LABORATORY REPORT

Redcliffe labs

Patient Name	: **Ms Dummy**		
DOB/Age/Gender	: 30 Y/Female	Bill Date	: Feb 09, 2024, 12:30 AM
Patient ID / UHID	: XXX	Sample Collected	: Feb 09, 2024, 10:07 AM
Referred By	: Dr.	Sample Received	: Feb 09, 2024, 12:46 PM
Sample Type	: Serum	Report Date	: Feb 09, 2024, 03:07 PM
Barcode No	: XXX	Report Status	: Final Report

MC-5280

Test Description	Value(s)	Unit(s)	Reference Range

BIOCHEMISTRY REPORT

Anti Mullerian Hormone (AMH)

ANTI MULLERIAN HORMONE; AMH,SERUM	1.9	ng/mL	

Method : CLIA

Interpretation:

Adult Reference Group	Age Range (years)	Reference Interval ng/mL
Females	18-25	0.96-13.34
Females	26-30	0.17-7.37
Females	31-35	0.07-7.35
Females	36-40	0.03-7.15
Females	41-45	0.00-3.27
Females	≥ 46	0.00-1.15
Males	> 18	0.73-16.05
Pediatric Reference Group		
Male Tanner Stage 1	8 - 13	4.95-144.48
Male Tanner Stage 2	8 - 17	5.02-140.06
Male Tanner Stage 3	10 - 19	2.61-75.90
Male Tanner Stage 4	12 - 18	0.43-20.14
Male Tanner Stage 5	11 - 19	1.95-21.20

Notes

1. AMH stars declining years prior to rise in FSH thus it is much more sensitive marker of ovarian reserve.
2. Discordant results between AMH and antral follicle count (AFC) may be observed as AMH reflects population of preantral follicles whereas AFC measures only those visualized-on USG

Comment

Antimullerian hormone (AMH), also known as mullerian-inhibiting substance is produced by Sertoli cells of the testis in males and by ovarian granulosa cells in females. In males, AMH serum concentrations are elevated under 2 years and then progressively decrease until puberty, when there is a sharp decline. In females, AMH is produced by the granulosa cells of small growing follicles from the 36th week of gestation onwards until menopause when levels become undetectable. Due to the gender differences in AMH concentrations, its changes in circulating concentrations with sexual development, and its specificity for Sertoli and granulosa cells, measurement of AMH has utility in the assessment of gender, gonadal function, fertility, and as a gonadal tumor marker. Since AMH is produced continuously in the granulosa cells of small follicles during the menstrual cycle, it is superior to the episodically released gonadotropins and ovarian steroids as a marker of ovarian reserve. Studies in fertility clinics have shown that females with higher concentrations of AMH have a better response to ovarian stimulation and tend to produce more retrievable oocytes than females with low or undetectable AMH. Females at risk of ovarian hyperstimulation syndrome after gonadotropin administration can have significantly elevated AMH concentrations. Polycystic ovarian syndrome can elevate serum AMH levels because it is associated with the presence of large numbers of small follicles. Serum AMH levels are increased in some patients with ovarian granulosa cell tumors, which comprise approximately 10% of ovarian tumors.

Clinical applications

· To assess ovarian status, including follicle development, ovarian reserve, and ovarian responsiveness, as part of evaluation for infertility and assisted reproduction protocols.
· To assess menopausal status, including premature ovarian failure.

Sohini Sengupta

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· To assess ovarian function in patients with Polycystic ovarian syndrome (PCOS).
· To evaluate infants with ambiguous genitalia and other intersex conditions.
· To evaluate testicular function in infants and children
· To diagnose and monitor patients with AMH secreting Ovarian granulosa cell tumors.

Disclaimer: This is a sample report. The method and reference range in the actual report might vary as per lab accreditation or certification and equipments where sample is processed.

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