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94-A Pocket F, MIG FLAT Guru Teg Bahadur Hospital Opp. Gate No.5 G.T.B. Enclave, Delhi-110095

LABORATORY TEST REPORT

Barcode No:	00511047	Reg No.	181080
Patient Name:	MR. OM PARKASH	Reg Date	03-Aug-2024 05:03 AM
Age/Sex:	65Y 0M 0D/Male	Sample Coll. Date	03-Aug-2024 05:03 AM
Refered By:	Dr. LIFE CARE LAB	Sample Rec.Date	03-Aug-2024 05:05 AM
Client Code/Name:	HR0175-KKR LAB	Report Date:	03-Aug-2024 08:43 AM
Panel Address:	KURUKSHETRA		

HAEMATOLOGY

HS1.1

TestName	Result	Flag	Biological Ref. Range/Unit
CBC (Complete Blood Count), Whole Blood EDTA			
Hemoglobin (Hb) Photometric Cyanmethemoglobin Method	6.70	Low	13.0-17.0 gm/dl
Erythrocyte Count (RBCs Counts) Optical Flow Cytometry	2.50	Low	4.5–5.5 10^6/uL
Packed Cell Volume (PCV) Hematocrit RBC Pulse Hight Detection	21.40	Low	40-50 %
Mean Corpuscular Volume (MCV) Automated/Calculated	85.30	Normal	83 - 101 fL
Mean Corpuscular Hemoglobin (MCH) Automated/Calculated	26.70	Normal	24-32 pg/cell
Mean Corpuscular Hb concentration (MCHC) Automated/Calculated	31.30	Normal	28 - 35 g/dL
Red Blood Cell Distribution Width Coefficient of Variation (RDW-CV) Automated/Calculated	13.70	Normal	11.7 - 17.2 %
Red Blood Cell Distribution Width Standard Deviation (RDW-SD) Automated/Calculated	45.30	Normal	36.4 - 58.0 10^3/uL
Platelet Count Automated Optical Flow Cytometry /Manual Calculated	174	Normal	150-410 10^3/ul
Plateletcrit (PCT) Automated Optical Flow Cytometry /Manual Calculated	0.20	Normal	0.15 - 0.39 %
Mean Platelet Volume (MPV). Automated/Calculated	11.20	Normal	7.0- 12.5 %
Platelet Distribution Width (PDW) Automated/Calculated	15.1	Normal	9.2-17.9 %
Platelet-Large Cell Count (P-LCC) Automated/Calculated	67.0	Normal	
Platelet Larger Cell Ratio (P-LCR) Automated/Calculated	38.50	Normal	18.5 - 68.0 %
Total Leukocyte Count (TLC/WBC Counts) Automated Optical Flow Cytometry /Manual Calculated	5.14	Normal	4.0-11 10^3/uL
Differential Leukocyte Count (DLC) Cytometry/Manual/ Microscopic			
Neutrophils Impedance Flow Cytometry/ Microscopy	42.0	Normal	40 - 75 %
Lymphocytes Impedance Flow Cytometry/ Microscopy	54.0	High	20 - 40 %
Monocytes Impedance Flow Cytometry/ Microscopy	2.0	Normal	2 - 10 %
Eosinophils Impedance Flow Cytometry/ Microscopy	2.0	Normal	1 - 6 %

Dr. DEVENDRA KUMAR
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CONSULTANT PATHOLOGIST, DMC NO-35884

Dr. MOOL KUMAR
CONSULTANT BIOCHEMIST
Ph.D (MEDICAL BIOCHEMISTRY)

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Age/Sex:	65Y 0M 0D/Male	Sample Coll. Date	03-Aug-2024 05:03 AM
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Client Code/Name:	HR0175-KKR LAB	Report Date:	03-Aug-2024 08:43 AM
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HAEMATOLOGY

HS1.1

TestName	Result	Flag	Biological Ref. Range/Unit
sophils pedance Flow Cytometry/ Microscopy	0.0	Normal	0 - 2 %
olute Neutrophil Count mated/Calculated	2.16	Normal	2.00-8.00 10^3/uL
ute Lymphocyte Count ated/Calculated	2.78	Normal	1.00-3.00 10^3/uL
te monocyte Count ted/Calculated	**0.10**	**Low**	0.20 - 1.00 10^3ul
e Eosinophils ed/Calculated	0.10	Normal	0.02-0.50 10^3/ul
Basophils l/Calculated	**0.00**	**Low**	0.02 - 0.10 10^3ul

TATION: Hemoglobin: Decreases in hemoglobin occur for the same reasons as decreased RBCs. **RBCs**: The RBC count will be low with iron lood loss, hemolysis and bone marrow suppression. Increases may be found when one moves to a higher altitude or after prolonged physical exercise, /cythemia vera. **Hematocrit:** After hemorrhage or excessive intravenous fluid infusion, the hematocrit will be low. If the patient is dehydrated, the ill be increased. **MCV**: Low values indicate the cells are microcytic and are evident with conditions such as iron deficiency, lead poisoning and High values indicate macrocytic cells (large cells), and are found in conditions as megaloblastic anemia, folate or Vitamin B12 deficiency, liver disease, ny, chemotherapy or hypothyroidism. **MCH & MCHC:** Low values are associated with iron deficiency thalassemia and malnutrition. **RDW**: nay indicate iron deficiency or other conditions with a wide distribution of various cell sizes. **Platelets:** Thrombocytopenia (reduced platelets) can ding. Thrombocytopenia may occur in case of aplastic anemia, drug-induced, leukemia. Elevated platelet number can be seen in following cases ythemia, chronic leukemia, post-splenectomy, iron deficiency anemia, malignancy, chronic infection or inflammation and other conditions which et function are atherosclerosis, diabetes, smoking and elevated lipid and cholesterol levels. **WBCs:** Low white blood cell count (leukopenia) may cal condition, such as an autoimmune disorder that destroys white blood cells, bone marrow problems. Certain medications also can cause white lrop. If your white blood cell count is higher than normal, you may have an infection or inflammation. It could indicate that you have an immune one marrow disease. A high white blood cell count can also be a reaction to medication.

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LABORATORY TEST REPORT

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Refered By:	Dr. LIFE CARE LAB	Sample Rec.Date	03-Aug-2024 05:05 AM
Client Code/Name:	HR0175-KKR LAB	Report Date:	03-Aug-2024 08:46 AM
Panel Address:	KURUKSHETRA		

HAEMATOLOGY

HS1.1

TestName	Result	Flag	Biological Ref. Range/Unit
Erythrocyte Sedimentation Rate (ESR), Whole Blood EDTA			
Erythrocyte Sedimentation Rate (ESR) Westergreen Method	75	High	<15 mm/hr

CLINICAL COMMENTS: Erythrocyte sedimentation rate (ESR or sed rate) is a relatively simple, inexpensive, non-specifictest that indirectly measures the degree of inflammation present in the body. Inflammation is part of the body's immune response. It can be acute, developing rapidly after trauma, injury or infection, for example, or can occur over an extended time (chronic) with conditions such as autoimmune diseases or cancer. Moderately elevated ESR occurs with inflammation but also with anemia, infection, pregnancy, and with aging. A very high ESR usually has an obvious cause, such as a severe infection, marked by an increase in globulins, systemic vasculitis, polymyalgia rheumatica or temporal arteritis. People with multiple myeloma or Waldenstrom's macroglobulinemia (tumors that make large amounts of immunoglobulins) typically have very high ESRs even if they don't have inflammation.

Factors increasing ESR:

- Advanced age
- Anemia
- Pregnancy
- *High fibrinogen*
- *Macrocytosis*
- *Kidney problems*
- *Thyroid disease*
- *Some cancers, such as multiple myeloma*
- Infection

Factors decreasing ESR

- Microcytosis
- Low fibrinogen
- Polycythemia
- Marked leukocytosis

Dr. MOOL KUMA

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LABORATORY TEST REPORT

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Refered By:	Dr. LIFE CARE LAB	Sample Rec.Date	03-Aug-2024 05:05 AM
Client Code/Name:	HR0175-KKR LAB	Report Date:	03-Aug-2024 08:42 AM
Panel Address:	KURUKSHETRA		

BIOCHEMISTRY & IMMUNOLOGY

HS1.1

TestName	Result	Flag	Biological Ref. Range/Unit
Lipid (Heart Risk) Profile, Serum			
TOTAL CHOLESTEROL Chod/Pap Method	119.44	Normal	Desirable:80-200 Borderline High: 200 - 239 High > 240 mg/dL
TRIGLYCERIDES Gpo/Pap Method	78.46	Normal	Normal 150 Border line High 150-199 High 200-499 Very High> 500 mg/dL
HDL CHOLESTEROL Direct Enzymatic Method	49.50	Normal	35 - 60 mg/dL
LDL CHOLESTEROL Direct Enzymatic Method	54.25	Normal	Normal: 00-100, Above optimal: 101-130, Borderline High: 130-160, High; 160-200 mg/dL
VERY LOW DENSITY LIPOPROTEIN (VLDL) Automated/Calculated	15.69	Normal	0.0-30.0 mg/dL
TOTAL CHOLESTEROL / HDL CHOLESTEROL Ratio Automated/Calculated	2.41	Normal	<5.0 mg/dL
LDL / HDL CHOLESTEROL Ratio Automated/Calculated	1.10	Low	Less than 3.50 mg/dL
TOTAL LIPIDS Automated/Calculated	326.65	Low	400-1000 mg/dL

LINICAL COMMENTS: *Lipid Profile is the blood test useful in screening the abnormalities associated with lipids. The results of this test can assess approxim cardiovascular disease (Heart attack, Heart Failure, stroke, coronary artery disease), certain forms of pancreatitis, Hypertriglyceridemia (indicative of insulin r certain genetic disorders. Total cholesterol is an estimate of all the cholesterol in the blood. Thus, higher total cholesterol may be due to high levels of HD ls of LDL. So knowing the breakdown is important. High-density lipoprotein (HDL) is good cholesterol. HDL helps carry bad cholesterol out of the bloods ies. It plays a very important role in preventing clogged arteries. So, the higher the HDL number, the better. Low-density lipoprotein (LDL) is bad cholest levels increase the risk of heart disease. Your actual LDL goal depends on whether or not you have existing risk factors for heart disease, such as diabe pressure. Very Low-density lipoprotein (VLDL) is a type of bad cholesterol that contains the highest amount of triglycerides. The higher your VLDL leve you are to have a heart attack or stroke. Triglycerides are a type of blood fat that has been linked to heart disease and diabetes. If you have high triglyc holesterol and LDL levels may be high, as well. Lifestyle plays a large role in your triglyceride level. Smoking, excessive drinking, uncontrolled di ions such as estrogen, steroids, and some acne treatments can contribute to high triglyceride levels. Total cholesterol to HDL ratio is useful in predictin ing atherosclerosis (plaque build-up inside the arteries).* **NOTE: 10-12 Hours Fasting is Mandatory for Lipid Profile.** **In case of t ly turbid due to lipoproteins mainly chylomicrons,the test cannot be performed on the specimen but the patient can request for this nsuming a fat free diet for at least a weak.**

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LABORATORY TEST REPORT

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Refered By:	Dr. LIFE CARE LAB	Sample Rec.Date	03-Aug-2024 05:05 AM
Client Code/Name:	HR0175-KKR LAB	Report Date:	03-Aug-2024 08:44 AM
Panel Address:	KURUKSHETRA		

BIOCHEMISTRY & IMMUNOLOGY

HS1.1

TestName	Result	Flag	Biological Ref. Range/Unit
Liver Function Test (LFT) - Extended, Serum			
Bilirubin Total Mod.Jendrassik and Grof"s Method	0.82	Normal	0.1-1.2 mg/dL
Bilirubin Direct DCA METHOD	0.14	Normal	0.00 - 0.30 mg/dL
Bilirubin Indirect Calculated	0.68	Normal	0.1 - 1.10 mg/dL
Aspartate Transaminase (AST/SGOT) Mod. IFCC Method	19.30	Normal	0-50 U/L
Alanine Amino Transferase (ALT/SGPT) Mod. IFCC Method	28.10	Normal	3-50 U/L
SGOT/SGPT Ratio Automated/Calculated	0.69	Normal	0.00 - 3.50 g/dL
Alkaline Phosphatase (ALP) Mod. IFCC Method	82.60	Normal	43-115 U/L
Gamma Glutamyl Transferase (GGT) Carboxy Substrate Method	23.50	Normal	5 - 64 U/L
Protein Total Biuret Method	7.11	Normal	6.4-8.3 g/dL
Albumin BCG (Bromo Cresol Green) Method	4.27	Normal	3.5-5.6 g/dL
Globulin Automated/Calculated	2.84	Normal	2.5 - 3.8 g/dL
Albumin/Globulin Ratio (A/G) Automated/Calculated	1.50	Normal	1.00 - 2.30 g/dL

INICAL COMMENTS: Liver function tests can be suggested in case of hepatitis, liver cirrhosis and monitor possible side effects of medications. A variety of diseases and infections ca
e or chronic damage to the liver, causing inflammation (hepatitis), scarring (cirrhosis), bile duct obstructions, liver tumors, and liver dysfunction. Alcohol, drugs, some herbal supplem
s can also inure the liver. A significant amount of liver damage may occur before symptoms such as jaundice, dark urine, light-colored stools, itching (pruritus), nausea, fatigue, diarr
plained weight loss or gain appear. Early detection of liver injury is essential in order to minimize damage and preserve liver function. **Alanine aminotransferase (ALT)** A very high
is frequently seen with acute hepatitis. Moderate increases may be seen with chronic hepatitis. People with blocked bile ducts, cirrhosis, and liver cancer may have ALT concentration
noderately elevated or close to normal. **Aspartate aminotransferase (AST)** A very high level of AST is frequently seen with acute hepatitis. AST may be normal to moderately
hronic hepatitis. In people with blocked bile ducts, cirrhosis, and liver cancer, AST concentrations may be moderately increased or close to normal. When liver damage is due t
ften increases much more than ALT (this is a pattern seen with few other liver diseases). AST is also increased after heart attacks and with muscle injury.AST is a less sensitiv
e marker of liver injury than ALT. AST is more elevated than ALT in alcohol-induced liver injury. AST could elevated more than ALT like: (i) alcoholic liver disease
ondrial toxicity and pyridoxal phosphate, which is a co-factor for AST; (ii) Wilson disease results in subclinical haemolysis and release of AST; (iii) the presence of liver cirrhosis;
s is established, AST remains higher than ALT because of destroyed sinusoidal architecture, which results in impaired clearance of AST. **Alkaline phosphatase (ALP)** may be s
d with obstructed bile ducts, cirrhosis, liver cancer, and also with bone disease.. Albumin is often normal in liver disease but may be low due to decreased production, especi
Total protein (TP) is typically normal with liver disease. **Gamma-glutamyl transferase (GGT)** test may be used to help determine the cause of an elevated ALP. Both ALP an
in bile duct and liver disease, but only ALP will be elevated in bone disease. Increased GGT levels are also seen with alcohol consumption and with conditions, such as cong

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may show interlaboratory variations. The Patients identity is not
Test results are not valid for medico-leg

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Client Code/Name:	HR0175-KKR LAB	Report Date:	03-Aug-2024 08:18 PM
Panel Address:	KURUKSHETRA		

BIOCHEMISTRY & IMMUNOLOGY

HS1.1

TestName	Result	Flag	Biological Ref. Range/Unit
KIDNEY PROFILE (KFT), Serum			
Urea GLDH KINETIC METHOD	108.78	High	17.0-44.0 mg/dL
Creatinine ,Serum Enzymatic Pap Method	8.94	High	0.5-1.2 mg/dL
Uric Acid Uricase/ Pap Method	4.00	Normal	3.5-7.2 mg/dL
Blood Urea Nitrogen (BUN) Automated/Calculated	50.83	High	6.0 - 20.0 mg/dL
BUN/Creatinine Ratio Automated/Calculated	5.69	Normal	0.00 - 23.0 mg/dL
Urea/Creatinine Ratio Automated/Calculated	12.17	Normal	0.00 - 45.0 mg/dL
Calcium Total	9.14	Normal	8.6 - 10.5 mg/dL
ELECTROLYTE PROFILE (*)			
Sodium	132.60	Low	135-145 mmol/L
Potassium	5.68	High	3.5-5.2 mmol/L
Chloride Serum	114.20	High	97.0–110 mmol/L

COMMENTS: KINDLY CORRELATE WITH CLINICAL FINDINGS.

INICAL COMMENTS ***UREA:*** *High urea levels suggest poor kidney function, congestive heart failure, shock, stress, recent heart attack or severe burns; bleedin intestinal tract; conditions that cause obstruction of urine flow or dehydration. Low urea levels can be seen in severe liver disease or malnutrition but are not used to diagnose or mo ions. Low urea levels are also seen in normal pregnancy.* **CREATININE:** *Increases in any renal functional impairment (intrinsic renal lesions, decreased perfusion of the kidney, or ower urinary tract), acromegaly and hyperthyroidism. Decreases in pregnancy, muscle wasting.* **URIC ACID:** *Increases in case of renal failure, disseminated neoplasms, pregnanc s, liver disease, sarcoidosis etc. Decrease is reported in Wilson's disease, Fanconi's syndrome, xanthinuria.* **SODIUM:** *Increases due to water loss (severe diarrhea profuse sweati ing), hypergluco- or mineralo-corticoidism, and inadequate water intake. Decreases due to intake of free water or hypotonic solutions. Dilutional hyponatremia (liver failure, car e syndrome, malnutrition, renal tubular abnormalities).* **POTASSIUM:** *Increases due to excess destruction of cells, redistribution of K^+ from the intra- to the extracellular c uries, massive haemolysis, malignant hyperpyrexia and hyperkinetic activity). Decreased renal K^+ excretion (acute renal failure, some cases of chronic renal failure, Addison's um-depleted states). Decreases due to excess K^+ loss (vomiting, diarrhea, renal tubular defects,villous adenoma of the colorectum, hypercorticoidism, etc), Redistribution b nsulin therapy, alkalosis and periodic paralysis).* **CHLORIDE:** *Increases in case of dehydration, acute renal failure, renal tubular acidosis, diabetes insipidus, prolonge alkalosis, salicylate toxicity, , hypothalamic lesions, and adrenocortical hyperfunction. Decreases in case of excessive sweating, prolonged vomiting, adrenocortical deficiency , acute intermittent porphyria, various acid base disturbances, expansion of extracellular fluid volume etc.* **Urea nitrogen (BUN):** *Increases in case of acute & chronic ir renal obstruction of urine, high protein intake. Decreases with high carbohydrate/low protein diets, increased anabolic demand (late pregnancy, infancy, acromegaly), malab damage.* **CALCIUM:** *Increases in case of malignant neoplasms (with or without bone involvement), vit-D intoxication, primary and tertiary hyperparathyroidism, sarcoid ne (with immobilization), thyrotoxicosis, acromegaly, diuretic phase of renal acute tubular necrosis*

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BIOCHEMISTRY & IMMUNOLOGY

HS1.1

TestName	Result	Flag	Biological Ref. Range/Unit
eGFR, Serum			
eGFR	8.94	High	0.50 - 1.30 mg/dL
ESTIMATED GFR BY CKD	5.56	Low	>60 mL/min/1.73m2
ESTIMATED GFR BY MDRD	6.36	Low	>60 mL/min/1.73m2

INTERPRETATION:

AGE IN YEARS	GFR IN mL/min/1.73m²
20-29	116
30-39	107
40-49	99
50-59	93
60-69	85
>=70	75

NOTE:
1.National Kidney Disease Education program recommends the use of MDRD equation to estimate or predict GFR in adults (>=20 years) with Chronic Kidney Disease (CKD)
2. MDRD equation is most accurate for GFR <=60 mL/min/1.73m2 .
3. Recalculation of estimated GFR is required for African American race.

INTERPRETATION:

CKD STAGE	DESCRIPTION	GFR (mL/min/1.73m²)	ASSOCIATED FINDINGS
0	Normal kidney function	>90	No proteinuria
1	Kidney damage with normal or high GFR	>90	Presence of Protein, albumin, cells or casts in urine
2	Mild decrease in GFR	60-89	-
3	Moderate decrease in GFR	30-59	-
4	Severe decrease in GFR	15-29	-
5	Kidney failure	<15	-

COMMENTS:

Modification of diet in renal disease (MDRD) equation is most thoroughly validated and superior to all the other methods for es of GFR. It does not require weight as a variable and yields an estimated GFR normalized to 1.73m2 body surface area. Usin creatinine alone gives a poor inference of GFR because they are inversely related and effects of age, sex and race on cr production complicate interpretation. For African American races a modified formula is used for calculation of GFR.

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Client Code/Name:	HR0175-KKR LAB	Report Date:	03-Aug-2024 09:22 AM
Panel Address:	KURUKSHETRA		

IMMUNOLOGY

HS1.1

TestName	Result	Flag	Biological Ref. Range/Unit
Thyroid Function Test (TFT), Serum			
Tri-Idothyronine (TT3) Electro Chemiluminescence Immunoassay (ECLIA)	1.48	Normal	0.80–2.0 ng/mL
Thyroxine Total (TT4) Electro Chemiluminescence Immunoassay (ECLIA)	8.63	Normal	4.0–12 ug/dL
Thyroid Stimulating Hormone (TSH) (CMIA), ULTRA SENSITIVE Electro Chemiluminescence Immunoassay (ECLIA)	1.510	Normal	Non-Pregnant 0.38-5.33 pregnant female 1st trimester 0.05-3.70 2nd trimester 0.31-4.35 3rd trimester 0.41-5.18 mU/L

Comments:

is physiologically more active than T4 & plays an important role in maintaining euthyroidism. T3 circulates in free form (0.3 %) and in bound form (99.7%

T4 is predominantly bound to carrier protein - thyroid binding globulin (TBG-99.9%). T4 assay aids in diagnosis of hyperthyroidism - primary or secon hypothyroidism & thyroid hormone resistances. T4 tre must also be associated with the other tre of the thyroid assessment, such as TSH & T3 as well as wit clinical examina on to the patient TSH levels are subject to circadian varia on, reaching peak levels between 2am to 4am and at a minimum between 6pm to The varia on is of the order of 50%; hence time of the day has influence on the measured serum TSH concentrations.

Significant numbers of parents particularly those above 55 years of age have a serum TSH level between 4.68 & 10 µIU/ml. This borderline eleva on may b presence of SUBCLINICAL HYPOTHYROIDISM. Thyroid profile and an -thyroid (an TPO & TG) an bodies es ma on is suggested in all such cases.

Very low serum TSH values are observed in patients who are being treated for hypothyroidism. In such pa ents Serum Free T3 & Free T4 estimation performed.

In Pregancy as per American Thyroid Association Reference range for TSH is as follows:-

Level	Total T3(ng/ml)	Total T4(ug/dl)	TSH(uIU/ml)	Free T3(pmol/L)	Free T4(ng/dl)
1st Trimester	1.25-2.93	4.60-10.50	0.3-4.5	3.2-6.8	0.7-2.0
2nd Trimester	1.54-4.00	6.92-12.38	0.5-4.6	3.1-5.9	0.5-1.60
3rd Trimester	1.54-4.00	5.98-12.98	0.8-5.2	3.1-5.9	0.6-1.60

All reports must be interpreted by treating physician only.

********** End of Report **********

Dr. MOOL KUMAR