| | | | |
|---|---|---|---|
| Patient NAME | | | |
| DOB/Age/Gender | | Report STATUS : | |
| Patient ID / UHID | | Barcode NO : | |
| Referred BY | | Sample Type : | |
| Sample Collected | | Report Date : | |

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

## Bad Obstetric History (BOH) Profile- Comprehensive

### Activated Partial Thromboplastin Time (APTT)

| | | | |
|---|---|---|---|
| APTT<br>*Photo Optical Clot* | **39.1** | sec | 23.8 - 34.8 |
| Control (MNAPTT) | 30.5 | Sec | |

**Interpretation:**
The APTT is a one-stage test. This is used for the diagnosis of bleeding disorders. APTT may be used in the patient to check treatment for those who are taking Heparin or other blood-thinning medicines. APTT measures the intrinsic system and common pathways. APTT used in the diagnosis of Hemophilia and Christmas disease.

**Abnormal High results of APTT are due to:**
1. All congenital deficiencies of Intrinsic system coagulation factors.
2. Cirrhosis, Drugs,Heparin therapy, Warfarin therapy.
3. Disseminated intravascular coagulopathy (DIC ), Fibrin breakdown products.
4. Factor XII deficiency, Hemophilia A and B, Hypofibrinogenemia, Von Willebrand's disease.
5. Malabsorption, Vit K deficiency, Fibrin breakdown products, Leukemia.
6. In the case of streptokinase and urokinase.
7. Circulating anticoagulant inhibitors.

These may be specific for factor VIII.
1. These are seen as anti-factor VIII and anti-factor IX in 5% to 10% of hemophilic patients.
2. These are also in multiple plasma transfusions.
3. Drug reactions.
4. In the case of tuberculosis.
5. In autoimmune diseases like SLE and rheumatoid arthritis.

Note: This is a sample report for illustrative purpose only. Actual report may vary

Dr. Rayapa Reddy Thumma
Consultant Pathologist(MD Pathology)

| | | | |
|---|---|---|---|
| Patient NAME | : | | |
| DOB/Age/Gender | : | eport STATUS | |
| Patient ID / UHID | : | arcode NO | |
| Referred BY | : | ample Type | |
| Sample Collected | : | eport Date | |

| Test Description | Value(s) | Unit(s) | Reference Range |
|---|---|---|---|
| **Lupus Anticoagulant** | | | |
| Patient Value | 33.2 | sec | 33.1-45.1 |
| Control value | 39.1 | sec | |
| Screen Ratio | 0.85 | | <1.20 |
| DRVVT Screening | Negative | | |

**Interpretation:**
**Method :** Dilute Russell viper venom method ( dRVV), electromechanical clot detection.

**Remarks:**
1. This is only a screening test.
2. If Screening test is positive, then a confirmatory test is necessary.
3. The presence of LA in the sample is confirmed when the Normalized Ratio ( calculated as ratio of dRVV screen ratio to dRVV confirmatory ratio) value is greater or equal to reference value.

**Test description:** Diluted RVV Screen test is performed with reagent containing a low concentration of phospholipids. If lupus anticoagulant (LA) is present, the clotting time will be lengthened. dRVV confirmatory testing is done with reagent containing higher concentration of phospholipids, which neutralizes the LA (when present in the sample) and corrects the clotting time to normal thereby confirming the presence of LA.

**Notes:**
1. As per ISTH( International society on thrombosis and hemostatsis) guidelines , Lupus Anticoagulant detection must be done by using at least two clot based assays employing separate clotting principles like Lupus sensitive APTT & dRVVT.
2. Results of this test should always be interpreted in conjunction with the patient's medical history, clinical presentation and other findings.
3. A positive LA can be seen in otherwise normal individuals and in certain viral or other infections.
4. Once a patient has been tested positive for LA, it is imperative that testing be repeated on a second occasion > 12 weeks after the initial testing.
5. Anticoagulation therapy effects such as Warfarin (especially when the effect is supratherapeutic), excess Heparin, direct thrombin inhibitors (DTI) (eg, Dabigatran [Pradaxa]), Argatroban [Ancova], Bivalirudin [Angiomax]), direct factor Xa inhibitors (eg, Rivaroxaban [Xarelto], Apixaban [Eliquis], Edoxaban [Savaysa]) may result in a false-positive assay performance for LA. Clinical correlation and repeat testing after discontinuation (>1 week) of anticoagulation therapy is suggested.
6. Although the dilute Russell viper venom time (dRVVT) reagents contain a heparin inhibitor (Polybrene) that is sufficient for neutralization of heparin (up to 1-2 U/mL), the results may not necessarily represent what would occur if no heparin were present in the specimen. Therefore, DRVVT results from heparinized plasma should be interpreted with caution.
7. dRVVT assays, when performed in isolation, will not distinguish LA from heparin or inhibitors of factors V or VIII, which may cause false-positive results of LA testing.

**Comments:** Lupus Anticoagulants are heterogenous IgG or IgM autoantibodies which interfere with phospholipid dependent in vitro coagulation tests, particularly activated partial thromboplastin time (APTT). These antibodies are associated with thrombosis (arterial & venous), recurrent abortions, neurological & neuropsychiatric disorders. Various methods for testing Lupus Anticoagulants include Lupus sensitive APTT (PTT-LA), activated kaolin clotting time and dilute Russell Viper Venom time. Out of these the dRVVT assay is the most robust & specific because dRVVT is not influenced by deficiencies of intrinsic pathway or antibodies to factors VIII, IX or XI.a

Note: This is a sample report for illustrative purpose only. Actual report may vary

Dr. Neha Prabhakar
MBBS, MD(Pathology)

| | | | |
|---|---|---|---|
| Patient NAME | : | | |
| DOB/Age/Gender | : | Report STATUS | |
| Patient ID / UHID | : | Barcode NO | |
| Referred BY | : | Sample Type | |
| Sample Collected | : | Report Date | |

| Test Description | Value(s) | Unit(s) | Reference Range |
|---|---|---|---|
| **TSH 3rd Generation** | | | |
| Thyroid Stimulating Hormone (Ultrasensitive)<br>*ECLIA* | **4.3** | mIU/L | 0.27 - 4.20 |

**Interpretation:**

| Pregnancy | Reference ranges TSH |
|---|---|
| 1 st Trimester | 0.1 - 2.5 |
| 2 ed Trimester | 0.2 - 3.0 |
| 3 rd Trimester | 0.3 - 3.0 |

**Note:**
TSH levels are subject to circadian variation, reaching peak levels between 2-4 am. and at a minimum between 6-10 pm. The variation is of 50 %, hence time of the day has influence on the measured serum TSH concentrations.

**Clinical Use:**
- Diagnose Hypothyroidism and Hyperthyroidism
- Monitor T4 replacement or T4 suppressive therapy
- Qunatify TSH levels in the subnormal range

**Increased Levels :** Primary hypothyroidism, Subclinical hypothyroidis, TSH dependent Hyperthyroidism, Thyroid hormone resistance
**Decreased Levels:** Grace disease, Autonomous thyroid hormone secretion, TSH deficiency

Note: This is a sample report for illustrative purpose only. Actual report may vary

Dr. Rayapa Reddy Thumma
Consultant Pathologist(MD Pathology)

| | | | |
|---|---|---|---|
| Patient NAME | : | | |
| DOB/Age/Gender | : | Report STATUS | |
| Patient ID / UHID | : | Barcode NO | |
| Referred BY | : | Sample Type | |
| Sample Collected | : | Report Date | |

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

## Anti Nuclear Antibody (ANA) By IFA (HEP-2)

| | | | |
|---|---|---|---|
| Anti Nuclear Antibody by IFA | Negative | | Negative |

**Interpretation:**
**Guidelines (Sample screening Dilution - 1:100):**

Negative : No Immunofluorescence
+ : Weak Positive
++ : Moderate Positive
+++ : Strong Positive
++++ : Very strong Positive

**Test Description:** Antinuclear antibodies (ANAs) are unusual antibodies, detectable in the blood, that have the capability of binding to certain structures within the nucleus of the cells. ANAs indicate the possible presence of autoimmunity & provide, therefore, an indication of autoimmune illness. Fluorescence tech. are frequently used to actually detect the antibodies in the cells, thus ANA testing is sometimes referred to as fluorescent antinuclear antibody test (FANA). The ANA test is a sensitive screening test used to detect autoimmune diseases

**Technique:** Indirect Immunofluorescence.
The BIOCHIP Slide is a combination of Hep-20-10 cells and primate liver and has the following advantages.
1. It is a global standard tech. with a natural antigen spectrum capable of detecting more than 30 diagnostically relevant auto antibodies.
2. Hep 20-10 cell lines contain 40% mitotic cells, facilitating easier identification of rare patterns.
3. If the test is negative, detectable level of auto antibodies is ruled out. In case of a positive result, autoantibodies against any one or in some cases simultaneously against more than one antigens may be present and further monospecific tests or panel of profiles can be used to determine the specific autoantibodies present.

NOTE- All weak positive (+) results may be repeated after 6 - 8 weeks.**Associated Tests:** Monospecific ELISA to define single antigens, ANA Immunoblot assay.
**Abbreviations:** SLE: Systemic Lupus Erythematosus, SCL: Scleroderma, MCTD: Mixed Connective Tissue Disease; CFS: Chronic Fatigue Syndrome; AIH: Autoimmune Hepatitis, PBC: Primary Bilary Cirrhosis, PM:Polymyositis, DM:Dermatomyositis, SS: Systemic sclerosis, RA:Rheumatoid Arthritis.
Please view next page for co-relation table including various single antigens with their Immunoflourescence patterns and clinical associations

| Location | Pattern | Target Antigen | Clinical Association |
|---|---|---|---|
| Nucleus | Homogeneous | Double strand DNA Histones Nucleosome, RNA,Single Strand DN | SLE Drug Induced Lupus, SLE , RA SLE, MCTD,RA, PM, DM, SS |
| | Speckled | Sm U1-snRNP SSA/Ro SSB/La Ku Cyclin1(PCNA) Mitosin/Cyclin II | SLE MCTD,SLE,RA, sharp syndrome Sjogren`s syndromes (SS)/SLE/Neonatal Lupus PM/DM/SLE/SS SLE/Overlap Syndromes DM |
| | Dense Fine Speckled(DFS) | Lens epithelium-derived growth factor (LEDGF), DNA binding transcription coactivator p75.(DFS-70) | Healthy individuals, Various Inflammatory conditions like atopic dermatitis, interstitial cystitis, Asthma. |
| | Centomeres | Proteins of Kinetochores | CREST syndrome, PSS limited form |
| | Nuclear Dots | Sp-100 , NDP53 | PBC,Rheumatic Disease |
| | Nuclear Membrane | Lamins, gp210, p62 | CFS,Collagenoses,PBC,AIH |
| Nucleolus | Nucleolar homogeneous | PM-Scl Scl-70 | PM, DM, PSS(Diffuse) PSS(Diffuse) |

Nitin

**Dr. Nitin Arora**
**MBBS,MD (Microbiology)**

Note: This is a sample report for illustrative purpose only. Actual report may vary

Patient NAME

DOB/Age/Gender

Patient ID / UHID

Referred BY

Sample Collected

Report STATUS :

Barcode NO :

Sample Type :

Report Date :

| Test Description | | | Value(s) | Unit(s) | Reference Range |
|---|---|---|---|---|---|
| | Nucleolar speckled | RNA-Polymerase I / NOR-90 | Progressive Systemic Sclerosis(Diffuse) | | |
| | Nucleolar Pattern | Fibrillarin | Progressive Systemic Sclerosis(Diffuse) | | |
| Cytoplasm | Cytoplasmic speckled | Mitochondrial Lysosomal Golgi Complex Ribosome P Jo -1 SRP, PL12, TIF1-Gamma | PBC, Unknown SS/SLE/RA SLE Polymyositis (PM), PM/ DM, Myositis | | |
| | Cytoplasmic filament | F-Actin Vimentin Tropomyosin Cytoplasmic Rings & rods | AIH Unknown Unknown HCV Infection- on therapy | | |
| Cell Cycle (mitotic cells) | Centriole<br>Mid-Body<br>Spindle Fibres | --<br>--<br>-- | Unknown<br>Unknown<br>Rheumatic Disease | | |

Note: This is a sample report for illustrative purpose only. Actual report may vary

Nitin

Dr. Nitin Arora
MBBS,MD (Microbiology)

| | | | |
|---|---|---|---|
| Patient NAME : | | | |
| DOB/Age/Gender : | | Report STATUS : | |
| Patient ID / UHID : | | Barcode NO : | |
| Referred BY : | | Sample Type : | |
| Sample Collected : | | Report Date : | |

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

**Anti Cardiolipin IgA Antibodies**

| | | | |
|---|---|---|---|
| Cardiolipin Antibody ACL-IgA<br>*(Serum,EIA)* | 0.04 | Index | Negative: < 0.9<br>Equivocal: 0.9-1.1<br>Positive: > 1.1 |

**Interpretation:**
The systemic autoimmune disorder which causes recurrent vascular thrombosis and pregnancy losses is Anti- phospholipid syndrome (APS). The pathogenesis of APS is production of auto antibodies to phospholipid protein. Anti-phospholipid syndrome is detected either by a positive Anti-Cardiolipin antibody (aCL) or lupus anticoagulant test. APS may be either primary or secondary; when APS is present in patients without any underlying clinical illness it is primary. Secondary APS occurs in patients with systemic lupus erythematosus (SLE) or any other underlying autoimmune disease. The symptoms are observed by disturbing balance between procoagulant and anticoagulant factors and disruption of the clotting mechanism by the antiphospholipid antibodies (APLA) leading to leg ulcers, toe gangrene, myocardial infarction, purpura, stroke, recurrent miscarriage or preterm births. The autoantibodies are present in 50% of patients with SLE and 1-5% of the general population. The antiphospholipid antibodies are found in serum in 1% of healthy persons and 3% of older age group. Though APS can involve in any age group, the target group is young to middle aged adults.

Note: This is a sample report for illustrative purpose only. Actual report may vary

Nitin

**Dr. Nitin Arora**
**MBBS,MD (Microbiology)**

| | | | |
|---|---|---|---|
| Patient NAME | : | | |
| DOB/Age/Gender | : | Report STATUS | : |
| Patient ID / UHID | : | Barcode NO | : |
| Referred BY | : | Sample Type | : |
| Sample Collected | : | Report Date | : |

| Test Description | Value(s) | Unit(s) | Reference Range |
|---|---|---|---|
| **Torch Panel IgG (5 Parameters)** | | | |
| Toxoplasma IgG<br>*CLIA* | 0.004 | IU/mL | Non-Reactive <0.81 IU/mL<br>Equivocal 0.81 - 1.2 IU/mL<br>Reactive >1.2 IU/mL |
| Rubella IgG<br>*CLIA* | **64.325** | IU/mL | Non-Reactive <5 IU/mL<br>Equivocal 5 - 10 IU/mL<br>Reactive >10 IU/mL |
| Cytomegalovirus, IgG<br>*CLIA* | **291.772** | AU/mL | Non-Reactive <10 AU/mL<br>Equivocal 10 - 14 AU/mL<br>Reactive >14 AU/mL |
| Herpes simplex virus-1 IgG<br>*CLIA* | 0.001 | AU/mL | Non-Reactive <14 AU/mL<br>Equivocal 14 - 19 AU/mL<br>Reactive >19 AU/mL |
| Herpes simplex virus-2 IgG<br>*CLIA* | 0.001 | AU/mL | Non-Reactive <9 AU/mL<br>Equivocal 9 - 13 AU/mL<br>Reactive >13 AU/mL |

Note: Results reported in AU/mL cannot be compared with values reported in IU/mL.

**Interpretation:**

1. This assay is used for quantitative detection of specific IgG antibodies to TORCH in serum samples.
2. Positive result indicates past infection with TORCH. Pregnant females with positive TORCH specific IgG antibodies are considered to be immune and hence risk of transmission of infection to fetus is minimal.
3. Equivocal results should be re-tested in 10-14 days.
4. Negative result indicates person has not been exposed to TORCH in the past. Patients with negative results in suspected disease should be re-tested after 10-14 days. False negative results can be due to immunosuppression or due to low/undetectable level of IgG antibodies.
5. To differentiate between recent and past infection, Toxoplasma, Rubella & CMV IgG avidity test is indicated.
6. Demonstration of rising antibody titer (four folds) in acute and convalescent sera taken 2-3 weeks apart are indicative of TORCH infection.
7. The result should be interpreted in conjunction with clinical finding and other diagnostic tests. The magnitude of the measured result is not indicative of the amount of antibody present

Note: This is a sample report for illustrative purpose only. Actual report may vary

Nitin

**Dr. Nitin Arora**
**MBBS,MD (Microbiology)**

| | |
|---|---|
| Patient NAME | |
| DOB/Age/Gender | Report STATUS : Final Report |
| Patient ID / UHID | Barcode NO : RL05742400 |
| Referred BY | Sample Type : Serum |
| Sample Collected | Report Date : Oct 10, 2025, 06:48 PM. |

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

## Anti Cardiolipin IgG Antibodies

| | | | |
|---|---|---|---|
| Cardiolipin Antibody ACL- IgG *(Serum,EIA)* | <3.0 | GPLU/ml | < 12.0 GPLU/ml |

**Interpretation:**

| RESULT IN GPLU/ml | REMARKS |
|---|---|
| < 11.9 | Negative |
| ≥ 12.0-17.9 | Equivocal |
| ≥ 18.0 | Positive |

**Comments**

Antibodies against cardiolipin belong to the group of anti- phospholipid antibodies specific for negatively charged phospholipids, components of biological membranes. Cardiolipin is an acidic phospholipid derived from glycerol . Antiphospholipid antibodies are frequently found in sera of patients with systemic lupus erythematosus (SLE) and related diseases. The prevalence of anti-cardiolipin antibodies in SLE is 24-50%. The occurrence of anti-cardiolipin antibodies in patients with SLE and related diseases is typical of a secondary anti- phospholipid syndrome (APS). In contrast, anti-cardiolipin antibodies in patients with no other autoimmune diseases characterize the primary anti-phospholipid syndrome (APS). Many studies have shown a correlation between these autoantibodies and an enhanced incidence of thrombosis, thrombocytopenia and habitual abortions (as a consequence of placental infarct). The exact mechanism by which pathogenic anti-phospholipid antibodies induce thrombosis is not yet fully revealed.

## Anti Cardiolipin IgM Antibodies

| | | | |
|---|---|---|---|
| Cardiolipin AntibodyACL- IgM *(Serum,EIA)* | 0.07 | MPLU/ml | < 12.0 |

**Interpretation:**

| RESULT IN MPLU/ml | REMARKS |
|---|---|
| < 11.9 | Negative |
| ≥ 12.0-17.9 | Equivocal |
| ≥ 18.0 | Positive |

**Comments**

Antibodies against cardiolipin belong to the group of anti- phospholipid antibodies specific for negatively charged phospholipids, components of biological membranes. Cardiolipin is an acidic phospholipid derived from glycerol . Antiphospholipid antibodies are frequently found in sera of patients with systemic lupus erythematosus (SLE) and related diseases. The prevalence of anti-cardiolipin antibodies in SLE is 24-50%. The occurrence of anti-cardiolipin antibodies in patients with SLE and related diseases is typical of a secondary anti- phospholipid syndrome (APS). In contrast, anti-cardiolipin antibodies in patients with no other autoimmune diseases characterize the primary anti-phospholipid syndrome (APS). Many studies have shown a correlation between these autoantibodies and an enhanced incidence of thrombosis, thrombocytopenia and habitual abortions (as a consequence of placental infarct). The exact mechanism by which pathogenic anti-phospholipid antibodies induce thrombosis is not yet fully revealed.

Note: This is a sample report for illustrative purpose only. Actual report may vary

Nitin

**Dr. Nitin Arora**
**MBBS,MD (Microbiology)**

| | | | |
|---|---|---|---|
| Patient NAME | : | | |
| DOB/Age/Gender | : | Report STATUS | : |
| Patient ID / UHID | : | Barcode NO | : |
| Referred BY | : | Sample Type | : |
| Sample Collected | : | Report Date | : |

| Test Description | Value(s) | Unit(s) | Reference Range |
|---|---|---|---|
| **Torch Panel IgM (5 Parameters)** | | | |
| Toxoplasma IgM<br>*CLIA* | 0.001 | AU/mL | Non-Reactive <6 AU/mL<br>Equivocal 6 - 10 AU/mL<br>Reactive >10 AU/mL |
| Rubella IgM<br>*CLIA* | 0.001 | AU/mL | Non-Reactive <5 AU/mL<br>Equivocal 5 - 10 AU/mL<br>Reactive >10.0 AU/mL |
| Cytomegalovirus ,IgM<br>*CLIA* | 0.001 | AU/mL | Non-Reactive <8 AU/mL<br>Equivocal 8 - 12 AU/mL<br>Reactive >12 AU/mL |
| Herpes simplex virus-1 IgM<br>*CLIA* | 0.015 | AU/mL | Non-Reactive <6 AU/mL<br>Equivocal 6 - 10 AU/mL<br>Reactive >10 AU/mL |
| Herpes simplex virus-2 IgM<br>*CLIA* | 0.03 | AU/mL | Non-Reactive <6 AU/mL<br>Equivocal 6 - 10 AU/mL<br>Reactive >10 AU/mL |

**Interpretation:**

1. This assay is used for quantitative detection of specific IgM antibodies to TORCH in serum samples.
2. Positive result for TORCH IgM indicates possible acute infection with TORCH. False positive reaction due to rheumatoid factor and persistence of positive IgM (except Herpes Simplex virus) for upto 2 years is not uncommon.
3. An equivocal result requires repeat testing in 10-14 days.
4. Negative result indicates no serological evidence of infection with TORCH. False negative can be due to immunosuppression or due to low/undetectable level of IgM antibodies. A suspected diagnosis of acute TORCH infection should be confirmed by PCR analysis or repeat test after 10-14 days.
5. The diagnosis should not be established on the basis of single test and the results should be interpreted in conjunction with clinical findings.
6. The magnitude of the measured result is not indicative of the amount of antibody present.

**Anti Phospholipid IgG Antibodies**

| | | | |
|---|---|---|---|
| PHOSPHOLIPID ANTIBODY, IgG, SERUM<br>*(EIA)* | 0.25 | U/mL | <12.00 |

**Interpretation:**

| RESULT IN U/ml | REMARKS |
|---|---|
| < 12 | Negative |
| 12.00-18.00 | Borderline |
| >18.00 | Positive |

**NOTE-The assay is an aid in the diagnosis and risk estimation of thrombosis in patients with systemic lupus erythematosus and antiphospholipid syndrome (APS).**

Phospholipid-Screen-IgG is a solid phase enzyme immunoassay for the quantitative detection of IgG against phospholipids in human serum.Antibodies against phospholipids, components of the biological membranes, are specific for phospholipids such as Cardiolipin, Phosphatidyl -inositol, -ethanolamine,- serine, -choline and Sphingomyelin.Anti-phospholipid antibodies are frequently found in sera of patients with systemic lupus erythematosus (SLE) and related diseases. The occurrence of anti-phospholipid antibodies in patients with SLE and related diseases is typical for a secondary anti-phospholipid syndrome (APS). In contrast, anti-phospholipid antibodies in patients with no other autoimmune diseases characterize the primary APS.

Nitin

**Dr. Nitin Arora**
**MBBS,MD (Microbiology)**

Note: This is a sample report for illustrative purpose only. Actual report may vary

| | | | |
|---|---|---|---|
| Patient NAME | | | |
| DOB/Age/Gender | | Report STATUS | |
| Patient ID / UHID | | Barcode NO | |
| Referred BY | | Sample Type | |
| Sample Collected | | Report Date | |

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

**Anti Phospholipid IgM Antibodies**

| | | | |
|---|---|---|---|
| PHOSPHOLIPID ANTIBODY, IgM, SERUM *(EIA)* | 0.44 | U/mL | <12.00 |

**Interpretation:**

| RESULT IN U/ml | REMARKS |
|---|---|
| < 12 | Negative |
| 12.00-18.00 | Borderline |
| >18.00 | Positive |

**NOTE-The assay is an aid in the diagnosis and risk estimation of thrombosis in patients with systemic lupus erythematosus and antiphospholipid syndrome (APS).**

Phospholipid-Screen-IgM is a solid phase enzyme immunoassay for the quantitative detection of IgM against phospholipids in human serum.Antibodies against phospholipids, components of the biological membranes, are specific for phospholipids such as Cardiolipin, Phosphatidyl -inositol, -ethanolamine,- serine, -choline and Sphingomyelin.Anti-phospholipid antibodies are frequently found in sera of patients with systemic lupus erythematosus (SLE) and related diseases. The occurrence of anti-phospholipid antibodies in patients with SLE and related diseases is typical for a secondary anti-phospholipid syndrome (APS). In contrast, anti-phospholipid antibodies in patients with no other autoimmune diseases characterize the primary APS.

Note: This is a sample report for illustrative purpose only. Actual report may vary
2

Nitin

Dr. Nitin Arora
MBBS,MD (Microbiology)

| | | | |
|---|---|---|---|
| Patient NAME | : | | |
| DOB/Age/Gender | : | Report STATUS | |
| Patient ID / UHID | : | Barcode NO | |
| Referred BY | : | Sample Type | SOD HEPARIN |
| Sample Collected | : | Report Date | :52 AM. |

ilac-MRA MC-5280

**Karyotyping: Blood Lympho Culture, Couple**

**Wife :**

| | |
|---|---|
| **CLINICAL INDICATION** | To rule out chromosome abnormality |
| **SUMMARY OF RESULTS** | **NORMAL FEMALE KARYOTYPE** |
| **NOMENCLATURE** | **46,XX**<br>*(As per International System for Human Cytogenomic Nomenclature, ISCN,2020)* |

**CLINICAL INTERPRETATION**

Within the limits of standard cytogenetic methodologies, the chromosomes of the patient showed normal female karyotype G-banding patterns with no evidence of aneuploidy or without apparent structural abnormality or rearrangement. The following possibilities, although rare, cannot be ruled out: a) low level mosaicism, b) very subtle rearrangements, c) genetic disorders that cannot be detected beyond the resolution of by standard cytogenetic methods. d) There is a possiblility of technical error (2%) in absence of clinical history and sub-optimal quality of sample.

| | |
|---|---|
| **RECOMMENDATION** | Genetic Counseling for the family is recommended. |
| **SAMPLE DESCRIPTION** | The sample was of optimal quality for conventional cytogenetics culture techniques. The 72 hours of stimulated peripheral blood sample was initiated in karyotyping medium yielded analyzable metaphases for karyotype. |

Note: This is a sample report for illustrative purpose only. Actual report may vary

**Dr. Ankur Jindal (Ph.D)**
**Consultant Cytogenomics**

| | |
|---|---|
| Patient NAME | |
| DOB/Age/Gender | Report STATUS : |
| Patient ID / UHID | Barcode NO : |
| Referred BY | Sample Type : |
| Sample Collected | Report Date : |

**Husband :**

| | |
|---|---|
| **CLINICAL INDICATION** | To rule out chromosome abnormality |
| **SUMMARY OF RESULTS** | **NORMAL MALE KARYOTYPE** |
| **NOMENCLATURE** | **46,XY**<br>*(As per International System for Human Cytogenomic Nomenclature, ISCN,2020)* |

**CLINICAL INTERPRETATION**

Within the limits of standard cytogenetic methodologies, the chromosomes of the patient showed normal male karyotype G-banding patterns with no evidence of aneuploidy or without apparent structural abnormality or rearrangement. The following possibilities, although rare, cannot be ruled out: a) low level mosaicism, b) very subtle rearrangements, c) genetic disorders that cannot be detected beyond the resolution of by standard cytogenetic methods. d) There is a possiblility of technical error (2%) in absence of clinical history and sub-optimal quality of sample.

| | |
|---|---|
| **RECOMMENDATION** | Genetic Counseling for the family is recommended. |
| **SAMPLE DESCRIPTION** | The sample was of optimal quality for conventional cytogenetics culture techniques. The 72 hours of stimulated peripheral blood sample was initiated in karyotyping medium yielded analyzable metaphases for karyotype. |

*** End Of Report ***

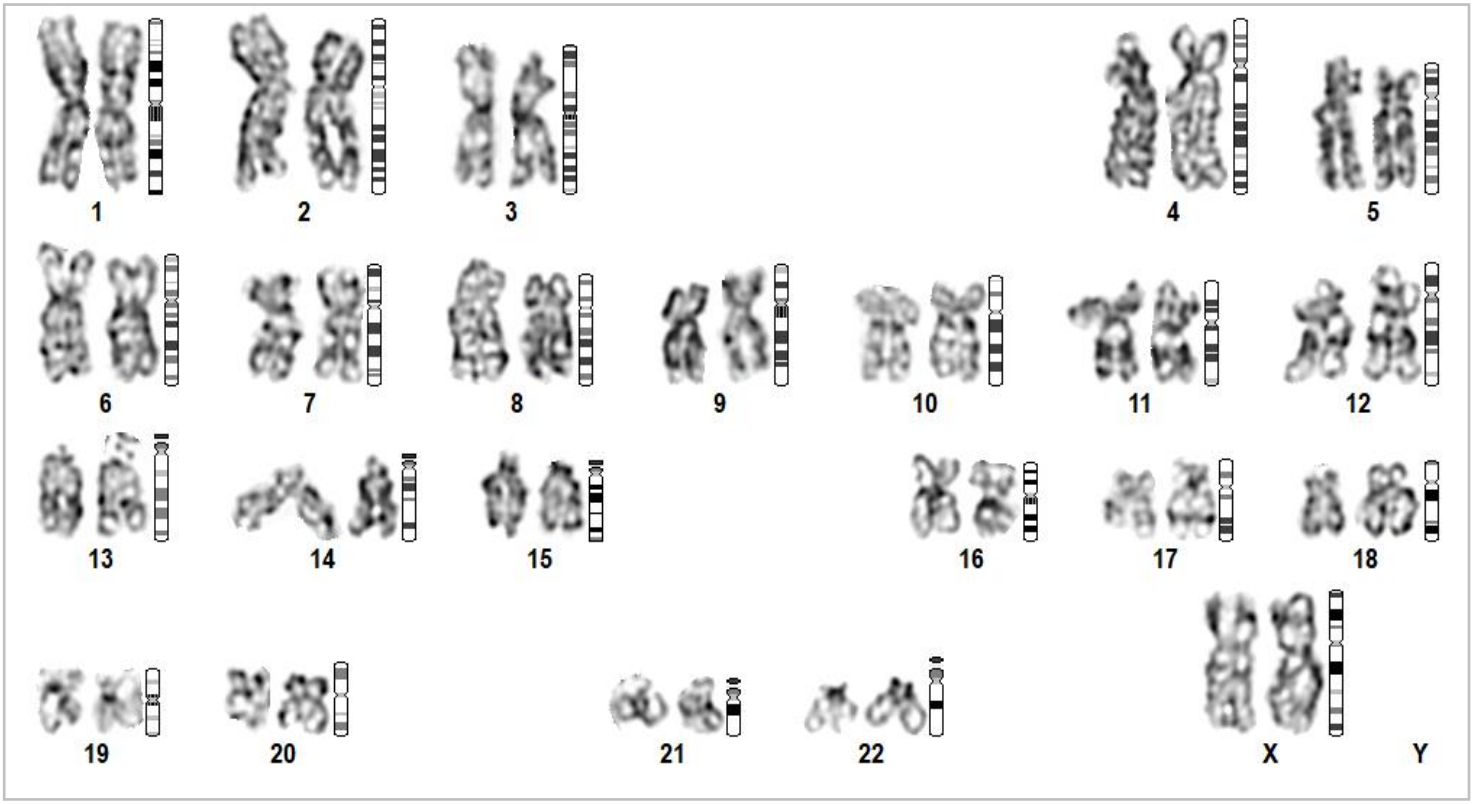
Note: This is a sample report for illustrative purpose only. Actual report may vary

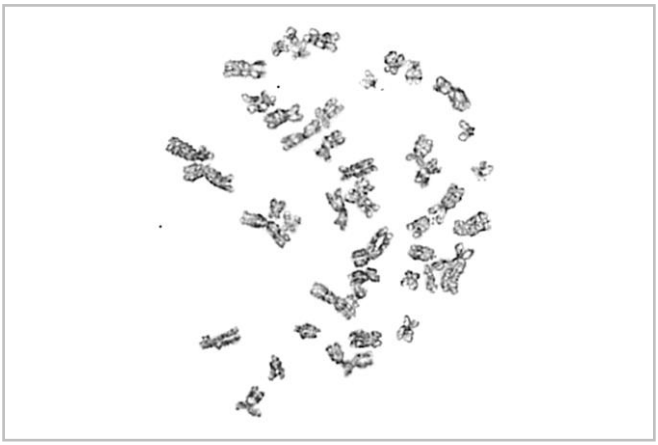
Dr. Ankur Jindal (Ph.D)
Consultant Cytogenomics

# LABORATORY REPORT

Redcliffe labs

**KARYOTYPE IMAGE:**



| | |
|---|---|
| **METHOD:** | G-BANDING |
| **Metaphase Counted:** | 20 |
| **Metaphase Analyzed:** | 10 |
| **Metaphase Karyotyped:** | 10 |
| **Banding Resolution:** | **525** |
| **Metaphase Quality:** | **Good** |

**Ms. Ritu ( Scientist)**

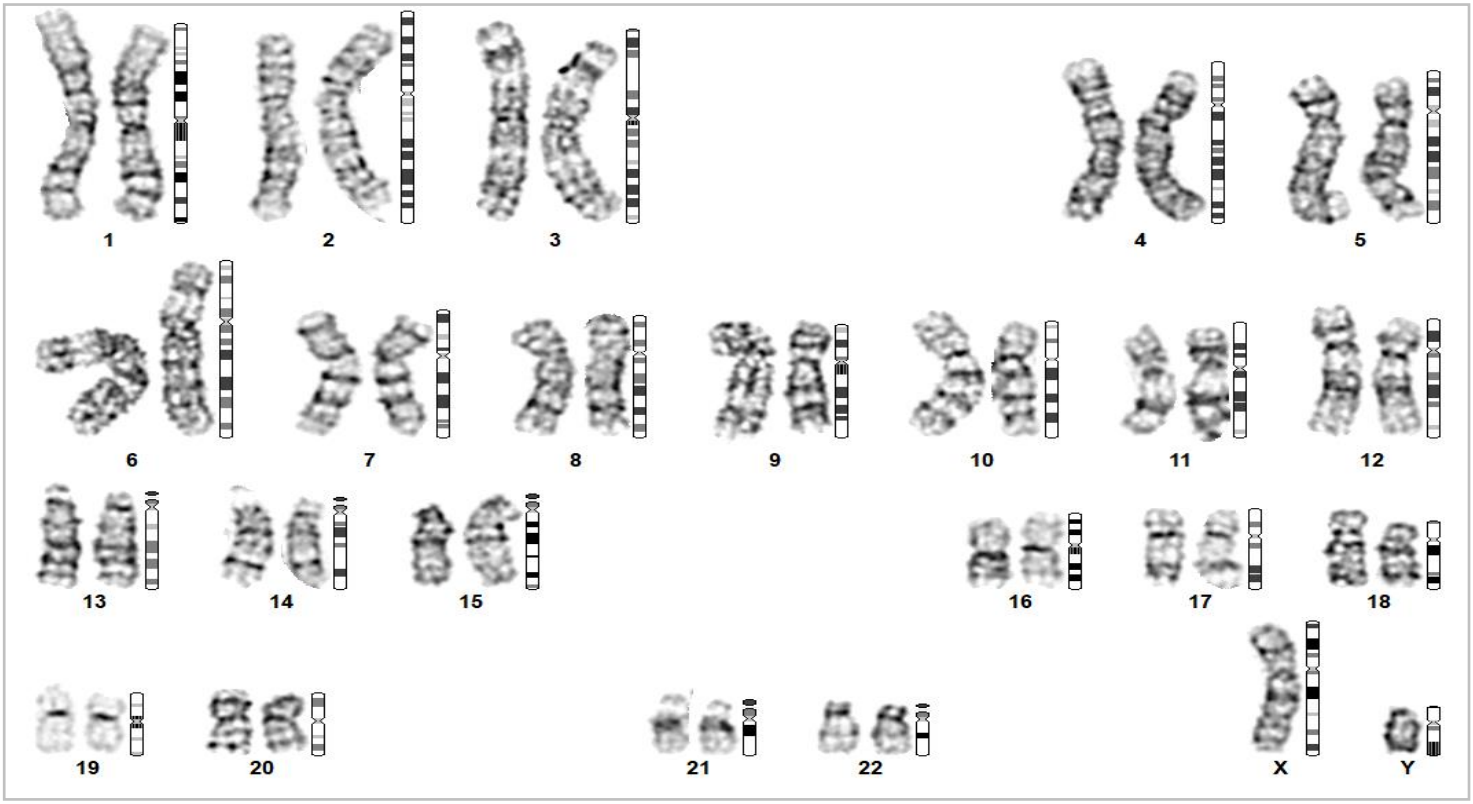
**Cytogenetics**

**Reviewed and Signed out on: 14-Oct-2025**

Note: This is a sample report for illustrative purpose only. Actual report may vary

# LABORATORY REPORT

**KARYOTYPE IMAGE:**




| | |
|---|---|
| **METHOD:** | G-BANDING |
| **Metaphase Counted:** | 20 |
| **Metaphase Analyzed:** | 10 |
| **Metaphase Karyotyped:** | 10 |
| **Banding Resolution:** | **700** |
| **Metaphase Quality:** | **Good** |

**Ms. Ritu ( Scientist)**

**Cytogenetics**

**Reviewed and Signed out on: 14-Oct-2025**

Note: This is a sample report for illustrative purpose only. Actual report may vary

# Terms and Conditions of Reporting

1. The presented findings in the Reports are intended solely for informational and interpretational purposes by the referring physician or other qualified medical professionals possessing a comprehensive understanding of reporting units, reference ranges, and technological limitations. The laboratory shall not be held liable for any interpretation or misinterpretation of the results, nor for any consequential or incidental damages arising from such interpretation.

2. It is to be presumed that the tests performed pertain to the specimen/sample attributed to the Customer's name or identification. It is presumed that the verification particulars have been cleared out by the customer or his/her representation at the point of generation of said specimen / sample. It is hereby clarified that the reports furnished are restricted solely to the given specimen only.

3. It is to be noted that variations in results may occur between different laboratories and over time, even for the same parameter for the same Customer. The assays are performed and conducted in accordance with standard procedures, and the reported outcomes are contingent on the specific individual assay methods and equipment(s) used, as well as the quality of the received specimen.

4. This report shall not be deemed valid or admissible for any medico-legal purposes.

5. The Customers assume full responsibility for apprising the Company of any factors that may impact the test finding. These factors, among others, includes dietary intake, alcohol, or medication / drug(s) consumption, or fasting. This list of factors is only representative and not exhaustive.