Dr. Shyba Vinayaraj
B.D.S. Dental Surgeon
Dr. Ankita Vinayaraj
B.D.S. Dental Surgeon

Vista Dental Care
T.T. Road, Kannur-670 002
Clinic : 2706290
Resi : 2726715

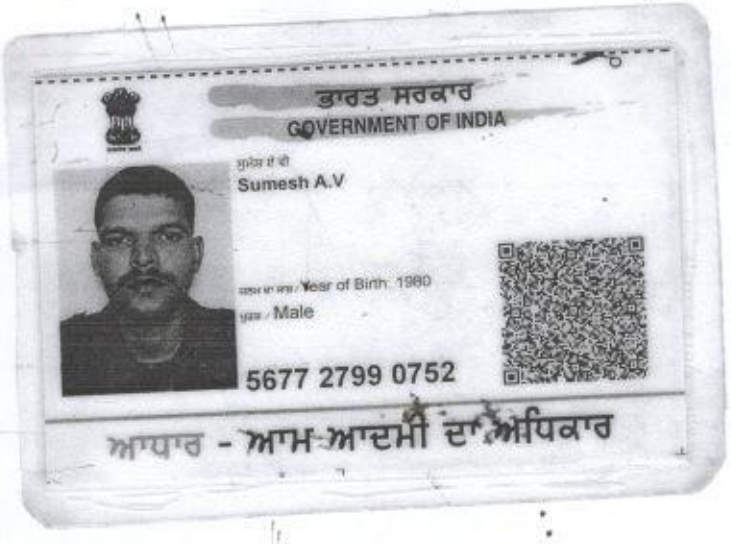
Name ..... Date 30/11/2022

℞

Mr. Suresh AV 42 years underwent dental consultation. No abnormalities detected.

Dr. Shyba Vinayaraj

Dr. SHYBA VINAYARAJ
B.D.S. Dental Surgeon
Vista Dental Care
T.T. Road, Kannur - 670002
Reg. No. 2031



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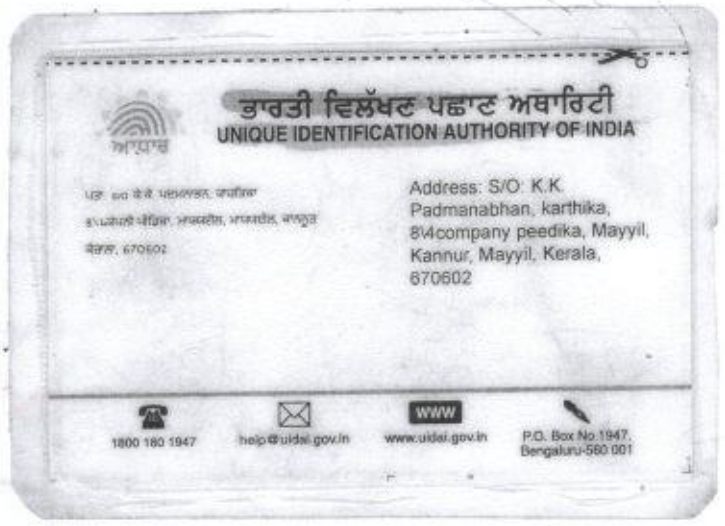
Date: .....
KANNUR



DIAGNOSTIC REPORT

Patient Ref. No. 666000002493882

DDRC SRL Diagnostic Services

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 : SUMESH A V PATIENT ID : **SUMEM3011804053**

ACCESSION NO : **4053VK002852** AGE : 42 Years SEX : Male ABHA NO :

DRAWN : RECEIVED : 30/11/2022 08:55 REPORTED : 30/11/2022 17:44

REFERRING DOCTOR : SELF CLIENT PATIENT ID :

Test Report Status **Preliminary**	Results	Biological Reference Interval	Units

MEDIWHEEL HEALTH CHECKUP ABOVE 40(M)TMT

TREADMILL TEST

TREADMILL TEST	COMPLETED

DENTAL CHECK UP

DENTAL CHECK UP	COMPLETED

OPTHAL

OPTHAL	COMPLETED

PHYSICAL EXAMINATION

PHYSICAL EXAMINATION	COMPLETED

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MEDIWHEEL HEALTH CHECKUP ABOVE 40(M)TMT

SERUM BLOOD UREA NITROGEN

BLOOD UREA NITROGEN	7		Adult(<60 yrs) : 6 to 20	mg/dL

BUN/CREAT RATIO

BUN/CREAT RATIO	7.7		5.00 - 15.00	

CREATININE, SERUM

CREATININE	0.90		18 - 60 yrs : 0.9 - 1.3	mg/dL

GLUCOSE, POST-PRANDIAL, PLASMA

GLUCOSE, POST-PRANDIAL, PLASMA	**218**	**High**	Diabetes Mellitus : > or = 200. Impaired Glucose tolerance/ Prediabetes : 140 - 199. Hypoglycemia : < 55.	mg/dL

GLUCOSE, FASTING, PLASMA

GLUCOSE, FASTING, PLASMA	105		Diabetes Mellitus : > or = 126. Impaired fasting Glucose/ Prediabetes : 101 - 125. Hypoglycemia : < 55.	mg/dL

GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

GLYCOSYLATED HEMOGLOBIN (HBA1C)	**7.2**	**High**	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%.	

LIPID PROFILE, SERUM

CHOLESTEROL	192		Desirable : < 200 Borderline : 200-239 High : >or= 240	mg/dL
TRIGLYCERIDES	131		Normal : < 150 High : 150-199 Hypertriglyceridemia : 200-499 Very High : > 499	mg/dL
HDL CHOLESTEROL	55		General range : 40-60	mg/dL

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DIRECT LDL CHOLESTEROL	120		Optimum : < 100 Above Optimum : 100-139 Borderline High : 130-159 High : 160-189 Very High : >or= 190	mg/dL
NON HDL CHOLESTEROL	**137**	**High**	Desirable-Less than 130 Above Desirable-130-159 Borderline High-160-189 High-190-219 Very High- >or =220	mg/dL
CHOL/HDL RATIO	3.5		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	2.2		0.5-3 Desirable/Low risk 3.1-6 Borderline/Moderate risk >6.0 High Risk	
VERY LOW DENSITY LIPOPROTEIN	26.1		</= 30.0	mg/dL
LIVER FUNCTION TEST WITH GGT				
BILIRUBIN, TOTAL	0.60		General Range : < 1.1	mg/dL
BILIRUBIN, DIRECT	0.16		General Range : < 0.3	mg/dL
BILIRUBIN, INDIRECT	0.44		0.00 - 0.60	mg/dL
TOTAL PROTEIN	7.0		Ambulatory : 6.4 - 8.3 Recumbant : 6 - 7.8	g/dL
ALBUMIN	4.8		20-60yrs : 3.5 - 5.2	g/dL
GLOBULIN	2.2		2.0 - 4.0	g/dL
ALBUMIN/GLOBULIN RATIO	**2.2**	**High**	1.0 - 2.0	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	41		Adults : < 40	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)	60		Adults : < 45	U/L
ALKALINE PHOSPHATASE	82		Adult(<60yrs) : 40 - 130	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)	63		Adult(male) : < 60	U/L
TOTAL PROTEIN, SERUM				
TOTAL PROTEIN	7.0		Ambulatory : 6.4 - 8.3 Recumbant : 6 - 7.8	g/dL
URIC ACID, SERUM				
URIC ACID	5.8		Adults : 3.4-7	mg/dL
ABO GROUP & RH TYPE, EDTA WHOLE BLOOD				
ABO GROUP	TYPE B			
RH TYPE	POSITIVE			

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BLOOD COUNTS,EDTA WHOLE BLOOD			
HEMOGLOBIN	15.4	13.0 - 17.0	g/dL
RED BLOOD CELL COUNT	5.24	4.5 - 5.5	mil/µL
WHITE BLOOD CELL COUNT	6.42	4.0 - 10.0	thou/µL
PLATELET COUNT	198	150 - 410	thou/µL
RBC AND PLATELET INDICES			
HEMATOCRIT	45.4	40 - 50	%
MEAN CORPUSCULAR VOL	86.7	83 - 101	fL
MEAN CORPUSCULAR HGB.	29.4	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION	33.9	31.5 - 34.5	g/dL
MENTZER INDEX	16.6		
MEAN PLATELET VOLUME	8.8	6.8 - 10.9	fL
WBC DIFFERENTIAL COUNT			
SEGMENTED NEUTROPHILS	**37** **Low**	40 - 80	%
LYMPHOCYTES	**49** **High**	20 - 40	%
MONOCYTES	2	2 - 10	%
EOSINOPHILS	**11** **High**	1 - 6	%
BASOPHILS	1	0 - 2	%
ABSOLUTE NEUTROPHIL COUNT	2.38	2.0 - 7.0	thou/µL
ABSOLUTE LYMPHOCYTE COUNT	**3.15** **High**	1 - 3	thou/µL
ABSOLUTE MONOCYTE COUNT	**0.13** **Low**	0.20 - 1.00	thou/µL
ABSOLUTE EOSINOPHIL COUNT	**0.71** **High**	0.02 - 0.50	thou/µL
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	0.8		
ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD			
SEDIMENTATION RATE (ESR)	3	0 - 14	mm at 1 hr
STOOL: OVA & PARASITE	RESULT PENDING		
SUGAR URINE - POST PRANDIAL			
SUGAR URINE - POST PRANDIAL	**DETECTED (++)**	NOT DETECTED	
PROSTATE SPECIFIC ANTIGEN, SERUM			
PROSTATE SPECIFIC ANTIGEN	0.869	< 2.5	ng/mL
THYROID PANEL, SERUM			
T3	113.60	80.00 - 200.00	ng/dL
T4	7.47	5.10 - 14.10	µg/dl

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Test Report Status **Preliminary**	Results		Units
TSH 3RD GENERATION	1.620	21-50 yrs : 0.4 - 4.2	µIU/mL
PHYSICAL EXAMINATION, URINE			
COLOR	PALE YELLOW		
APPEARANCE	CLEAR		
CHEMICAL EXAMINATION, URINE			
PH	6.0	4.8 - 7.4	
SPECIFIC GRAVITY	**1.010** **Low**	1.015 - 1.030	
PROTEIN	NOT DETECTED	NOT DETECTED	
GLUCOSE	NOT DETECTED	NOT DETECTED	
KETONES	NOT DETECTED	NOT DETECTED	
BILIRUBIN	NOT DETECTED	NOT DETECTED	
UROBILINOGEN	NORMAL	NORMAL	
MICROSCOPIC EXAMINATION, URINE			
RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
WBC	0-1	0-5	/HPF
EPITHELIAL CELLS	NOT DETECTED	NOT DETECTED	/HPF
CASTS	NOT DETECTED		
CRYSTALS	NOT DETECTED		
BACTERIA	NOT DETECTED	NOT DETECTED	
SUGAR URINE - FASTING			
SUGAR URINE - FASTING	NOT DETECTED	NOT DETECTED	

Interpretation(s)
SERUM BLOOD UREA NITROGEN-
Causes of Increased levels
Pre renal
• High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal
• Renal Failure
Post Renal
• Malignancy, Nephrolithiasis, Prostatism

Causes of decreased levels
• 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:

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ARCOFEMI HEALTHCARE LIMITED

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• Myasthenia Gravis
• Muscular dystrophy
GLUCOSE, POST-PRANDIAL, PLASMA-
ADA Guidelines for 2hr post prandial glucose levels is only after ingestion of 75grams of glucose in 300 ml water,over a period of 5 minutes.
GLUCOSE, FASTING, PLASMA-
ADA 2012 guidelines for adults as follows:
Pre-diabetics: 100 - 125 mg/dL
Diabetic: > or = 126 mg/dL

(Ref: Tietz 4th Edition & ADA 2012 Guidelines)
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 patients metabolic control has remained continuously within the target range.
1.eAG (Estimated average glucose) converts percentage HbA1c to md/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 paltform (Boronate affinity chromatography) is recommended for testing of HbA1c.Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy
LIPID PROFILE, SERUM-Serum cholesterol is a blood test that can provide valuable information for the risk of coronary artery disease This test can help determine your risk of the build up of plaques in your arteries that can lead to narrowed or blocked arteries throughout your body (atherosclerosis). High cholesterol levels usually don''''''''''''''t cause any signs or symptoms, so a cholesterol test is an important tool. High cholesterol levels often are a significant risk factor for heart disease and important for diagnosis of hyperlipoproteinemia, atherosclerosis, hepatic and thyroid diseases.

Serum Triglyceride are a type of fat in the blood. When you eat, your body converts any calories it doesn''''''''''''''t need into triglycerides, which are stored in fat cells. High triglyceride levels are associated with several factors, including being overweight, eating too many sweets or drinking too much alcohol, smoking, being sedentary, or having diabetes with elevated blood sugar levels. Analysis has proven useful in the diagnosis and treatment of patients with diabetes mellitus, nephrosis, liver obstruction, other diseases involving lipid metabolism, and various endocrine disorders. In conjunction with high density lipoprotein and total serum cholesterol, a triglyceride determination provides valuable information for the assessment of coronary heart disease risk.It is done in fasting state.

High-density lipoprotein (HDL) cholesterol. This is sometimes called the ""good"" cholesterol because it helps carry away LDL cholesterol, thus keeping arteries open and blood flowing more freely.HDL cholesterol is inversely related to the risk for cardiovascular disease. It increases following regular exercise, moderate alcohol consumption and with oral estrogen therapy. Decreased levels are associated with obesity, stress, cigarette smoking and diabetes mellitus.

SERUM LDL The small dense LDL test can be used to determine cardiovascular risk in individuals with metabolic syndrome or established/progressing coronary artery disease, individuals with triglyceride levels between 70 and 140 mg/dL, as well as individuals with a diet high in trans-fat or carbohydrates. Elevated sdLDL levels are associated with metabolic syndrome and an 'atherogenic lipoprotein profile', and are a strong, independent predictor of cardiovascular disease.
Elevated levels of LDL arise from multiple sources. A major factor is sedentary lifestyle with a diet high in saturated fat. Insulin-resistance and pre-diabetes have also been implicated, as has genetic predisposition. Measurement of sdLDL allows the clinician to get a more comprehensive picture of lipid risk factors and tailor treatment accordingly. Reducing LDL levels will reduce the risk of CVD and MI.

Non HDL Cholesterol - Adult treatment panel ATP III suggested the addition of Non-HDL Cholesterol as an indicator of all atherogenic lipoproteins (mainly LDL and VLDL). NICE guidelines recommend Non-HDL Cholesterol measurement before initiating lipid lowering therapy. It has also been shown to be a better marker of risk in both primary and secondary prevention studies.

Recommendations:
Results of Lipids should always be interpreted in conjunction with the patient's medical history, clinical presentation and other findings.

NON FASTING LIPID PROFILE includes Total Cholesterol, HDL Cholesterol and calculated non-HDL Cholesterol. It does not include triglycerides and may be best used in patients for whom fasting is difficult.
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

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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's
• Multiple Sclerosis

Nutritional tips to manage increased Uric acid levels
• Drink plenty of fluids
• Limit animal proteins
• High Fibre foods
• Vit C Intake
• Antioxidant rich foods
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, Vasculities, 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: Polycythermia 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 :

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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
PROSTATE SPECIFIC ANTIGEN, SERUM-
Prostate Specific Antigen (PSA) is a single-chain glycoprotein normally found in the cytoplasm of the epithelial cells lining the acini and ducts of the prostate gland. PSA is detected in the serum of males with normal, benign hyperplastic and malignant prostate tissue and in patients with prostatitis. PSA is not detected (or detected at very low levels) in the serum of males without prostate tissue (because of radical prostatectomy or cystoprostatectomy) or in the serum of most females.

The fact that PSA is unique to prostate tissue makes it a suitable marker for monitoring men with cancer of the prostate. PSA is also useful for determining possible recurrence after therapy when used in conjunction with other diagnostic indices. PSA levels increase in men with cancer of the prostate. After radical prostatectomy PSA levels routinely fall to a very low level, which may not be seen in patients undergoing radiation therapy. Monitoring PSA levels appears to be useful in detecting residual disease and early recurrence of tumor. Therefore, serial PSA levels can help determine the success of prostatectomy and the need for further treatment, such as radiation, endocrine or chemotherapy and in the monitoring of the effectiveness of therapy.

PSA levels should not be interpreted as absolute evidence of the presence or the absence of malignant disease. Before treatment, patients with confirmed prostate carcinoma frequently have levels of PSA within the range observed in healthy individuals. Elevated levels of PSA can be observed in the patients with nonmalignant diseases. Measurement of PSA should always be used in conjunction with other diagnostic procedures, including information from the patient's clinical evaluation. The concentration of total PSA in a given specimen determined with assays from different manufacturers can vary due to differences in assay methods, calibration, and reagent specificity. Values obtained with different assay method cannot be used interchangeably.

Heterophilic antibodies in human serum can react with reagent immunoglobulins, interfering with in vitro immunoassays. Patients routinely exposed to animals or to animal serum products can be prone to this interference and anomalous values may be observed. Specimens for total PSA assay should be obtained before biopsy, prostatectomy or prostatic massage, since manipulation of the prostate gland may lead to elevated PSA levels persisting upto 3 weeks.
THYROID PANEL, SERUM-
Triiodothyronine T3 , is a thyroid hormone. It affects 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.
Thyroxine T4, Thyroxine's principal function is to stimulate the metabolism of all cells and tissues in the body. Excessive secretion of thyroxine in the body is hyperthyroidism, and deficient secretion is called 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.
In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hypothyroidism, TSH levels are low.
Below mentioned are the guidelines for Pregnancy related reference ranges for Total T4, TSH & Total T3

Levels in Pregnancy	TOTAL T4 (µg/dL)	TSH3G (µIU/mL)	TOTAL T3 (ng/dL)
First Trimester	6.6 - 12.4	0.1 - 2.5	81 - 190
2nd Trimester	6.6 - 15.5	0.2 - 3.0	100 - 260
3rd Trimester	6.6 - 15.5	0.3 - 3.0	100 - 260

Below mentioned are the guidelines for age related reference ranges for T3 and T4.

	T3 (ng/dL)	T4 (µg/dL)
New Born:	75 - 260	1-3 day: 8.2 - 19.9
.		1 Week: 6.0 - 15.9

NOTE: TSH concentrations in apparently normal euthyroid subjects are known to be highly skewed, with a strong tailed distribution towards higher TSH values. This is well documented in the pediatric population including the infant age group.
Kindly note: Method specific reference ranges are appearing on the report under biological reference range.

Reference:
1. Burtis C.A., Ashwood E. R. Bruns D.E. Teitz textbook of Clinical Chemistry and Molecular Diagnostics, 4th Edition.
2. Gowenlock A.H. Varley's Practical Clinical Biochemistry, 6th Edition.
3. Behrman R.E. Kilegman R.M., Jenson H. B. Nelson Text Book of Pediatrics, 17th Edition
SUGAR URINE - FASTING-METHOD: DIPSTICK/BENEDICT'S TEST

DIAGNOSTIC REPORT

Patient Ref. No. 666000002493882

DDRC SRL Diagnostic Services

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 : SUMESH A V PATIENT ID : **SUMEM3011804053**

ACCESSION NO : **4053VK002852** AGE : 42 Years SEX : Male ABHA NO :

DRAWN : RECEIVED : 30/11/2022 08:55 REPORTED : 30/11/2022 17:44

REFERRING DOCTOR : SELF CLIENT PATIENT ID :

Test Report Status **Preliminary**	Results	Units

MEDIWHEEL HEALTH CHECKUP ABOVE 40(M)TMT

ECG WITH REPORT

REPORT
COMPLETED

USG ABDOMEN AND PELVIS

REPORT
COMPLETED

CHEST X-RAY WITH REPORT

REPORT
COMPLETED

****End Of Report****
Please visit www.srlworld.com for related Test Information for this accession

JINSHA KRISHNAN
LAB TECHNOLOGIST

RESHMA RAJAN
LAB TECHNOLOGIST

VINITHA MOL T A
LAB TECHNOLOGIST

DR.INDUSARATH S
CONSULTANT PATHOLOGIST

Scan to View Details

Scan to View Report

OPTHALMOLOGY REPORT

TO WHOM-SO-EVER IT MAY CONCERN

This is to certify that I have examined Mr. SUMESH V, 42 years Male on 30.11.2022 and his visual standards are as follows:

	OD	OS
UNCORRECTED DISTANCE VISUAL ACUITY	6/9(P)	6/6
UNCORRECTED NEAR VISUAL ACUITY	N6(B)	N6(B)
BEST CORRECTED VISUAL ACUITY	6/6,N6	6/6,N6
COLOUR VISION	DEFECTIVE	DEFECTIVE

NOTE:
NO HISTORY OF SPECS
NO RELEVANT MEDICAL HISTORY
PATIENT WAS ABLE TO READ ONLY 1 PLATE ON OU (ISHIHARA COLOUR VISION CHART).
PATIENT READ 16/16 ON OU WITH RED GOOGLES AND ALSO IDENTIFY PRIMARY COLOURS.
N6 BLURRED ON OU.

VIMEGA .V
OPTOMETRIST

DDRC SRL DIAGNOSTICS Pvt. Ltd. Date: ..... KANNUR

DATE: 30.11.2022

Name	Mr. SUMESH	Age/Sex	42/Male
Ref: By:	MEDI WHEEL	Date	30.11.2022

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, 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 could not be visualized due to poor acoustic window.

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

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

RIGHT KIDNEY: Measures 107 x 40 mms

LEFT KIDNEY: Measures 110 x 46 mms

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

PROSTATE: 18 cc, normal in size and echotexture.

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

IMPRESSION:

- **GRADE I FATTY LIVER.**
- **NO OTHER SONOLOGICALLY DETECTED ABNORMALITY.**

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


R
SUMESH A V 42Y/M MEDIWHEEL CHEST P-A 30-Nov-22 10:31 AM
DDRC SRL KANNUR

DDRC SRL
Diagnostic Services
INDIA'S LEADING DIAGNOSTICS NETWORK

LABORATORY SERVICES

Name	Mr. SUMESH.A.V	Age/Sex	42/Male
Ref: By:	MEDI WHEEL	Date	30.11.2022

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 and soft tissue shadows - not remarkable.
The anterior aspect of right 4th rib appears bifurcated.

IMPRESSION:

- **Bifid right 4th rib.**
- **No other abnormality detected.**

DR. P. NIYAZI NASIR,
MBBS, DMRD

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