

DIAGNOSTIC REPORTPatient Ref. No. **66600003635303****CLIENT CODE :** CA00010147 - MEDIWHEEL
CLIENT'S NAME AND ADDRESS: MEDIWHEEL ARCOFEMI HEALTHCARE LIMITEDMEDIWHEEL ARCOFEMI HEALTHCARE LIMITED
F701A, LADO SARAI, NEW DELHI,
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Cert. No. MC-2812

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ASTER SQUARE BUILDING, ULLOOR,
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KERALA, INDIA
Tel : 93334 93334, Fax : CIN - U85190MH2006PTC
Email : customercare.ddrc@srl.in**PATIENT NAME :** MRS GEETHU MOHAN**PATIENT ID :** MRSGF0603934182**ACCESSION NO :** 4182WC002103 **AGE :** 30 Years **SEX :** Female**ABHA NO :****DRAWN :****RECEIVED :** 06/03/2023 08:07**REPORTED :** 07/03/2023 14:03**REFERRING DOCTOR :** SELF**CLIENT PATIENT ID :**

Test Report Status	Preliminary	Results	Biological Reference Interval	Units
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MEDIWHEEL HEALTH CHECKUP BELOW 40(F)TMT*** TREADMILL TEST**

TREADMILL TEST

REPORT GIVEN

*** OPHTHAL**

OPHTHAL

REPORT GIVEN

*** PHYSICAL EXAMINATION**

PHYSICAL EXAMINATION

REPORT GIVEN



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MEDIWHEEL HEALTH CHECKUP BELOW 40(F)TMT

BLOOD UREA NITROGEN (BUN), SERUM

BLOOD UREA NITROGEN 9 Adult(<60 yrs) : 6 to 20 mg/dL
BUN/CREAT RATIO

BUN/CREAT RATIO 13.2

CREATININE, SERUM

CREATININE 0.68 18 - 60 yrs : 0.6 - 1.1 mg/dL

GLUCOSE, POST-PRANDIAL, PLASMA

GLUCOSE, POST-PRANDIAL, PLASMA 94 Diabetes Mellitus : > or = 200. mg/dL
 Impaired Glucose tolerance/
 Prediabetes : 140 - 199.
 Hypoglycemia : < 55.

GLUCOSE FASTING, FLUORIDE PLASMA

GLUCOSE, FASTING, PLASMA 92 Diabetes Mellitus : > or = 126. mg/dL
 Impaired fasting Glucose/
 Prediabetes : 101 - 125.
 Hypoglycemia : < 55.

GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

GLYCOSYLATED HEMOGLOBIN (HBA1C) 4.8 Normal : 4.0 - 5.6%. %
 Non-diabetic level : < 5.7%.
 Diabetic : >6.5%

Glycemic control goal
 More stringent goal : < 6.5 %.
 General goal : < 7%.
 Less stringent goal : < 8%.

Glycemic targets in CKD :-
 If eGFR > 60 : < 7%.
 If eGFR < 60 : 7 - 8.5%.

MEAN PLASMA GLUCOSE 91.1 < 116.0 mg/dL

LIPID PROFILE, SERUM

CHOLESTEROL 202 Desirable : < 200 mg/dL
 Borderline : 200-239
 High : >or= 240



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TRIGLYCERIDES		94	mg/dL
		Normal : < 150 High : 150-199 Hypertriglyceridemia : 200-499 Very High : > 499	
HDL CHOLESTEROL		51	mg/dL
DIRECT LDL CHOLESTEROL		142	mg/dL
		Optimum : < 100 Above Optimum : 100-139 Borderline High : 130-159 High : 160-189 Very High : > or = 190	
NON HDL CHOLESTEROL		151	mg/dL
		High Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	
VERY LOW DENSITY LIPOPROTEIN		18.8	mg/dL
		Desirable value : 10 - 35	
CHOL/HDL RATIO		4.0	
		3.3-4.4 Low Risk 4.5-7.0 Average Risk 7.1-11.0 Moderate Risk > 11.0 High Risk	
LDL/HDL RATIO		2.8	
		0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	





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Interpretation(s)

- 1) Cholesterol levels help assess the patient risk status and to follow the progress of patient under treatment to lower serum cholesterol concentrations.
- 2) Serum Triglyceride (TG) are a type of fat and a major source of energy for the body. Both quantity and composition of the diet impact on plasma triglyceride concentrations. Elevations in TG levels are the result of overproduction and impaired clearance. High TG are associated with increased risk for CAD (Coronary artery disease) in patients with other risk factors, such as low HDL-C, some patient groups with elevated apolipoprotein B concentrations, and patients with forms of LDL that may be particularly atherogenic.
- 3) HDL-C plays a crucial role in the initial step of reverse cholesterol transport, this considered to be the primary atheroprotective function of HDL
- 4) LDL -C plays a key role in causing and influencing the progression of atherosclerosis and, in particular, coronary sclerosis. The majority of cholesterol stored in atherosclerotic plaques originates from LDL, thus LDL-C value is the most powerful clinical predictor.
- 5) Non HDL cholesterol: Non-HDL-C measures the cholesterol content of all atherogenic lipoproteins, including LDL hence it is a better marker of risk in both primary and secondary prevention studies. Non-HDL-C also covers, to some extent, the excess ASCVD risk imparted by the sdLDL, which is significantly more atherogenic than the normal large buoyant particles, an elevated non-HDL-C indirectly suggests greater proportion of the small, dense variety of LDL particles

Serum lipid profile is measured for cardiovascular risk prediction. Lipid Association of India recommends LDL-C as primary target and Non HDL-C as co-primary treatment target.

Risk Stratification for ASCVD (Atherosclerotic cardiovascular disease) by Lipid Association of India

Risk Category	
Extreme risk group	A. CAD with > 1 feature of high risk group B. CAD with > 1 feature of Very high risk group or recurrent ACS (within 1 year) despite LDL-C < or = 50 mg/dl or polyvascular disease
Very High Risk	1. Established ASCVD 2. Diabetes with 2 major risk factors or evidence of end organ damage 3. Familial Homozygous Hypercholesterolemia
High Risk	1. Three major ASCVD risk factors. 2. Diabetes with 1 major risk factor or no evidence of end organ damage. 3. CKD stage 3B or 4. 4. LDL >190 mg/dl 5. Extreme of a single risk factor. 6. Coronary Artery Calcium - CAC >300 AU. 7. Lipoprotein a >= 50mg/dl 8. Non stenotic carotid plaque
Moderate Risk	2 major ASCVD risk factors
Low Risk	0-1 major ASCVD risk factors
Major ASCVD (Atherosclerotic cardiovascular disease) Risk Factors	
1. Age > or = 45 years in males and > or = 55 years in females	3. Current Cigarette smoking or tobacco use
2. Family history of premature ASCVD	4. High blood pressure
5. Low HDL	

Newer treatment goals and statin initiation thresholds based on the risk categories proposed by LAI in 2020.

Risk Group	Treatment Goals	Consider Drug Therapy
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	LDL-C (mg/dl)	Non-HDL (mg/dl)	LDL-C (mg/dl)	Non-HDL (mg/dl)
Extreme Risk Group Category A	<50 (Optional goal < OR = 30)	< 80 (Optional goal <OR = 60)	>OR = 50	>OR = 80
Extreme Risk Group Category B	<OR = 30	<OR = 60	> 30	>60
Very High Risk	<50	<80	>OR= 50	>OR= 80
High Risk	<70	<100	>OR= 70	>OR= 100
Moderate Risk	<100	<130	>OR= 100	>OR= 130
Low Risk	<100	<130	>OR= 130*	>OR= 160

*After an adequate non-pharmacological intervention for at least 3 months.

References: Management of Dyslipidaemia for the Prevention of Stroke: Clinical Practice Recommendations from the Lipid Association of India. Current Vascular Pharmacology, 2022, 20, 134-155.

LIVER FUNCTION TEST WITH GGT

BILIRUBIN, TOTAL	0.65	General Range : < 1.1	mg/dL
BILIRUBIN, DIRECT	0.22	General Range : < 0.3	mg/dL
BILIRUBIN, INDIRECT	0.43	0.00 - 0.60	mg/dL
TOTAL PROTEIN	7.2	Ambulatory : 6.4 - 8.3 Recumbant : 6 - 7.8	g/dL
ALBUMIN	4.6	20-60yrs : 3.5 - 5.2	g/dL
GLOBULIN	2.6	2.0 - 4.0 Neonates - Pre Mature: 0.29 - 1.04	g/dL
ALBUMIN/GLOBULIN RATIO	1.8	1.0 - 2.0	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	16	Adults : < 33	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)	14	Adults : < 34	U/L
ALKALINE PHOSPHATASE	59	Adult (<60yrs) : 35 - 105	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)	14	Adult (female) : < 40	U/L
TOTAL PROTEIN, SERUM			
TOTAL PROTEIN	7.2	Ambulatory : 6.4 - 8.3 Recumbant : 6 - 7.8	g/dL
URIC ACID, SERUM			
URIC ACID	4.3	Adults : 2.4-5.7	mg/dL

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD



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ABO GROUP		TYPE B	
RH TYPE		NEGATIVE	
METHOD : COLUMN AGGLUTINATION TECHNOLOGY			
BLOOD COUNTS,EDTA WHOLE BLOOD			
HEMOGLOBIN		13.5	12.0 - 15.0 g/dL
METHOD : SPECTROPHOTOMETRIC			
RED BLOOD CELL COUNT		4.15	3.8 - 4.8 mil/ μ L
METHOD : IMPEDANCE VARIATION			
WHITE BLOOD CELL COUNT		8.42	4.0 - 10.0 thou/ μ L
PLATELET COUNT		233	150 - 410 thou/ μ L
METHOD : IMPEDANCE VARIATION			
RBC AND PLATELET INDICES			
HEMATOCRIT		40.2	36 - 46 %
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR VOL		96.7	83 - 101 fL
MEAN CORPUSCULAR HGB.		32.5	High 27.0 - 32.0 pg
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION		33.6	31.5 - 34.5 g/dL
RED CELL DISTRIBUTION WIDTH		13.6	11.6 - 14.0 %
MENTZER INDEX		23.3	
MEAN PLATELET VOLUME		7.4	6.8 - 10.9 fL
WBC DIFFERENTIAL COUNT			
SEGMENTED NEUTROPHILS		59	40 - 80 %
LYMPHOCYTES		31	20 - 40 %
MONOCYTES		8	2 - 10 %
EOSINOPHILS		2	1 - 6 %
BASOPHILS		0	0 - 2 %
ABSOLUTE NEUTROPHIL COUNT		4.97	2.0 - 7.0 thou/ μ L
ABSOLUTE LYMPHOCYTE COUNT		2.61	1 - 3 thou/ μ L
ABSOLUTE MONOCYTE COUNT		0.67	0.20 - 1.00 thou/ μ L
ABSOLUTE EOSINOPHIL COUNT		0.17	0.02 - 0.50 thou/ μ L
ABSOLUTE BASOPHIL COUNT		0.0	thou/ μ L
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		1.9	



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ABHA NO :

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ERYTHROCYTE SEDIMENTATION RATE (ESR), WHOLE BLOOD

SEDIMENTATION RATE (ESR)	15	0 - 20	mm at 1 hr
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SUGAR URINE - POST PRANDIAL

SUGAR URINE - POST PRANDIAL	NOT DETECTED	NOT DETECTED	
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THYROID PANEL, SERUM

T3	107.90	80 - 200	ng/dL
T4	8.65	5.1 - 14.1	µg/dl
TSH 3RD GENERATION	2.070	Non-Pregnant : 0.4-4.2	µIU/mL

Pregnant Trimester-wise :

1st : 0.1 - 2.5

2nd : 0.2 - 3

3rd : 0.3 - 3



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Interpretation(s)

Triiodothyronine T3 , Thyroxine T4, and Thyroid Stimulating Hormone TSH are thyroid hormones which affect almost every physiological process in the body, including growth, development, metabolism, body temperature, and heart rate. Production of T3 and its prohormone thyroxine (T4) is activated by thyroid-stimulating hormone (TSH), which is released from the pituitary gland. Elevated concentrations of T3, and T4 in the blood inhibit the production of TSH. Excessive secretion of thyroxine in the body is hyperthyroidism, and deficient secretion is called hypothyroidism. In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hyperthyroidism, TSH levels are low. Below mentioned are the guidelines for Pregnancy related reference ranges for Total T4, TSH & Total T3. Measurement of the serum TT3 level is a more sensitive test for the diagnosis of hyperthyroidism, and measurement of TT4 is more useful in the diagnosis of hypothyroidism. Most of the thyroid hormone in blood is bound to transport proteins. Only a very small fraction of the circulating hormone is free and biologically active. It is advisable to detect Free T3, FreeT4 along with TSH, instead of testing for albumin bound Total T3, Total T4.

Sr. No.	TSH	Total T4	FT4	Total T3	Possible Conditions
1	High	Low	Low	Low	(1) Primary Hypothyroidism (2) Chronic autoimmune Thyroiditis (3) Post Thyroidectomy (4) Post Radio-Iodine treatment
2	High	Normal	Normal	Normal	(1)Subclinical Hypothyroidism (2) Patient with insufficient thyroid hormone replacement therapy (3) In cases of Autoimmune/Hashimoto thyroiditis (4). Isolated increase in TSH levels can be due to Subclinical inflammation, drugs like amphetamines, Iodine containing drug and dopamine antagonist e.g. domperidone and other physiological reasons.
3	Normal/Low	Low	Low	Low	(1) Secondary and Tertiary Hypothyroidism
4	Low	High	High	High	(1) Primary Hyperthyroidism (Graves Disease) (2) Multinodular Goitre (3)Toxic Nodular Goitre (4) Thyroiditis (5) Over treatment of thyroid hormone (6) Drug effect e.g. Glucocorticoids, dopamine, T4 replacement therapy (7) First trimester of Pregnancy
5	Low	Normal	Normal	Normal	(1) Subclinical Hyperthyroidism
6	High	High	High	High	(1) TSH secreting pituitary adenoma (2) TRH secreting tumor
7	Low	Low	Low	Low	(1) Central Hypothyroidism (2) Euthyroid sick syndrome (3) Recent treatment for Hyperthyroidism
8	Normal/Low	Normal	Normal	High	(1) T3 thyrotoxicosis (2) Non-Thyroidal illness
9	Low	High	High	Normal	(1) T4 Ingestion (2) Thyroiditis (3) Interfering Anti TPO antibodies

REF: 1. TIETZ Fundamentals of Clinical chemistry 2.Guidlines of the American Thyroid association duriing pregnancy and Postpartum, 2011.
NOTE: It is advisable to detect Free T3,FreeT4 along with TSH, instead of testing for albumin bound Total T3, Total T4.TSH is not affected by variation in thyroid - binding protein. TSH has a diurnal rhythm, with peaks at 2:00 - 4:00 a.m. And troughs at 5:00 - 6:00 p.m. With ultradian variations.

PHYSICAL EXAMINATION, URINE

COLOR **AMBER**
APPEARANCE **CLEAR**

CHEMICAL EXAMINATION, URINE

PH **6.0** **4.7 - 7.5**



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SPECIFIC GRAVITY		1.031	1.003 - 1.035
PROTEIN		NEGATIVE	NOT DETECTED
GLUCOSE		NEGATIVE	NOT DETECTED
KETONES		NEGATIVE	NOT DETECTED
BLOOD		DETECTED (++) IN URINE	NOT DETECTED
BILIRUBIN		NEGATIVE	NOT DETECTED
UROBILINOGEN		NORMAL	NORMAL
METHOD : DIPSTICK			
NITRITE		NEGATIVE	NOT DETECTED
MICROSCOPIC EXAMINATION, URINE			
RED BLOOD CELLS		3 - 5	NOT DETECTED /HPF
WBC		0-1	0-5 /HPF
EPITHELIAL CELLS		3-5	0-5 /HPF
CASTS		NEGATIVE	
CRYSTALS		NEGATIVE	
REMARKS		NIL	
METHOD : AUTOMATED ANALYSER, MICROSCOPY			



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Interpretation(s)

The following table describes the probable conditions, in which the analytes are present in urine

Presence of	Conditions
Proteins	Inflammation or immune illnesses
Pus (White Blood Cells)	Urinary tract infection, urinary tract or kidney stone, tumors or any kind of kidney impairment
Glucose	Diabetes or kidney disease
Ketones	Diabetic ketoacidosis (DKA), starvation or thirst
Urobilinogen	Liver disease such as hepatitis or cirrhosis
Blood	Renal or genital disorders/trauma
Bilirubin	Liver disease
Erythrocytes	Urological diseases (e.g. kidney and bladder cancer, urolithiasis), urinary tract infection and glomerular diseases
Leukocytes	Urinary tract infection, glomerulonephritis, interstitial nephritis either acute or chronic, polycystic kidney disease, urolithiasis, contamination by genital secretions
Epithelial cells	Urolithiasis, bladder carcinoma or hydronephrosis, ureteric stents or bladder catheters for prolonged periods of time
Granular Casts	Low intratubular pH, high urine osmolality and sodium concentration, interaction with Bence-Jones protein
Hyaline casts	Physical stress, fever, dehydration, acute congestive heart failure, renal diseases
Calcium oxalate	Metabolic stone disease, primary or secondary hyperoxaluria, intravenous infusion of large doses of vitamin C, the use of vasodilator naftidrofuryl oxalate or the gastrointestinal lipase inhibitor orlistat, ingestion of ethylene glycol or of star fruit (Averrhoa carambola) or its juice
Uric acid	arthritis
Bacteria	Urinary infection when present in significant numbers & with pus cells.
Trichomonas vaginalis	Vaginitis, cervicitis or salpingitis

SUGAR URINE - FASTING

SUGAR URINE - FASTING	NOT DETECTED	NOT DETECTED
* PHYSICAL EXAMINATION, STOOL	RESULT PENDING	
CHEMICAL EXAMINATION, STOOL	RESULT PENDING	
MICROSCOPIC EXAMINATION, STOOL	RESULT PENDING	





CLIENT CODE : CA00010147 - MEDIWHEEL
CLIENT'S NAME AND ADDRESS: MEDIWHEEL HEALTHCARE LIMITED

MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED
 F701A, LADO SARAI, NEW DELHI,
 SOUTH DELHI, DELHI,
 SOUTH DELHI 110030
 DELHI INDIA
 8800465156



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 ASTER SQUARE BUILDING, ULLOOR,
 MEDICAL COLLEGE P.O
 TRIVANDRUM, 695011
 KERALA, INDIA
 Tel : 93334 93334, Fax : CIN - U85190MH2006PTC
 Email : customercare.ddrc@srl.in

PATIENT NAME : MRS GEETHU MOHAN **PATIENT ID :** MRSGF0603934182

ACCESSION NO : 4182WC002103 **AGE :** 30 Years **SEX :** Female **ABHA NO :**

DRAWN : **RECEIVED :** 06/03/2023 08:07 **REPORTED :** 07/03/2023 14:03

REFERRING DOCTOR : SELF **CLIENT PATIENT ID :**

Test Report Status	Preliminary	Results	Units
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Interpretation(s)

Stool routine analysis is only a screening test for disorders of gastrointestinal tract like infection, malabsorption, etc. The following table describes the probable conditions, in which the analytes are present in stool.

PRESENCE OF	CONDITION
Pus cells	Pus in the stool is an indication of infection
Red Blood cells	Parasitic or bacterial infection or an inflammatory bowel condition such as ulcerative colitis
Parasites	Infection of the digestive system. Stool examination for ova and parasite detects presence of parasitic infestation of gastrointestinal tract. Various forms of parasite that can be detected include cyst, trophozoite and larvae. One negative result does not rule out the possibility of parasitic infestation. Intermittent shedding of parasites warrants examinations of multiple specimens tested on consecutive days. Stool specimens for parasitic examination should be collected before initiation of anti-diarrheal therapy or antiparasitic therapy. This test does not detect presence of opportunistic parasites like Cyclospora, Cryptosporidia and Isospora species. Examination of Ova and Parasite has been carried out by direct and concentration techniques.
Mucus	Mucus is a protective layer that lubricates, protects & reduces damage due to bacteria or viruses.
Charcot-Leyden crystal	Parasitic diseases.
Ova & cyst	Ova & cyst indicate parasitic infestation of intestine.
Frank blood	Bleeding in the rectum or colon.
Occult blood	Occult blood indicates upper GI bleeding.
Macrophages	Macrophages in stool are an indication of infection as they are protective cells.
Epithelial cells	Epithelial cells that normally line the body surface and internal organs show up in stool when there is inflammation or infection.
Fat	Increased fat in stool maybe seen in conditions like diarrhoea or malabsorption.
pH	Normal stool pH is slightly acidic to neutral. Breast-fed babies generally have an acidic stool.

ADDITIONAL STOOL TESTS :

- Stool Culture:** - This test is done to find cause of GI infection, make decision about best treatment for GI infection & to find out if treatment for GI infection worked.
- Fecal Calprotectin:** It is a marker of intestinal inflammation. This test is done to differentiate Inflammatory Bowel Disease (IBD) from Irritable Bowel Syndrome (IBS).
- Fecal Occult Blood Test (FOBT):** This test is done to screen for colon cancer & to evaluate possible cause of unexplained anaemia.
- Clostridium Difficile Toxin Assay:** This test is strongly recommended in healthcare associated bloody or watery diarrhoea, due to overuse of broad spectrum antibiotics which alter the normal GI flora.
- Biofire (Film Array) GI PANEL:** In patients of Diarrhoea, Dysentery, Rice watery Stool, FDA approved, Biofire Film Array Test, (Real Time Multiplex PCR) is strongly recommended as it identifies organisms, bacteria, fungi, virus, parasite and other opportunistic pathogens, Vibrio cholera infections only in 3 hours. Sensitivity 96% & Specificity 99%.





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PATIENT NAME : MRS GEETHU MOHAN **PATIENT ID :** MRSGF0603934182

ACCESSION NO : 4182WC002103 **AGE :** 30 Years **SEX :** Female **ABHA NO :**

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Test Report Status	Preliminary	Results	Units
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6. **Rota Virus Immunoassay:** This test is recommended in severe gastroenteritis in infants & children associated with watery diarrhoea, vomiting & abdominal cramps. Adults are also affected. It is highly contagious in nature.

Interpretation(s)

BLOOD UREA NITROGEN (BUN), SERUM- Causes of Increased levels include Pre renal (High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal), Renal Failure, Post Renal (Malignancy, Nephrolithiasis, Prostatism)
 Causes of decreased level include Liver disease, SIADH.

CREATININE, SERUM- Higher than normal level may be due to:

- Blockage in the urinary tract
- Kidney problems, such as kidney damage or failure, infection, or reduced blood flow
- Loss of body fluid (dehydration)
- Muscle problems, such as breakdown of muscle fibers
- Problems during pregnancy, such as seizures (eclampsia)), or high blood pressure caused by pregnancy (preeclampsia)

Lower than normal level may be due to:

- Myasthenia Gravis
- Muscular dystrophy

GLUCOSE, POST-PRANDIAL, PLASMA- High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glycosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc. Additional test HbA1c

GLUCOSE FASTING, FLUORIDE PLASMA- TEST DESCRIPTION

Normally, the glucose concentration in extracellular fluid is closely regulated so that a source of energy is readily available to tissues and so that no glucose is excreted in the urine.

Increased in

Diabetes mellitus, Cushing's syndrome (10 - 15%), chronic pancreatitis (30%). Drugs: corticosteroids, phenytoin, estrogen, thiazides.

Decreased in

Pancreatic islet cell disease with increased insulin, insulinoma, adrenocortical insufficiency, hypopituitarism, diffuse liver disease, malignancy (adrenocortical, stomach, fibrosarcoma), infant of a diabetic mother, enzyme deficiency diseases (e.g., galactosemia), Drugs- insulin, ethanol, propranolol; sulfonylureas, tolbutamide, and other oral hypoglycemic agents.

NOTE: While random serum glucose levels correlate with home glucose monitoring results (weekly mean capillary glucose values), there is wide fluctuation within individuals. Thus, glycosylated hemoglobin (HbA1c) levels are favored to monitor glycemic control.

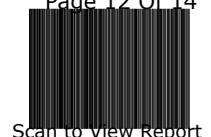
High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glycosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.

GLYCOSYLATED HEMOGLOBIN (HBA1C), EDTA WHOLE BLOOD- Used For

1. Evaluating the long-term control of blood glucose concentrations in diabetic patients.
2. Diagnosing diabetes.
3. Identifying patients at increased risk for diabetes (prediabetes).
 The ADA recommends measurement of HbA1c (typically 3-4 times per year for type 1 and poorly controlled type 2 diabetic patients, and 2 times per year for well-controlled type 2 diabetic patients) to determine whether a patient's metabolic control has remained continuously within the target range.
 1. eAG (Estimated average glucose) converts percentage HbA1c to mg/dl, to compare blood glucose levels.
 2. eAG gives an evaluation of blood glucose levels for the last couple of months.
 3. eAG is calculated as $eAG (mg/dl) = 28.7 * HbA1c - 46.7$

HbA1c Estimation can get affected due to :

- I. Shortened Erythrocyte survival: Any condition that shortens erythrocyte survival or decreases mean erythrocyte age (e.g. recovery from acute blood loss, hemolytic anemia) will falsely lower HbA1c test results. Fructosamine is recommended in these patients which indicates diabetes control over 15 days.
- II. Vitamin C & E are reported to falsely lower test results. (possibly by inhibiting glycation of hemoglobin).
- III. Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia, uremia, hyperbilirubinemia, chronic alcoholism, chronic ingestion of salicylates & opiates addiction are reported to interfere with some assay methods, falsely increasing results.
- IV. Interference of hemoglobinopathies in HbA1c estimation is seen in
 - a. Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.
 - b. Heterozygous state detected (D10 is corrected for HbS & HbC trait.)
 - c. HbF > 25% on alternate platform (Boronate affinity chromatography) is recommended for testing of HbA1c. Abnormal Hemoglobin electrophoresis (HPLC method) is





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PATIENT NAME : MRS GEETHU MOHAN **PATIENT ID : MRSGF0603934182**

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recommended for detecting a hemoglobinopathy
TOTAL PROTEIN, SERUM-Serum total protein,also known as total protein, is a biochemical test for measuring the total amount of protein in serum..Protein in the plasma is made up of albumin and globulin

Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma, Waldenstrom's disease
Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage), Burns, Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome, Protein-losing enteropathy etc.
URIC ACID, SERUM- Causes of Increased levels: -Dietary(High Protein Intake, Prolonged Fasting, Rapid weight loss), Gout, Lesch nyhan syndrome, Type 2 DM, Metabolic syndrome
Causes of decreased levels - Low Zinc intake, OCP, Multiple Sclerosis

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD-
Blood group is identified by antigens and antibodies present in the blood. Antigens are protein molecules found on the surface of red blood cells. Antibodies are found in plasma. To determine blood group, red cells are mixed with different antibody solutions to give A, B, O or AB.

Disclaimer: "Please note, as the results of previous ABO and Rh group (Blood Group) for pregnant women are not available, please check with the patient records for availability of the same."

The test is performed by both forward as well as reverse grouping methods.
BLOOD COUNTS, EDTA WHOLE BLOOD-The cell morphology is well preserved for 24hrs. However after 24-48 hrs a progressive increase in MCV and HCT is observed leading to a decrease in MCHC. A direct smear is recommended for an accurate differential count and for examination of RBC morphology.
RBC AND PLATELET INDICES-Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia (>13) from Beta thalassaemia trait (<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.
WBC DIFFERENTIAL COUNT-The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR < 3.3, COVID-19 patients tend to show mild disease.
(Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients ; A.-P. Yang, et al.; International Immunopharmacology 84 (2020) 106504

This ratio element is a calculated parameter and out of NABL scope.
ERYTHROCYTE SEDIMENTATION RATE (ESR), WHOLE BLOOD-**TEST DESCRIPTION** :-
Erythrocyte sedimentation rate (ESR) is a test that indirectly measures the degree of inflammation present in the body. The test actually measures the rate of fall (sedimentation) of erythrocytes in a sample of blood that has been placed into a tall, thin, vertical tube. Results are reported as the millimetres of clear fluid (plasma) that are present at the top portion of the tube after one hour. Nowadays fully automated instruments are available to measure ESR.

ESR is not diagnostic; it is a non-specific test that may be elevated in a number of different conditions. It provides general information about the presence of an inflammatory condition. CRP is superior to ESR because it is more sensitive and reflects a more rapid change.

TEST INTERPRETATION
Increase in: Infections, Vasculitis, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Tissue injury, Pregnancy, Estrogen medication, Aging.

Finding a very accelerated ESR (>100 mm/hour) in patients with ill-defined symptoms directs the physician to search for a systemic disease (Paraproteinemias, Disseminated malignancies, connective tissue disease, severe infections such as bacterial endocarditis).
In pregnancy BRI in first trimester is 0-48 mm/hr (62 if anemic) and in second trimester (0-70 mm/hr (95 if anemic). ESR returns to normal 4th week post partum.

Decreased in: Polycythemia vera, Sickle cell anemia

LIMITATIONS

False elevated ESR : Increased fibrinogen, Drugs (Vitamin A, Dextran etc), Hypercholesterolemia
False Decreased ESR : Poikilocytosis, (Sickle Cells, spherocytes), Microcytosis, Low fibrinogen, Very high WBC counts, Drugs (Quinine, salicylates)

REFERENCE :

- Nathan and Oski's Haematology of Infancy and Childhood, 5th edition; 2. Paediatric reference intervals. AACC Press, 7th edition. Edited by S. Soldin; 3. The reference for the adult reference range is "Practical Haematology by Dacie and Lewis, 10th edition.
- SUGAR URINE - POST PRANDIAL-METHOD: DIPSTICK/BENEDICT'S TEST
SUGAR URINE - FASTING-METHOD: DIPSTICK/BENEDICT'S TEST



DIAGNOSTIC REPORT

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PATIENT NAME : MRS GEETHU MOHAN

PATIENT ID : MRSGF0603934182

ACCESSION NO : 4182WC002103 **AGE :** 30 Years **SEX :** Female

ABHA NO :

DRAWN :

RECEIVED : 06/03/2023 08:07

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MEDIWHEEL HEALTH CHECKUP BELOW 40(F)TMT

*** ECG WITH REPORT**

REPORT

REPORT GIVEN

*** USG ABDOMEN AND PELVIS**

REPORT

REPORT GIVEN

*** CHEST X-RAY WITH REPORT**

REPORT

REPORT GIVEN

****End Of Report****

Please visit www.srlworld.com for related Test Information for this accession
TEST MARKED WITH '*' ARE OUTSIDE THE NABL ACCREDITED SCOPE OF THE LABORATORY.

BABU K MATHEW
HOD -BIOCHEMISTRY

DR.VAISHALI RAJAN, MBBS
DCP(Pathology)
(Reg No - TCC 27150)
HOD - HAEMATOLOGY

DR. ASTHA YADAV, MD
Biochemistry
(Reg No - DMC/R/20690)
CONSULTANT BIOCHEMIST

DR NISHA UNNI, MBBS,MD
(RD),DNB (Reg.No:50162)
Consultant Radiologist



RADIOLOGY DIVISION

Acc no: 4182WC002103	Name: Mrs. Geethu Mohan	Age: 30 y	Sex: Female	Date: 06.03.23
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US SCAN WHOLE ABDOMEN (TAS ONLY)

LIVER is normal in size (12.9 cm). Margins are regular. **Hepatic parenchyma shows mildly increased echogenicity.** No focal lesions seen. No dilatation of intrahepatic biliary radicles. CBD is not dilated. Portal vein is normal in caliber (8.1 mm).

GALL BLADDER is partially distended and grossly normal. No pericholecystic fluid seen.

SPLEEN is normal in size (8.6 cm) and parenchymal echotexture. No focal lesion seen.

PANCREAS Head and body visualized, appears normal in size and parenchymal echotexture. Pancreatic duct is not dilated.

RIGHT KIDNEY is normal in size (10.9 x 3.7 cm) and shows normal parenchymal echotexture. Cortico medullary differentiation is maintained. Parenchymal thickness is normal. No echogenic focus with shadowing suggestive of renal calculi seen. No dilatation of pelvicalyceal system seen. Ureter is not dilated. Perinephric spaces are normal.

LEFT KIDNEY is normal in size (11.5 x 4.5 cm) and shows normal parenchymal echotexture. Cortico medullary differentiation is maintained. Parenchymal thickness is normal. No echogenic focus with shadowing suggestive of renal calculi seen. No dilatation of pelvicalyceal system seen. Ureter is not dilated. Perinephric spaces are normal.

PARAAORTIC AREA No retroperitoneal lymphadenopathy or mass seen.

URINARY BLADDER is distended, normal in wall thickness, lumen clear.

UTERUS measures 9.9 x 3.9 x 4.8 cm, myometrial echopattern normal. No focal lesions seen.


Endometrial thickness is 13.8 mm.

Both ovaries are normal. Right ovary measures 2.4 x 1.3 cm. Left ovary measures 3.7 x 1.9 cm and show dominant follicle measuring 2.2 x 1.5 cm. No adnexal mass seen. No fluid in pouch of Douglas.

No ascites or pleural effusion.

CONCLUSION:-

- **Grade I fatty liver.**


Dr. Nisha Unni MD , DNB (RD)
Consultant radiologist.

*Thanks for referral. Your feedback will be appreciated.
(Please bring relevant investigation reports during all visits)
Because of technical and technological limitations complete accuracy cannot be assured on imaging.
Suggested correlation with clinical findings and other relevant investigations consultations, and if required repeat imaging recommended in the event of controversies.*

(For appointments please contact 9496005190 between 9 am – 5.30 pm).



V1

V2

V3

V4

ID: 002103

Female
30 Years
cm

mmHg
kg

Diagnosis Information:

Regular mokers

HR : 83 bpm
 P : 111 ms
 PR : 156 ms
 QRS : 81 ms
 QT/QTc : 354/417 ms
 P/QRS/T : 69/68/43 °
 RV5/SVI : 1.647/0.985 mV

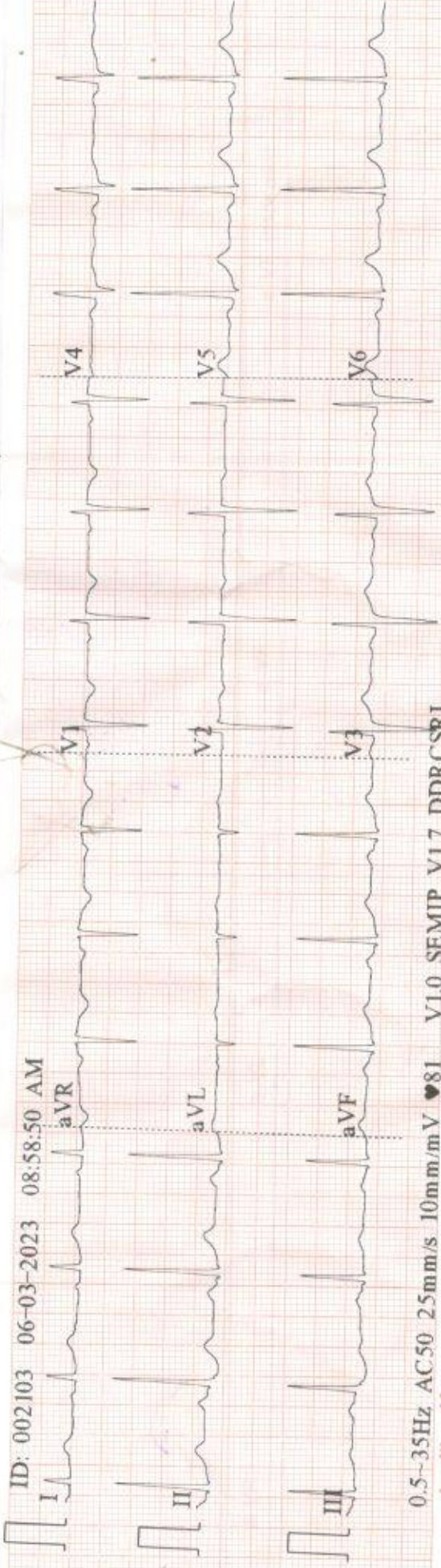
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Report Confirmed by:

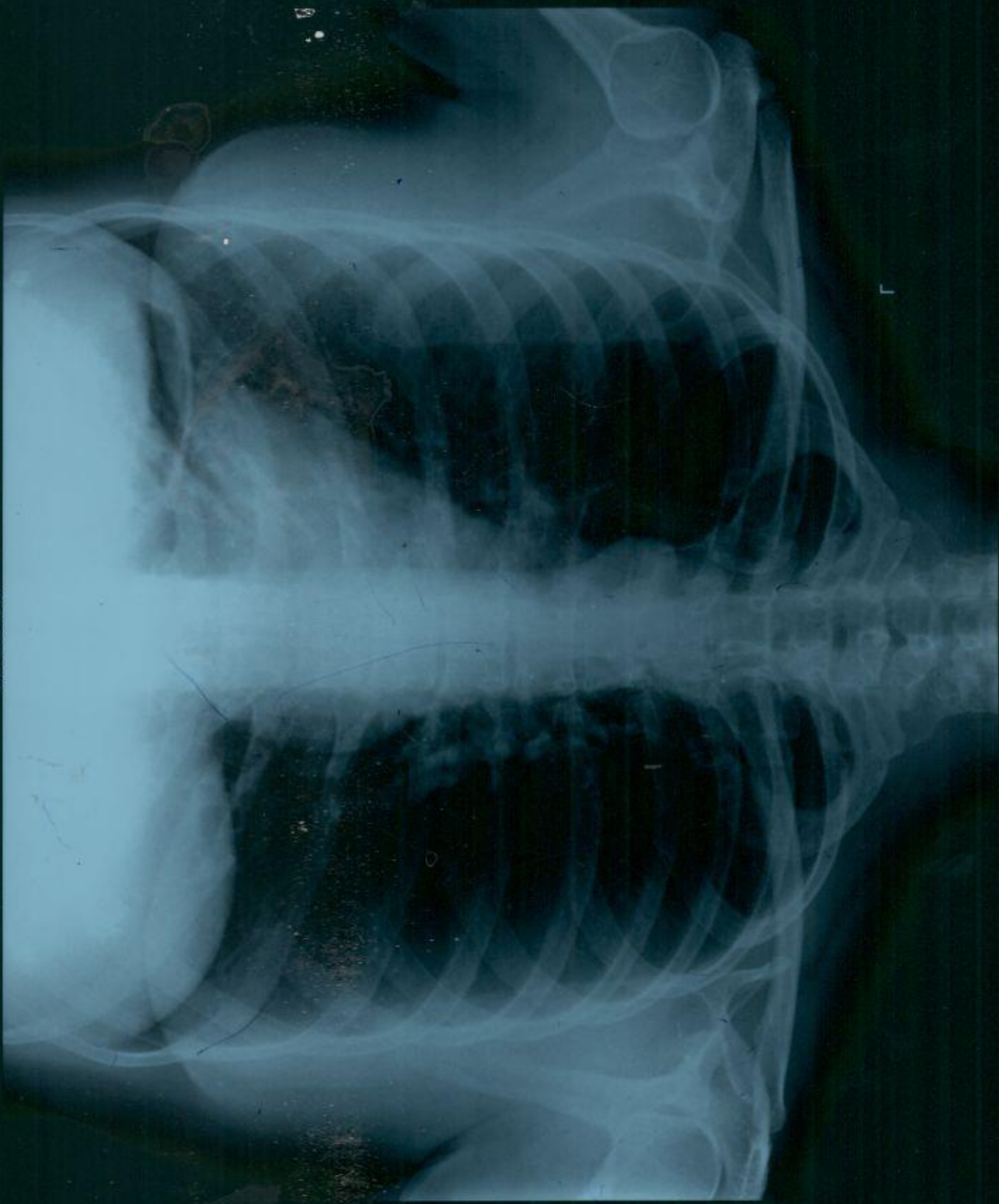


[Signature]
 Dr. SERIN LOPEZ, MBBS
 MEDICAL OFFICER
 DERC SRL Diagnostics Ltd.
 Reg. No. 77656
 Medical College P.O., TVM

Standard

Standard	L 1	L II	L III	L III Inspiration
	<p data-bbox="821 1332 877 1892">ID: 002103 06-03-2023 08:58:50 AM</p>  <p data-bbox="869 1355 917 1433">I aVR</p> <p data-bbox="1029 1377 1077 1433">II aVL</p> <p data-bbox="1236 1377 1284 1433">III aVF</p> <p data-bbox="885 459 933 504">V4</p> <p data-bbox="1061 459 1109 504">V5</p> <p data-bbox="1252 459 1300 504">V6</p> <p data-bbox="1332 884 1388 1904">0.5~35Hz, AC.50 25mm/s 10mm/mV ♥81 V1.0 SEMIP V1.7 DDRCSRL A-25W CE</p>			

МБЭ СЕЕТНУ МОНВИ 30У Ү ЗИЭС033 CHEST-BA MC005.103 IE
DPRC 2RF



MEDICAL EXAMINATION REPORT (MER)

If the examinee is suffering from an acute life threatening situation, you may be obliged to disclose the result of the medical examination to the examinee.

1. Name of the examinee	:	Mr./Mrs./Ms. <u>Geethy Nishan</u>
2. Mark of Identification	:	(Mole/Scar/any other (specify location)):
3. Age/Date of Birth	:	<u>90 / Kerala</u> Gender: F/M
4. Photo ID Checked	:	(Passport/Election Card/PAN Card/Driving Licence/Company ID)

PHYSICAL DETAILS:

a. Height <u>162</u> (cms)	b. Weight <u>66</u> (Kgs)	c. Girth of Abdomen <u>80</u> (cms)
d. Pulse Rate <u>80</u> (/Min)	e. Blood Pressure:	Systolic Diastolic
	1 st Reading	<u>110</u> <u>80</u>
	2 nd Reading	

FAMILY HISTORY:

Relation	Age if Living	Health Status	If deceased, age at the time and cause
Father			
Mother			
Brother(s)			
Sister(s)			

HABITS & ADDICTIONS: Does the examinee consume any of the following?

Tobacco in any form	Sedative	Alcohol

PERSONAL HISTORY

- | | |
|---|---|
| a. Are you presently in good health and entirely free from any mental or Physical impairment or deformity. If No, please attach details. <u>Y/N</u> | c. During the last 5 years have you been medically examined, received any advice or treatment or admitted to any hospital? <u>Y/N</u> |
| b. Have you undergone/been advised any surgical procedure? <u>Y/N</u> | d. Have you lost or gained weight in past 12 months? <u>Y/N</u> |

Have you ever suffered from any of the following?

- | | |
|--|---|
| • Psychological Disorders or any kind of disorders of the Nervous System? <u>Y/N</u> | • Any disorder of Gastrointestinal System? <u>Y/N</u> |
| • Any disorders of Respiratory system? <u>Y/N</u> | • Unexplained recurrent or persistent fever, and/or weight loss <u>Y/N</u> |
| • Any Cardiac or Circulatory Disorders? <u>Y/N</u> | • Have you been tested for HIV/HBsAg / HCV before? If yes attach reports <u>Y/N</u> |
| • Enlarged glands or any form of Cancer/Tumour? <u>Y/N</u> | • Are you presently taking medication of any kind? <u>Y/N</u> |
| • Any Musculoskeletal disorder? <u>Y/N</u> | |

DDRC SRL Diagnostics Limited

Corp. Office: DDRC SRL Tower, G- 131, Panampilly Nagar, Ernakulam - 682 036
 Ph No. 0484-2318223, 2318222, e-mail: info@ddrcsrl.com, web: www.ddrcsrl.com

Corp. Office: DDRC SRL Tower, G-131, Panampilly Nagar, Ernakulam - 682 036. Ph No. 2310688, 2318222. web: www.ddrcsrl.com

• Any disorders of Urinary System?

Y/N ✓

• Any disorder of the Eyes, Ears, Nose, Throat or Mouth & Skin

Y/N ✓

FOR FEMALE CANDIDATES ONLY

a. Is there any history of diseases of breast/genital organs?

Y/N

d. Do you have any history of miscarriage/abortion or MTP

Y/N

b. Is there any history of abnormal PAP Smear/Mammogram/USG of Pelvis or any other tests? (If yes attach reports)

Y/N

e. For Parous Women, were there any complication during pregnancy such as gestational diabetes, hypertension etc

Y/N

c. Do you suspect any disease of Uterus, Cervix or Ovaries?

Y/N

f. Are you now pregnant? If yes, how many months?

Y/N

CONFIDENTIAL COMMENTS FROM MEDICAL EXAMINER

➤ Was the examinee co-operative?

Y/N ✓

➤ Is there anything about the examinee's health, lifestyle that might affect him/her in the near future with regard to his/her job?

Y/N ✓

➤ Are there any points on which you suggest further information be obtained?

Y/N ✓

➤ Based on your clinical impression, please provide your suggestions and recommendations below;

.....
Grade 2 fatty liver,
.....

➤ Do you think he/she is MEDICALLY FIT or UNFIT for employment.

MEDICAL EXAMINER'S DECLARATION

I hereby confirm that I have examined the above individual after verification of his/her identity and the findings stated above are true and correct to the best of my knowledge.

Name & Signature of the Medical Examiner :

[Handwritten Signature]

Seal of Medical Examiner :

Dr. SERIN LOPEZ. MBBS
MEDICAL OFFICER
DDRC SRL Diagnostics Ltd.
Aster Square, Medical College P.O., TVM
Reg. No. 2002

Name & Seal of DDRC SRL Branch :



Date & Time :

06/03/2023

DDRC SRL Diagnostics Limited

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Regd. Office: 4th Floor, Prime Square, Plot No.1, Gaiwadi Industrial Estate, S.V. Road, Goregaon (West), Mumbai - 400062.



NAME : MRS GEETHU MOHAN	AGE:30/F	DATE: 06/03/2023
-------------------------	----------	------------------

CHEST X-RAY REPORT

CHEST X-RAY PA VIEW : Trachea central
 No cardiomegaly
 Normal vascularity
 No parenchymal lesion.
 Costophrenic and cardiophrenic angles clear

➤ **IMPRESSION** : Normal Chest Xray

ELECTRO CARDIOGRAM : NSR :62/minute
 No evidence of ischaemia.

➤ **IMPRESSION** : Normal Ecg.



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 MEDICAL OFFICER
 DDRC SRL Diagnostics Ltd.
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Company name: BOB

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