LB-MED-305

Patient Name	:	Mr. NOUR SHEBI MAHMOUD SHEBI ABDEL HAMID EL	**Sample UID No.**	:	4106421
Age / Gender	:	2 Y / Male	**Sample Collected On**	:	08-08-2025 16:43
Patient ID	:	QLD105967	**Registered On**	:	08-08-2025 16:45
Referred By	:	DR BUSHRA	**Reported on**	:	09-08-2025 07:23
Referral Client	:	CITICARE MEDICAL CENTER(INSURANCE)	**External Patient ID**	:	47560
Emirates ID / Passport No	:		**Print Version**	:	V 1

Department of BIOCHEMISTRY

Investigation	Results	Flag	Units	Biological Reference Interval	Method
* C-REACTIVE PROTEIN (CRP)	3.0		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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Department of BIOCHEMISTRY

Investigation	Results	Flag	Units	Biological Reference Interval	Method
IRON	64		µg/dl	33-193	Ferrozine-no deproteinization

Sample: Serum

Comments :

CLINICAL IMPLICATIONS:

1. The combined results of iron, transferrin, and TIBC are helpful in the differential diagnosis of anaemia ,in assessment of iron deficiency anemia and in the evaluation of thalassemia, sideroblastic anemia and haemochromatosis.

2. Transferrin saturation is a better index of iron saturation. Percent saturation is a better index of iron stores than serum alone. Saturation <15% denotes iron deficiency.

INTERFERING FACTORS:

1. Homolysis of the blood sample may interfere with testing. Drugs like aspirin, antibiotics, testosterone may cause decreased levels and drugs like ethanol, estrogen may cause an increased iron level.

2. Diurnal variation in iron. Normal values in the morning, low in mid-afternoon, very low in the evening.

3. Serum iron and TIBC may be normal in iron deficiency anemia if Hb is >than 9.0g/dl or >90g/L.

RECOMMENDATION:

In patients receiving folate or Vitamin B12 recommended to repeat iron studies after 1 to 3 months of completion of treatment.

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

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Referred By	:	DR BUSHRA	**Reported on**	:	08-08-2025 19:03
Referral Client	:	CITICARE MEDICAL CENTER(INSURANCE)	**External Patient ID**	:	47560
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Department of HEMATOLOGY

COMPREHENSIVE COMPLETE BLOOD COUNT

Investigation	Results	Flag	Units	Biological Reference Interval	Method
HEMOGLOBIN	12.2		g/dl	11-14	photometric
RBC COUNT	5.26	H	10^6/uL	4-5.2	Electrical Impedance
HEMATOCRIT	37.3		%	33-43	Calculation
MCV	70.9	L	fL	76-90	Calculation
MCH	23.1	L	pg	25-31	Calculation
MCHC	32.6		g/dl	31-37	Calculation
RDW	13.1		%	9.3-16	Calculation
RDW-SD	33.3	L	fL	38.9-49	Calculation
MPV	8.9		fL	8.8-12.5	Calculation
PLATELET COUNT	323		10^3/uL	200-450	Electrical Impedance
* PCT	0.3		%	0.01-9.99	Calculation
* PDW	16.8			0.1-99.9	Calculation
* NUCLEATED RBC (NRBC)^	0.28		/100 WBC		Flow Cytometry
* ABSOLUTE NRBC COUNT^	0.03		10^3/uL		Calculation
* EARLY GRANULOCYTE COUNT (EGC)^	NA		%		Flow Cytometry
* ABSOLUTE EGC^	NA		10^3/uL		Calculation
WBC COUNT	9.2		10^3/uL	5-15	Electrical Impedance
* Neutrophil	32.43		%	23-52	VCS-Method
* Lymphocyte	55.93		%	40-69	VCS-Method
* Eosinophil	2.06		%	0-7	VCS-Method
* Monocyte	8.93		%	1-9	VCS-Method
* Basophil	0.65		%	0-2	VCS-Method
* ABSOLUTE NEUTROPHIL COUNT	2.97		10^3/uL	1.5-7	Calculation
* ABSOLUTE LYMPHOCYTE COUNT	5.12	H	10^3/uL	1.5-4	Calculation
* ABSOLUTE MONOCYTE COUNT	0.82	H	10^3/uL	0-0.8	Calculation
* ABSOLUTE EOSINOPHIL COUNT	0.19		10^3/uL	0-0.6	Calculation
* ABSOLUTE BASOPHIL COUNT	0.06		10^3/uL	0-0.2	Calculation

Sample: EDTA Whole Blood

Note:

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Department of IMMUNOLOGY

Investigation	Results	Flag	Units	Biological Reference Interval	Method
VITAMIN D, 25-OH (TOTAL)	75.6		ng/mL	Deficient : ≤ 20 insufficient: 21-29 Sufficient: ≥ 30 Toxicity : >80	ECLIA

Sample: Serum

Comments :

CLINICAL IMPLICATIONS:

1. Increased Vitamin D levels are seen in gastrointestinal symptoms like anorexia, nausea, vomiting, constipation, hypercalcemia, renal colic, supplements, normal growing children, pregnant and lactating females, tuberculosis, idiopathic hypercalciuria, sarcoidosis. Levels can increase to 200 -300pg/ml during treatment of osteoma Lacia with physiological doses of vitamin D.
2. Decreased levels are seen in Inadequate diet, Inadequate exposure to sunlight, liver disease, Malabsorption syndrome, osteoma Lacia, Anticonvulsants, rickets, chronic renal failure, pseudohypoparathyroidism, post-menopausal osteoporosis and adults with insulin requiring diabetes mellitus.
3. 25(OH) levels do not indicate clinical vitamin D status in patients with chronic renal failure or type 1 vitamin D dependent rickets or when calcitriol is used as a supplement.

INTERFERING FACTORS:

Age, season of the year, diarrhoea or vomiting, certain drugs, diseases, and long term hyperalimentation are the factors that may interfere with the vitamin levels.

RECOMMENDATION:

Recommended to evaluate alternate cause of impaired mineralization ,if the levels are not consistent with the suspected diagnosis.

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

3) Clinical microbiology procedures 4th edition AMY L LEBER

- END OF REPORT -

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