

From,  
DDRC SRL  
Kannur


To,  
Medimheel

Respected Sir (Madam,

we have a client on 11-March-2023 named as  
Kanchi Sreevalli. She is not willing to do stool slr,  
Pap smear . . . . . due to personal issues.  
Kindly do needful.



Kanchi Sreevalli  
K. Sreevalli

Standard	L I	L II	L III	L III Inspiration
	<p data-bbox="280 542 795 582">ID: 11-03-2023 12:42:17 COPY</p>  <p data-bbox="280 1045 1164 1085">0.5~100Hz AC50 25mm/s 10mm/mV ♥83 V1.0 SEMIP V1.7</p> <p data-bbox="884 1085 1030 1117">A<sub>0</sub>W CE</p>			

ID:  
KANCHI SREEVALLI

Female / mmHg  
30 Years  
cm

Dr. INDUSARATHI S, MBBS, MD, DNB  
Regd. No: 41964  
DDRC SRL, KANNUR

*within normal limits*

HR : 83 bpm  
P : 101 ms  
PR : 130 ms  
QRS : 87 ms  
QT/QTc : 364/430 ms  
P/QRS/T : 61/78/56 °  
RV5/SV1 : 1.065/0.350 mV

V1	V2	V3	V4
		Standard	
	V6		



## ECHOCARDIOGRAPHY REPORT

Name:	KANCHI SREEVALLI	Age: 30	Date:	11/03/2023
Ref By:	MEDI WHEEL	Sex: M	SRD No:	

M MODE

AORTA : 20 mm  
 LA : 29 mm  
 LVIDD : 39 mm  
 LVIDS : 26 mm  
 IVSD : 8.0 mm  
 IVSS : 10 mm  
 LVPWD : 9.0 mm  
 LVPWS : 12 mm  
**LVEF : 65 %**  
 FS : 35 %

2D ECHO

MV : Normal  
 AV: Normal  
 RWMA: Nil  
 LA: Normal  
 LV: Normal  
 IAS: Intact  
 Situs: Solitus  
 V-A Relationship: Normal  
 Syst. V. Drainage: Normal  
 Pericardial Effusion: Nil

MV/Area : Normal

PV: Normal  
 TV: Normal  
 RA: Normal  
 RV: Normal  
 IVS: Normal  
 A-V Relationship : Normal  
 Great Vessel Relationship: Normal  
 Pulmonary V Drainage: Normal

DOPPLER

Pul Velocity : 0.7m/s  
 MV Velocity : E : 0.81 m/s      A : 0.60 m/s      E/A : 1.14      MV Area (PHT):  
 AV Velocity : 1.2 m/s  
 AO Area :  
 TV Velocity : 0.6 m/s      **TR : 26mmHg**      RVSP : mmHg

COLOUR

MR: Nil      ASD:  
 AR: Nil      VSD:  
**TR: Trivial - Mild**      PDA  
 PR: Nil      CoA:

Wall motion abnormalities : Nil
Pericardium: No pericardial effusion
Vegetation/ Thrombus: Nil

IMPRESSION:

- Trivial – Mild TR, No PAH
- No RWMA
- Normal LV Systolic function

**DIAGNOSTIC REPORT**

Patient Ref. No. 66600003701534

**CLIENT CODE :** CA00010147 - MEDIWHEEL  
**CLIENT'S NAME AND ADDRESS:**MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED  
F701A, LADO SARAI, NEW DELHI,  
SOUTH DELHI, DELHI,  
SOUTH DELHI 110030  
DELHI INDIA  
8800465156

DDRC SRL DIAGNOSTICS

KANNUR  
KERALA, INDIA  
Tel : 93334 93334  
Email : customercare.ddrc@srl.in**PATIENT NAME :** KANCHI SREEVALLIPATIENT ID : **KANCF0103934053**ACCESSION NO : **4053WC000960** AGE : 30 Years SEX : Female

ABHA NO :

DRAWN :

RECEIVED : 11/03/2023 09:34

REPORTED : 11/03/2023 18:33

**REFERRING DOCTOR :** DR. MEDIWHEEL

CLIENT PATIENT ID :

Test Report Status	Final	Results	Biological Reference Interval	Units
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**MEDIWHEEL HEALTH CHECKUP BELOW 40(F)2DECHO****OPHTHAL**

OPHTHAL COMPLETED

**PHYSICAL EXAMINATION**

PHYSICAL EXAMINATION COMPLETED



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**PATIENT NAME :** KANCHI SREEVALLI **PATIENT ID :** KANCF0103934053  
**ACCESSION NO :** 4053WC000960 **AGE :** 30 Years **SEX :** Female **ABHA NO :**  
**DRAWN :** **RECEIVED :** 11/03/2023 09:34 **REPORTED :** 11/03/2023 18:33  
**REFERRING DOCTOR :** DR. MEDIWHEEL **CLIENT PATIENT ID :**

Test Report Status	Final	Results	Units
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**MEDIWHEEL HEALTH CHECKUP BELOW 40(F)2DECHO**

**BLOOD UREA NITROGEN (BUN), SERUM**

BLOOD UREA NITROGEN	10	6 - 20	mg/dL
<b>BUN/CREAT RATIO</b>			
BUN/CREAT RATIO	14.3	5.00 - 15.00	
<b>CREATININE, SERUM</b>			
CREATININE	0.7	18 - 60 yrs : 0.6 - 1.1	mg/dL

**GLUCOSE, POST-PRANDIAL, PLASMA**

GLUCOSE, POST-PRANDIAL, PLASMA	<b>144</b>	<b>High</b> Diabetes Mellitus : > or = 200. Impaired Glucose tolerance/ Prediabetes : 140 - 199. Hypoglycemia : < 55.	mg/dL
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**Comments**

Note : Value rechecked.

**GLUCOSE FASTING, FLUORIDE PLASMA**

GLUCOSE, FASTING, PLASMA	100	Diabetes Mellitus : > or = 126. Impaired fasting Glucose/ Prediabetes : 101 - 125. Hypoglycemia : < 55.	mg/dL
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**GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD**

GLYCOSYLATED HEMOGLOBIN (HBA1C)	5.5	Normal : 4.0 - 5.6%. Non-diabetic level : < 5.7%. Diabetic : >6.5%	%
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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%.

**LIPID PROFILE, SERUM**

CHOLESTEROL	141	< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
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TRIGLYCERIDES		63	mg/dL
		< 150 Normal 150 - 199 Borderline High 200 - 499 High >/=500 Very High	
HDL CHOLESTEROL		54	mg/dL
		< 40 Low >/=60 High	
DIRECT LDL CHOLESTEROL		75	mg/dL
		< 100 Optimal 100 - 129 Near or above optimal 130 - 159 Borderline High 160 - 189 High >/= 190 Very High	
NON HDL CHOLESTEROL		87	mg/dL
		Desirable-Less than 130 Above Desirable-130-159 Borderline High-160-189 High-190-219 Very High- >or =220	
VERY LOW DENSITY LIPOPROTEIN CHOL/HDL RATIO		12.6	mg/dL
		<b>2.6</b>	
		<b>Low</b> 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		1.4	
		0.5-3 Desirable/Low risk 3.1-6 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	
	LDL-C (mg/dl)	Non-HDL (mg/dl)	LDL-C (mg/dl)	Non-HDL (mg/dl)







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ACCESSION NO : **4053WC000960** AGE : 30 Years SEX : Female ABHA NO :

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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	0.4	General Range : < 1.1	mg/dL
BILIRUBIN, DIRECT	0.03	General Range : < 0.3	mg/dL
BILIRUBIN, INDIRECT	0.37	General Range : <0.85	mg/dL
TOTAL PROTEIN	7.2	Ambulatory : 6.4 - 8.3 Recumbant : 6 - 7.8	g/dL
ALBUMIN	4.2	20-60yrs : 3.5 - 5.2	g/dL
GLOBULIN	3	General Range : 2 - 3.5 Premature Neonates : 0.29 - 1.04	g/dL
ALBUMIN/GLOBULIN RATIO	1.4	General Range : 1.1 - 2.5	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	21	Adults : < 33	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)	10	Adults : < 34	U/L
ALKALINE PHOSPHATASE	58	Adult(<60yrs) : 35 - 105	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)	12	Adult(female) : < 40	U/L

**TOTAL PROTEIN, SERUM**

TOTAL PROTEIN	7.2	6.4 - 8.3	g/dL
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**URIC ACID, SERUM**

URIC ACID	0.3	<b>Low</b> Adults : 2.4-5.7	mg/dL
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**ABO GROUP & RH TYPE, EDTA WHOLE BLOOD**

ABO GROUP	TYPE AB
RH TYPE	POSITIVE

**BLOOD COUNTS, EDTA WHOLE BLOOD**

HEMOGLOBIN	13.8	12.0 - 15.0	g/dL
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**PATIENT NAME : KANCHI SREEVALLI** PATIENT ID : **KANCF0103934053**

ACCESSION NO : **4053WC000960** AGE : 30 Years SEX : Female ABHA NO :

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**REFERRING DOCTOR :** DR. MEDIWHEEL CLIENT PATIENT ID :

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RED BLOOD CELL COUNT	<b>5.04</b>	<b>High</b> 3.8 - 4.8	mil/ $\mu$ L
WHITE BLOOD CELL COUNT	<b>10.05</b>	<b>High</b> 4.0 - 10.0	thou/ $\mu$ L
PLATELET COUNT	293	150 - 410	thou/ $\mu$ L
<b>RBC AND PLATELET INDICES</b>			
HEMATOCRIT	42.4	36 - 46	%
MEAN CORPUSCULAR VOL	84.1	83 - 101	fL
MEAN CORPUSCULAR HGB.	27.3	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION	32.5	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH	12.0	11.6 - 14.0	%
MENTZER INDEX	16.7		
MEAN PLATELET VOLUME	8.5	6.8 - 10.9	fL
<b>WBC DIFFERENTIAL COUNT</b>			
SEGMENTED NEUTROPHILS	71	40 - 80	%
LYMPHOCYTES	27	20 - 40	%
MONOCYTES	<b>1</b>	<b>Low</b> 2 - 10	%
EOSINOPHILS	<b>0</b>	<b>Low</b> 1 - 6	%
BASOPHILS	1	0 - 2	%
ABSOLUTE NEUTROPHIL COUNT	<b>7.14</b>	<b>High</b> 2.0 - 7.0	thou/ $\mu$ L
ABSOLUTE LYMPHOCYTE COUNT	2.71	1 - 3	thou/ $\mu$ L
ABSOLUTE MONOCYTE COUNT	<b>0.10</b>	<b>Low</b> 0.20 - 1.00	thou/ $\mu$ L
ABSOLUTE EOSINOPHIL COUNT	<b>0.00</b>	<b>Low</b> 0.02 - 0.50	thou/ $\mu$ L
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	2.6		
<b>ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD</b>			
SEDIMENTATION RATE (ESR)	7	0 - 20	mm at 1 hr
<b>SUGAR URINE - POST PRANDIAL</b>			
SUGAR URINE - POST PRANDIAL	NOT DETECTED	NOT DETECTED	
<b>THYROID PANEL, SERUM</b>			
T3	106.2	80.00 - 200.00	ng/dL
T4	5.1	5.10 - 14.10	$\mu$ g/dl
TSH 3RD GENERATION	<b>7.54</b>	<b>High</b> 0.270 - 4.200	$\mu$ IU/mL



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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 during 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 PALE YELLOW  
 APPEARANCE SLIGHTLY HAZY

**CHEMICAL EXAMINATION, URINE**

PH 7 4.7 - 7.5



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**REFERRING DOCTOR :** DR. MEDIWHEEL

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SPECIFIC GRAVITY		1.010	1.003 - 1.035
PROTEIN		<b>DETECTED (SMALL)</b>	NOT DETECTED
GLUCOSE		NOT DETECTED	NOT DETECTED
KETONES		NOT DETECTED	NOT DETECTED
BILIRUBIN		NOT DETECTED	NOT DETECTED
UROBILINOGEN		NORMAL	NORMAL
<b>MICROSCOPIC EXAMINATION, URINE</b>			
RED BLOOD CELLS		NOT DETECTED	NOT DETECTED /HPF
WBC		3-5	0-5 /HPF
EPITHELIAL CELLS		<b>15-20</b>	0-5 /HPF
CASTS		ABSENT	
CRYSTALS		ABSENT	
BACTERIA		<b>DETECTED (FEW)</b>	NOT DETECTED





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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

**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.





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

DDRC SRL DIAGNOSTICS

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 DELHI INDIA  
 8800465156

KANNUR  
 KERALA, INDIA  
 Tel : 93334 93334  
 Email : customercare.ddrc@srl.in

**PATIENT NAME : KANCHI SREEVALLI** PATIENT ID : **KANCF0103934053**

ACCESSION NO : **4053WC000960** AGE : 30 Years SEX : Female ABHA NO :

DRAWN : RECEIVED : 11/03/2023 09:34 REPORTED : 11/03/2023 18:33

**REFERRING DOCTOR : DR. MEDIWHEEL** CLIENT PATIENT ID :

Test Report Status	Final	Results	Units
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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 Glyosuria, 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 Glyosuria, 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 addition 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 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



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Patient Ref. No. 666000003701534

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DDRC SRL DIAGNOSTICS

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 Email : customercare.ddrc@srl.in

PATIENT NAME : KANCHI SREEVALLI

PATIENT ID : KANCF0103934053

ACCESSION NO : 4053WC000960 AGE : 30 Years SEX : Female

ABHA NO :

DRAWN :

RECEIVED : 11/03/2023 09:34

REPORTED : 11/03/2023 18:33

REFERRING DOCTOR : DR. MEDIWHEEL

CLIENT PATIENT ID :

Test Report Status	Final	Results	Units
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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, Vasculitides, 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** : Poikilocytosis,(SickleCells,spherocytes),Microcytosis, Low fibrinogen, Very high WBC counts, Drugs(Quinine, salicylates)

**REFERENCE :**

1. 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



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**DIAGNOSTIC REPORT**

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

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**PATIENT NAME : KANCHI SREEVALLI** PATIENT ID : **KANCF0103934053**

ACCESSION NO : **4053WC000960** AGE : 30 Years SEX : Female ABHA NO :

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**REFERRING DOCTOR :** DR. MEDIWHEEL CLIENT PATIENT ID :


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**MEDIWHEEL HEALTH CHECKUP BELOW 40(F)2DECHO**

- ECG WITH REPORT**
- REPORT**
- COMPLETED**
- USG ABDOMEN AND PELVIS**
- REPORT**
- COMPLETED**
- CHEST X-RAY WITH REPORT**
- REPORT**
- COMPLETED**
- 2D - ECHO WITH COLOR DOPPLER**
- REPORT**
- COMPLETED**

**\*\*End Of Report\*\***  
Please visit [www.srlworld.com](http://www.srlworld.com) for related Test Information for this accession

  
**JINSHA KRISHNAN**  
LAB TECHNOLOGIST

  
**DR.INDUSARATH S**  
CONSULTANT PATHOLOGIST

  
**NIMISHA K**  
LAB TECHNOLOGIST

  
**SREENA A**  
LAB TECHNOLOGIST






## OPHTHALMOLOGY REPORT

TO WHOM-SO-EVER IT MAY CONCERN

This is to certify that I have examined Mrs. KANCHI SREEVALLI , 30 years Female on 11.03.2023 and her visual standards are as follows:

	OD	OS
UNCORRECTED DISTANCE VISUAL ACUITY	6/18	6/12
UNCORRECTED NEAR VISUAL ACUITY	N6	N6
BEST CORRECTED VISUAL ACUITY	6/6,N6	6/6,N6
COLOUR VISION	NORMAL	NORMAL

NOTE : NO H/O SPECS  
NO RELEVANT MEDICAL HISTORY

  
SHEHZIYA V P  
OPTOMETRIST



DATE: 11.03.2023



Name	Mrs. KANCHI SREEVALLI	Age/Sex	30Yrs/Female
Ref: By:	MEDI WHEEL	Date	11.03.2023

## ULTRASOUND SCAN OF ABDOMEN AND PELVIS

(With relevant image copies)

**LIVER:** Normal in size and **shows diffusely increased echotexture**. No e/o focal parenchymal lesions / IHBD. PV, HV & IVC are within normal limits.

**GB:** Normally distended, shows normal wall thickness. No e/o calculi/polyps/ pericholecystic collections.

**CBD:** Normal.

**PANCREAS:** Head and body visualized and are of normal size and echotexture. No e/o focal/diffuse parenchymal lesions/ductal dilatation/calculi. Tail cannot be visualized due to poor window.

**SPLEEN:** Normal in size and echotexture. Splenic vein shows normal diameter.

**KIDNEY'S:** Both kidneys are normal in size and echotexture. No e/o calculi/ hydronephrosis/ focal lesions/ perinephric collections.

**RIGHT KIDNEY:** Measures 100 x 38 mms

**LEFT KIDNEY:** Measures 106 x 43mms

**UB:** Normally distended, shows normal wall thickness. No e/o calculi/growth/diverticulae. Both UV junctions are within normal limits.

**UTERUS:** AV, measures 75 x 37 x 41 mms. Normal in size and echotexture.

**A large subserosal fibroid measuring 114 x 86 x 102mm is noted arising from fundo-anterior uterine wall and extending into the lower abdomen.**

EMT: 8 mm, normal.

**OVARIES:**

**RIGHT OVARY:** measures 31 x 19 mms normal in size

**LEFT OVARY :** Not well visualized.

**POD:** No free fluid.

No e/o intraperitoneal free fluid/ abdominal lymphadenopathy/ mass lesion.

### IMPRESSION

- **A LARGE SUBSEROSAL UTERINE FIBROID AS MENTIONED.**
- **GRADE I FATTY LIVER.**

**Dr. P.NIYAZI NASIR**  
**MBBS, DMRD**

*(Because of technical and technological limitation complete diagnosis cannot be assured on imaging sonography. Clinical correlation, consultation if required repeat imaging required in the event of controversies. This document is not for legal purposes).*

**Dr. P. NIYAZI NASIR, MBBS, DMRD**  
**REG. No. 41419**  
**CONSULTANT RADIOLOGIST**  
**DDRC SRL DIAGNOSTIC (P) LTD.**  
**KANNUR**



Name	Mrs. KANCHI SREEVALLI	Age/Sex	30Yrs/Female
Ref: By:	MEDI WHEEL	Date	11.03.2023

**Thanks for referral**

### CHEST X-RAY – PA VIEW

Trachea is central. Carina and principal bronchi are normal.

Cardio-thoracic ratio is within normal limits.

Both lungs show normal Broncho-vascular markings. No definite focal opacities noted.

No volume loss in either hemithorax.

No definite mediastinal widening or other abnormalities noted.

CP angles, diaphragm, bony cage and soft tissue shadows - not remarkable.

### IMPRESSION:

- Normal X-ray chest

**DR. P. NIYAZI NASIR,  
MBBS, DMRD**

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R

KANCHI SREEVALLI 30Y/F MEDIWHEEL CHEST ,P-A 11-Mar-23 01:53 PM  
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