Report to **HAYNE, LISA**
Shop 7, 63-65 Maitland St
, Narrabri, NSW, 2390

Patient **GLENN, FIONA**
200 THE ISLAND RD NARRABRI NSW 2390
Phone 0437234303
D.O.B 09/08/1966 Age 57 years Sex F

Ref. by/copy to HAYNE, LISA
Collect date 15/03/2024 Lab ref 24-25952400
Collect time 01:04 PM Your ref
Reported 28/03/2024 12:13 PM

Tests requested HST, RT3, STE, TFT, DVI, COR, MBA, LIP, TAA, EBV, GLU, I12, FE HMA*,UTE*

Clinical notes

Clinical Notes : REK sent to NARRABRI ACC.

Blood Histamine	0.9	umol/L	(0.2-1.8)

Reference range under review.
QML Pathology's NATA accreditation does not cover the performance of this test.

Clinical Notes : REK sent to NARRABRI ACC.

Serum Reverse T3 (RT3)	280	pmol/L	(170-539)

PLASMA TRACE ELEMENTS

			(RI)
Zinc	13.4	umol/L	(10.0-18.0)
Selenium	1.68	umol/L	(0.80-1.90)

RI = Reference Interval

THYROID PROFILE

Specimen Type: Serum

TSH	**38**	mIU/L	(0.5-4.0)
FT4	10	pmol/L	(10-20)
FT3	4.5	pmol/L	(3.5-6.5)

SURGERY USE
Normal
No Action/File
Patient Notified
Make Appoint.
Further Tests
Notes Required
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VITAMIN D

Haemolysis	1+	
Serum 25(OH) Vitamin D	101	nmol/L

Suggested decision limits for Vitamin D status:

Sufficiency	51 -200	nmol/L
Mild deficiency	25 - 50	nmol/L
Marked deficiency	< 25	nmol/L
Toxicity	>250	nmol/L

References: Vitamin D and health in adults in Australia and New Zealand: Position Statement. MJA 2012 June 18; 196(11),686-687.

SERUM CORTISOL

Time	13:04	
Cortisol	325	nmol/L

PM Reference Interval 100-400 nmol/L

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Clinical notes

SERUM CHEMISTRY

Specimen Type: Serum

Haemolysis	1+		
Icterus	Nil		
Lipaemia	Nil		
Sodium	140	mmol/L	(135-145)
Potassium	5.4	mmol/L	(3.6-5.4)
Chloride	99	mmol/L	(95-110)
Bicarbonate	24	mmol/L	(22-32)
Anion Gap	**22**	mmol/L	(10-20)
Urea	6.6	mmol/L	(2.5-9.0)
Creatinine	70	umol/L	(45-90)
eGFR	80		mL/min/1.73m^2
Urate	**0.40**	mmol/L	(0.14-0.36)
Bilirubin	13	umol/L	(< 15)
AST	27	U/L	(< 35)
ALT	21	U/L	(< 30)
GGT	**42**	U/L	(< 35)
Alkaline Phosphatase	69	U/L	(30-115)
Protein	75	g/L	(60-82)
Albumin	47	g/L	(38-50)
Globulin	28	g/L	(20-39)
Calcium	2.44	mmol/L	(2.10-2.60)
Corrected Calcium	2.36	mmol/L	(2.10-2.60)
Phosphate	1.16	mmol/L	(0.75-1.50)

eGFR values between 60 and 89 mL/min/1.73m2 should be interpreted with caution. These results are only consistent with CKD in the presence of other evidence such as microalbuminuria, proteinuria or haematuria.
Ref:Lamb EJ etal in Ann Clin Biochem 2005; 42:321-345.

As a result of haemolysis in this sample, the following analytes may be falsely elevated: Phosphate, AST

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LIPID STUDIES

Specimen Type: Serum

Reference intervals are included for reference only, and interpretation / treatment goals should be guided by patient-specific cardiovascular risk assessment (see Australian Cardiovascular Risk Charts. Alternatively, the web-site www.cvdcheck.org.au can be accessed in order to complete a risk assessment for individual patients.)

Haemolysis	1+		
Icterus	Nil		
Lipaemia	Nil		
Fasting status	Random		
Total Cholesterol	**6.7**	mmol/L	(3.9-5.2)
Triglycerides	**1.9**	mmol/L	(0.5-1.7)

NVDPA TARGET LIPID RANGES (MMOL/L) FOR PATIENTS AT HIGH / MODERATE RISK OF CARDIOVASCULAR DISEASE:

TOTAL CHOLESTEROL	<4.0
TRIGS (FASTING)	<2.0
HDL-C	>= 1.0
LDL-C	<2.0
NON HDL-C	<2.5

High levels of cholesterol can be seen in disorders of apolipoprotein metabolism, nephrotic syndrome, endocrine dysfunction or cholestasis.

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THYROID AUTOANTIBODIES

Specimen Type: Serum

Anti-Thyroglobulin Abs (aTGII)	3.0	IU/mL	(< 4.5)
Anti-Thyroidal Peroxidase Abs	**> 1300**	IU/ml	(< 60)

Over 90% of patients with autoimmune thyroiditis show moderate to high levels of Anti-Thyroidal Peroxidase Abs (anti-TPO) with Anti-Thyroglobulin Abs (anti-Tg) also present in about 90% of such patients. Up to 75% of patients with Graves' hyperthyroidism show increased anti-TPO with anti-Tg present in 50-60%. Low levels of both anti-TPO and anti-Tg may be found in up to 10% of "normal" asymptomatic adults. In most cases of autoimmune thyroid disease increased anti-TPO is the predominant finding although a small proportion of patients show a predominant increase in anti-Tg.

Please note that as of 08/09/2021, Laverty Pathology changed to a reformulated Atellica anti-thyroglobulin antibody (aTGII) assay. The reference interval has been updated. Differences in individual patient results may be observed compared to the previous method. If further information is required please contact a Chemical Pathologist on 9005 7000.

EBV SEROLOGY

Epstein-Barr virus (VCA) IgG	**POSITIVE**	
Epstein-Barr virus (VCA) IgM	Negative	
EBV Nuclear Antigen (EBNA) IgG	**POSITIVE**	

Consistent with past exposure to Epstein Barr virus. Please note that antibodies to EBV nuclear antigen (EBNA) are usually detected 2- 3 months after infection and usually persist for life.

All testing performed on serum or plasma unless otherwise specified.

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SERUM/PLASMA GLUCOSE

Fasting status	Random		
Serum	**3.1**	mmol/L	(3.4-7.7)

Low glucose result. Although no transport and centrifugation delay was evident, if clinically unexpected, a repeat collection could be considered for confirmation.

SERUM VITAMIN B12

Request Number			25952400
Date Collected			15 Mar 24
Time Collected			13:04
B12	(156-740)	pmol/L	394

IRON STUDIES

Specimen Type: Serum

Serum Iron	13	umol/L	(10-30)
Transferrin	37	umol/L	(32-48)
Transferrin Saturation	18	%	(13-45)
Serum Ferritin	44	ug/L	(30-400)

Normal iron studies.

SURGERY USE
Normal
No Action/File
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