H 93.10	pg/mL	15 - 68.30	

**INTERPRETATIONS:**

Useful for Diagnosis and differential diagnosis of hypercalcemia , Diagnosis of primary, secondary, and tertiary hyperparathyroidism, Diagnosis of hypoparathyroidism, Monitoring end-stage renal failure patients for possible renal osteodystrophy.

About 90% of the patients with primary hyperparathyroidism have elevated parathyroid hormone (PTH) levels. The remaining patients have normal (inappropriate for the elevated calcium level) PTH levels. About 40% of the patients with primary hyperparathyroidism have serum phosphorus levels <2.5 mg/dL and about 80% have serum phosphorus <3.0 mg/dL.

An (appropriately) low PTH level and high phosphorus level in a hypercalcemic patient suggests that the hypercalcemia is not caused by PTH or PTH-like substances. An (appropriately) low PTH level with a low phosphorus level in a hypercalcemic patient suggests the diagnosis of paraneoplastic hypercalcemia caused by parathyroid related peptide (PTHRP), produced by many different tumor types.

A low or normal PTH in a patient with hypocalcemia suggests hypoparathyroidism, provided the serum magnesium level is normal. Low magnesium levels inhibit PTH release and action and can mimic hypoparathyroidism.

Low serum calcium and high PTH levels in a patient with normal renal function suggest resistance to PTH action( pseudohypoparathyroidism type 1a, 1b, 1c, or 2) or, very rarely, bio-ineffective PTH.

**CAUTIONS:**

Normal reference ranges may vary based on geographical locations of the populations studied. The carboxyl-terminal fragments (PTH-C) fragment 7-84, which accumulates in renal failure, shows substantial cross-reactivity in this assay. Healthy population reference ranges, therefore, do not apply in renal failure. Parathyroid hormone (PTH) values should be interpreted in conjunction with serum calcium and phosphorus levels, and the overall clinical presentation and history of the patient.

Do not interpret an elevated PTH value with a normal serum calcium as necessarily indicative of primary hyperparathyroidism. It is possible that the elevation in PTH is due to secondary causes, the most likely being vitamin D deficiency.

In rare cases, interference due to extremely high titers of antibodies to ruthenium or streptavidin can occur.

As with all tests containing monoclonal mouse antibodies, erroneous findings may be obtained from specimens taken from patients who have been treated with monoclonal mouse antibodies or have received them for diagnostic purposes.

In patients receiving high dose (>5 mg/day) biotin therapy, the specimen should be collected at least 8 hours after the last biotin administration.

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Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)

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## Labcore Speciality Laboratory

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Sample Date and Time : 06-Oct-2025 17:14	Sample Coll. By : non	Ref Id1 : -
Report Date and Time : 06-Oct-2025 19:08	Acc. Remarks	Ref Id2 :

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
Vitamin D (Total) CMIA	21.06	ng/mL	< 10 Deficiency 10 - 20 Insufficiency 20 - 32 Normal Level 32 - 100 Sufficiency > 100 Toxicity	

25-OH-VitD plays a primary role in the maintenance of calcium homeostasis. It promotes intestinal calcium absorption and, in concert with PTH, skeletal calcium deposition, or less commonly, calcium mobilization. Modest 25-OH-VitD deficiency is common; in institutionalised elderly, its prevalence may be >50%. Although much less common, severe deficiency is not rare either. Reasons for suboptimal 25-OH-VitD levels include lack of sunshine exposure, a particular problem in Northern latitudes during winter; inadequate intake; malabsorption (e.g. due to Celiac disease); depressed hepatic vitamin D 25-hydroxylase activity, secondary to advanced liver disease; and enzyme-inducing drugs, in particular many antiepileptic drugs, including phenytoin, phenobarbital, and carbamazepine, that increase 25-OH-VitD metabolism. Hypervitaminosis D is rare, and is only seen after prolonged exposure to extremely high doses of vitamin D. When it occurs, it can result in severe hypercalcemia and hyperphosphatemia.

## INTERPRETATION

- Levels <10 ng/mL may be associated with more severe abnormalities and can lead to inadequate mineralization of newly formed osteoid, resulting in rickets in children and osteomalacia in adults. In these individuals, serum calcium levels may be marginally low, and parathyroid hormone (PTH) and serum alkaline phosphatase are usually elevated. Definitive diagnosis rests on the typical radiographic findings or bone biopsy/histomorphometry.
- Patients who present with hypercalcemia, hyperphosphatemia, and low PTH may suffer either from ectopic, unregulated conversion of 25-OH-VitD to 1,25 (OH)2-VitD, as can occur in granulomatous diseases, particularly sarcoidosis, or from nutritionally-induced hypervitaminosis D. Serum 1,25 (OH)2-VitD levels will be high in both groups, but only patients with hypervitaminosis D will have serum 25-OH-VitD concentrations of >80 ng/mL, typically >150 ng/mL.
- Patients with CKD have an exceptionally high rate of severe vitamin D deficiency that is further exacerbated by the reduced ability to convert 25-OH-VitD into the active form, 1,25 (OH)2-VitD. Emerging evidence also suggests that the progression of CKD & many of the cardiovascular complications may be linked to hypovitaminosis D.
- Approximately half of Stage 2 and 3 CKD patients are nutritional vitamin D deficient (25-OH-VitD, less than 30 ng/mL), and this deficiency is more common among stage 4 CKD patients. Additionally, calcitriol (1,25 (OH)2-VitD) levels are also overtly low (less than 22 pg/mL) in CKD patients. Similarly, vast majority of dialysis patients are found to be deficient in nutritional vitamin D and have low calcitriol levels. Recent data suggest an elevated PTH is a poor indicator of deficiencies of nutritional vitamin D and calcitriol in CKD patients. CAUTIONS Long term use of anticonvulsant medications may result in vitamin D deficiency that could lead to bone disease; the anticonvulsants most implicated are phenytoin, phenobarbital, carbamazepine, and valproic acid.

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Sample Date and Time : 06-Oct-2025 17:14	Sample Coll. By : non	Ref Id1 : -
Report Date and Time : 06-Oct-2025 18:22	Acc. Remarks	Ref Id2 :

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
C- Reactive Protein <i>Turbidimetric</i>	<0.6	mg/L	0 - 5	

**INTERPRETATIONS:**

Detecting systemic inflammatory processes. Detecting infection and assessing response to antibiotic treatment of bacterial infections Differentiating between active and inactive disease forms with concurrent infection CRP levels can increase dramatically (100-fold or more) after severe trauma, bacterial infection, inflammation, surgery, or neoplastic proliferation. CRP has been used to assess activity of inflammatory disease, to detect infections after surgery, to detect transplant rejection, and to monitor these inflammatory processes. Elevated values are consistent with an acute inflammatory process.

**CAUTIONS :**

Elevated C-reactive protein (CRP) values are nonspecific and should not be interpreted without a complete clinical history. Oral contraceptives may increase CRP levels. HSCRP/C-Reactive Protein, High Sensitivity, Serum is the appropriate CRP test to order to assess risk of cardiovascular disease or events.

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Reg Date and Time : 06-Oct-2025 17:13	Sample Type : Urine	Mobile No. : 8200055742
Sample Date and Time : 06-Oct-2025 17:14	Sample Coll. By : non	Ref Id1 : -
Report Date and Time : 06-Oct-2025 17:37	Acc. Remarks	Ref Id2 :

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
<b>Urine Examination</b>				

Physical Examination

Colour	Yellow
Transparency	Clear

Chemical Examination (strip test)

Sp.Gravity	1.020	1.005 - 1.030
pH	6.0	5 - 8
Protein	Negative	Negative
Blood	Negative	Negative
Glucose Urine	Negative	Negative
Ketone Bodies Urine	Negative	Negative
Bilirubin	Negative	Negative
Urobilinogen	Negative	Negative
Leucocytes (ESTERASE)	Negative	Negative
Nitrite	Negative	Negative

Microscopic Examination

Leucocyte	Nil	/HPF	Nil
Red Blood Cell	Nil	/HPF	Nil
Epithelial Cell	Nil	/HPF	Nil
Crystals	Nil	/HPF	Nil
Cast	Nil	/HPF	Nil

----- End Of Report -----

# For test performed on specimens received or collected from non-NLCL locations, it is presumed that the specimen belongs to the patient named or identified as labeled on the container/test request and such verification has been carried out at the point generation of the said specimen by the sender. NLCL will be responsible Only for the analytical part of test carried out. All other responsibility will be of referring Laboratory.

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