



BML444896

Laboratory Investigation Report

Name	: Mr. ASHRAF HASSAN HUSSEIN ELGHAMRY ABOUELGHIT	Ref No.	: 25997
DOB	: 24/07/1985	Sample No.	: 2407454731
Age / Gender	: 39 Y / Male	Collected	: 27/07/2024 20:00
Referred by	: DR AHSAN	Registered	: 27/07/2024 22:21
Centre	: CITICARE MEDICAL CENTER	Reported	: 27/07/2024 23:35

BIOCHEMISTRY

Test	Result	Flag	Unit	Reference Range	Methodology
C-REACTIVE PROTEIN (CRP)	7.6	H	mg/L	< 5.0 Please note change. Source: Roche IFU.	Immunoturbidimetry

INTERPRETATION NOTES :

- CRP measurements are used as aid in diagnosis, monitoring, prognosis, and management of suspected inflammatory disorders and associated diseases, acute infections and tissue injury.
- C-reactive protein is the classic acute phase protein in inflammatory reactions.
- CRP is the most sensitive of the acute phase reactants and its concentration increases rapidly during inflammatory processes. The CRP response frequently precedes clinical symptoms, including fever. After onset of an acute phase response, the serum CRP concentration rises rapidly and extensively. The increase begins within 6 to 12 hours and the peak value is reached within 24 to 48 hours. Levels above 100 mg/L are associated with severe stimuli such as major trauma and severe infection (sepsis).
- CRP response may be less pronounced in patients suffering from liver disease.
- CRP assays are used to detect systemic inflammatory processes (apart from certain types of inflammation such as systemic lupus erythematosus (SLE) and Colitis ulcerosa); to assess treatment of bacterial infections with antibiotics; to detect intrauterine infections with concomitant premature amniorrhexis; to differentiate between active and inactive forms of disease with concurrent infection, e.g. in patients suffering from SLE or Colitis ulcerosa; to therapeutically monitor rheumatic disease and assess anti-inflammatory therapy; to determine the presence of post-operative complications at an early stage, such as infected wounds, thrombosis and pneumonia, and to distinguish between infection and bone marrow transplant rejection.

Sample Type : Serum

End of Report

Dr. Adley Mark Fernandes
M.D (Pathology)
Pathologist

Dr. Vyoma V Shah
M.D (Pathology)
Clinical Pathologist

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HARSHAD MANIKANDAN
Laboratory Technician
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HEMATOLOGY

Test	Result	Flag	Unit	Reference Range	Methodology
COMPLETE BLOOD COUNT (CBC)					
HEMOGLOBIN	16.2		g/dL	13.5 - 17.5	Spectrophotometry (Oxyhemoglobin)
RBC COUNT	4.8		10 ⁶ /μL	4.3 - 5.7	Electrical Impedance
HEMATOCRIT	47.3		%	38 - 50	Calculation
MCV	97.7		fL	82 - 98	Calculation
MCH	33.5	H	pg	27 - 32	Calculation
MCHC	34.3		g/dL	32 - 37	Calculation
RDW	13.2		%	11.8 - 15.6	Calculation
RDW-SD	44.6		fL		Calculation
MPV	10.1		fL	7.6 - 10.8	Calculation
PLATELET COUNT	190		10 ³ /uL	150 - 450	Electrical Impedance
PCT	0.2		%	0.01 - 9.99	Calculation
PDW	17.5		Not Applicable	0.1 - 99.9	Calculation
NUCLEATED RBC (NRBC) [^]	0.1		/100 WBC		Flow Cytometry
ABSOLUTE NRBC COUNT [^]	0.01		10 ³ /uL		Calculation
EARLY GRANULOCYTE COUNT (EGC) [^]	0.5		%		Flow Cytometry
ABSOLUTE EGC [^]	0.0		10 ³ /uL		Calculation
WBC COUNT	9.1		10 ³ /μL	4 - 11	Electrical Impedance
DIFFERENTIAL COUNT (DC)					
NEUTROPHILS	56		%	40 - 75	Flow Cytometry
LYMPHOCYTES	34		%	20 - 45	Flow Cytometry
EOSINOPHILS	4		%	0 - 6	Flow Cytometry
MONOCYTES	5		%	1 - 6	Flow Cytometry
BASOPHILS	1		%	0 - 1	Flow Cytometry
ABSOLUTE COUNT					
ABSOLUTE NEUTROPHIL COUNT	5.0		10 ³ /uL	1.6 - 8.25	Calculation
ABSOLUTE LYMPHOCYTE COUNT	3.1		10 ³ /uL	0.8 - 4.95	Calculation
ABSOLUTE MONOCYTE COUNT	0.6		10 ³ /uL	0.04 - 0.66	Calculation
ABSOLUTE EOSINOPHIL COUNT	0.3		10 ³ /uL	0 - 0.66	Calculation
ABSOLUTE BASOPHIL COUNT	0.0		10 ³ /uL	0 - 0.11	Calculation

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Reena Babu
Laboratory Technologist

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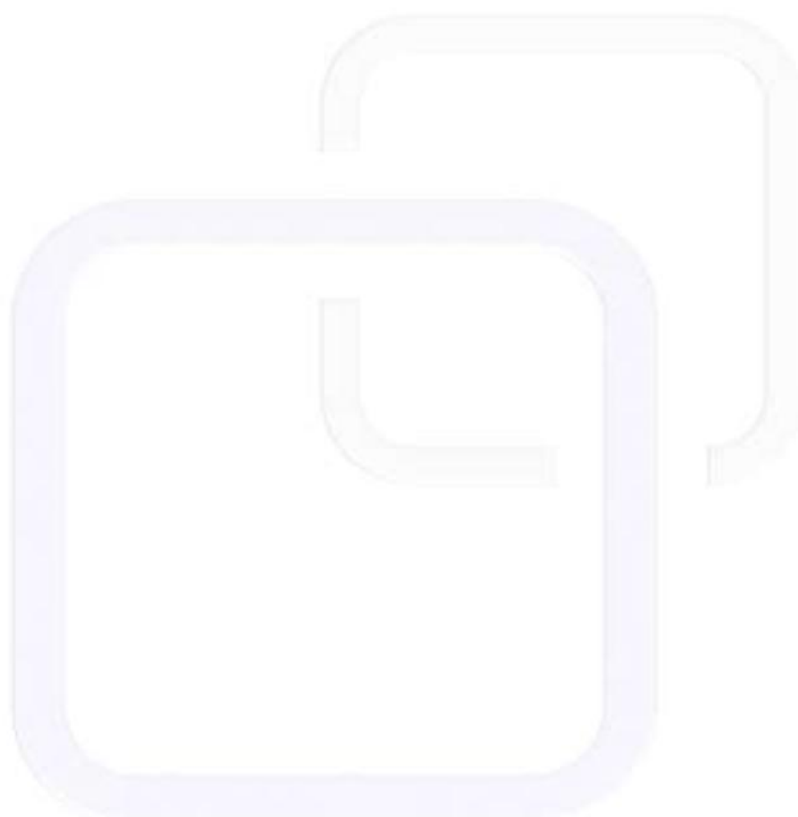
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HEMATOLOGY

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COMPLETE BLOOD COUNT (CBC)

INTERPRETATION NOTES : Please note update on CBC report format and changes in reference ranges.



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HAEMATOLOGY

Test	Result	Flag	Unit	Reference Range	Methodology
ERYTHROCYTE SEDIMENTATION RATE (ESR)	22	H	mm/hr	< 15 Please note change in reference range and method.	Automated

Comments : Please correlate clinically.

INTERPRETATION NOTES :

Increased ESR is seen in inflammation, pregnancy, anemia, autoimmune disorders (such as rheumatoid arthritis and lupus), infections, some kidney diseases and some cancers (such as lymphoma and multiple myeloma).

The ESR is decreased in polycythemia, hyperviscosity, sickle cell anemia, leukemia, low plasma protein (due to liver or kidney disease), congestive heart failure, hypofibrinogenemia and leukocytosis.

Sample Type : EDTA Whole Blood

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