

REPORT

Name	: Master. KANNAYYA	Sample ID	: 24864035
Age/Gender	: 1 Years/Male	Reg. No	: 0312404130019
Referred by	: Dr. VISHNAVI	SPP Code	: SPL-CV-172
Referring Customer	: V CARE MEDICAL DIAGNOSTICS	Collected On	: 13-Apr-2024 11:48 AM
Primary Sample	: Whole Blood	Received On	: 13-Apr-2024 01:16 PM
Sample Tested In	: Whole Blood EDTA	Reported On	: 13-Apr-2024 06:52 PM
Client Address	: Kimtee colony ,Gokul Nagar,Tarnaka	Report Status	: Final Report

HAEMATOLOGY

COMPLETE HEMOGRAM

Test Name	Results	Units	Ref. Range	Method
Complete Blood Picture(CBP)				
Haemoglobin (Hb)	8.4	g/dL	11.1-14.1	Cynmeth Method
Haematocrit (HCT)	28.6	%	30-38	Calculated
RBC Count	5.20	10 ¹² /L	3.9-5.1	Cell Impedance
MCV	55	fl	72-84	Calculated
MCH	16.1	pg	25-29	Calculated
MCHC	29.2	g/dL	32-36	Calculated
RDW-CV	18.7	%	11.6-14.0	Calculated
Platelet Count (PLT)	1088	10 ⁹ /L	200-550	Cell Impedance
Total WBC Count	17.1	10 ⁹ /L	6.0-16.0	Impedance
Differential Leucocyte Count (DC)				
Neutrophils	32	%	21-42	Cell Impedance
Lymphocytes	60	%	51-71	Cell Impedance
Monocytes	06	%	1-9	Microscopy
Eosinophils	02	%	0-7	Microscopy
Basophils	00	%	0-2	Microscopy
Absolute Neutrophils Count	5.47	10 ⁹ /L	1.3-7.4	Impedance
Absolute Lymphocyte Count	10.26	10 ⁹ /L	3.1-12.4	Impedance
Absolute Monocyte Count	1.03	10 ⁹ /L	0.1-1.6	Calculated
Absolute Eosinophils Count	0.34	10 ⁹ /L	0.0-1.2	Calculated
Absolute Basophil ICount	0.00	10 ⁹ /L	0.0-1.2	Calculated
Morphology	Microcytic hypochromic anemia with Mild Leucocytosis and Marked Thrombocytosis with small platelets			PAPs Staining



Swannabala - M
DR.SWARNA BALA
MD PATHOLOGY

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HAEMATOLOGY

COMPLETE HEMOGRAM

Test Name	Results	Units	Ref. Range	Method
Blood Picture - Peripheral Smear Examination				
Red Blood Cells	Anisopoikilocytosis; Microcytic hypochromic anemia with leptocytes pencil forms ovalocytes tear drop cells and many target cells			Microscopy
White Blood Cells	Mild Leucocytosis			Microscopy
Platelets	Marked Thrombocytosis with small platelet clumps			Microscopy
Hemoparasites	Not seen.			Microscopy
Impression	Microcytic hypochromic anemia with Mild Leucocytosis and Marked Thrombocytosis			
Advice	Suggested serum iron studies and HPLC to rule out Haemoglobinopathy			
Erythrocyte Sedimentation Rate (ESR)	23		3-13	Westergren method

Comments : ESR is an acute phase reactant which indicates presence and intensity of an inflammatory process. It is never diagnostic of a specific disease. It is used to monitor the course or response to treatment of certain diseases. Extremely high levels are found in cases of malignancy, hematologic diseases, collagen disorders and renal diseases.



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Primary Sample	: Whole Blood	Received On	: 13-Apr-2024 01:22 PM
Sample Tested In	: Serum	Reported On	: 13-Apr-2024 03:55 PM
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CLINICAL BIOCHEMISTRY

Test Name	Results	Units	Ref. Range	Method
Lactate Dehydrogenase (LDH)	238	U/L	180-430	IFCC

Interpretation:

- Lactate dehydrogenase is present in all cells of the body but its higher concentrations are found in liver, heart, kidney, skeletal muscle and erythrocytes
- Total LDH concentration in serum or plasma is increased in patients with liver disease, renal disease, myocardial infarction, many malignant diseases, progressive muscular dystrophy and almost any cause of hemolysis.

Vitamin- B12 (cyanocobalamin)	247	pg/mL	211-911	CLIA
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Interpretation:

This test is most often done when other blood tests suggest a condition called megaloblastic anemia. Pernicious anemia is a form of megaloblastic anemia caused by poor vitamin B12 absorption. This can occur when the stomach makes less of the substance the body needs to properly absorb vitamin B12.

Causes of vitamin B12 deficiency include:Diseases that cause malabsorption

- 1.Lack of intrinsic factor, a protein that helps the intestine absorb vitamin B12
- 2.Above normal heat production (for example, with hyperthyroidism)

An increased vitamin B12 level is uncommon in:

- 1.Liver disease (such as cirrhosis or hepatitis)
- 2.Myeloproliferative disorders (for example, polycythemia vera and chronic myelogenous leukemia)

Folic Acid (Vitamin B9)	14.6	ng/mL	Deficient:0.35-3.37 Indeterminate:3.38-5.38 Normal:>5.38	CLIA
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Interpretation:

Folic acid is a type of B vitamin.This test is done to check for folic acid deficiency.

Folic acid helps form red blood cells and produce DNA that stores genetic codes. Taking the right amount of folic acid before and during pregnancy helps prevent neural tube defects, such as spina bifida.

Women who are pregnant or planning to become pregnant should take at least 600 micrograms (mcg) of folic acid every day. Some women may need to take more if they have a history of neural tube defects in earlier pregnancies.

Lower-than-normal folic acid levels may indicate:

- Poor diet
- Malabsorption syndrome (for example, celiac sprue)
- Malnutrition



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Test Name	Results	Units	Ref. Range	Method
Liver Function Test (LFT)				
Bilirubin(Total)	0.4	mg/dL	0.3-1.2	Diazo
Bilirubin (Direct)	0.1	mg/dL	0.0 - 0.5	Diazo
Bilirubin (Indirect)	0.3	mg/dL	0.2-1.0	Calculated
Aspartate Aminotransferase (AST/SGOT)	54	U/L	9-80	IFCC with out (P-5-P)
Alanine Aminotransferase (ALT/SGPT)	18	U/L	13-45	IFCC with out (P-5-P)
Alkaline Phosphatase(ALP)	349	U/L	< 500	Kinetic PNPP-AMP
Gamma Glutamyl Transpeptidase (GGTP)	19	U/L	15-85	IFCC
Protein - Total	7.0	g/dL	6.4-8.2	Biuret
Albumin	4.4	g/dL	3.4-5.0	Bromocresol purple (BCP)
Globulin	2.6	g/dL	2.0-4.2	Calculated
A:G Ratio	1.69	%	0.8-2.0	Calculated
SGOT/SGPT Ratio	3.00			

Alanine Aminotransferase(ALT) is an enzyme found in liver and kidneys cells. ALT helps create energy for liver cells. Damaged liver cells release ALT into the bloodstream, which can elevate ALT levels in the blood.

Aspartate Aminotransferase (AST) is an enzyme in the liver and muscles that helps metabolizes amino acids. Similarly to ALT, elevated AST levels may be a sign of liver damage or liver disease.

Alkaline phosphate (ALP) is an enzyme present in the blood. ALP contributes to numerous vital bodily functions, such as supplying nutrients to the liver, promoting bone growth, and metabolizing fat in the intestines.

Gamma-glutamyl Transpeptidase (GGTP) is an enzyme that occurs primarily in the liver, but it is also present in the kidneys, pancreas, gallbladder, and spleen. Higher than normal concentrations of GGTP in the blood may indicate alcohol-related liver damage. Elevated GGTP levels can also increase the risk of developing certain types of cancer.

Bilirubin is a waste product that forms when the liver breaks down red blood cells. Bilirubin exits the body as bile in stool. High levels of bilirubin can cause jaundice - a condition in which the skin and whites of the eyes turn yellow- and may indicate liver damage.

Albumin is a protein that the liver produces. The liver releases albumin into the bloodstream, where it helps fight infections and transport vitamins, hormones, and enzymes throughout the body. Liver damage can cause abnormally low albumin levels.



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Test Name	Results	Units	Ref. Range	Method
Iron Profile-I				
Iron(Fe)	17	µg/dL	65-175	Ferene
Total Iron Binding Capacity (TIBC)	510	µg/dL	100 - 400	Ferene
Transferrin	356.64	mg/dL	215-365	Calculated
Iron Saturation((% Transferrin Saturation)	3.33	%	20-50	Calculated
Unsaturated Iron Binding Capacity (UIBC)	493	µg/dL	110 - 370	FerroZine

Interpretation:

- Serum transferrin (and TIBC) high, serum iron low, saturation low. Usual causes of depleted iron stores include blood loss, inadequate dietary iron. RBCs in moderately severe iron deficiency are hypochromic and microcytic. Stainable marrow iron is absent. Serum ferritin decrease is the earliest indicator of iron deficiency if inflammation is absent.
- **Anemia of chronic disease:** Serum transferrin (and TIBC) low to normal, serum iron low, saturation low or normal. Transferrin decreases with many inflammatory diseases. With chronic disease there is a block in movement to and utilization of iron by marrow. This leads to low serum iron and decreased erythropoiesis. Examples include acute and chronic infections, malignancy and renal failure.
- **Sideroblastic Anemia:** Serum transferrin (and TIBC) normal to low, serum iron normal to high, saturation high.
- **Hemolytic Anemia:** Serum transferrin (and TIBC) normal to low, serum iron high, saturation high.
- **Hemochromatosis:** Serum transferrin (and TIBC) slightly low, serum iron high, saturation very high.
- **Protein depletion:** Serum transferrin (and TIBC) may be low, serum iron normal or low (if patient also is iron deficient). This may occur as a result of malnutrition, liver disease, renal disease.
- **Liver disease:** Serum transferrin variable; with acute viral hepatitis, high along with serum iron and ferritin. With chronic liver disease (eg, cirrhosis), transferrin may be low. Patients who have cirrhosis and portacaval shunting have saturated TIBC/transferrin as well as high ferritin.

Correlate Clinically.

Result rechecked and verified for abnormal cases

Laboratory is NABL Accredited

*** End Of Report ***



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