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MEDICAL LABORATORY

BML445520

Laboratory Investigation Report

Name	:	Mr. PANJAIL JAIN	**Ref No.**	:	40927
DOB	:	13/07/1999	**Sample No.**	:	2407455371
Age / Gender	:	25 Y / Male	**Collected**	:	28/07/2024 18:00
Referred by	:	DR. HUMAIRA MUMTAZ	**Registered**	:	29/07/2024 14:25
Centre	:	CITICARE MEDICAL CENTER	**Reported**	:	29/07/2024 19:16

BIOCHEMISTRY

Test	Result	Flag	Unit	Reference Range	Methodology
C-REACTIVE PROTEIN (CRP)	3.3		mg/L	< 5.0 Please note change. Source: Roche IFU.	Immunoturbidimetry

INTERPRETATION NOTES :

1. CRP measurements are used as aid in diagnosis, monitoring, prognosis, and management of suspected inflammatory disorders and associated diseases, acute infections and tissue injury.
2. C-reactive protein is the classic acute phase protein in inflammatory reactions.
3. 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).
4. CRP response may be less pronounced in patients suffering from liver disease.
5. 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

Greeshma P Sidharthan

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HEMATOLOGY

Test	Result	Flag	Unit	Reference Range	Methodology
COMPLETE BLOOD COUNT (CBC)					
HEMOGLOBIN	13.2	L	g/dL	13.5 - 17.5	Spectrophotometry (Oxyhemoglobin)
RBC COUNT	3.9	L	10^6/µL	4.3 - 5.7	Electrical Impedance
HEMATOCRIT	38.8		%	38 - 50	Calculation
MCV	98.9	H	fL	82 - 98	Calculation
MCH	33.6	H	pg	27 - 32	Calculation
MCHC	34		g/dL	32 - 37	Calculation
RDW	15.1		%	11.8 - 15.6	Calculation
RDW-SD	51.6		fL		Calculation
MPV	9.4		fL	7.6 - 10.8	Calculation
PLATELET COUNT	233		10^3/uL	150 - 450	Electrical Impedance
PCT	0.2		%	0.01 - 9.99	Calculation
PDW	17.7		Not Applicable	0.1 - 99.9	Calculation
NUCLEATED RBC (NRBC)^	1.0		/100 WBC		Flow Cytometry
ABSOLUTE NRBC COUNT^	0.08		10^3/uL		Calculation
EARLY GRANULOCYTE COUNT (EGC)^	0.2		%		Flow Cytometry
ABSOLUTE EGC^	0.0		10^3/uL		Calculation
WBC COUNT	8.6		10^3/µL	4 - 11	Electrical Impedance
DIFFERENTIAL COUNT (DC)					
NEUTROPHILS	52		%	40 - 75	Flow Cytometry
LYMPHOCYTES	27		%	20 - 45	Flow Cytometry
EOSINOPHILS	14	H	%	0 - 6	Flow Cytometry
MONOCYTES	6		%	1 - 6	Flow Cytometry
BASOPHILS	1		%	0 - 1	Flow Cytometry
ABSOLUTE COUNT					
ABSOLUTE NEUTROPHIL COUNT	4.5		10^3/uL	1.6 - 8.25	Calculation
ABSOLUTE LYMPHOCYTE COUNT	2.3		10^3/uL	0.8 - 4.95	Calculation
ABSOLUTE MONOCYTE COUNT	0.6		10^3/uL	0.04 - 0.66	Calculation
ABSOLUTE EOSINOPHIL COUNT	1.2	H	10^3/uL	0 - 0.66	Calculation
ABSOLUTE BASOPHIL COUNT	0.1		10^3/uL	0 - 0.11	Calculation

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CHRISTEENA FRANCIS
Laboratory Technologist

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HEMATOLOGY

Test	Result	Flag	Unit	Reference Range	Methodology

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)	10		mm/hr	< 15 Please note change in reference range and method.	Automated

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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