DDRC SRL Diagnostic Services

**PATIENT NAME : ISHAMMA** **REF. DOCTOR :** DR. SUDHEENDRA GHOSH

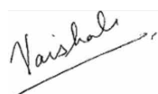
| | | |
|---|---|---|
| ISHAMMA | ACCESSION NO : **4182VI013105** | AGE/SEX :75 Years Female |
| | PATIENT ID : ISHAF2009474182 | DRAWN :27/09/2022 09:27:16 |
| | CLIENT PATIENT ID: | RECEIVED : 27/09/2022 09:30:30 |
| | ABHA NO : | REPORTED :27/09/2022 12:54:22 |

| Test Report Status **Final** | Results | Biological Reference Interval | Units |
|---|---|---|---|

## HAEMATOLOGY - CBC

**CBC + ESR**

| **BLOOD COUNTS** | | | |
|---|---|---|---|
| HEMOGLOBIN | **11.0 Low** | 12.0 - 15.0 | g/dL |
| RED BLOOD CELL COUNT | 3.80 | 3.8 - 4.8 | mil/μL |
| WHITE BLOOD CELL COUNT | 9.55 | 4.0 - 10.0 | thou/μL |
| PLATELET COUNT | **501 High** | 150 - 410 | thou/μL |
| **RBC AND PLATELET INDICES** | | | |
| HEMATOCRIT | **33.3 Low** | 36 - 46 | % |
| MEAN CORPUSCULAR VOL | 87.5 | 83 - 101 | fL |
| MEAN CORPUSCULAR HGB. | 29.0 | 27.0 - 32.0 | pg |
| MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION | 33.2 | 31.5 - 34.5 | g/dL |
| RED CELL DISTRIBUTION WIDTH | **16.6 High** | 11.6 - 14.0 | % |
| MEAN PLATELET VOLUME | 7.1 | 6.8 - 10.9 | fL |
| **WBC DIFFERENTIAL COUNT - NLR** | | | |
| SEGMENTED NEUTROPHILS | 65 | 40 - 80 | % |
| ABSOLUTE NEUTROPHIL COUNT | 6.21 | 2.0 - 7.0 | thou/μL |
| LYMPHOCYTES | 27 | 20 - 40 | % |
| ABSOLUTE LYMPHOCYTE COUNT | 2.58 | 1 - 3 | thou/μL |
| NEUTROPHIL LYMPHOCYTE RATIO (NLR) | 2.4 | | |
| EOSINOPHILS | 2 | 1 - 6 | % |
| ABSOLUTE EOSINOPHIL COUNT | 0.19 | 0.02 - 0.50 | thou/μL |
| MONOCYTES | 6 | 2 - 10 | % |
| ABSOLUTE MONOCYTE COUNT | 0.57 | 0.20 - 1.00 | thou/μL |
| BASOPHILS | 0 | 0 - 2 | % |



**DR.VAISHALI RAJAN, MBBS DCP (Pathology)**
**(Reg No - TCC 27150)**
**Lab Director & HOD Hematology**

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ULR No.666000001698926-4182

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INDIA'S LEADING DIAGNOSTICS NET WORK

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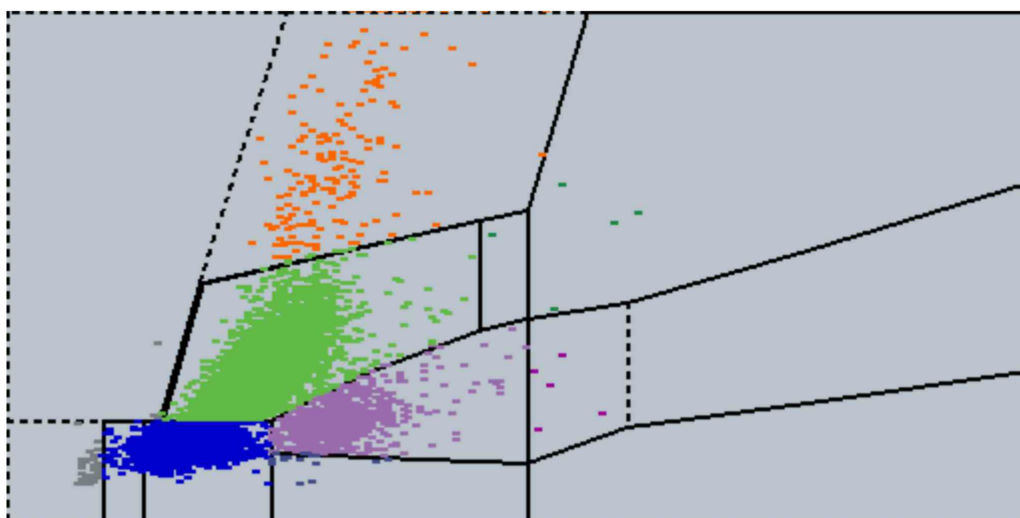
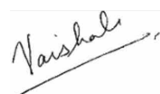


YumizenNEU%

**ERYTHRO SEDIMENTATION RATE, BLOOD**

| | | | |
|---|---|---|---|
| SEDIMENTATION RATE (ESR) | **62 High** | 0 - 35 | mm at 1 hr |

**Interpretation(s)**
BLOOD COUNTS,EDTA WHOLE BLOOD-The cell morphology is well preserved for 24hrs. However after 24-48 hrs a progressive increase in MCV and HCT is observed leading to a decrease in MCHC. A direct smear is recommended for an accurate differential count and for examination of RBC morphology.
RBC AND PLATELET INDICES-Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia(>13) from Beta thalassaemia trait (<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.
WBC DIFFERENTIAL COUNT-The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR < 3.3, COVID-19 patients tend to show mild disease.
(Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients A.-P. Yang, et al. International Immunopharmacology 84 (2020) 106504
This ratio element is a calculated parameter and out of NABL scope.
ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD-**TEST DESCRIPTION** :- Erythrocyte sedimentation rate (ESR) is a test that indirectly measures the degree of inflammation present in the body. The test actually measures the rate of fall (sedimentation) of erythrocytes in a sample of blood that has been placed into a tall, thin, vertical tube. Results are reported as the millimetres of clear fluid (plasma) that are present at the top portion of the tube after one hour. Nowadays fully automated instruments are available to measure ESR.
- ESR is not diagnostic it is a non-specific test that may be elevated in a number of different conditions. It provides general information about the presence of an inflammatory condition.CRP is superior to ESR because it is more sensitive and reflects a more rapid change.
**TEST INTERPRETATION** : **Increase** in: Infections, Vasculities, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Tissue injury, Pregnancy, Estrogen medication, Aging.
Finding a very accelerated ESR**(>100 mm/hour)** in patients with ill-defined symptoms directs the physician to search for a systemic disease (Paraproteinemias, Disseminated malignancies, connective tissue disease, severe infections such as bacterial endocarditis).
In pregnancy BRI in first trimester is 0-48 mm/hr(62 if anemic) and in second trimester (0-70 mm /hr(95 if anemic). ESR returns to normal 4th week post partum.



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**Decreased** in: Polycythermia vera, Sickle cell anemia
**LIMITATIONS** : **False elevated** ESR : Increased fibrinogen, Drugs(Vitamin A, Dextran etc), Hypercholesterolemia
**False Decreased** : Poikilocytosis,(SickleCells,spherocytes),Microcytosis, Low fibrinogen, Very high WBC counts, Drugs(Quinine, salicylates)
REFERENCE : Nathan and Oski's Haematology of Infancy and Childhood, 5th edition 2. Paediatric reference intervals. AACC Press, 7th edition. Edited by S. Soldin 3. The reference for the adult reference range is "Practical Haematology by Dacie and Lewis,10th edition.

## SEROLOGY

**CRP, SEMI-QUANTITATIVE, SERUM**

| | | | |
|---|---|---|---|
| C-REACTIVE PROTEIN | 4.89 | < 5 | mg/L |

**Interpretation(s)**
CRP, SEMI-QUANTITATIVE, SERUM-C - reactive protein (CRP) is an acute phase reactant protein that has the property of showing elevations in concentrations in response to stressful or inflammatory states that occur with infection, injury, surgery, trauma or other tissue necrosis.

Synthesis of CRP increases within 4-6 hours of onset of inflammation, reaching peak values within 1-2 days. CRP levels also fall quickly after resolution of inflammation since its half life is 6 hours. The main limitation of CRP is in its non-specific response and should not be interpreted without a complete clinical history and evaluation.: Latex particle agglutination

## ALLERGY

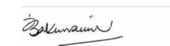
**TOTAL IGE, SERUM**

| | | | |
|---|---|---|---|
| TOTAL IGE | **134.4 High** | Upto 100 | IU/mL |

**Interpretation(s)**
TOTAL IGE, SERUM-Introduction:
Total Immunoglobulin (IgE), serum measures the total quantity of circulating IgE in human serum samples. Immunoglobulin E (IgE) is one of the 5 classes of immunoglobulins and is defined by the presence of the epsilon heavy chain.

Test Utility:
Elevated levels may be found in,
1.Allergy - IgE antibodies appear as a result of sensitization to allergens, and the measurement of circulating total IgE assists the clinical diagnosis of IgE-mediated allergic disorders. Elevated levels of circulating total IgE are usually seen in atopic eczema, 60% of patients with extrinsic asthma, and about 30% cases of hay fever. However a markedly elevated total IgE may bind non-specifically with allergen solid phase and result in weakly positive specific IgE that may not be clinically relevant.
2. Parasitic infestations - Ascariasis, Visceral larva migrans, Hookworm disease, Schistosomiasis, Echinococcosis.
3. Monoclonal IgE myeloma
4. Allergic Bronchopulmonary Aspergillosis (ABPA)

Decreased levels may be found in,
1. Hereditary deficiencies
2. Acquired immunodeficiency
3. Ataxia telangiectasia
4. Non-secretory myeloma
Limitation:
A normal level of IgE does not eliminate the possibility of allergy, hence test is not recommended as a stand-alone screen. Value is influenced by type of allergen, duration of stimulation, presence of symptoms, hyposensitization treatment.



**BABU K MATHEW**
**HOD -BIOCHEMISTRY**

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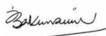
****End Of Report****
**Please visit www.ddrcsrl.com for related Test Information for this accession**



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