Mr. YASH JHAVERI
GOVALAI TANK
Tel No : 8898078870
PID NO: P81170008528
Age: 17 Year(s) Sex: Male

Reference: Dr.SAMRAT D SHAH
Sample Collected At:
SHREE PALANPURI STANKAVASI JAIN ASSOCIATION
C/O , SAMIR DIAMONDS 910 PRASAD CHAMBERS 9TH FLOOR OPERA HOUSE MUMBAI 400004
400004

VID: 81180105507
Registered On:
13/06/2018 09:54 AM
Collected On:
13/06/2018 9:54AM
Reported On:
13/06/2018 01:18 PM

CBC Haemogram

Investigation	Observed Value	Unit	Biological Reference Interval
Erythrocytes			
Haemoglobin (Hb)	13.6	gm/dL	12.5-16.5
Erythrocyte (RBC) Count	5.15	mill/cu.mm	4.2-5.6
PCV (Packed Cell Volume)	40.9	%	36-47
MCV (Mean Corpuscular Volume)	79.4	fL	78-95
MCH (Mean Corpuscular Hb)	26.4	pg	26-32
MCHC (Mean Corpuscular Hb Concn.)	33.3	g/dL	32-36
RDW (Red Cell Distribution Width)	12.8	%	11.5-14.0
Leucocytes			
Total Leucocytes (WBC) count	5,700	cells/cu.mm	4000-10500
Absolute Neutrophils Count	2622	/c.mm	2000-7000
Absolute Lymphocyte Count	2280	/c.mm	1000-3000
Absolute Monocyte Count	285	/c.mm	200-1000
Absolute Eosinophil Count	456	/c.mm	20-500
Absolute Basophil Count	57	/c.mm	20-100
Neutrophils	46	%	44-76
Lymphocytes	40	%	15-43
Monocytes	5	%	4.0-9.0
Eosinophils	**8**	%	0-6
Basophils	1	%	0-2
Platelets			
Platelet count	245	10^3 / µl	150-450
MPV (Mean Platelet Volume)	**9.9**	fL	6-9.5
PCT (Platelet Haematocrit)	0.24	%	0.2-0.5
PDW (Platelet Distribution Width)	11.5	%	9-17

EDTA Whole Blood - Tests done on Automated Five Part Cell Counter. (WBC, RBC Platelet count by impedance method, WBC differential by VCS technology other parameters calculated) All Abnormal Haemograms are reviewed confirmed microscopically. Differential count is based on approximately 10,000 cells.

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Investigation	Observed Value	Unit	Biological Reference Interval
ESR - Erythrocyte Sedimentation Rate (EDTA Whole Blood)	1	mm/hr	0-15

Method: Automated Westergren

Interpretation:

1. It indicates presence and intensity of an inflammatory process, never diagnostic of a specific disease. Changes are more significant than a single abnormal test.
2. It is a prognostic test and used to monitor the course or response to treatment of diseases like tuberculosis, bacterial endocarditis, acute rheumatic fever, rheumatoid arthritis, SLE, Hodgkins disease, temporal arteritis, polymyalgia rheumatica.
3. It is also increased in pregnancy, multiple myeloma, menstruation, and hypothyroidism.

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Investigation	Observed Value	Unit	Biological Reference Interval
Vitamin B12 level (Serum,CMIA)	**146**	pg/mL	187-883

Interpretation :

1. Vit B12 levels are decreased in megaloblastic anemia, partial/total gastrectomy, pernicious anemia, peripheral neuropathies, chronic alcoholism, senile dementia, and treated epilepsy.
2. An associated increase in homocysteine levels is an independent risk marker for cardiovascular disease and deep vein thrombosis.
3. HoloTranscobalamin II levels are a more accurate marker of active VitB12 component.

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Investigation	Observed Value	Unit	Biological Reference Interval
25 Hydroxy (OH) Vit D (Serum,CMIA)	**10.3**	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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