iJRASET
International Journal For Research in Applied Science and Engineering Technology

INTERNATIONAL JOURNAL FOR RESEARCH

IN APPLIED SCIENCE & ENGINEERING TECHNOLOGY

Volume: 12 **Issue:** X **Month of publication:** October 2024

DOI: https://doi.org/10.22214/ijraset.2024.64755

www.ijraset.com

Call: 08813907089 | E-mail ID: ijraset@gmail.com

International Journal for Research in Applied Science & Engineering Technology (IJRASET)
ISSN: 2321-9653; IC Value: 45.98; SJ Impact Factor: 7.538
Volume 12 Issue X Oct 2024- Available at www.ijraset.com

Brief Overview on Pathology of Blood and Urine

Mr. Abhishek D. Pawar[1], Proff. Dnyaneshwar Vyavhare [2], Dr. Megha T. Salve[3]
[1]*Student, Department of Pharmacy, Shivajirao Pawar College of Pharmacy Pachegaon Newasa*
[2]*Professor, Department of Pharmacy, Shivajirao Pawar College of Pharmacy Pachegaon Newasa*
[3]*Principal, Department of Pharmacy, Shivajirao Pawar College of Pharmacy Pachegaon Newasa*

Abstract: ***Clinical pathology is recognized as an essential component of the preclinical safety evaluation of test articles (new chemical entities, exploratory novel medicines, and xenobiotics), particularly in short- and medium-term toxicity studies. Traditionally, this evaluation includes clinical chemistry, coagulation, hematology, and urinalysis assessments. The findings of these assessments include details on the general state of health of the animals as well as target organs and general metabolic, adaptive, or harmful processes linked to test material exposure. Consequently, in the preclinical safety assessment of a test article, clinical pathology evaluations aid in the establishment of toxicological dose-response correlations. These findings hold significance and relevance for dose selection in long-term research, as well as for risk assessment and management when applied to humans. Guidance on the fundamentals of clinical pathology testing and interpretation in the species utilized in toxicological investigations is the aim of this chapter. In order to increase testing capacity and enhance its ability to identify more sensitive, early signals of drug-induced target organ toxicity or pathophysiology, the application of clinical pathology testing in preclinical safety assessment as well as the areas of development for novel biomarker implementation within the laboratory are discussed. Lastly, the significance of interpreting clinical pathology and combining the results with data from other studies is emphasized when assessing overall safety or risk assessment.***
Keywords: Blood components, Blood chemistry, light microscope, Auto analyzer, Anemia.

I. INTRODUCTION

In the circulatory systems of humans and other animals, blood is a bodily fluid that carries metabolic waste products away from the cells while also supplying them with nutrients and oxygen. Hemato, hemato, haemo, or haemato are common prefixes for blood, derived from the Greek word (haima), which means “blood”. Blood is regarded as a specialized type of connective tissue in terms of anatomy and histology, given that it originates in the bones and contains fibrinogen, a potential source of molecular fibers. It is possible to separate whole blood, which is a mixture of cells, colloids, and crystalloids, into distinct blood components such as cryoprecipitate, fresh frozen plasma, platelet concentrate, and packed red blood cell (PRBC) concentrate. The utility of a single whole blood unit has been maximized by component separation since each blood component is used for a distinct indication. For therapeutic efficacy, various components have varying needs for temperature and storage conditions. Equipment to maintain appropriate ambient conditions during shipping and storage is widely available. Due to the blood components being foreign to the patient, side effects could range from minor allergic reactions to lethal ones. Leucocytes, red cell antigens, plasma, plasma proteins, and other pathogens are typically the source of these reactions. In order to prevent and minimize An organ that can save lives is blood. Colloids, crystalloids, and cellular components are all mixed together to form whole blood. Centrifugal force can be used to separate distinct blood components since they differ in relative density, sediment rate, and size[1] .

Red blood cell (RBC), plasma, platelets, and granulocyte products are among the blood components that can be generated using whole blood (WB) or automated apheresis donation. Each component may be made and stored under ideal circumstances thanks to component preparation and production. The use of component treatment has mainly superseded WB because it was possible to select parts that catered to the demands of individual patients and provide for the best possible storage of every component. Furthermore, parts can be Altered (such as irradiated) or chosen (such as hemoglobin S negative) to fulfill particular requirements for patients[2] .

A. Clinical Chemistry Of Blood

The branch of chemistry known as “clinical chemistry” is primarily focused on the quantitative examination of the constituents of biological fluids. Urine and blood are the most often utilized specimens in clinical chemistry. One of the fastest and least expensive kinds of laboratory testing that is available is blood analysis. Blood testing gives doctors the ability to rapidly assess a patient’s general health, including their immune system, vitamin, and organ function, as well as any concerns regarding potential diseases.

Multiple panels are used in blood testing to screen for different components in your blood, such as hormones, certain proteins, and electrolytes, among others[3].

1) Electrolyte

The particular constitution of body fluids matters because cells need the right environment to carry out their metabolic and electrophysiological processes. This chapter does not, unfortunately, address the reason it is possible to find the deters of the electrolyte components of compartments in any physiology text, but examines the conditions from the perspective of fluid regulation[6] .

2) Sodium

A 70 kg man's total body sodium has a turnover of about 3000 mmol per day, meaning that an adult's usual daily requirement is about 100 mmol (1–1.5 mmol/kg). Serum sodium levels in the plasma compartment are typically 140 mmol/L, while the interstitial space has a similar value. However, intracellular concentrations are far lower, with potassium being the predominant ion. There is a three compartments that make up the body: the intracellular, interstitial, and intravascular compartments. Sodium is mostly distributed in the intravascular and interstitial compartments, where it is in a state of dynamic equilibrium. Although not exactly the same, the concentrations are basically rather similar. Equilibrium is reached via diffusion through the sodium-permeable "compartment barriers." When considered in conjunction with hydration, the plasma sodium serves as a reasonable indicator of the total amount of sodium in the body because both compartments are the primary site of sodium. Control mechanisms are intimately related to both sodium and fluid. Osmoreceptors and volume are the two mediating factors in control. Water and salt retention are caused by osmotic pressure or volume reduction. In diseased conditions, both high and low sodium concentrations exist and are clinically[6] .

3) Potassium

The most prevalent exchangeable cation in the body is potassium. Potassium is mostly contained inside cells, mostly in muscle cells, where it can be found at concentrations of 140 to 150 meq/liter. The extracellular fluid contains 4 to 4.5 meq/liter of potassium. Consequently, there is a gradient in the fluid that separates intracellular and extracellular potassium diffusion. Sodium has a high external concentration and a low intracellular concentration; this gradient is the opposite for sodium.

Both of these gradients are used for diffusion, and they are restored by pumps in the cell membrane that transfer potassium out and sodium in. It is essential that these pumps be present and that the cell's potassium concentration be high. The potassium content throughout the cell membrane ratioand its quantity inside the cell controls a wide range of processes, such as the pace at which proteins, nucleic acids, glycogen, and other intracellular metabolites are synthesized, as well as the regulation of electrophysiologic events and cell volume and its quantity inside the cell controls a wide range of processes, such as the pace at which proteins, nucleic acids, glycogen, and other intracellular metabolites are synthesized, as well as the regulation of electrophysiologic events and cell volume[7] .

4) Chloride

Because nature needs electrochemical neutrality, anions are also crucial. If the bicarbonate level is abnormally low and reabsorbed salt cannot be balanced by other anions such phosphate, urate, or acetoacetate, the kidneys will retain the chloride. Because chloride cannot take hydrogen ions at physiological pH, unlike bicarbonate or phosphate, it cannot function as a buffer, which results in hyperchloraemic acidosis. This happens after ureter transplantation into the colon and in renal tubular acidosis. Iatrogenic reasons include the delivery of high amounts of chloride as saline and suppression of carbonic anhydrase. Since excess chloride is a powerful ion, it causes an acidosis when present in excess. This is due to the chloride ion's need for electrochemical neutrality, which is provided by a cation. When chloride is lost without sodium, as in the case of pyloric stenosis, it is referred to as chloride depletion. Renal sodium is typically reabsorbed along with chloride, although in the absence of chloride subsequently further bicarbonate is taken up, resulting in an acid urine and a metabolic alkalosis. This illustrates that there is a close relationship between anions and cations having a balanced acid-base[6] .

5) Enzymes

Enzymes are biocatalysts that are widely employed in medical diagnosis due to their exceptional qualities. Over the past 20 years, there has been a greater focus on therapeutic uses of enzymes including acid phosphatase, alkaline phosphatase, creatine kinase–MB, alanine transaminase, aspartate transaminase, etc.

In many illness situations, including myocardial infarction, jaundice, pancreatitis, cancer, neurological disorders, etc., enzymes are the preferred indicators. By evaluating the prognosis, response to treatment, and diagnosis, they shed light on the course of the illness[4] .

Another way to think of enzymes is as organic, liquid, colloidal catalysts that are made by living cells yet have the ability to function alone . Nowadays, the usage of enzymes reduces costs significantly in a variety of industries, including agriculture, food, feed, paper, leather, and textiles. Concerns about energy, raw materials, health, and the environment are supporting the chemistry and pharmaceutical industries' adoption of enzyme technology at the same time that fast scientific advancements are pushing the field in this direction. The fact that enzymes can continue to work even after being removed or separated from cells is one of their most well-known benefits[5] .

Enzymes are primarily non-toxic, biodegradable, and abundantly manufactured by microorganisms for use in industrial processes. The isolation, synthesis, purification, use, and application of enzymes (in soluble, immobilized, or insoluble form) are covered in detail in this chapter. To create more useful and efficient enzymes, techniques like protein engineering and recombinant DNA technology are widely employed. Enzyme manufacturing and use in industry are significant aspects of the sector. To create the best enzyme technology possible, increase production, and preserve the physico-chemical characteristics of the enzyme in in vitro settings, interdisciplinary cooperation between fields like chemistry, process engineering, microbiology, and biochemistry is needed[5] .

6) Hormones

Thyroid Hormones **:** Thyroid hormone, also known as 3,5,3'-tri-iodothyronine (T3), is the common name for the active hormone and the inactive precursor thyroxine (T4). Thyroid hormone is essential for the formation of almost all tissues, as well as the regulation of basal metabolism and tissue regeneration throughout life[8] .

The thyroid gland secretes thyroid hormone (T3), which is crucial for development, differentiation, and metabolism. Early in human life, a deficiency in T3 causes growth abnormalities and severe mental retardation[9] .

Insulin**:** Insulin is a polypeptide hormone consisting of two chains of amino acids: the A chain has twenty-one amino acids and the B chain has thirty. The chains, which have a molecular weight of 6,000 and 51 amino acids each, are joined to one another via disulphide bonding. When blood glucose levels rise, the pancreatic β cells secrete it. Insulin stimulates the cell to integrate glucose transport proteins into its membrane as it binds to insulin receptors on the target cell and initiates signal transduction. This results in hypoglycemia, or "low sugar," which lowers blood glucose levels and prevents additional insulin release from β cells via a negative feedback mechanism. It may be brought on by low insulin levels or by tissue cells' decreased ability to respond to insulin[10] .

7) Protein

Human Albumin: With HA, the body's primary regulator of fluid distribution across compartments, 70–80% of the total plasma oncotic pressure is produced. The Gibbs-Donnan effect, which is caused by the molecule's negative net charge drawing positively charged molecules (sodium and water) into the intravascular compartment, accounts for one-third of the oncotic property, while the remaining two thirds come from the direct osmotic effect connected to the molecule's molecular mass[11] .

Globulin**:** Significant amounts of cholesterol, bile pigments, phospholipids, fatty acids, and other fat-soluble vitamins and hormones are present in ventricular plasma. They are mostly not free; instead, they are carried in the plasma in close proximity to specific globulin components. There are known to be at least two of these components: one of them is a fraction of the p-, and the other is one of the plasma's a-globulins. They are able to retain very high concentrations of materials that are nearly insoluble in pure water or aqueous salt solutions in plasma, a stable aqueous solution. It is clear how these facts affect the interchange and transportation of elements that are soluble in fat[12] .

II. ERYTHROCYTES – ABNORMAL CELL AND THERE SIGNIFICANCE

The majority of blood's cell composition are erythrocytes. Hematopoietic stem cells undergo differentiation to become red blood cells (RBCs) in the bone marrow. This process results in the production of these red blood cells. After nuclei's extrusion and the endoplasmic reticulum's breakdown, reticulocytes appear in the circulation. from here, they quickly mature into mature RBCs, which have a 120-day lifespan and an 8 µm biconcave disk. Despite these characteristics, the RBCs' lipid and protein makeup can alter during its lifespan. This can be notably evident at the level of its plasma membrane[13] .

The body's highly specialized oxygen transporters, known as erythrocytes or red blood cells (RBCs), are transported by the circulatory system. They release the as they squeak past the capillaries. Oxygen held in reserve in their gills or lungs. These cells' cytoplasm is rich in haemoglobin, an biomolecule with iron that binds oxygen and provides blood has a crimson hue . The bone marrow generates crimson body's blood cells, which move around for 100 to 120 days until the constituents of macrophages are recycled components. The process by which erythropoiesis occurs is known as which red blood cells are produced by the body. These cells are produced in the crimson bone marrow and are managed by the erythroprotein and hemopoeitic hormone[14] .

A. Abnormal Cells And There Significance

1) Sickle Cell Erythrocytes

The clinical signs of sickle cell disease (SCD) are varied and frequently necessitate medical attention. These include increased susceptibility to infections, persistent haemolysis, and vaso-occlusive consequences. Individuals suffering from sickle cell disease (SCD) may experience particular, occasionally fatal complications in addition to significant organ damage that lowers their life expectancy and quality of life. The only proven successful treatments available to sickle cell patients are bone marrow transplants, blood transfusions, and hydroxyurea. Medical professionals in the Netherlands need to have a basic awareness of the pathophysiology and clinical symptoms of sickle cell disease (SCD) due to the disease's rising prevalence[15] .

Significance: These cells can obstruct blood flow, leading to pain crises, increased risk of infections, and organ damage due to reduced oxygen delivery.

2) Spherocyte

This phrase is used to describe a cell that started off as a red blood cell with a normal size, shape, and lifespan but later transformed into a spherocyte. It is the delicate, short-lived red cell associated with acquired haemolytic anemia, which has become spheroidal due to damage brought on in many cases by antibodies. The when normal cells are transfused into such a patient, the patient's own red blood cells experience this shape change. Injecting admit-i-red-cell serum into healthy animals in- causes the animal's regular red blood cells to alter in a similar way. During the transition to the third shape, the accreted spherocyte's volume is impacted [16] .

Significance**:** Associated with hereditary spherocytosis and autoimmune hemolytic anemia. They are more prone to rupture, leading to hemolytic anemia[16] .

3) Elliptocytes

In many anemias, elliptical red cells are present. In acquired anemias, the degree of deviation from the circular shope of d iscocytes varies from cell to cell, and frequently, only a small number of elliptocytes are noticed. Almost all cells in hereditary elliptocytosis are elliptocytes. It's possible that heredity and ptocytes mayor are unrelated. Accompanied with pathological signs (hemolysis). Different all optical cell classifications according to the length-to width ratio have been suggested. As an illustration, one might sort the approximately circular cells into groups I and II, respectively. Human elliptocytes have a little biconcavity[17] .

Significance**:** Can indicate hereditary elliptocytosis or various anemias. They can lead to decreased flexibility and impaired circulation.

d. Reticulocytes

When the metarubricyte is released into the peripheral circulation, immature red blood cells (RBC) known as reticulocytes are in the last stages of development. When an orthochromatic erythroblast (metarubricyte) ejects its nucleus, a reticulocyte is created. When the erythroblast divides unevenly, the bigger portion becomes the reticulocyte and the smaller portion contains the nucleus and a narrow border of cytoplasm. A nearby macrophage swiftly consumes the released nucleus and destroys it. The reticulocyte then needs to pass through the wall of the marrow sinusoid, a specialized marrow conduit, to enter the peripheral blood circulation[18] Significance**:** Elevated levels indicate increased red blood cell production, often in response to anemia. Low levels can indicate inadequate bone marrow function.

4) Anisocytes

Anemia frequently results in the phenomena of anisocytosis. This appears to be closely associated with stressed erythropoiesis in critical situations and could be the outcome of a crucial adaptation process. However, until recently, general hematologists were unaware of the mechanism causing anisocytosis. It will be shown in this communication that erythroblast denucleation at a polychromatic stage can cause anisocytosis, as observed in anemic rabbits[19] .

Significance**:** Often seen in various types of anemia, suggesting issues with red blood cell production or maturation.

ISSN: 2321-9653; IC Value: 45.98; SJ Impact Factor: 7.538
Volume 12 Issue X Oct 2024- Available at www.ijraset.com

III. ANEMIA

Although the name "anemia" comes from two Greek origins that combined mean "without blood," it would be greatly exaggerated to take this literal translation to reflect what the condition actually is. Nonetheless, the modern definition of anemia is straightforward: it refers to any illness in which the body's total red blood cell mass abnormally decreases. Understanding red blood cells and their functions, the body's response to abnormally low red cell mass, and what happens when red cell mass drops to a point where the body is unable to adjust are all necessary to comprehend the concept. These topics will be covered in this chapter, but first we will examine the background to anemia research.

When the nineteenth century began, the term "anemia" was used in medicine to describe mucous membranes, or the thin layers that cover the insides of mouths, whites of eyes, inner surfaces of eyelids, and other areas not covered by skin, as well as pallor of the skin. The fundamental idea that there isn't enough red blood cells to cause clinical anemia was not understood when French physician Gabriel Andral published the first hematology textbook in 1843[20] .

A. Classification Of Anemia:

1) Iron Deficiency Anemia

Currently regarded as the most prevalent nutritional deficiency globally is iron deficiency anemia. This kind of anemia is classified as microcytic, hypochromic, albeit it is frequently normocytic, normochromic in the early stages of depletion. Iron deficiency is typically caused by a significant negative iron balance, which ends in depleted or reduced iron stores. Prior to the confirmation of the IDA diagnosis, there are successive alterations in iron status. This anemia is actually a late manifestation of IDA; it develops gradually as iron reserves are gradually reduced. The phases of iron deficiency are as follows: iron deficiency, iron depletion, iron-deficient erythropoiesis, and iron deficiency syndrome (IDA). Iron deficiency with mild to moderate symptoms, such as depleted iron reserves or iron insufficiency without anemia, may or may not present with obvious symptoms[21] .

2) Vitamin Deficiency Anemia

A vitamin B12 shortage causes your body to produce insufficient healthy red blood cells, a disease known as vitamin B12 deficiency anemia. The production of red blood cells, which distribute oxygen throughout your body, depends on this vitamin. Our tissues and organs don't obtain enough oxygen if we don't have enough red blood cells. A body that does not get adequate oxygen cannot function correctly. A low vitamin B12 level may cause pernicious anemia. The absence of intrinsic factor is one of the causes of vitamin B12 deficient anemia. A protein produced in the stomach is called intrinsic factor. For the absorption of vitamin B12. We refer to this kind of B12 deficient anemia as pernicious anemia. Surgery in which the small intestine's end is removed or avoided[22] .

3) Chronic Disease Anemia

Although the idea of chronic disease-related anemia is not new, new findings about the pathophysiology of the disorder, particularly with regard to iron biology and pro inflammatory cytokines, have provided fresh insights. Chronic disease anemia has been linked in recent epidemiologic research to obesity, age, kidney failure, critical illness, and the well-known links to cancer, chronic infection, and autoimmune disease. Patients with neoplasia are frequently affected by anemia. While solid tumors frequently produce anemia even in the absence of bone marrow involvement, hematologic malignancies are more prone to do so due to the infiltration of the bone marrow by an aberrant cell population[23] .

4) Aplastic Anemia

The illness known as aplastic anemia has a lengthy past. The first case description was published by Paul Ehrlich in 1888, the term "anemia aplas- tique" originated with Louis Henri Vaquez in 1904, and clinical symptoms were characterized by Richard C. Cabot and other pathologists in the early 20th century. What was formerly a terrible, enigmatic illness that typically struck young people and had a quick start may today be successfully treated in nearly all cases. Effective treatments have been developed as a result of research laboratory understanding of the pathophysiology of aplastic anemia. Genetic mutations, both inherited and acquired, early stages of leukemogenesis, environmental pollutants, viral infection, and normal aging-related hematopoiesis have all been connected to bone failure syndromes[24] .

5) Hemolytic Anemia

Hemolysis might manifest as jaundice, reticulocytosis, or acute or chronic anemia. The diagnosis is confirmed by peripheral blood smear results, decreased haptoglobin, elevated unconjugated bilirubin and lactate dehydrogenase, and reticulocytosis. Either intravascularly or extravascularly, erythrocytes might be prematurely destroyed. Hemolysis etiologies are frequently classified as acquired or inherited. Infection, microangiopathy, and autoimmune are common acquired causes of hemolytic anemia. Antierythrocyte antibodies, which trigger immune-mediated hemolysis, can exacerbate autoimmune diseases, cancers, medication reactions, and transfusion reactions. Damage to the red cell membrane during circulation can result in intravascular hemolysis and the appearance of schistocytes, which is known as microangiopathic hemolytic anemia[25] .

B. Symptoms Of Anemia

1) Fatigue
2) Pale or sallow skin
3) Shortness of breath
4) Dizziness or light-headedness
5) Cold hands and feet

C. Treatment Of Anemia

In the past, recommendations for the treatment of IDA were based less on evidence-based research and more on the perception of safety and efficacy. An audit was recently carried out to compare current practice with published standards for the correction of iron deficiency. 134 findings showed that IDA and iron deficiency were treated haphazardly, with one out of every four hospitalized patients not having their deficit corrected. It is obvious that uniform standards that prevent and rectify IDA are still required for all practice contexts[21] .

Nutritional anemia brought on by the body's lack of certain vital nutrients. Since anemia primarily affects women, it is largely gender specific. It also has a significant impact on younger kids. Eating a diet high in nutrients and healthful foods can treat it. Anemia can be avoided by changing one's eating habits. There is an urgent demand for government initiative to increase iron supplementation and raise awareness among individuals in rural and urban areas foods enriched for the [22] .

Most satisfyingly, immunosuppressive regimens and improved transplantation techniques have led to significant advancements in the treatment of immunological aplastic anemia patients during the past few decades. All forms of marrow failure can benefit from transplantation, but future developments in constitutive diseases may be possible thanks to gene editing and function restoration[24] .

IV. DISORDER OF WBCS

A. Leucocytosis

The patient's leukogram is used to assess their leukocyte responses. The differential leukocyte count , total leukocyte count (WBC), and description of WBC morphology are all included in the leukogram, which is the leukocyte component of the complete blood count (CBC). The percentages of distinct leukocyte types, such as lymphocytes, monocytes, eosinophils, basophils, and segmented neutrophils (or "segs"), are called the relative leukocyte differential count, or "relative Diff." A leukocyte count measured in microliters or liters, the quantity of each type of leukocyte per volume is called the absolute differential leukocyte count, or absolute Difference.

Since leukocytes are inflammatory cells, alterations in the leukogram are primarily used to determine whether an inflammatory condition is present and to classify the kind and degree of inflammation. Since the leukogram is not very sensitive in identifying moderate, localized, or chronic inflammation, an inflammatory condition cannot be ruled out by a normal WBC count and Difference[26] .

B. Leukopenia Or Neutropenia

Neutropenia can result from any type of illness, although viruses such the respiratory syncytial virus, cytomegalovirus, and influenza are the most common causes. Rather than streptococcal or staphylococcal infections, chronic illnesses such as tuberculosis, brucellosis, or typhoid are the most common bacterial causes of neutropenia. The lungs and the spleen both experience sequestration and margination as part of the pathophysiology of severe neutropenia. HIV infection can frequently cause neutropenia, with over two-thirds of individuals becoming neutropenia sometime throughout their disease.

Antibody production, bone marrow suppression, and cytokine-mediated neutrophil destruction are the mechanisms underlying this, and some antiretroviral drugs may also lower neutrophil levels[27] .

Leukopenia patients should be treated for their susceptibility to infection and the fact that infections can spread more quickly than in people with normal WBC counts, in addition to finding and treating the underlying cause of their condition when feasible. It is therefore optimal to handle leukopenic patients in a side room, or protective isolation. If an infection is suspected, as it can be from a fever or other clinical signs like hypotension, immediate medical attention is needed[27] .

C. Leukemia

A frequent carcinoma that affects both adults and children, leukemia arises when changes in normal cell regulatory mechanisms result in uncontrollable growth of hematopoietic stem cells in the bone marrow. Acute lymphoblastic leukemia and acute myelogenous leukemia in children are linked to a number of hereditary disorders, such as neurofibromatosis and Down syndrome.

People who have been exposed to ionizing radiation, including survivors of atomic bombs, medical radiation workers from before 1950, and cancer patients undergoing radiation therapy, are more likely to develop acute lymphoblastic leukemia, acute myelogenous leukemia, and chronic myelogenous leukemia. The amount of radiation from two or three computed tomography scans is linked to a statistically significant increase in the risk of cancer, including leukemia, with a greater risk in younger individuals, according to evidence from epidemiologic studies[28] .

D. Lymphoma

A diverse collection of malignant lymphocyte neoplasms, lymphomas can affect lymphatic tissue, bone marrow, or extranodal locations. The classification system used by the World Health Organization distinguishes over 90 distinct subtypes. The first classification is based on the origin of B-cells, T-cells, or natural killer cells. Although it is outside of the scope of this page to further classify individual lymphoma subtypes, each is finally identified by its morphology, immunophenotype, genetic, molecular, and clinical characteristics. This article will concentrate on the lymphoma kinds that are conventionally categorized as either Hodgkin or non-Hodgkin [29] .

E. Autoimmune Disorder

Pathophysiological mechanisms are notably impacted by autoimmune disorders. The immune system's multifaceted functions are primarily intended to protect hosts against infectious microorganisms. There are two primary ways in which a pliotropic immune system can lead to pathology: immune deficiency syndromes, where immune system cells are unable to respond to a pathogen in a protective manner, and autoimmune diseases. Once believed to be rare, autoimmune disorders are now estimated to affect 3-5% of the population; the most common conditions are autoimmune thyroid disease (ATD) and type 1 diabetes (T1D). More noteworthy is the existence of nearly 100 distinct autoimmune diseases[30] .

F. Lymphocytes And Platelets

Lymphocytes: Lymphocytes play important a role in the immune system due to their effect immunological responses to pathogenic bacteria and other external substances. They offer a particular defense against microbial invasion, shield against malignancies like multiple myeloma, and trigger organ transplant tissue rejection because they view the transplanted tissues as alien intruders. They are found in blood and lymph, the colourless fluid in the lymphatic tubes that carry blood from the body's lymph nodes to one another.

They also exist in lymphoid organs like the human appendix, spleen, lymph nodes, and thymus[31] .

Platelets: Specialized blood cells called platelets are essential to the physiologic and pathologic processes of wound healing, inflammation, tumors metastasis, hemostasis, and host defense. For platelets to function, which involves a complex interaction of adhesion and signaling chemicals, they must be activated.

The activation mechanisms, such as platelet adhesion, secretion, aggregation, micro vesicle creation, and clot retraction/stabilization, that are involved in primary and secondary hemostasis. Furthermore, active platelets communicate primarily with other vascular and blood cells through cross talk. Under high shear circumstances, leukocytes can be recruited to areas of vascular damage by stimulated "sticky" platelets. Leukocytes and endothelial cells can be triggered in turn by platelet-derived micro particles and the soluble adhesion molecules sP-selectin and sCD40L that are released from the surface of activated platelets[32] .

V. ABNORMAL CONSTITUENT OF URINE

A. Blood Cells

In therapeutic work, the stability of blood cells in urine is a crucial practical consideration. There are two factors to consider: the length of the collection period and the interval between voiding and specimen inspection. The degree of lysis in urine with an alkaline pH rises as the alkalinity and exposure period increase. Particularly vulnerable to cytolysis under alkaline conditions are leucocytes. Results are unreliable if there is bacterial contamination[33] .

Significance: Blood traces in the urine have a unique significance of their own and should prompt the investigator to take into account the possibility that the patient, regardless of age or gender, has a lesion that isn't seeming to be causing any inflammation. Inflammatory response and not affecting the urine excretory systems chemically system. It believed that the majority of these individuals had neoplasms of the bladder, early new growths of the renal pelvis, either benign or cancerous, or of the kidney parenchyma that coincidentally borders the pelvic epithelium. It ought to keep in mind, nevertheless, that mild hamaturia alone is not a reliable physical indicator[34] .

B. Glucose

The amount of glucose that produces typical glucoses zone will vary, as noted by H6st [1923], if it is introduced to regular pee. After adding roughly 10 mg of glucose per 100 cc, the host was able to extract normal glucoses zones from regular urine and occasionally not prior to the administration of 20 mg. What led to these variations can be understood in light of what has already been said about chemistry chemicals that cause interference. There is minimal question that the ozone's' inclination These variations occur when the urine sugars combine to produce crystal mixes statements. It is also possible to obtain variable crystalline shapes with mixed crystal types. When looking at mixed sugar aqueous solutions. From an aquatic Mixture with lactose and glucose Sometimes, nothing occurs but standard glucosazone is produced [35].

Significance: After the overnight fast, the blood sugar is measured and the urine is checked in the morning. Following the immediate administration of 100 grams of glucose in a lemonade, the blood sugar is measured and the urine is checked for sugar for the next 45, 60, and 72 hours.

The blood sugar level rises quickly in normal people in response to this test, rarely rising above 0 to 14 percent. The high point is usually achieved at the end of one-half hour and the original fasting level after an hour or an hour and a half. There is no sweetness in the urination[36] .

C. Albumin

The primary objective of this study is to ascertain if blood-albumin goes through the kidney unchanged or whether there is a difference between blood- and urine-albumin. Generally, albuminuria is associated with a decrease in the quantity of albumin in the blood[37] .

Significance**:** to albumin alone, there is a high excess mortality point between the ages of 35 and 44, and beyond that age, the excess mortality declines. During the earliest age range, which was 15 to 24, only individuals with a very slight albumin trace and casts had a favourable mortality rate. Age-related increases in albumin levels are associated with a higher prevalence of heart disease, which is particularly severe in older adults[38] .

D. Proteins

It is obvious that modest amounts of a wide variety of proteins are present in normal urine. Since most of them are immunochemically and electrophoretically identical to the plasma protein fractions, they most likely originate from blood. Others, the most prevalent of which is likely the mucoprotein reported by Tamm and Horsfall, have not been detected in plasma and hence most likely originate from the urinary tract[39] . Significance: a collection of protein fractions that have most likely filtered out of the blood through the glomeruli due to their apparent similarity to the corresponding plasma protein fractions.

It was discovered that the mucoprotein reported by Tamm and Horsfall belongs to a smaller group of urinary tract proteins that are not visible in blood and are most likely produced by the urinary system[39] .

E. Ketone Group

Ketone bodies (acetoacetic acid, acetone, and 3-hydroxybutyric acid) are by-products of fat catabolism. When dieting, they are created in overabundance. Individuals or those with higher calorie metabolism than they eat, and they are insulin-dependent individuals with diabetes, whose liver metabolic pathways are turned on.

Fatty acid metabolism under such conditions is enhanced, resulting in higher concentrations of plasma's ketone bodies, which are later eliminated in urine[40] .

Ketone Group: The addition of ketones to glucose changes mitochondrial metabolism profoundly. A physiological level of ketone bodies oxidizes the co-enzyme Q pair, decreases the mitochondrial NAD couple, and raises the 1G 0 of ATP when added to glucose. Enhances the efficiency of metabolism through hydrolysis[41] .

VI. INTRODUCTION OF LIGHT MICROSCOPE

The earliest compound microscopes were created in the 17th century, however the history of microscopy began with the invention of basic magnifying glasses in the 13th century. Antoine von Leeuwenhoek is credited with being the first microbiologist and microscopist to create one of the early compound microscopes, which allowed for the observation of microorganisms that are invisible to the unaided eye. These microscopes already reflected the structure and architecture of the modern microscope, which hasn't changed since then. Despite their apparent simplicity, these compound microscopes had nearly all of the modern microscope's components, which were cutting edge for the time[42] .

Modern microscopes have undergone a revolution thanks to the integration of these technologies. The conceptual understanding of optical physics and photochemistry has advanced tremendously in tandem to technological advancements, resulting in a radical shift in our understanding of light and its interaction with materials. The wave/particle duality of light, which was proposed in the early 20th century, is the most well-known advancement. The creation of contemporary light sensors which are necessary for the construction of extremely sensitive photomultiplier tubes and CCD cameras was prompted by the realization of this duality. These conceptual and technological developments culminate in the creation of super-resolution microscopes that surpass the unbreakable diffraction barrier. We go over the optical parts of a contemporary light microscope in this chapter[42] .

In many of its configurations, the light microscope is a somewhat sophisticated instrument with a large number of changeable parts. For high-quality images, alignment is crucial, particularly in quantitative research. It will attempt to offer a few easy rules for the best possible alignment of all those light components. Microscope with centering and focusing capabilities. A deeper comprehension of the way in which these elements work and how their manipulation affects the image intensify in importance for electronic imaging [43] .

A. Components Of Microscope

1) Light Source

The effective production of light, which is necessary for the excitation of fluorophores, is the first step in the fluorescence process. Light sources are therefore an essential part of a fluorescence microscope. Selecting the appropriate lighting instrument can enhance not only the caliber of test outcomes but also the financial and ecological impact of the microscope. Solid-state light-emitting diodes (LEDs) have emerged as the preferred light source for new fluorescence microscopy systems, despite the fact that arc lamps have traditionally shown to be a dependable light source for widefield fluorescence microscopy[44].

2) Diffusers And Filters

Large amounts of light from tungsten or halogen lamps are infrared in nature. A microscope's parts and components may heat up and eventually become damaged if they are exposed to such light without any protection. Heat-absorbing filters, which stop infrared radiation from entering the optical system, are typically found in the lamp house in order to prevent this. Special Pyrex glass, typically blue or blue-green in colour, makes up the heat-absorbing filters[42] .

3) Field Diaphragm

It specifies the circular field that is lighted and helps with illumination focus and centering when it is imaged into the specimen plane by the condenser (transmitted light) or the objective (incident light) and epifluorescence[43] .

4) Condenser

An essential precondition for successful imaging is the efficient and uniform lighting of the samples. The condenser, also known as a substage condenser, is a simple or complex lens system that focuses light rays from the illuminator onto a single point of focus on the specimen. This creates uniform lighting throughout the entire field of view, which is necessary to get the best resolution and contrast[42].

5) Aperture Diaphragm

The aperture diaphragm, which is often integrated into the condenser and placed at the front focal plane, regulates the illuminating colour light and hence affects resolution, contrast, and depth of focus. The diaphragm closure serves as the source in the epi light route and is optically conjugate to the objective's exit (entry) pupil in incoming light illumination. It can also be used to attenuate light in fluorescence[43] .

6) Specimen Stage

As the light from the condenser enters the specimen, it reacts with it to create the generation contrast that is required for sample observation. Consequently, the quality of photomicrographs is largely determined by the specimens, and a crucial part of microscopy is preparing the specimens. The prepared specimens' quality cannot be superior to the quality of the photographs[42] .

7) Objectives

The most important element for a high-quality image is this one. Not only do its characteristics and level of optical correction play a major role in determining the magnification ratio, but they also play a significant role in determining resolution, contrast, brightness, spectrum throughput, depth of focus, sharpness from center to edge, and colour rendition. Achromats and Planapochromats to a wide range of extremely specialized lenses the microscope objective must be carefully chosen based on application and budget. But remember that an objective can only be achieved to its fullest potential if all other factors are in perfect harmony[43] .

VII. INTRODUCTION TO SEMI AUTO ANALYZER

At the core of the extraction and information search problems is automatic natural language processing. It appears clear that increased language comprehension will be necessary for future advancement. The status of research now is far from this understanding, and there are numerous challenges at every stage of the writing analysis process. The issues may be pragmatic, syntactic, semantic, or morphological. In order for the computer to comprehend the texts and do the several duties of classification, search, and filtering for documents, it becomes necessary to represent the texts in a practical manner. To do that, a variety of disciplines, including information retrieval, artificial intelligence, and natural language processing, may be interested in this issue. The analyzer Is devoted to information study, beginning with the mono-domain textual corpus. Its foundation is an algorithm that brings the research on intents and its working principle closer to a domain specialist. A knowledge base is used by the system to represent an author's ability to clarify his objectives. During the initial stage, human domain experts manually recognize the set of intentions in a corpus of text, enriching the knowledge base[45] .

A. Test Perform using Semi auto Analyzer

1) Estimation of urea by urease method (semiauto Analyzer)
2) Estimation of urea by full automatic analyzer(kinetic Ureases and glutamate dehydrogenase method)
3) Estimation of total cholesterol by semiauto analyzer (cholesterol oxidase and peroxidase method)
4) Estimation of total cholesterol by full automatic analyzer (cholesterol oxidase and peroxidase method)
5) Estimation of triacylglycerol by semiauto analyzer (enzymatic glycerol phosphate oxidase and peroxidase method) estimation of triacylglycerol by fully automatic analyzer(enzymatic glycerol phosphate oxidase and peroxidase: GPO POD method)
6) Estimation of SGOT by semiauto analyzer (International Federation of Clinical Chemistry [IFCC] kinetic method)
7) Estimation of SGOT by fully automatic analyzer (IFCC kinetic method)
8) Estimation of SGPT by semiauto analyzer (IFCC kinetic method)
9) Estimation of SGPT by fully automatic analyzer (IFCC kinetic method without pyridoxal phosphate)[46] .

B. Analysis of Normal and Abnormal Constituent of Blood and Urine

Haematological value: The standard method was used to calculate the hemoglobin and volume coefficients, and the average coefficients for the subject's age and sex were used to compute the colour, saturation, and volume indices. skeletal hemoglobin, corpuscular volume, and corpuscular hemoglobin concentration were calculated using the Wintrobe method. The average of two counts of 100 cells is represented by the differential cell counts. Every one chesked against the other. The thin ends of blood were used to make them. Wright's stain-stained smears, phosphate buffer solution with a using pn of 6.4 in place of water[47] .

Thyroid Function Test: The selection of primary thyroid function tests is contingent upon regional agreements and laboratory procedures. For initial screening, many labs utilize a very sensitive TSH test (second or third generation, with a limit of detection

<0·1 mU/L)1 alone. This is acceptable as long as its limitations are understood. At a higher expense, the sensitive TSH test can be paired with a single measurement of total or free thyroid hormone concentrations to resolve these limitations. However, using a T3 or T4 estimate alone as a first screening is not recommended as it will overlook subclinical thyroid problems[48] .

Glucose: The most significant substrate for the synthesis of energy during the prenatal, neonatal, and postnatal stages is blood glucose. Normal fasting blood glucose concentrations are maintained within a limited physiological range of 3.5-5.5 mmol/L, with the exception of the first few days of birth. Blood glucose concentrations may "flicker" on continuous glucose monitoring devices. Either of these two values, particularly after a meal, but then quickly and uncontrollably revert to fall inside this typical range[49].

Creatine: The system of creatine (Cr) and phosphocreatine (PCr) is crucial for the transfer and storage of energy. In addition to the cytosolic and mitochondrial creatine kinase (CK) system acting as a transporter of high-energy phosphates, the synthesis and movement of Cr are essential components of biological energy metabolism. Significant progress has been made in the past several years toward a deeper comprehension of the pathophysiological consequences of altered cell energy balance in humans[50].

Creatinine: The breakdown of creatine and phosphocreatine yields creatinine, another NPN waste product that can be used as a renal function indicator. The amino acids arginine, glycine, and methionine are transaminated to produce creatine in the liver, pancreas, and kidneys. After then, creatine circulates throughout the body and is phosphorylated in the brain and skeletal muscle to become phosphocreatine. Muscle produces the majority of the creatinine. Therefore, the patient's muscle mass affects the plasma creatinine concentration. Creatinine is a better measure of renal function and is less influenced by diet than BUN[51] .

Cholesterol: The waxy chemical known as cholesterol is produced by animal liver and is also consumed through animal-based foods such meat, poultry, fish, and dairy products. The body needs cholesterol as a lipid in particular membranes, to build cell membranes, to insulate nerves, and to manufacture certain hormones. But since the body produces enough cholesterol on its own, no dietary cholesterol is required[53] .

Alkaline Phosphate: A class of isoenzymes called alkaline phosphatases (ALPs) is found on the cell membrane's outer layer. In the extracellular area, they catalyze the hydrolysis of organic phosphate esters. This enzyme requires zinc and magnesium as necessary cofactors. Because ALPs may catalyze the same reaction, they are categorized as real isoenzymes despite having different physiochemical properties and a diverse tissue distribution[52].

Acidic Phosphate: An enzyme found in many lysosomes, acid phosphatase hydrolyzes organic phosphates at an acid pH. The cellular components of bone, spleen, kidney, liver, intestine, and blood also contain acid phosphatase, despite the postpubertal prostatic epithelial cell having a notably high quantity of this enzyme[54] .

Bilirubin**:** When diluted with alkali, bilirubin in serum or plasma forms a direct bond with diazotized sulfonic acid. A promoting agent is required for its coupling in serum solutions that are neutral or acidic. It is necessary to release bilirubin from its albumin binding and make it soluble. Alcohols presumably accomplish this by first rupturing the salt bonds, whereas compounds that resemble benzoates produce a displacement effect[55]

SGOT/SGPT**:** The first thing to do when presented with an aberrant SGOT on a screening panel is to retake the test, if at all possible, using the particular NAD-linked technique. The repeat value will most likely be normal. Elking and Kabat provided a list of 34 medications they believe can artificially raise SGOT test results. When the SGOT is tested using the colorimetric method in patients receiving erythromycin or para-aminosalicylic acid, some observers have reported erroneous elevations[56] .

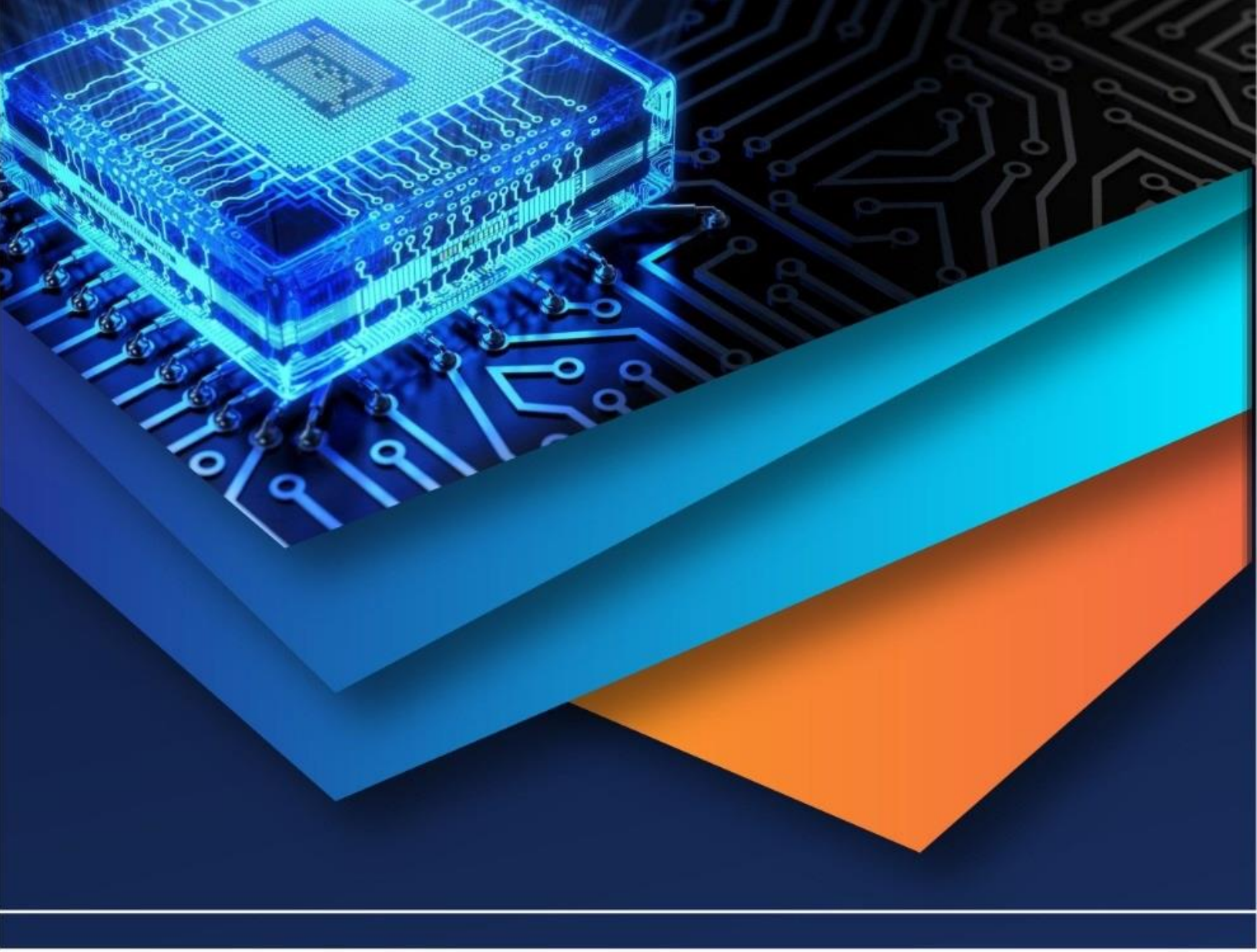
Diastase And Lipase: It has long been known that the body's blood and extracts from numerous organs and viscera have the ability to split starch. We have difficulty comprehending the physiological function of this ferment or the nature of the mechanism regulating its activity.

The previous scientists, including Doyon, Morel, and Arthus, believed that blood is not lipolytic under normal circumstances. This is evident when we look at the fat-splitting enzyme. The former proposed keeping the generic name "esterase," which is frequently used synonymously, for the entire group and referring to the ferment that is especially active on oils as "lipase" [57] .

REFERENCES

[1] Basu, D., & Kulkarni, R. (2014). Overview of blood components and their preparation. Indian journal of anaesthesia, 58(5), 529-537.
[2] Shaz, B. H., & Hillyer, C. D. (Eds.). (2013). Transfusion medicine and hemostasis: clinical and laboratory aspects. Newnes.
[3] Kuper, M., & Soni, N. (2006). Fluids and electrolytes. Anaesthesia Science, 198-220. Fluids and electrolytes.
[4] Hemalatha, T., UmaMaheswari, T., Krithiga, G., Sankaranarayanan, P., & Puvanakrishnan, R. (2013). Enzymes in clinical medicine: an overview. Indian Journal of Experimental Biology Vol. 51, October 2013, pp. 777-788
[5] Bhatia, S., & Bhatia, S. (2018). Introduction to enzymes and their applications. Introduction to pharmaceutical biotechnology, 2, 1-29.
[6] Webster, N., & Galley, H. F. (Eds.). (2008). Anaesthesia science. John Wiley & Sons. Books.google.com
[7] Thier, S. O. (1986). Potassium physiology. The American journal of medicine, 80(4), 3-7.

[8] Groeneweg, S., van Geest, F. S., Peeters, R. P., Heuer, H., & Visser, W. E. (2020). Thyroid hormone transporters. Endocrine reviews, 41(2), 146-201.
[9] Zhang, J., & Lazar, M. A. (2000). The mechanism of action of thyroid hormones. Annual review of physiology, 62(1), 439-466.
[10] Qaid, M. M., & Abdelrahman, M. M. (2016). Role of insulin and other related hormones in energy metabolism—A review. Cogent Food & Agriculture, 2(1), 1267691.
[11] Caraceni, P., Tufoni, M., & Bonavita, M. E. (2013). Clinical use of albumin. Blood transfusion, 11(Suppl 4), s18.
[12] Edsall, J. T. (1947). The plasma proteins and their fractionation. In Advances in protein chemistry (Vol. 3, pp. 383-479a). Academic Press.
[13] De Oliveira, S., & Saldanha, C. (2010). An overview about erythrocyte membrane. Clinical hemorheology and microcirculation, 44(1), 63-74. DOI 10.3233/CH-2010-1253
[14] Baskurt, O. K., & Meiselman, H. J. (2013). Erythrocyte aggregation: basic aspects and clinical importance. Clinical hemorheology and microcirculation, 53(1-2), 23-37.
[15] Schnog, J. B., Duits, A. J., Muskiet, F. A., Ten Cate, H., Rojer, R. A., & Brandjes, D. P. (2004). Sickle cell disease; a general overview. Neth J Med, 62(10), 364-74.
[16] CROSBY, W. H. (1952). Analytical Review: The Pathogenesis of Spherocytes and Leptocytes (Target Cells). Blood, 7(2), 261-274.
[17] Bessis, M., & Bessis, M. (1974). Elliptocytes. Corpuscles: Atlas of Red Blood Cell Shapes, 71-78.
[18] Koepke, J. F., & Koepke, J. A. (1986). Reticulocytes. Clinical & Laboratory Haematology, 8(3), 169-179.
[19] Seno, S. (1964). Mechanisms for the Induction of Anisocytosis. Acta Haematologica, 31(3), 129-136.
[20] Uthman, E. (2009). Understanding anemia. Univ. Press of Mississippi E Uthman – 2009 – books.google.com
[21] Clark, S. F. (2008). Iron deficiency anemia. Nutrition in clinical practice, 23(2), 128-141.
[22] Bhadra, P., & Deb, A. (2020). A review on nutritional anemia. Indian Journal of Natural Sciences, 10(59), 18466-18474.
[23] Fraenkel, P. G. (2015). Understanding anemia of chronic disease. Hematology 2014, the American Society of Hematology Education Program Book, 2015(1), 14-18.
[24] Young, N. S. (2018). Aplastic anemia. New England Journal of Medicine, 379(17), 1643-1656.
[25] Dhaliwal, G., Cornett, P. A., & Tierney Jr, L. M. (2004). Hemolytic anemia. American family physician, 69(11), 2599-2607.
[26] Tvedten, H., & Raskin, R. E. (2012). Leukocyte disorders. Small animal clinical diagnosis by laboratory methods, 63.
[27] Hawkins, S. F., Thachil, J., & Hill, Q. A. (2014). Leukopenia. Haematology in Critical Care: A Practical Handbook, 9-11.
[28] Davis, A. S., Viera, A. J., & Mead, M. D. (2014). Leukemia: an overview for primary care. American family physician, 89(9), 731-738.
[29] Lewis, W. D., Lilly, S., & Jones, K. L. (2020). Lymphoma: diagnosis and treatment. American family physician, 101(1), 34-41.
[30] Cuthrell, K. M., Tzenios, N., & Umber, J. (2022). Burden of Autoimmune Disorders; a review. Asian Journal of Immunology, 6(3), 1-3.
[31] Orakpoghenor, O., Avazi, D. O., Markus, T. P., & Olaolu, O. S. (2019). Lymphocytes: a brief review. SCIRES Lit, 3(1), 005-8.
[32] Jurk, K., & Kehrel, B. E. (2005, August). Platelets: physiology and biochemistry. In Seminars in thrombosis and hemostasis (Vol. 31, No. 04, pp. 381-392). Copyright© 2005 by Thieme Medical Publishers, Inc., 333 Seventh Avenue, New York, NY 10001, USA..
[33] Gadeholt, H. (1968). Persistence of blood cells in urine. Acta Medica Scandinavica, 183(1-6), 49-54. Parker, G. E. (1936). The Significance of Small Traces of Blood in the Urine. Postgraduate Medical Journal, 12(133), 445.
[34] Hassan, A. (1928). Glucose in normal urine. Biochemical Journal, 22(5), 1332.From the Physiology Department, Faculty of Medicine, Cairo, Egypt. (Received July 13th, 1928.)
[35] Hamman, L. (1919). The Practical Significance of a Small Amount of Sugar in Urine. Canadian Medical Association Journal, 9(11), 961.
[36] Hewitt, L. F. (1927). Identity of urinary albumin. Biochemical Journal, 21(5), 1109.
[37] DUBLIN, L. I. (1921). The significance of albumin and of albumin with casts in the urine. American Journal of Epidemiology, 1(3), 301-310.
[38] Grant, G. H., & Everall, P. H. (1957). The proteins of normal urine. Journal of clinical pathology, 10(4), 360.
[39] Kundu, S. K., & Judilla, A. M. (1991). Novel solid-phase assay of ketone bodies in urine. Clinical chemistry, 37(9), 1565- 1569.
[40] Veech, R. L., Chance, B., Kashiwaya, Y., Lardy, H. A., & Cahill Jr, G. F. (2001). Ketone bodies, potential therapeutic uses. IUBMB life, 51(4), 241-247.
[41] Pirozzi, M., & Parashuraman, S. (2022). Optical Components of a Light Microscope. In Forensic Microscopy (pp. 19-40). CRC Press.
[42] Keller, H. E. (2003). Proper alignment of the microscope. Methods in Cell Biology, 72, 45-55.
[43] Mubaid, F., Kaufman, D., Wee, T. L., Nguyen-Huu, D. S., Young, D., Anghelopoulou, M., & Brown, C. M. (2019).
[44] Fluorescence microscope light source stability. Histochemistry and cell biology, 151(4), 357-366.
[45] Hassan, K., Ali, E., Chantal, S. D., & Said, T. (2008). Semi-Automatic Analyzer to Detect Authorial Intentions in Scientific Documents. International Journal of Computer Science, 3(1).
[46] Kumari, S., Bahinipati, J., Pradhan, T., & Sahoo, D. P. (2020). Comparison of test performance of biochemical parameters in semiautomatic method and fully automatic analyzer method. Journal of Family Medicine and Primary Care, 9(8), 3994-4000.
[47] Osgood, E. E. (1935). Normal Hematologic Standards. EE Osgood 1935 – cabidigitallibrary.org
[48] Dayan, C. M. (2001). Interpretation of thyroid function tests. The Lancet, 357(9256), 619-624.
[49] Güemes, M., Rahman, S. A., & Hussain, K. (2016). What is a normal blood glucose?. Archives of disease in childhood, 101(6), 569-574.
[50] Schulze, A. (2003). Creatine deficiency syndromes. Guanidino Compounds in Biology and Medicine, 143-150.
[51] Salazar, J. H. (2014). Overview of urea and creatinine. Laboratory medicine, 45(1), e19-e20.
[52] Lowe, Dhruv, Terrence Sanvictores, Muhammad Zubair, and Savio John. “Alkaline phosphatase.” StatPearls (2023).
[53] Ma, Hongbao, and Kuan-Jiunn Shieh. “Cholesterol and human health.” The Journal of American Science 2, no. 1 (2006): 46-50.
[54] Henneberry, Michael O., Geoffrey Engel, and John T. Grayhack. “Acid phosphatase.” Urologic Clinics of North America 6, no. 3 (1979): 629-641.
[55] Watson, D. (1961). Analytic methods for bilirubin in blood plasma. Clinical Chemistry, 7(6), 603-625.
[56] Babb, R. R. (1973). The clinical significance of the SGOT test. California Medicine, 118(5), 89. Ncbi.nlm.nih.gov
[57] Wapshaw, H. (1948). Blood diastase and lipase changes in acute pancreatitis. British Medical Journal, 2(4566), 68.



10.22214/IJRASET

45.98

IMPACT FACTOR: 7.129

IMPACT FACTOR: 7.429

INTERNATIONAL JOURNAL FOR RESEARCH

IN APPLIED SCIENCE & ENGINEERING TECHNOLOGY