

REPORT

Name	: Mr. CHANDRAKANTH D	Sample ID	: 24216984
Age/Gender	: 31 Years/Male	Reg. No	: 0312309120079
Referred by	: Dr. SELF	SPP Code	: SPL-CV-172
Referring Customer	: V CARE MEDICAL DIAGNOSTICS	Collected On	: 12-Sep-2023 08:24 PM
Primary Sample	: Whole Blood	Received On	: 12-Sep-2023 09:56 PM
Sample Tested In	: Serum	Reported On	: 13-Sep-2023 12:34 PM
Client Address	: Kimtee colony ,Gokul Nagar,Tarnaka	Report Status	: Final Report

IMMUNOLOGY & SEROLOGY

Test Name	Results	Units	Ref. Range	Method
Inhibin B	128.10	ng/L	80-300	ELISA

Interpretation

- Inhibin values fluctuate during the menstrual cycle thus levels in premenopausal women should be interpreted with caution.
- Serum Inhibin levels should not be interpreted as absolute evidence of the presence or the absence of malignant disease. Results are to be used in conjunction with clinical evaluation of the patient and other diagnostic procedures

Note

- All result interpretation should be in conjunction with clinical evaluation of the patient and other diagnostic procedures.
- Elevation of Inhibin B after treatment is suggestive of residual, recurrent or progressive disease.

Comments

Inhibins are protein hormones secreted by Granulosa cells of the ovary in females and Sertoli cells of the testes in males. Inhibin B is primarily produced by small developing follicles and fluctuates during the menstrual cycle. It increases early in the follicular phase to reach a peak corresponding with mid-follicular phase decline in FSH levels and decreases in late follicular phase. Inhibin B levels are elevated in 89-100% patients with Granulosa cell tumors and 55-60% patients with Epithelial ovarian tumors. Normal Inhibin B level does not rule out a Mucinous or Granulosa cell ovarian tumor.



DR. RUTURAJ MANIKLAL KOLHAPURE
MD, MICROBIOLOGIST

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Primary Sample	: Whole Blood	Received On	: 12-Sep-2023 09:56 PM
Sample Tested In	: Whole Blood EDTA	Reported On	: 22-Sep-2023 04:50 PM
Client Address	: Kimtee colony ,Gokul Nagar,Tarnaka	Report Status	: Final Report

MOLECULAR BIOLOGY

Y Chromosome Microdeletion

Y CHROMOSOME MICRODELETION TEST REPORT

Referral Reason: Genetic screening test for Y chromosome microdeletion.

Test Results :-Y chromosome microdeletion Not detected

Interpretation: Molecular investigation results revealed absence of Y chromosome microdeletions (AZFa, AZFb and AZFc region) in this individual.

Recommendations:

- Genetic counseling and clinical correlation are required.
- If the above result does not correlate completely with patient phenotype, additional testing is advised based on clinician's discretion.

Method: Polymerase chain reaction (PCR) followed by agarose gel electrophoresis.

Background: Most commonly detected abnormalities in men with azoospermia (complete absence of sperm) and severe oligospermia (sperm count less than 5 million/ml) are Y chromosome microdeletions. Three common regions AZFa, AZFb, and AZFc on the long arm of Y chromosome are frequently micro deleted in infertile men.

Test Limitations: This test includes testing of Y chromosome STR markers which includes: **AZFa:** (sY84, sY86, sY746, DFFR) Y; **AZFb:** (Xkry, sY118, sY113, sY127, sY134, sY143, RBM1Y) and **AZFc:** (sY153, sY148, sY157, sY158, sY254, sY255, sY160) (EAA/EMQN guidelines, 2004)¹.

- **AZFa deletion:** result in spermatogenic failure (Sertoli-cell-only syndrome, SCOS).
- **AZFb deletion:** result in azoospermia/spermatogenetic arrest.
- **AZFc deletion:** most commonly found microdeletion with variable phenotype ranging from oligospermia to azoospermia and SCOS.

Limitations: Errors in our interpretation of results may occur if information given is inaccurate or incomplete.

- This testing method does not exclude the possibility of other genetic causes of infertility
- Breakpoints of identified microdeletions will not be determined
- All laboratory investigations are performed to support diagnosis in patient care and they carry some limitations due to Sensitivity and specificity of assay procedures and also depend on the quality of the sample received by the laboratory.
- Results should be correlated with clinical history, life style and medication given to the individual.
- *It is presumed that the specimen used to perform the test belongs to the patient specified above, such verification having been carried out at the collection level of sample.

Reference: Simoni M, Bakker E, Krausz C (2004) EAA/EMQN best practice guidelines for molecular diagnosis of Y- chromosomal microdeletions. State of the art 2004. Int J Androl 27: 240–249.



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Primary Sample	: Whole Blood	Received On	: 12-Sep-2023 09:56 PM
Sample Tested In	: Serum	Reported On	: 12-Sep-2023 10:43 PM
Client Address	: Kimtee colony ,Gokul Nagar,Tarnaka	Report Status	: Final Report

CLINICAL BIOCHEMISTRY

Test Name	Results	Units	Ref. Range	Method
Testosterone Total	285.6	ng/dL	Refer Table	CLIA

Interpretation:

(Testosterone Reference Ranges)

Age	Reference Range Male(ng/dL)	Reference Range Female(ng/dL)
Newborn(1-15days)	75-400	20-64
1-5 Months	1-177	1-5
6-11 Months	2-7	2-5
Children:		
1-5 Year	2-25	2-10
6-9 Year	3-30	2-20
Puberty Tanner Stage		
1	2-23	2-10
2	5-70	5-30
3	15-280	10-30
4	105-545	15-40
5	265-800	10-40
Adult	241-827	14-76

- Testosterone is a steroid hormone (androgen) made by the testes in males. Its production is stimulated and controlled by luteinising hormone (LH), which is manufactured in the pituitary gland. In males, testosterone stimulates development of secondary sex characteristics, including enlargement of the penis, growth of body hair and muscle, and a deepening voice. It is present in large amounts in males during puberty and in adult males to regulate the sex drive and maintain muscle mass. Testosterone is also produced by the adrenal glands in both males and females and, in small amounts, by the ovaries in females. The body can convert testosterone to oestradiol, the main sex hormone in females. There is great variability in testosterone levels between men and it is normal for testosterone levels to decline as men get older. Hypogonadism in a male refers to a reduction in sperm and/or testosterone production.



Dr. Vaishnavi
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CLINICAL BIOCHEMISTRY

Test Name	Results	Units	Ref. Range	Method
LH (Leutinizing Hormone)	11.4	mIU/mL	Refer Table	CLIA

Interpretation:

Age	Reference Range: Male (mIU/mL)	Reference Range: Female(mIU/mL)
Pre Puberty Child		
2-11 Months	0.02-8.0	0.02-8.0
1-10 Years	0.04-3.6	0.03-3.9
Puberty Tanner Stage		
1	0.04-3.6	0.03-3.0
2	0.26-4.8	0.10-4.1
3	0.56-6.3	0.20-9.1
4-5	0.56-7.8	0.50-15.0
Adult	20-70 years:1.5-9.3 > 70 years:3.1-34.6	
Follicular Phase	----	1.9-12.5
Midcycle Peak	----	8.7-76.3
Luteal Phase	----	0.5-16.9
Postmenopausal	----	15.9-54.0
Pregnant	----	< 0.1-1.5
Contraceptives	----	0.7-5.6

Increased Values Of LH Seen In:

- Menopause,ovarian dysgenesis. (Turner syndrome),Testicular dysgenesis (Klinefelter syndrome).
- Precocious puberty

Decreased Values Of LH Seen In:

- Pituitary failure. Both LH/ FSH are low.
- hypothalamic failure will also lead to low LH and FSH level.

Correlate Clinically.

Laboratory is NABL Accredited

*** End Of Report ***



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