DIAGNOSTIC REPORT

Patient Ref. No. 007

Cert. No. MC-3070

SRL Diagnostics

CLIENT CODE : C12345

CLIENT'S NAME AND ADDRESS :
FPSC PRIMECARE DIAGNOSTICS
SHOP NO. 15 GROUND FLOOR, ASIATIC ARCADE POKHARAN, ROAD NO. 1 VARTAK NAGAR,
THANE (W),
THANE 400606
MAHARASHTRA INDIA
8268383520

SRL Ltd
MULUND GOREGOAN LINK ROAD
MUMBAI, 400078
MAHARASHTRA, INDIA
Fax :
CIN - U74899PB1995PLC045956

PATIENT NAME : Minnie Mouse PATIENT ID : **ABC12345**

ACCESSION NO : **12345** AGE : 40 Years SEX : Female

DRAWN : 30/05/2022 10:29 RECEIVED : 30/05/2022 13:54 REPORTED : 30/05/2022 16:48

REFERRING DOCTOR : DR. TEJINDER SINGH CLIENT PATIENT ID :

Test Report Status **Final**	Results		Biological Reference Interval	Units
KIDNEY PANEL - 1				
SERUM BLOOD UREA NITROGEN				
BLOOD UREA NITROGEN	7		7.0 - 17.0	mg/dL
METHOD : UREASE WITH INDICATOR DYE				
CREATININE, SERUM				
CREATININE	0.62		0.52 - 1.04	mg/dL
METHOD : ENZYMETIC IDMS				
BUN/CREAT RATIO				
BUN/CREAT RATIO	11.29			
URIC ACID, SERUM				
URIC ACID	4.5		2.5 - 6.2	mg/dL
METHOD : URICASE UV				
TOTAL PROTEIN, SERUM				
TOTAL PROTEIN	6.4		6.3 - 8.30	g/dL
METHOD : BIURET, END POINT				
ALBUMIN, SERUM				
ALBUMIN	**2.9**	**Low**	3.5 - 5.0	g/dL
METHOD : BCG DYE BINDING METHOD				
GLOBULIN				
GLOBULIN	3.5		2.0 - 3.5	g/dL
METHOD : CALCULATED PARAMETER				
ELECTROLYTES (NA/K/CL), SERUM				
SODIUM	139		137 - 145	mmol/L
METHOD : ION SELECTIVE ELECTRODE TECHNOLOGY				
POTASSIUM	**3.40**	**Low**	3.6 - 5.0	mmol/L
METHOD : ION SELECTIVE ELECTRODE TECHNOLOGY				
CHLORIDE	107		98 - 107	mmol/L
METHOD : ION SELECTIVE ELECTRODE TECHNOLOGY				
PHYSICAL EXAMINATION, URINE				
COLOR	PALE YELLOW			
METHOD : VISUAL INSPECTION				
APPEARANCE	**SLIGHTLY HAZY**			
METHOD : VISUAL INSPECTION				
SPECIFIC GRAVITY	1.025		1.003 - 1.035	
METHOD : IONIC CONCENTRATION METHOD				

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CHEMICAL EXAMINATION, URINE			
PH	5.5	4.7 - 7.5	
METHOD : DOUBLE INDICATOR PRINCIPLE			
PROTEIN	NOT DETECTED	NOT DETECTED	
METHOD : TETRA BROMOPHENOL BLUE/SULFOSALICYLIC ACID			
GLUCOSE	NOT DETECTED	NOT DETECTED	
METHOD : GLUCOSE OXIDASE PEROXIDASE			
KETONES	NOT DETECTED	NOT DETECTED	
METHOD : NITROPRUSSIDE REACTION			
BLOOD	NOT DETECTED	NOT DETECTED	
METHOD : PEROXIDASE			
UROBILINOGEN	NORMAL	NORMAL	
METHOD : MODIFIED EHRLICH REACTION			
NITRITE	NOT DETECTED	NOT DETECTED	
METHOD : 1,2,3,4-TETRAHYDROBENZO(H)QUINOLIN-3-OL			
LEUKOCYTE ESTERASE	**DETECTED (++)**	NOT DETECTED	
MICROSCOPIC EXAMINATION, URINE			
PUS CELL (WBC'S)	**10-15**	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION			
EPITHELIAL CELLS	**5-7**	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION			
ERYTHROCYTES (RBC'S)	NOT DETECTED	NOT DETECTED	/HPF
METHOD : MICROSCOPIC EXAMINATION			
CASTS	NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION			
CRYSTALS	NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION			
BACTERIA	NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION			
YEAST	NOT DETECTED	NOT DETECTED	

Interpretation(s)
SERUM BLOOD UREA NITROGEN-Causes of Increased levels
Pre renal
• High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal
• Renal Failure
Post Renal
• Malignancy, Nephrolithiasis, Prostatism

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Causes of decreased levels
• 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's
• Multiple Sclerosis

Nutritional tips to manage increased Uric acid levels
• Drink plenty of fluids
• Limit animal proteins
• High Fibre foods
• Vit C Intake
• Antioxidant rich foods
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.
ELECTROLYTES (NA/K/CL), SERUM-ELECTROLYTES (NA/K/CL), SERUM

Sodium levels are Increased in dehydration, cushing'''''''s syndrome, aldosteronism & decreased in Addison'''''''s disease, hypopituitarism,liver disease. Hypokalemia (low K) is common in vomiting, diarrhea, alcoholism, folic acid deficiency and primary aldosteronism. Hyperkalemia may be seen in end-stage renal failure, hemolysis, trauma, Addison'''''''s disease, metabolic acidosis, acute starvation, dehydration, and with rapid K infusion.Chloride is increased in dehydration, renal tubular acidosis (hyperchloremia metabolic 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.Chloride is decreased in overhydration, chronic respiratory acidosis, salt-losing nephritis, metabolic alkalosis, congestive heart failure, Addisonian crisis, certain types of metabolic acidosis, persistent gastric secretion and prolonged vomiting,

HAEMATOLOGY

CBC-5, EDTA WHOLE BLOOD

BLOOD COUNTS, EDTA WHOLE BLOOD

HEMOGLOBIN	13.7	12.0 - 15.0	g/dL
METHOD : SLS- HEMOGLOBIN DETECTION METHOD			
RED BLOOD CELL COUNT	4.47	3.8 - 4.8	mil/µL

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METHOD : HYDRODYNAMIC FOCUSING BY DC DETECTION				
WHITE BLOOD CELL COUNT	9.72		4.0 - 10.0	thou/µL
METHOD : FLUORESCENCE FLOW CYTOMETRY				
PLATELET COUNT	283		150 - 410	thou/µL
METHOD : HYDRO DYNAMIC FOCUSING & DC DETECTION METHOD				
RBC AND PLATELET INDICES				
HEMATOCRIT	39.9		36.0 - 46.0	%
METHOD : CUMULATIVE PULSE HEIGHT DETECTION METHOD				
MEAN CORPUSCULAR VOLUME	89.3		83.0 - 101.0	fL
METHOD : CALCULATED FROM RBC & HCT				
MEAN CORPUSCULAR HEMOGLOBIN	30.6		27.0 - 32.0	pg
METHOD : CALCULATED FROM RBC & HCT				
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION	34.3		31.5 - 34.5	g/dL
METHOD : CALCULATED FROM RBC & HCT				
MENTZER INDEX	20.0			
RED CELL DISTRIBUTION WIDTH	12.5		11.6 - 14.0	%
METHOD : CALCULATED FROM RBC SIZE DISTRIBUTION CURVE				
MEAN PLATELET VOLUME	10.0		6.8 - 10.9	fL
METHOD : CALCULATED FROM PLATELET COUNT & PLATELET HEMATOCRIT				
WBC DIFFERENTIAL COUNT - NLR				
NEUTROPHILS	74		40.0 - 80.0	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
ABSOLUTE NEUTROPHIL COUNT	**7.19**	**High**	2.0 - 7.0	thou/µL
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
LYMPHOCYTES	20		20.0 - 40.0	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
ABSOLUTE LYMPHOCYTE COUNT	1.94		1.0 - 3.0	thou/µL
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	3.7			
METHOD : CALCULATED				
EOSINOPHILS	1		1 - 6	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
ABSOLUTE EOSINOPHIL COUNT	0.10		0.02 - 0.50	thou/µL
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
MONOCYTES	5		2.0 - 10.0	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
ABSOLUTE MONOCYTE COUNT	0.49		0.2 - 1.0	thou/µL

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METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
DIFFERENTIAL COUNT PERFORMED ON:	EDTA SMEAR		
METHOD : AUTOMATED ANALYZER / MICROSCOPY			
MORPHOLOGY			
RBC	NORMOCYTIC AND NORMOCHROMIC		
METHOD : MICROSCOPIC EXAMINATION			
WBC	NORMAL MORPHOLOGY		
PLATELETS	ADEQUATE		

Interpretation(s)
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 - NLR-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.

BIO CHEMISTRY

LIVER FUNCTION PROFILE, SERUM

BILIRUBIN, TOTAL	**2.07**	**High**	0.2 - 1.3	mg/dL
METHOD : DIPHYLLINE DIAZONIUM SALTS				
BILIRUBIN, DIRECT	0.20		0.0 - 0.3	mg/dL
METHOD : DIPHYLLINE DIAZONIUM SALTS				
BILIRUBIN, INDIRECT	**1.87**	**High**	0.0 - 1.1	mg/dL
METHOD : DIPHYLLINE DIAZONIUM SALTS				
TOTAL PROTEIN	6.4		6.3 - 8.3	g/dL
ALBUMIN	**2.9**	**Low**	3.5 - 5.0	g/dL
GLOBULIN	3.5		2.0 - 3.5	g/dL
ALBUMIN/GLOBULIN RATIO	**0.8**	**Low**	1.0 - 2.0	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	35		14 - 36	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)	27		< 35.0	U/L
ALKALINE PHOSPHATASE	87		38 - 126	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)	25		12 - 43	U/L
LACTATE DEHYDROGENASE	172		120 - 246	U/L

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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

****End Of Report****

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Dr. Ushma Wartikar, MD
Consultant Pathologist

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

CONDITIONS OF LABORATORY TESTING & REPORTING

1. It is presumed that the test sample belongs to the patient named or identified in the test requisition form.
2. All Tests are performed and reported as per the turnaround time stated in the SRL Directory of services (DOS).
3. SRL confirms that all tests have been performed or assayed with highest quality standards, clinical safety & technical integrity.
4. A requested test might not be performed if:
   a. Specimen received is insufficient or inappropriate specimen quality is unsatisfactory
   b. Incorrect specimen type
   c. Request for testing is withdrawn by the ordering doctor or patient
   d. There is a discrepancy between the label on the specimen container and the name on the test requisition form
5. The results of a laboratory test are dependent on the quality of the sample as well as the assay technology.
6. Result delays could be because of uncontrolled circumstances. e.g. assay run failure.
7. Tests parameters marked by asterisks are excluded from the "scope" of NABL accredited tests. (If laboratory is accredited).
8. Laboratory results should be correlated with clinical information to determine Final diagnosis.
9. Test results are not valid for Medico- legal purposes.
10. In case of queries or unexpected test results please call at SRL customer care (91115 91115). Post proper investigation repeat analysis may be carried out.

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Mohali 160062

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