LB-MED-305

Patient Name	:	Mr. SHOAIB KHAN RAHIM BAKSH	**Sample UID No.**	:	4104105
Age / Gender	:	34 Y / Male	**Sample Collected On**	:	02-08-2025 16:56
Patient ID	:	QLD103660	**Registered On**	:	02-08-2025 16:59
Referred By	:	Dr. AMAIZAH	**Reported on**	:	03-08-2025 04:32
Referral Client	:	CITICARE MEDICAL CENTER(INSURANCE)	**External Patient ID**	:	45306
Emirates ID / Passport No	:		**Print Version**	:	V.1

Department of BIOCHEMISTRY

Investigation	Results	Flag	Units	Biological Reference Interval	Method
* C-REACTIVE PROTEIN (CRP)	1.2		mg/L	< 5	Particle enhanced immunoturbidimetric assay

Sample: Serum

Comments :

CLINICAL IMPLICATIONS:

1. CRP is the most sensitive acute phase reactant that can increase dramatically (100-fold or more) after severe trauma, bacterial infection, inflammation, surgeryor neoplastic proliferation. CRP levels may predict future cardiovascular events and can be used as a screening tool.

2. The traditional test of CRP has added significance over the elevated ESR, which may be influenced by altered physiologic states. CRP tends to increase before rises in antibody titres and ESR level occurs. CRP levels also tend to decrease sooner than ESR levels.

3. The traditional test for CRP is elevated in rheumatic fever, RA, myocardial infarction, malignancy, bacterial and viral infections. The positive test indicates active inflammation but not its cause. In RA, the traditional test for CRP becomes negative with successful treatment and indicates that the inflammation has subsided.

4.High sensitive measurement of CRP (hs-CRP) are useful in assessing vascular inflammation and cardiovascular stratification. A single test for hs-CRP may not reflect an individual patient basal hs-CRP level, therefore follow up tests or serial measurements may be required in patients presenting with increased hs-CRP levels.

INTERFERING FACTORS: Haemolysed or lipemic sample may alter the results.

REFERENCE:

1) Manual of Laboratory and Diagnostics -Frances Fischbach Marshall B. Dunning III [9th Edition]

2) Tietz clinical guide to Laboratory tests(Fourth edition) ALAN H.B.WU

Note:

"The analytes with asterix (*) symbol are non-accredited parameters.".
"QLabs compliance with ISO 15189:2022 standards"

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DHA No:48036476-001

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Referred By	:	Dr. AMAIZAH	**Reported on**	:	03-08-2025 07:30
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Department of BIOCHEMISTRY

LIPID PROFILE TEST

Investigation	Results	Flag	Units	Biological Reference Interval	Method
CHOLESTEROL (TOTAL)	138		mg/dl	Desirable: < 200 Borderline High: 200-239 High: > 240	Enzymatic colorimteric assay
TRIGLYCERIDES	173	H	mg/dl	Normal Up to 150 Borderline-High 150-199 High 200-499 Very High > 500	Enzymatic colorimetric test
HDL CHOLESTEROL	23		mg/dl	High risk up to 40 Low risk > 60	Homogeneous Enzymatic Colorimetric
LDL CHOLESTEROL DIRECT	87		mg/dl	Optimal up to < 100 Near Optimal: 100-129 Borderline : 130-159 High: 160-189 Very High: > 190	Enzymatic, colorimetric method
VLDL CHOLESTEROL	35		mg/dl	10-35	Calculation
NON-HDL CHOLESTEROL	115		mg/dl	Desirable < 130 Borderline 130 – 159 High >159	Calculation
TOTAL CHOLESTEROL / HDL RATIO	6.0	H	--	< 4.5	Calculation
LDL / HDL RATIO	3.8		--	Low Risk < 3.0 Borderline 3.1-6.0 High Risk >6.0	Calculation

Interpretation Notes :

CLINICAL IMPLICATIONS:

1. Cholesterol testing evaluates the risk for atherosclerosis, myocardial occlusion, and coronary artery occlusion. Elevated cholesterol levels are a major component in the hereditary hyper lipoproteinemia. It is also used to monitor effectiveness of diet, medications, lifestyle, and stress management.
2.The cholesterol to HDL ratio provides more information than does either value alone. When a slightly increased cholesterol is due to high HDL, therapy is not indicated.
3. LDL cholesterol has a longer shelf life and determines the CHD risk.

INTERFERING FACTORS:

1. Seasonal and positional variations may alter cholesterol levels. Estrogens, ascorbic acid, bilirubin decrease the cholesterol levels .Pregnancy, bile salt, high saturated fat, and high cholesterol diet may increase the cholesterol values. Prolonged fasting with ketosis may increase the value.
2. Increased levels of HDL may be associated with estrogen therapy, drugs like steroids, alcohol and insulin therapy. Decreased levels are associated with stress, recent illness, starvation, obesity, smoking, hyper triglyceridemia, lack of exercise.
3. Increased LDL may be associated with pregnancy, drugs like steroids. Decreased LDL are found in women under estrogen therapy. No fasting may cause false elevation.
4. A transient increase in triglycerides occurs following heavy meal, alcohol ingestion, pregnancy, acute illness like cold ,flu, obesity, physical inactivity ,smoking. Transient decrease occurs after strenuous exercise, weight loss.

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Department of BIOCHEMISTRY

LIPID PROFILE TEST

Investigation	Results	Flag	Units	Biological Reference Interval	Method

RECOMMENDATION:

1. Cholesterol levels >200 mg/dl should be retested and the results averaged and if the results differ by > than 10%, a third test need to be done for confirmation. Perform a comprehensive lipoprotein analysis if cholesterol levels are not lowered within 6 months after start of therapy. If the values are altered in a normal condition, recommended to follow a stable diet for 1 week and overnight fasting (9 to 12 hours)before repeating the test.
2. Cholesterol and HDL should not be measured immediately after MI. A 3 month wait is suggested.
3. If triglyceride levels are more than 400mg/dl or >10.36mmol/L recommended to fast overnight(9 to 12 hours) and retest .Because of biological and analytical variation, at least 2 serial sample may be necessary for clinical decision making. VLDL cannot be calculated if triglycerides are more than 400mg/dl

REFERENCE: 1) Manual of Laboratory and Diagnostics -Frances Fischbach Marshall B. Dunning III [9th Edition]
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Sample: Serum

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Department of HEMATOLOGY

COMPREHENSIVE COMPLETE BLOOD COUNT

Investigation	Results	Flag	Units	Biological Reference Interval	Method
HEMOGLOBIN	15.4		g/dl	13-17	photometric
RBC COUNT	5.27		10^6/uL	4.5-5.5	Electrical Impedance
HEMATOCRIT	45.2		%	42-52	Calculation
MCV	85.8		fL	78-100	Calculation
MCH	29.1		pg	27-31	Calculation
MCHC	34		g/dl	31-35	Calculation
RDW	14.2		%	9.3-16	Calculation
RDW-SD	43.3		fL	38.9-49	Calculation
MPV	9.7		fL	8.8-12.5	Calculation
PLATELET COUNT	242		10^3/uL	150-400	Electrical Impedance
* PCT	0.2		%	0.01-9.99	Calculation
* PDW	16.8			0.1-99.9	Calculation
* NUCLEATED RBC (NRBC)^	0.22		/100 WBC		Flow Cytometry
* ABSOLUTE NRBC COUNT^	0.02		10^3/uL		Calculation
* EARLY GRANULOCYTE COUNT (EGC)^	0.2		%		Flow Cytometry
* ABSOLUTE EGC^	0.02		10^3/uL		Calculation
WBC COUNT	10.4		10^3/uL	4-11	Electrical Impedance
* Neutrophil	64.91		%	40-80	VCS-Method
* Lymphocyte	26.68		%	20-40	VCS-Method
* Eosinophil	1.36		%	1-8	VCS-Method
* Monocyte	5.94		%	2-10	VCS-Method
* Basophil	1.11		%	0-2	VCS-Method
* ABSOLUTE NEUTROPHIL COUNT	6.75		10^3/uL	1.5-7	Calculation
* ABSOLUTE LYMPHOCYTE COUNT	2.78		10^3/uL	1.5-4	Calculation
* ABSOLUTE MONOCYTE COUNT	0.62		10^3/uL	0-0.8	Calculation
* ABSOLUTE EOSINOPHIL COUNT	0.14		10^3/uL	0-0.6	Calculation
* ABSOLUTE BASOPHIL COUNT	0.12		10^3/uL	0-0.2	Calculation

Sample: EDTA Whole Blood

- END OF REPORT -

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