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Laboratory Investigation Report

Patient Name	Centre
Age/Gender	OP/IP No/UHID
MaxID/Lab ID	Collection Date/Time
Ref Doctor	Reporting Date/Time

SIN No:B2B2865589

Clinical Biochemistry

Test Name	Result	Unit	Bio Ref Interval
CPK-MB*			
CPK-MB	**36**	U/L	0.00-26.92

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Clinical Biochemistry

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C-Reactive Protein (CRP)*, Serum

Date	28/Dec/2022 01:11PM	Unit	Bio Ref Interval
CRP Turbitimetric	**67.4**	mg/L	< 10

Interpretation This helps in detecting neonatal septicemia, meningitis and useful to assess the activity of inflammatory diseases like rheumatoid arthritis. It is increased after myocardial infarction, stress, trauma, infection, inflammation, surgery, or neoplastic proliferation. The increase with inflammation occurs within 6 -12 hours and peaks at about 48 hours.

Calcium, Serum*

Date	28/Dec/2022 01:11PM	Unit	Bio Ref Interval
Calcium (Total) O-CPC	**7.4**	mg/dl	8.4-10.2

Comment

Increased in Primary and Tertiary hyperparathyroidism, malignant disease with bone involvement, Polycythemia vera, pheochromocytoma and Sarcoidosis.

Advise: PTH testing. If normal or increased, then check urine Ca^{++}/ Creatinine ratio to exclude Familial benign hypocalciuric hypercalcemia (FBHH)

Decreased in surgical or congenital hyperparathyroidism; Vitamin D deficiency, chronic renal failure; magnesium deficiency, prolonged anticonvulsant therapy, acute pancreatitis, hyperphosphatemia, massive blood transfusion, leprosy, proximal and distal renal tubular disease, alcoholism and hepatic cirrhosis.

Advice: Albumin, Phosphate, Creatinine, Alkaline Phosphatase and PTH.

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Liver Function Test (LFT)*, Serum

Date	28/Dec/2022 01:11PM	Unit	Bio Ref Interval
Total Protein Biuret	6.70	g/dL	6.3–8.2
Albumin BCG	**2.7**	g/dl	3.5-5.2
Globulin Calculated	**4.0**	g/dl	2.3 - 3.5
A.G. ratio Calculated	**0.7**		1.2 - 1.5
Bilirubin (Total) Diazo	**1.9**	mg/dl	0.2–1.3
Bilirubin (Direct) Diazo	**0.7**	mg/dl	0-0.3
Bilirubin (Indirect) Calculated	**1.20**	mg/dl	0.1 - 1.0
SGOT- Aspartate Transaminase (AST) IFCC without pyridoxal phosphate	**3436**	U/L	0-32
SGPT- Alanine Transaminase (ALT) IFCC without pyridoxal phosphate	**1489**	U/L	0-35
AST/ALT Ratio Calculated	2.31	Ratio	
Alkaline Phosphatase pNPP	**227**	U/L	38 - 126
GGTP (Gamma GT), Serum ENZYMATIC COLORIMETRIC ASSAY	38.0	U/L	12-43

Interpretation **AST/ALT Ratio : -**

In Case of deranged AST and/or ALT, the AST/ALT ratio is > 2.0 in alcoholic liver damage and < 2.0 in non – alcoholic liver damage

Kindly correlate with clinical findings

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Clinical Biochemistry

SIN No:B2B2865589

Shubhangi

Dr Shubhangi Shalley
MBBS, MD (Pathology)
Consultant pathologist

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SIN No:B2B2865589

Hematology

Test Name	Result	Unit	Bio Ref Interval

Peripheral Smear Examination*, EDTA

Peripheral Smear Examination

Light Microscopy

RBC picture shows mild anisocytosis with presence of microcytes, normocytes and few target cells. 5 NRBCs/100 WBCs noted.

Leucocytosis with neutrophilia noted.(absolute neutrophil count=41.9X10^3/ul). Toxic granules noted.

Platelets are in clumps and appear to be adequate manually.

IMPRESSION : Microcytic hypochromic anaemia with peripheral neutrophilia.

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Hematology

SIN No:B2B2865589

Prothrombin Time (PT-INR)*, Sodium Citrate

Date	28/Dec/2022 01:11PM	Unit	Bio Ref Interval
Prothrombin Time (PT) Photo-Optical-Nephlometry	**33.6**	Sec	12.1 - 15.1
MNPT Value	12.4	Sec	
INR	2.70		

Interpretation

(Syn: - Prothrombin Time)
PT is the test which checks the “extrinsic coagulation” pathway and is useful for detecting coagulation deficiency, liver disease and disseminated intravascular Coagulation (DIC).
PT can also be expressed as International normalized ratio (INR) used for monitoring warfarin therapy.
Raised PT value seen in - factor deficiency (Fibrinogen (I), Prothrombin (II), factor V, VII, X), oral anticoagulation therapy, liver diseases, Vitamin K deficiency and DIC.

Advice: - ‘**PT mixing study’**, ‘**specific factor(s) assay’**may be added on for further evaluation.

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Hematology

SIN No:B2B2865589

CBC (Complete Blood Count)*, Whole Blood EDTA

Date	28/Dec/2022 01:11PM	Unit	Bio Ref Interval
Haemoglobin Modified cyanmethemoglobin	**7.3**	g/dl	12.0 - 15.0
Packed Cell, Volume Calculated	**23.3**	%	40-50
Total Leucocyte Count (TLC) Electrical Impedance	**48.29**	10~9/L	4.0-10.0
Nucleated RBCs	2.73	/100WBCs	
RBC Count Electrical Impedance	**3.33**	10~12/L	3.8-4.8
MCV Electrical Impedance	**70.0**	fL	83-101
MCH Calculated	**22.0**	pg	27-32
MCHC Calculated	**31.4**	g/dl	31.5-34.5
Platelet Count Electrical Impedance	150	10~9/L	150-410
platelets seen in clumps			
MPV Calculated	**7.0**	fl	7.8-11.2
RDW Calculated	**19.8**	%	11.5-14.5

Differential Cell Count
VCS / Light Microscopy

Neutrophils	**86.9**	%	40-80
Lymphocytes	**9.7**	%	20-40
Monocytes	3.4	%	2-10
Eosinophils	**0.0**	%	1-6
Basophils	0.0	%	0-2

Absolute Leukocyte Count
Calculated from TLC & DLC

Absolute Neutrophil Count	**41.96**	10~9/L	2.0-7.0
Absolute Lymphocyte Count	**4.7**	10~9/L	1.0-3.0
Absolute Monocyte Count	**1.64**	10~9/L	0.2-1.0

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Hematology

SIN No:B2B2865589

Kindly correlate with clinical findings

***** End Of Report *****

Dr Shubhangi Shalley
MBBS, MD (Pathology)
Consultant pathologist

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Immunoassay

SIN No:B2B2865589

Trop I, (High Sensitive)*

Date	**28/Dec/2022 01:11PM**	**Unit**	**Bio Ref Interval**
Sample Type :.	EDTA		
Trop I CLIA	**0.43**	ng/ml	<0.02

Ref Range

"Important Note: The newly introduced high sensitive Trop I detects the analyte at a much lower concentration of 0.02 ng/mL. Thus the cut off reference range has been changed to 0.02 ng/mL"

Troponin I (High Sensitive) is a cardio-specific, highly sensitive marker for myocardial injury. Compared to contemporary troponin assays, high sensitive trop I demonstrate significantly improved precision at ≤ 0.02 ng/mL, allowing better discrimination of small differences in cardiac troponin values between serial measurements.

Clinical performance of high sensitive Trop I at cut of ≥ 0.02 ng/mL were as follows:

Hrs after admission to Emergency Department	Diagnostic sensitivity (% MI correctly diagnosed) %	Diagnostic Specificity (% non-MI Correctly Diagnosed) %	Positive Predictive Value (PPV-Probability of MI Diagnosis) %	Negative Predictive Value (NPV-Probability of non-MI diagnosis) %
Base Line	86	90	61	97
≥ 1 – 3 hr	95	90	55	99
≥ 3 – 6 hr	93	90	55	99
≥ 6 – 9 hr	99	86	52	1

Trop I is increased in congestive heart failure, acute and chronic trauma, electrical cardioversion, hypertension, hypotension, arrhythmias, pulmonary embolism, severe asthma, sepsis, critical illness, myocarditis, stroke, non-cardiac surgery, extreme exercise, drug toxicity (adriamycin , 5-fluorouracil, herceptin, snake venoms), end stage renal disease, and rhabdomyolysis with cardiac injury. These other etiologies rarely demonstrate the classic rising and falling pattern experienced with a MI which highlights the importance of serial monitoring when the clinical scenario is confusing.

Kindly correlate with clinical findings

***** End Of Report *****

Shubhangi

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Clinical Biochemistry

RFT BIO 1

Urea, Serum*

Date	28/Dec/2022 01:11PM	Unit	Bio Ref Interval
Urea Urease GLDH	**100.0**	mg/dl	15 - 36

Creatinine, Serum*

Date	28/Dec/2022 01:11PM	Unit	Bio Ref Interval
Creatinine Jaffe Kinetic	**2.3**	mg/dL	0.52-1.04
eGFR MDRD	29.39	ml/min/1.73 m²	

Ref. Range

eGFR - Estimated Glomerular Filteration Rate is calculated by MDRD equation which is most accurate for GFRs ≤ 60ml / m /1.73 m².MDRD equation is **used for adult population only.**

Category	Ref Interval (ml / min / 1.73 m²)	Condition
G1	≥90	Normal or High
G2	60 - 89	Mildly Decreased
G3a	45 - 59	Mildly to Moderately Decreased
G3b	30 - 44	Moderately to Severly Decreased
G4	15 - 29	Severly Decreased
G5	< 15	Kidney failure

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Clinical Biochemistry

RFT BIO 1

SIN No:B2B2865589

Sodium, Serum*

Date	28/Dec/2022 01:11PM	Unit	Bio Ref Interval
Sodium ISE Indirect	**129.0**	mmol/l	135-148

Potassium, Serum*

Date	28/Dec/2022 01:11PM	Unit	Bio Ref Interval
Potassium ISE Indirect	**5.5**	mmol/l	3.5 - 5.3

Chloride, Serum*

Date	28/Dec/2022 01:11PM	Unit	Bio Ref Interval
Chloride ISE Indirect	**97.0**	mmol/l	101-111

Kindly correlate with clinical findings

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SEROLOGY SPECIAL.

Dengue Fever Panel (Elisa)

Test Name	Result	Unit	Bio Ref Interval
Elisa Dengue IgG Antibody, Serum*			
Dengue IgG	Negative (2.10 Units)	Index	

Ref. Range

Negative	< 9.0
Equivocal	9.0 - 11.0
Positive	>11

Comment :

- Primary dengue virus infection is characterized by elevations in specific IgM antibody in 3 to 5 days after the onset of symptoms.
- IgG levels also become elevated after 10 to 14 days after the onset of symptoms. During secondary infection, IgM levels generally rise more slowly and reach lower levels than in primary infection, while IgG levels rise rapidly from 1 to 2 days after the onset of symptoms.
- Serological cross-reactivity across the flavi virus group (dengue virus, St. Louis encephalitis, Japanese encephalitis, West Nile virus and yellow fever virus) is common.

Note: Recommended test is NS1 Antigen by ELISA in the first 5 days of fever. After 7-10 days of fever, the recommended test is Dengue fever antibodies IgG & IgM by ELISA

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SEROLOGY SPECIAL.

Dengue Fever Panel (Elisa)

Test Name	Result	Unit	Bio Ref Interval

Elisa Dengue IgM Antibody, Serum*

Dengue IgM	Negative (1.50 Units)	Index	

Ref. Range
Negative < 9.0
Equivocal 9.0 - 11.0
Positive >11
Comment :

- Primary dengue virus infection is characterized by elevations in specific IgM antibody in 3 to 5 days after the onset of symptoms.
- IgG levels also become elevated after 10 to 14 days after the onset of symptoms. During secondary infection, IgM levels generally rise more slowly and reach lower levels than in primary infection, while IgG levels rise rapidly from 1 to 2 days after the onset of symptoms.
- Serological cross-reactivity across the flavi virus group (dengue virus, St. Louis encephalitis, Japanese encephalitis, West Nile virus and yellow fever virus) is common.
- A negative results does not preclude the possibility of early dengue virus infection.

Note: Recommended test is NS1 Antigen by ELISA in the first 5 days of fever. After 7-10 days of fever, the recommended test is Dengue fever antibodies IgG & IgM by ELISA

Dengue NS 1 Antigen Test (Elisa)*

Dengue NS 1 Antigen ELISA	Negative (0.01 Ratio)	Ratio	

Ref. Range
Negative Ratio < 0.50
Equivocal 0.50 ≤ Ratio - < 1.00
Positive Ratio ≥ 1.00
Comment :

- The detection of NS1 antigen has been described as an alternative method for early diagnosis of dengue virus infection.
- NS1 antigen was found circulating from the first day and up to 9 days after the onset of fever, with comparable levels observed in primary and secondary infections.
- A negative results does not preclude the possibility of early dengue virus infection.

Note: Recommended test is NS1 Antigen by ELISA in the first 5 days of fever. After 7-10 days of fever, the recommended test is Dengue fever antibodies IgG & IgM by ELISA

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SEROLOGY SPECIAL.

Dengue Fever Panel (Elisa)

Test Name	Result	Unit	Bio Ref Interval

Kindly correlate with clinical findings

*** End Of Report ***

Dr. Muktanjali Arya
MBBS, MD (Microbiology)
Senior Consultant

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Serology Special

Rapid Dengue Panel

Test Name	Result	Unit	Bio Ref Interval
Rapid Card Test-Dengue NS1 Antigen*, Serum Immunochromatography			
NS1 Antigen Card	Non reactive		

Advise: Confirmatory tests 'NS1 Antigen ELISA and Dengue PCR

Kindly correlate with clinical findings

***** End Of Report *****

Dr. Muktanjali Arya
MBBS, MD (Microbiology)
Senior Consultant

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Serology

Rapid Dengue Panel

Test Name	Result	Unit	Bio Ref Interval
Dengue Serology (Ig M & Ig G),Serum/EDTA*			
Immunochromatography			
Antibody IgM	Non reactive		
Immunochromatography			
Antibody IgG	Non reactive		
Immunochromatography			

Interpretation

This test detects the presence of antibodies to dengue virus in the specimen and should not be used as the sole criterion for the diagnosis of dengue virus infection.
In early infections and some secondary infections, detectable levels of IgM antibodies may be low.
Some patients may not produce detectable levels of antibody within the first seven to ten days after infection. If the test result is negative and clinical symptoms persist, patients should be retested 3-4 days after the first specimen.
Serological cross-reactivity across the flavi virus group (dengue virus, St. Louis encephalitis, Japanese encephalitis, West Nile virus and yellow fever virus) is common.
A negative results does not preclude the possibility of early dengue virus infection.
The report is based on screening test and is provisional.
Advise: "Dengue IgM capture ELISA or Dengue PCR" for diagnosis of acute infection

Kindly correlate with clinical findings

***** End Of Report *****

Dr. Muktanjali Arya
MBBS, MD (Microbiology)
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Results to follow:
Blood Gas Analysis with Electrolytes : 28/Dec/2022 02:05 PM

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