

Client
Gurugram
Pathkind Diagnostics Pvt. Ltd.
Plot No. 55-56, Udhog Vihar Ph-IV, Gurugram - 122015

Processed By
Pathkind Diagnostics Pvt. Ltd.
Plot No. 55-56, Udhog Vihar Ph-IV, Gurugram - 122015

Name : Mrs. PL71	Billing Date : 07/07/2023 12:26:58
Age : 35 Yrs	Sample Collected on : 10/07/2023 10:01:31
Sex : Female	Sample Received on : 10/07/2023 11:02:13
P. ID No. : P1000100012838	Report Released on : 15/07/2023 11:07:50
Accession No : 10002304894	Barcode No. : 10002304894-01
Referring Doctor : Self	
Referred By :	Ref no. :

Report Status - Final

Test Name	Result	Biological Ref. Interval	Unit
<u>Fertikind Total</u>			
Anti Mullerian Hormone (AMH) <i>Sample: Serum</i> <i>Method: ECLIA</i>	5.96	0.41 - 6.96	ng/mL
Luteinizing Hormone (LH) <i>Sample: Serum</i> <i>Method: ECLIA</i>	25.0	Follicular Phase : 2.4 - 12.6 Ovulatory Phase : 14.0 - 96.0 Luteal Phase : 1.0 - 11.4 Postmenopausal : 7.7 - 59.0	mIU/mL
Follicle-Stimulating Hormone (FSH) <i>Sample: Serum</i> <i>Method: ECLIA</i>	14.60	Follicular Phase : 3.5 - 12.5 Ovulatory Phase : 4.7 - 21.5 Luteal Phase : 1.7 - 7.7 Postmenopausal : 25.8 - 134.8	mIU/mL
Prolactin (PRL) <i>Sample: Serum</i> <i>Method: ECLIA</i>	26.3	6.0 - 29.9	ng/mL
TSH 3rd Generation <i>Sample: Serum</i> <i>Method: ECLIA</i>	4.200	0.270 - 4.200	µIU/mL

Anti Mullerian Hormone (AMH)

Clinical Significance :

Antimullerian hormone (AMH), is produced continuously in the granulosa cells of small follicles during the menstrual cycle and is used as a marker of ovarian reserve. 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 concentrations because it is associated with the presence of large numbers of small follicles. Serum AMH concentrations are increased in some patients with ovarian granulosa cell tumors along with other ovarian cancer markers. AMH estimation is used for assessment of menopausal status, including premature ovarian failure, assessing



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ovarian status, including ovarian reserve and ovarian responsiveness, as part of an evaluation for infertility and assisted reproduction protocols such as in vitro fertilization and in assessing ovarian function in patients with polycystic ovarian syndrome. Menopausal women or women with premature ovarian failure of any cause, including after cancer chemotherapy, have very low antimullerian hormone (AMH) levels.

Luteinizing Hormone (LH)

Clinical Significance :

Luteinizing Hormone (LH) levels are raised in both males and females in primary hypogonadism, menopause, Complete testicular feminization syndrome, Precocious puberty, Primary ovarian hypodysfunction in females and Polycystic ovary disease in females. LH is decreased in Primary ovarian hyperfunction in females, Primary hypergonadism in males and in both males and females in failure of the pituitary or hypothalamus.

Follicle-Stimulating Hormone (FSH)

Clinical Significance :

FSH levels are raised in both males and females in primary hypogonadism, primary gonadal failure, Complete testicular feminization syndrome, Precocious puberty and Menopause. Normal or decreased FSH are seen in Polycystic ovary disease.

Prolactin (PRL)

1. Prolactin is secreted in a pulsatile manner and is also influenced by a variety of physiologic stimuli, it is recommended to test pooled sample ie 3 specimens at 20-30 minute intervals.
2. Major circulating form of Prolactin is a nonglycosylated monomer, but several forms of Prolactin linked with immunoglobulin occur which can give falsely high Prolactin results.
3. Macroprolactin assay is recommended if prolactin levels are elevated, but signs and symptoms of hyperprolactinemia are absent or pituitary imaging studies are normal

Clinical Use

- * Diagnosis & management of pituitary adenomas
- * Differential diagnosis of male & female hypogonadism

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Increased Levels

- * Physiologic: Sleep, stress, postprandially, pain, coitus, pregnancy, nipple stimulation or nursing
- * Systemic disorders: Chest wall or thoracic spinal cord lesions, Primary / Secondary hypothyroidism, Adrenal insufficiency, Chronic renal failure, Cirrhosis
- * Medications:
 - * Psychiatric medications like Phenothiazine, Haloperidol, Risperidone, Domperidone, Fluoxetine, Amitriptylene, MAO inhibitors etc.,
 - * Antihypertensives: Alphamethyldopa, Reserpine, Verapamil
 - * Opiates: Heroin, Methadone, Morphine, Apomorphine
 - * Estrogens
 - * Oral contraceptives
 - * Cimetidine / Ranitidine
- * Prolactin secreting pituitary tumors: Prolactinoma, Acromegaly
- * Miscellaneous: Polycystic ovarian disease, Epileptic seizures, Ectopic secretion of prolactin by non-pituitary tumors, pressure / transection of pituitary stalk, macroprolactinemia
- * Idiopathic

Decreased levels

- * Pituitary deficiency: Pituitary necrosis / infarction
- * Bromocriptine administration
- * Pseudohypoparathyroidism

TSH 3rd Generation**Clinical Significance :**

TSH levels are elevated in primary hypothyroidism and low in primary hyperthyroidism. Evaluation of TSH is useful in the differential diagnosis of primary from secondary and tertiary hypothyroidism. In primary hypothyroidism, TSH levels are elevated, while secondary and tertiary hypothyroidism, TSH levels are low or normal. High TSH level in the presence of normal FT4 is subclinical hypothyroidism and low TSH with normal FT4 is called subclinical hyperthyroidism. Sick, hospitalized patients may have falsely low or transiently elevated TSH. Significant diurnal variation is also seen in TSH levels.

Guidelines for TSH levels in pregnancy, as per American Thyroid Association, are as follows:

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PREGNANCY TRIMESTER		BIOLOGICAL REFERENCE INTERVAL	UNIT
FIRST TRIMESTER		0.100 - 2.500	µIU/mL
SECOND TRIMESTER		0.200 - 3.000	µIU/mL
THIRD TRIMESTER		0.300 - 3.000	µIU/mL

** End of Report**

**Dr. Aarti Khanna Nagpal**DNB (Pathology)
Senior Consultant