

DIAGNOSTIC REPORTPatient Ref. No. **66600003724541****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
8800465156DDRC SRL DIAGNOSTICS
Phoenix Tower, Near Central Park Hotel,
Prathibha Junction, Kadappakada,
KOLLAM, 691008
KERALA, INDIA
Tel : 93334 93334
Email : customercare.ddrc@srl.in**PATIENT NAME :** PRENAMPATIENT ID : **PRENM0210904071**ACCESSION NO : **4071WC003196** AGE : 32 Years SEX : Male

ABHA NO :

DRAWN :

RECEIVED : 13/03/2023 08:40

REPORTED : 13/03/2023 17:28

REFERRING DOCTOR : DR. BABK OF BARODA

CLIENT PATIENT ID :

Test Report Status	Preliminary	Results	Biological Reference Interval	Units
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MEDIWHEEL HEALTH CHEKUP BELOW 40(M)TMT**OPHTHAL**

OPHTHAL REPORTED

TREADMILL TEST

TREADMILL TEST REPORTED

PHYSICAL EXAMINATION

PHYSICAL EXAMINATION REPORTED



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PATIENT NAME : PRENAM **PATIENT ID :** PRENM0210904071
ACCESSION NO : 4071WC003196 **AGE :** 32 Years **SEX :** Male **ABHA NO :**
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MEDIWHEEL HEALTH CHEKUP BELOW 40(M)TMT

BUN/CREAT RATIO

BUN/CREAT RATIO 9.6

CREATININE, SERUM

CREATININE 1.07 18 - 60 yrs : 0.9 - 1.3 mg/dL

GLUCOSE, POST-PRANDIAL, PLASMA

GLUCOSE, POST-PRANDIAL, PLASMA 137 Diabetes Mellitus : > or = 200. mg/dL
 Impaired Glucose tolerance/
 Prediabetes : 140 - 199.
 Hypoglycemia : < 55.

GLUCOSE FASTING, FLUORIDE PLASMA

GLUCOSE, FASTING, PLASMA 100 Diabetes Mellitus : > or = 126. mg/dL
 Impaired fasting Glucose/
 Prediabetes : 101 - 125.
 Hypoglycemia : < 55.

GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

GLYCOSYLATED HEMOGLOBIN (HBA1C) 4.7 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%.
 < 116.0 mg/dL

MEAN PLASMA GLUCOSE 88.2

LIPID PROFILE, SERUM

CHOLESTEROL 140 Desirable : < 200 mg/dL
 Borderline : 200-239
 High : >or= 240

TRIGLYCERIDES 198 **High** Normal : < 150 mg/dL
 High : 150-199
 Hypertriglyceridemia : 200-499
 Very High : > 499

HDL CHOLESTEROL 32 **Low** General range : 40-60 mg/dL



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DIRECT LDL CHOLESTEROL		104	mg/dL
		Optimum : < 100 Above Optimum : 100-139 Borderline High : 130-159 High : 160-189 Very High : >or= 190	
NON HDL CHOLESTEROL		108	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		39.6	mg/dL
		High Desirable value : 10 - 35	
CHOL/HDL RATIO		4.4	
		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		3.3	
		High 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	
	LDL-C (mg/dl)	Non-HDL (mg/dl)	LDL-C (mg/dl)	Non-HDL (mg/dl)





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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	1.46	General Range : < 1.1	mg/dL
BILIRUBIN, DIRECT	0.37	High General Range : < 0.3	mg/dL
BILIRUBIN, INDIRECT	1.09	High 0.00 - 0.60	mg/dL
TOTAL PROTEIN	7.0	Ambulatory : 6.4 - 8.3 Recumbant : 6 - 7.8	g/dL
ALBUMIN	4.7	20-60yrs : 3.5 - 5.2	g/dL
GLOBULIN	2.3	General Range : 2 - 3.5 Premature Neonates : 0.29 - 1.04	g/dL
ALBUMIN/GLOBULIN RATIO	2.0	1.0 - 2.0	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	144	Adults : < 40	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)	69	Adults : < 45	U/L
ALKALINE PHOSPHATASE	58	Adult(<60yrs) : 40 -130	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)	25	Adult (Male) : < 60	U/L

Comments

*Sample is icteric in appearance.
 *Kindly correlate clinically.

TOTAL PROTEIN, SERUM

TOTAL PROTEIN	7.0	Ambulatory : 6.4 - 8.3 Recumbant : 6 - 7.8	g/dL
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URIC ACID, SERUM

URIC ACID	5.9	Adults : 3.4-7	mg/dL
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ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

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ABO GROUP	TYPE O
RH TYPE	POSITIVE
BLOOD COUNTS,EDTA WHOLE BLOOD	
HEMOGLOBIN	17.1 High 13.0 - 17.0 g/dL
RED BLOOD CELL COUNT	5.83 High 4.5 - 5.5 mil/ μ L
WHITE BLOOD CELL COUNT	6.97 4.0 - 10.0 thou/ μ L
PLATELET COUNT	219 150 - 410 thou/ μ L

Comments

* KINDLY CORRELATE CLINICALLY.
 * CONFIRMED BY REPETITION.

RBC AND PLATELET INDICES

HEMATOCRIT	50.2 High 40 - 50 %
MEAN CORPUSCULAR VOL	86.1 83 - 101 fL
MEAN CORPUSCULAR HGB.	29.3 27.0 - 32.0 pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION	34.0 31.5 - 34.5 g/dL
RED CELL DISTRIBUTION WIDTH	13.5 11.6 - 14.0 %
MENTZER INDEX	14.8
MEAN PLATELET VOLUME	8.9 6.8 - 10.9 fL

WBC DIFFERENTIAL COUNT

SEGMENTED NEUTROPHILS	61 40 - 80 %
LYMPHOCYTES	34 20 - 40 %
MONOCYTES	03 2 - 10 %
EOSINOPHILS	02 1 - 6 %
BASOPHILS	00 < 1 - 2 %
ABSOLUTE NEUTROPHIL COUNT	4.25 2.0 - 7.0 thou/ μ L
ABSOLUTE LYMPHOCYTE COUNT	2.37 1.0 - 3.0 thou/ μ L
ABSOLUTE MONOCYTE COUNT	0.21 0.2 - 1.0 thou/ μ L
ABSOLUTE EOSINOPHIL COUNT	0.14 0.02 - 0.50 thou/ μ L
ABSOLUTE BASOPHIL COUNT	00 thou/ μ L

ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD

SEDIMENTATION RATE (ESR)	01 0 - 14 mm at 1 hr
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Test Report Status	Preliminary	Results	Units
SUGAR URINE - POST PRANDIAL			
SUGAR URINE - POST PRANDIAL		NOT DETECTED	NOT DETECTED
THYROID PANEL, SERUM			
T3		140.50	Adult : 80-200 ng/dL
T4		7.47	Adults : 4.5-12.1 µg/dl
TSH 3RD GENERATION		1.650	21-50 yrs : 0.4 - 4.2 µIU/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. Guidelines 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 CLEAR

CHEMICAL EXAMINATION, URINE

PH 6.0 4.8 - 7.4



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SPECIFIC GRAVITY		1.025	1.015 - 1.030
PROTEIN		NOT DETECTED	NOT DETECTED
GLUCOSE		NOT DETECTED	NOT DETECTED
KETONES		NOT DETECTED	NOT DETECTED
BLOOD		NOT DETECTED	NOT DETECTED
BILIRUBIN		NOT DETECTED	NOT DETECTED
UROBILINOGEN		NORMAL	NORMAL
NITRITE		NOT DETECTED	NOT DETECTED
MICROSCOPIC EXAMINATION, URINE			
RED BLOOD CELLS		NOT DETECTED	/HPF
WBC		2-3	/HPF
EPITHELIAL CELLS		1-2	/HPF
CASTS		NIL	
CRYSTALS		NIL	
BACTERIA		NOT DETECTED	NOT DETECTED
YEAST		NOT DETECTED	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

BLOOD UREA NITROGEN (BUN), SERUM

BLOOD UREA NITROGEN 10 Adult(<60 yrs) : 6 to 20 mg/dL

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



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REFERRING DOCTOR : DR. BABK OF BARODA

CLIENT PATIENT ID :

Test Report Status	<u>Preliminary</u>	Results	Units
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Patient Ref. No. 66600003724541

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

DDRC SRL DIAGNOSTICS
 Phoenix Tower, Near Central Park Hotel,
 Prathibha Junction, Kadappakada,
 KOLLAM, 691008
 KERALA, INDIA
 Tel : 93334 93334
 Email : customercare.ddrc@srl.in

PATIENT NAME : PRENAM

PATIENT ID : PRENM0210904071

ACCESSION NO : 4071WC003196 AGE : 32 Years SEX : Male

ABHA NO :

DRAWN :

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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%.
- Rota Virus Immunoassay**: This test is recommended in severe gastroenteritis in infants & children associated with watery



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PATIENT NAME : PRENAM

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ACCESSION NO : 4071WC003196 AGE : 32 Years SEX : Male

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diarrhoea, vomiting& abdominal cramps. Adults are also affected. It is highly contagious in nature.

Interpretation(s)

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 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, Waldenström's disease

Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage), Burns, Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic



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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, 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. AACCC 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

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.

SUGAR URINE - FASTING-METHOD: DIPSTICK/BENEDICT'S TEST



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DIAGNOSTIC REPORT

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CLIENT'S NAME AND ADDRESS:MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED
F701A, LADO SARAI, NEW DELHI,
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KERALA, INDIA
Tel : 93334 93334
Email : customercare.ddrc@srl.in**PATIENT NAME :** PRENAM**PATIENT ID :** PRENM0210904071ACCESSION NO : **4071WC003196** AGE : 32 Years SEX : Male

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MEDIWHEEL HEALTH CHEKUP BELOW 40(M)TMT**ECG WITH REPORT****REPORT**

REPORTED

****End Of Report****Please visit www.srlworld.com for related Test Information for this accessionDR. AMJAD A, M.D Pathology
(Reg No - TCMC 38949)
CONSULTANT PATHOLOGISTDR.AKHILA SEKHAR, M.D
Pathology
(Reg No - TCMC 55174)
CONSULTANT PATHOLOGISTJIBI J
LAB TECHNOLOGISTLAVANYA
LAB TECHNOLOGIST

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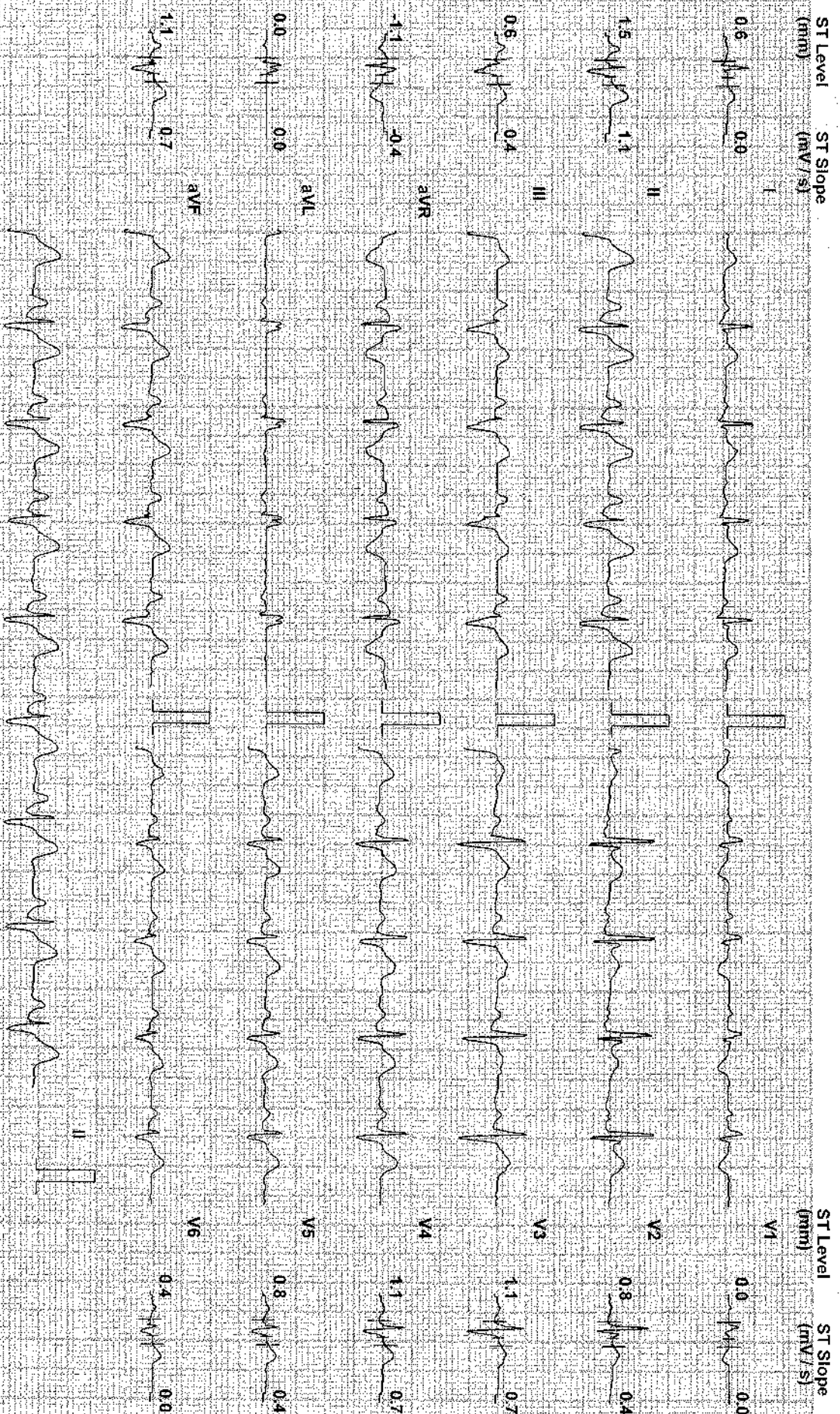


Chart Speed: 25 mm/sec Filter: 35 Hz Mains Filt: ON Amp: 10 mm Iso = R: 60 ms L: R + 60 ms Post I = 1.1, 60 ms

Schiffler Spindel V.4.7

DDRRC Hospital

MR. PRENAM (32 M)

ID: 2192

Date: 13-Mar-23

Exec Time : 0 m 0 s

Stage Time : 0 m 8 s

HR: 86 bpm

Protocol: Bruce

Stage: Standing

Speed: 0 mph

Grade: 0%

(THR: 169 bpm)

B.P: 110/80

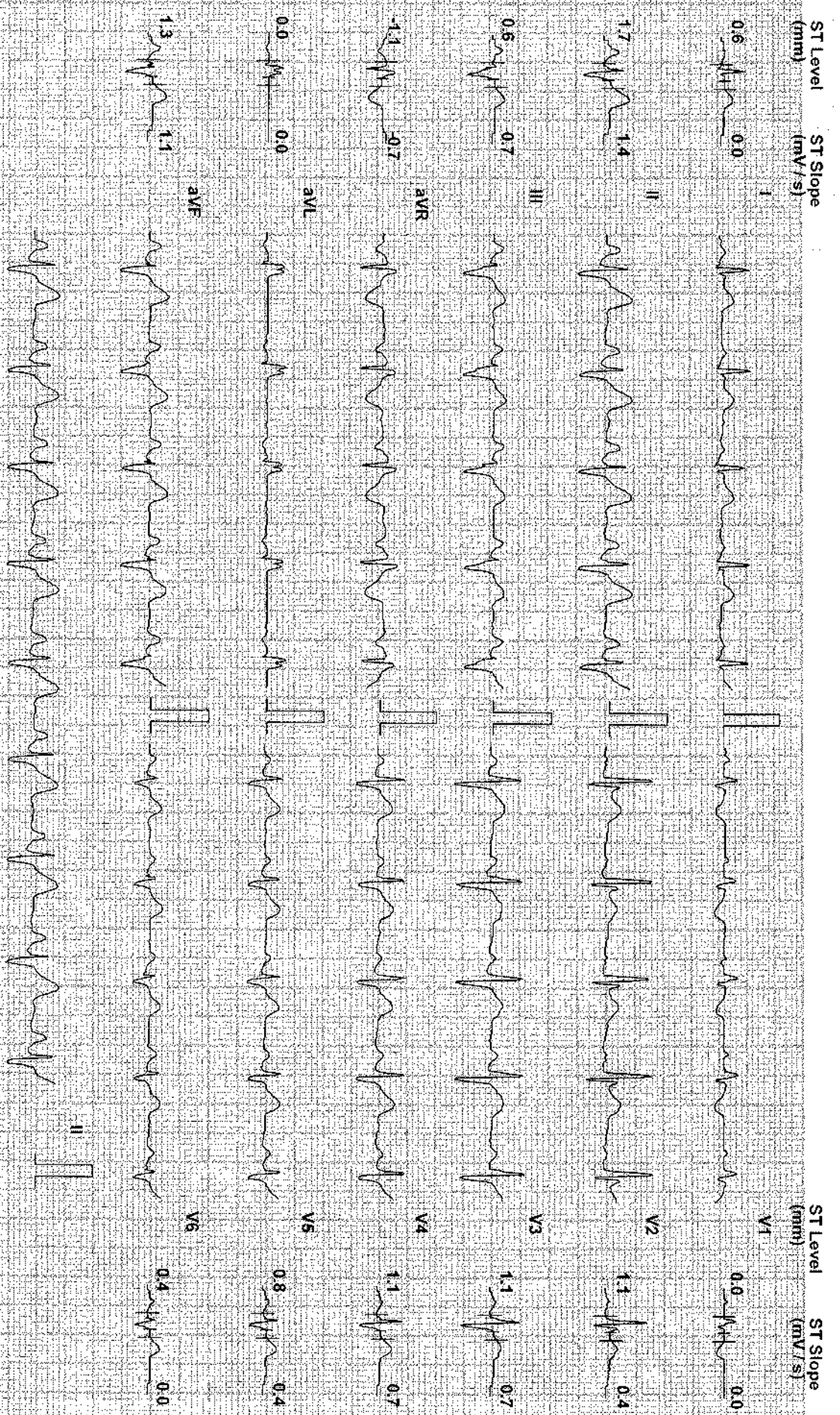


Chart Speed: 25 mm/sec
Schlier Speed: V.4.7

Filter: 35 Hz

Mains: Filtr. ON

Amp: 10 mm

ISO = R - 50 ms

J = R + 60 ms

Post J = J + 50 ms

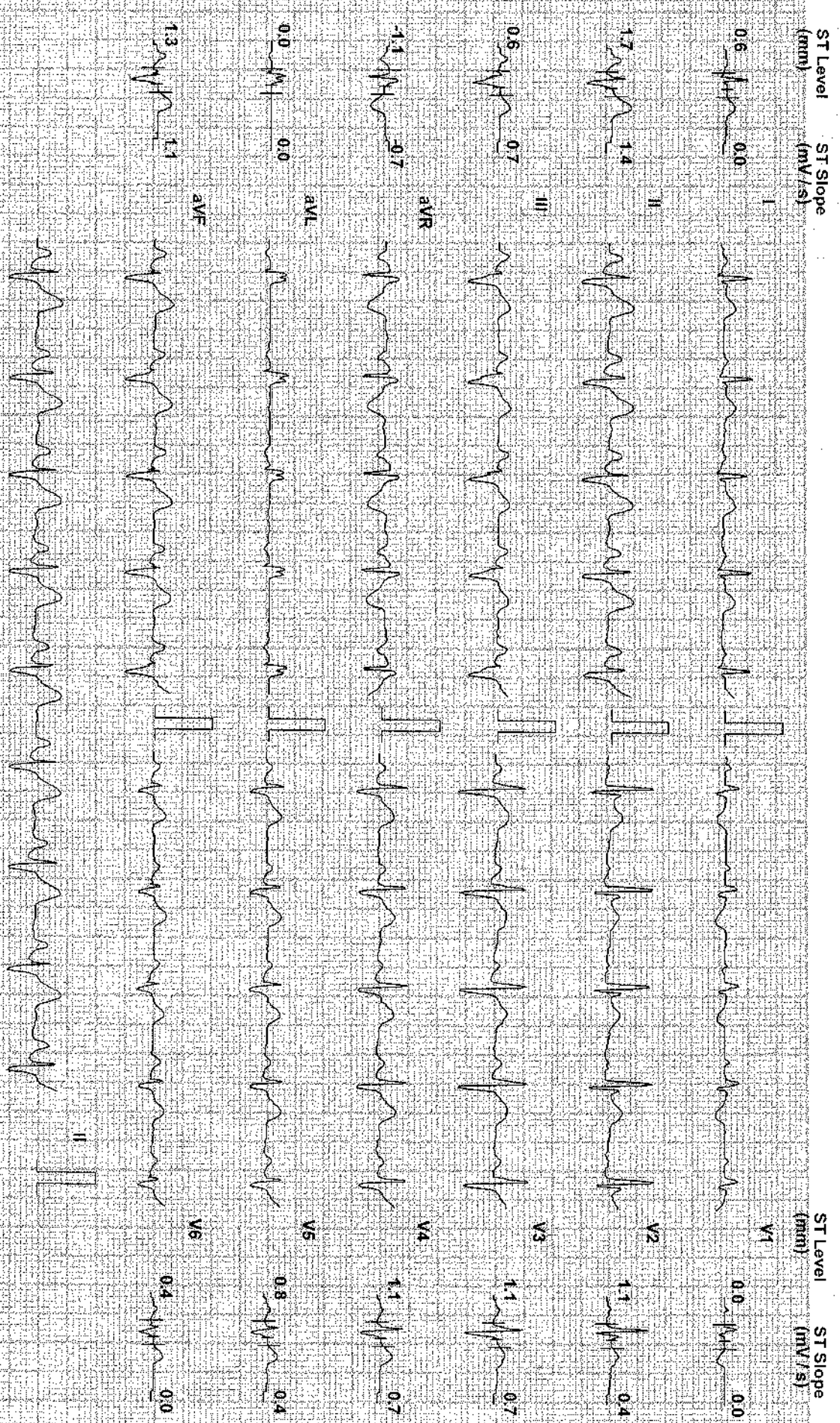


Chart Speed: 25 mm/sec
Schiller Sparten V4.7

Filter: 35 Hz

Mains Filtr. ON

Amp: 10 mm

ISO - R - 60 ms

J - R + 60 ms

Post J - J + 60 ms

Mr. PRENAM (32 M)

ID: 2192

Date: 13-Mar-23

Exec Time : 3 m 0 s

Stage Time : 3 m 0 s

HR: 129 bpm

Protocol: Bruce

Stage: 1

Speed: 1.7 mph

Grade: 10 %

(THR: 169 bpm)

B.P: 110 / 80

ST Level (mm) ST Slope (mV/s)

ST Level (mm) ST Slope (mV/s)

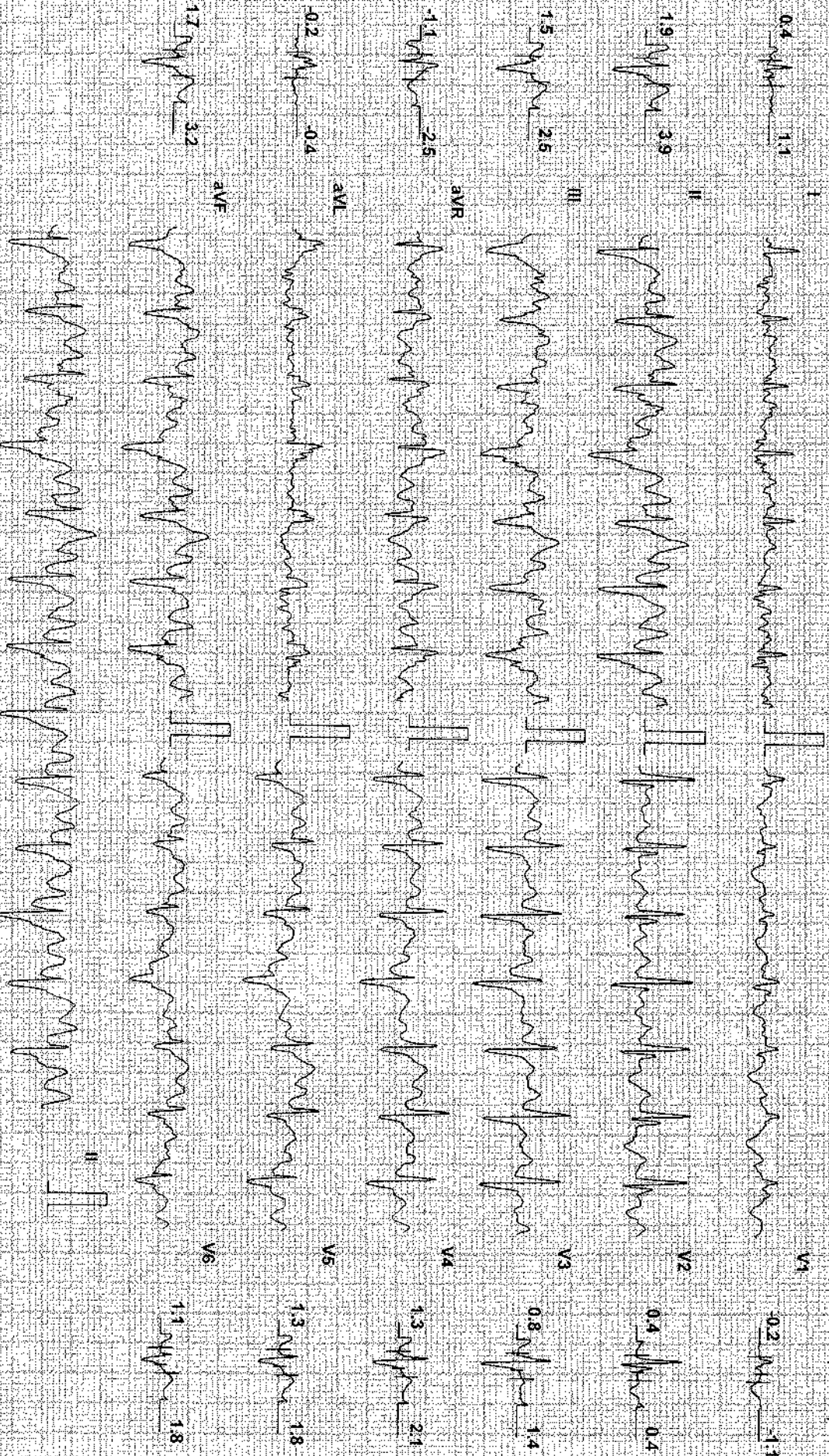


Chart Speed: 25 mm/sec
Schiller Standard 47

Filter: 35 Hz

Mains Filter ON

Amp: 10 mm

60 = R = 60 ms

J = R = 60 ms

Post J = J = 60 ms

MR. PRENAM (32 M)

LUCK HOSPITAL

ID: 2192

Date: 13-Mar-23

Exec Time : 6 m 0 s

Stage Time : 3 m 0 s

HR: 138 bpm

Protocol: Bruce

Stage: 2

Speed: 2.5 mph

Grade: 12 %

(THR: 169 bpm)

B.P.: 110 / 80

ST Level (mm) ST Slope (mV/s)

ST Level (mm) ST Slope (mV/s)

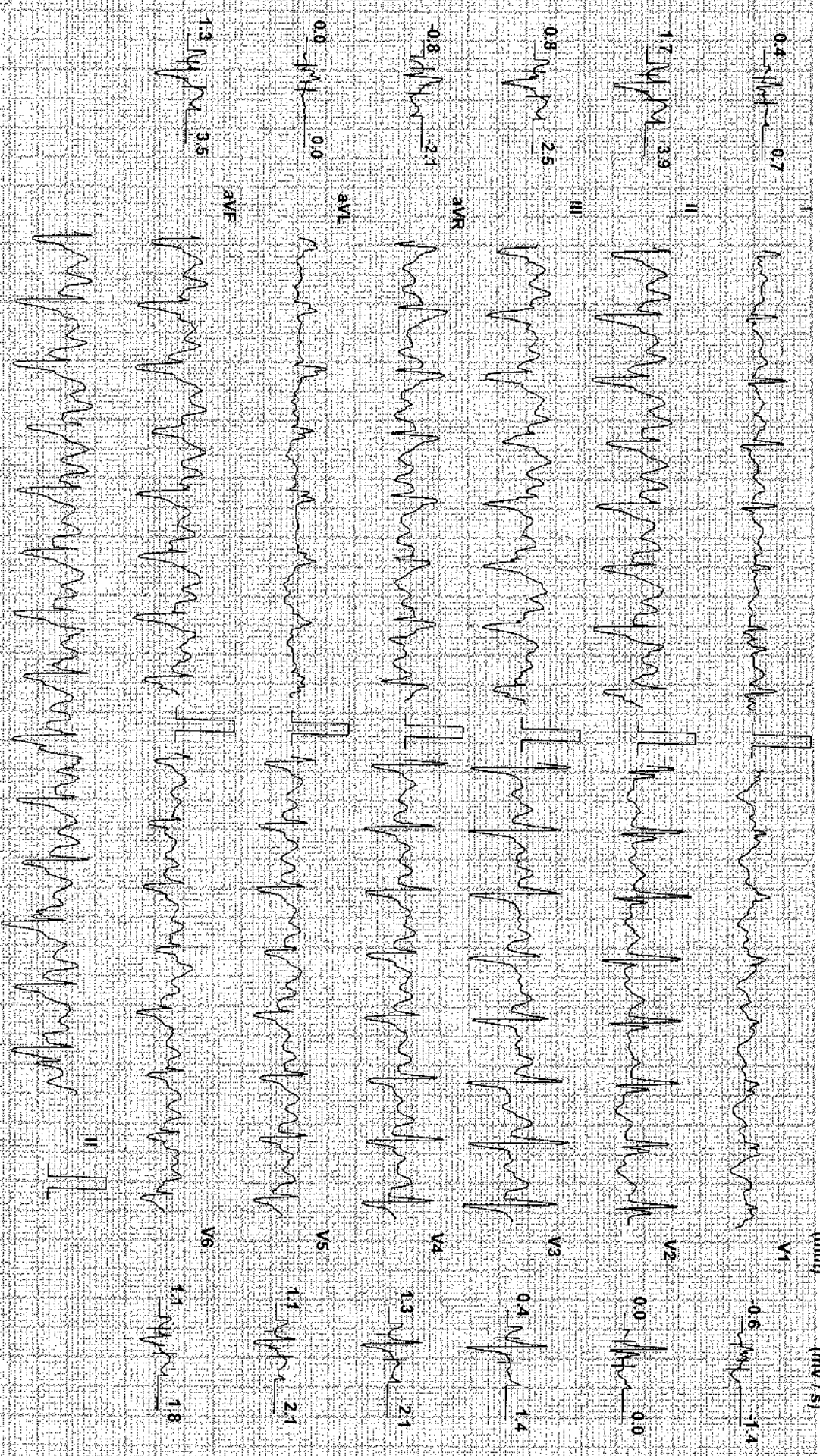


Chart Speed: 25 mm/sec
Schiller Speedon V.47

Filter: 35 Hz

Mains Fil: ON

Amp: 10 mm

60 = P - 60 ms

Q - R + 60 ms

Post U - U + 60 ms

DDRC Hospital

MR. PRENAM (32 M)

ID: 2192

Date: 13-Mar-23

Exec Time : 9 m 0 s

Stage Time : 3 m 0 s

HR: 155 bpm

Protocol: Bruce

Stage: 3

Speed: 3.4 mph

Grade: 14 %

(THR: 169 bpm)

B.P: 140 / 80

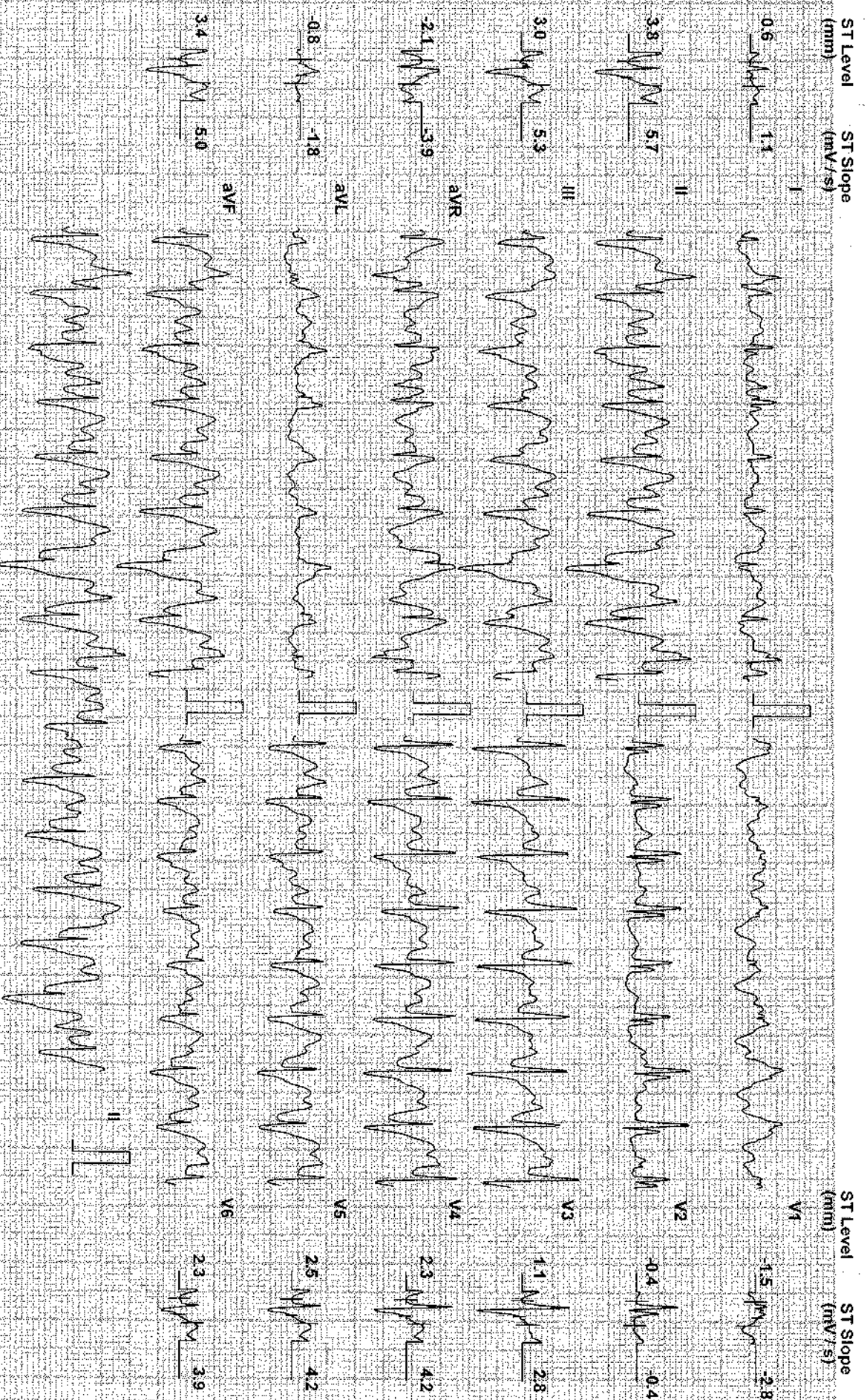


Chart Speed 25 mm/sec
Schlier-Spradan V 4.7

Filter: 35 Hz

Main: Fill: ON

Amp: 10 mm

ISO - R - 60 ms

J = R + 60 ms

Post J = J + 60 ms

DDRC Hospital

Mr. PRENAM (32 M)

ID: 2192

Date: 13-Mar-23

Exec Time : 11 m 1 s Stage Time : 2 m 1 s

HR: 164 bpm

Protocol: Bruce

Stage: Peak Ex

Speed: 4.2 mph

Grade: 16 %

(THR: 169 bpm)

B.P: 140 / 80

ST Level (mm) ST Slope (mV/s)

ST Level (mm) ST Slope (mV/s)

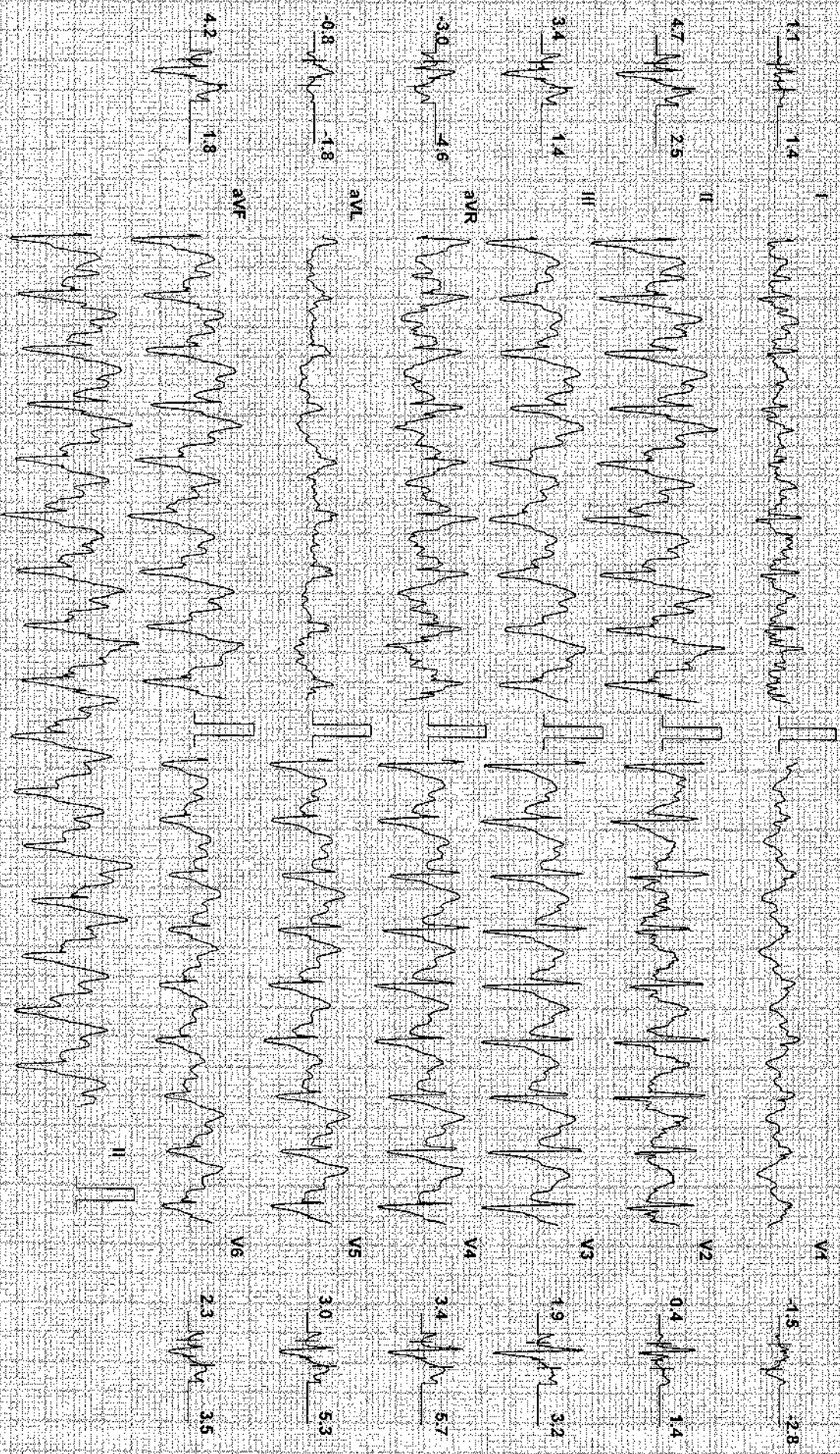


Chart Speed 25 mm/sec
Schiller Standard V.47

Filter: 35 Hz

Mains Filtr. ON

Amp: 10 mm

ISO = R + 60 ms

J = R + 60 ms

Post J = J + 60 ms

DDRC Hospital

MR. PRENAM (32 M)

ID: 2192

Date: 13-Mar-23

Exec Time : 11 m 1 s Stage Time : 1 m 0 s

HR: 129 bpm

Protocol: Bruce

Stage: Recovery(1)

Speed: 0 mph

Grade: 0 %

(THR: 169 bpm)

B.P: 140 / 80

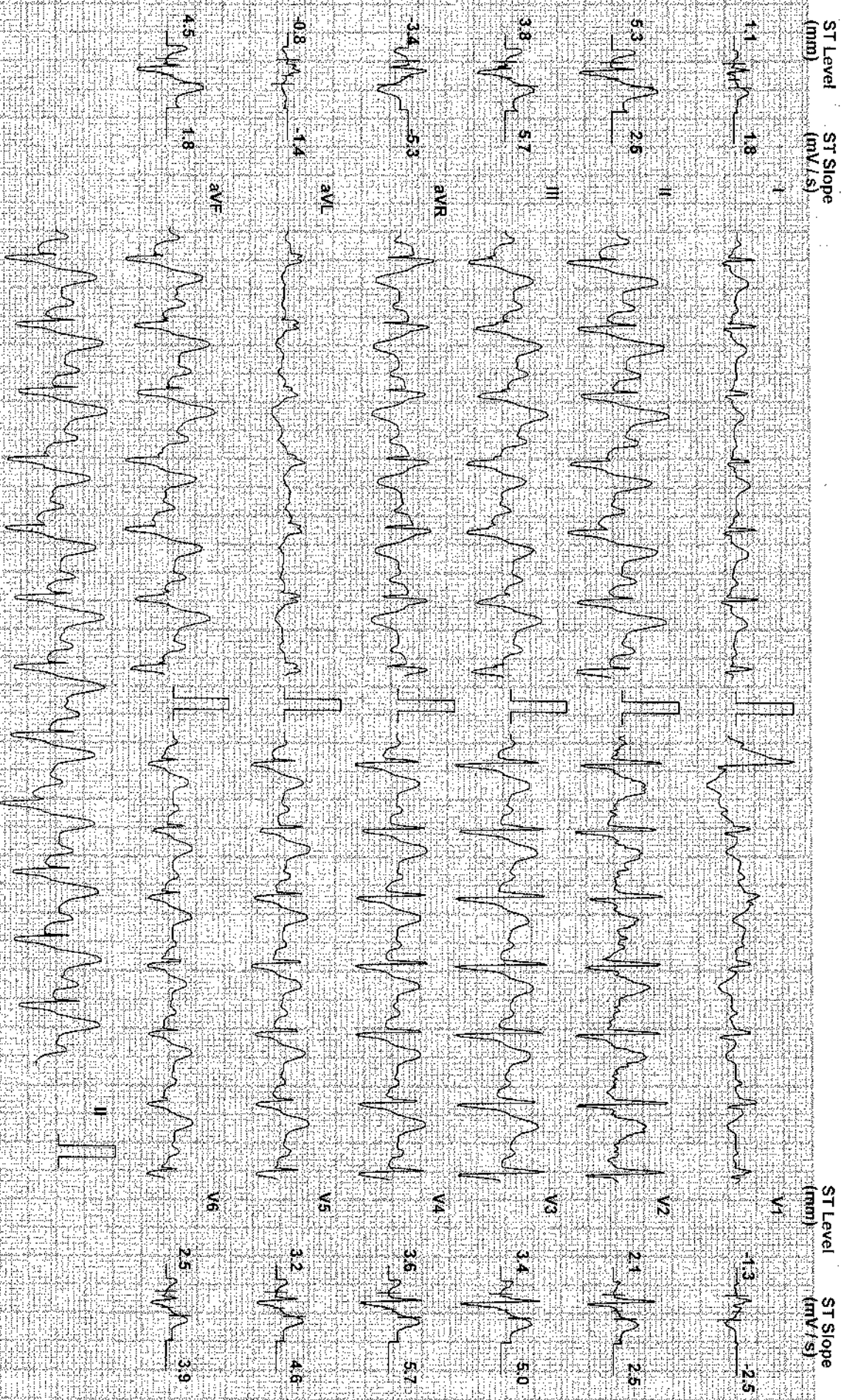


Chart Speed: 25 mm/sec
Schlier: Standard V47

Filter: 35 Hz

Mains: Fil ON

Amp: 10 mm

ISO = R + 60 ms

J = R + 60 ms

Post J = J + 60 ms

ST Level (mm) ST Slope (mV/s)

ST Level (mm) ST Slope (mV/s)

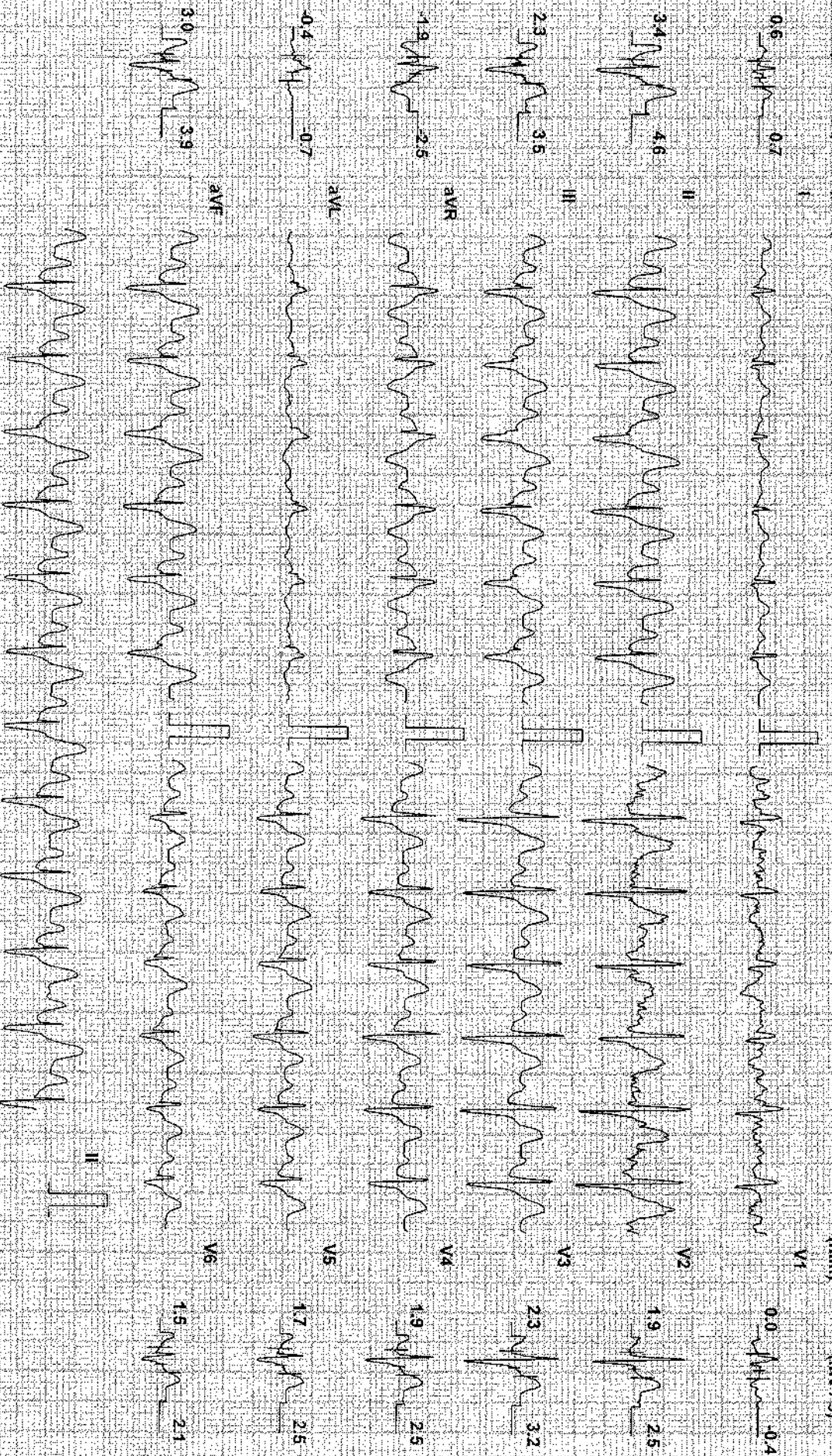


Chart Speed: 25 mm/sec
Schiller Spandtr V-47

Filter: 35 Hz

Mains Filtr: ON

Amp: 10 mm

60 = R - 60 ms

I = R + 60 ms

Post I = J + 60 ms

DDRC Hospital

MR. PRENAM (32 M)

ID: 2192

Date: 13-Mar-23

Exec Time : 11 m 1 s Stage Time : 1 m 0 s

HR: 113 bpm

Protocol: Bruce

Stage: Recovery(3)

Speed: 0 mph

Grade: 0%

(THR: 169 bpm)

B.P: 140 / 80

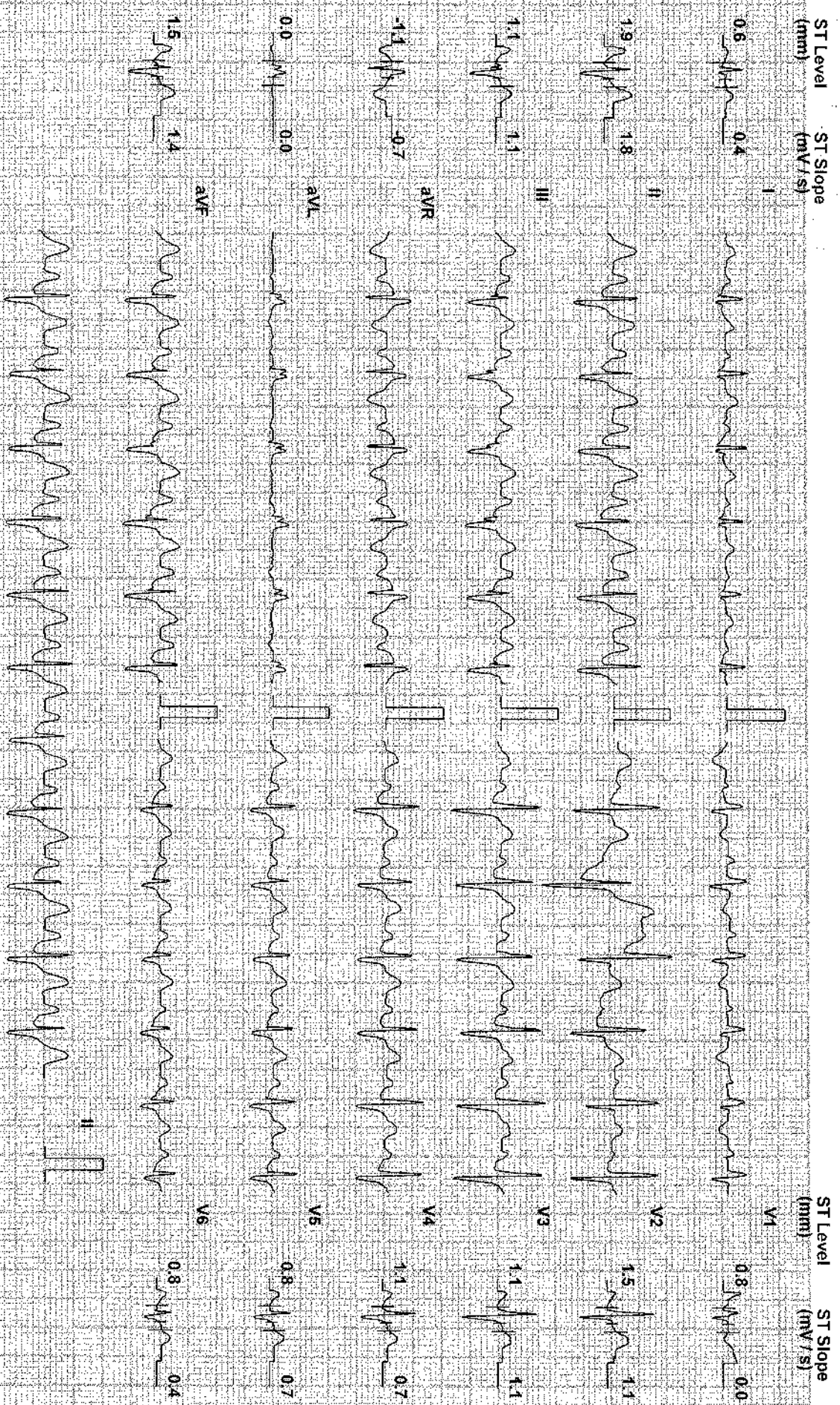


Chart Speed: 25 mm/sec Filter: 35 Hz Mains Fil: ON Amp: 10 mm Iso = R - 60 ms J = R + 60 ms Post J = J + 60 ms
Schiller Spandix V.4.7

Mr. PRENAM (32 M)

ID: 2192

Date: 13-Mar-23

Exec Time : 11 m 1 s Stage Time : 1 m 0 s

HR: 106 bpm

Protocol: Bruce

Stage: Recovery(4)

Speed: 0 mph

Grade: 0 %

(THR: 169 bpm)

B.P.: 120 / 80

ST Level (mm) ST Slope (mV/s)

ST Level (mm) ST Slope (mV/s)

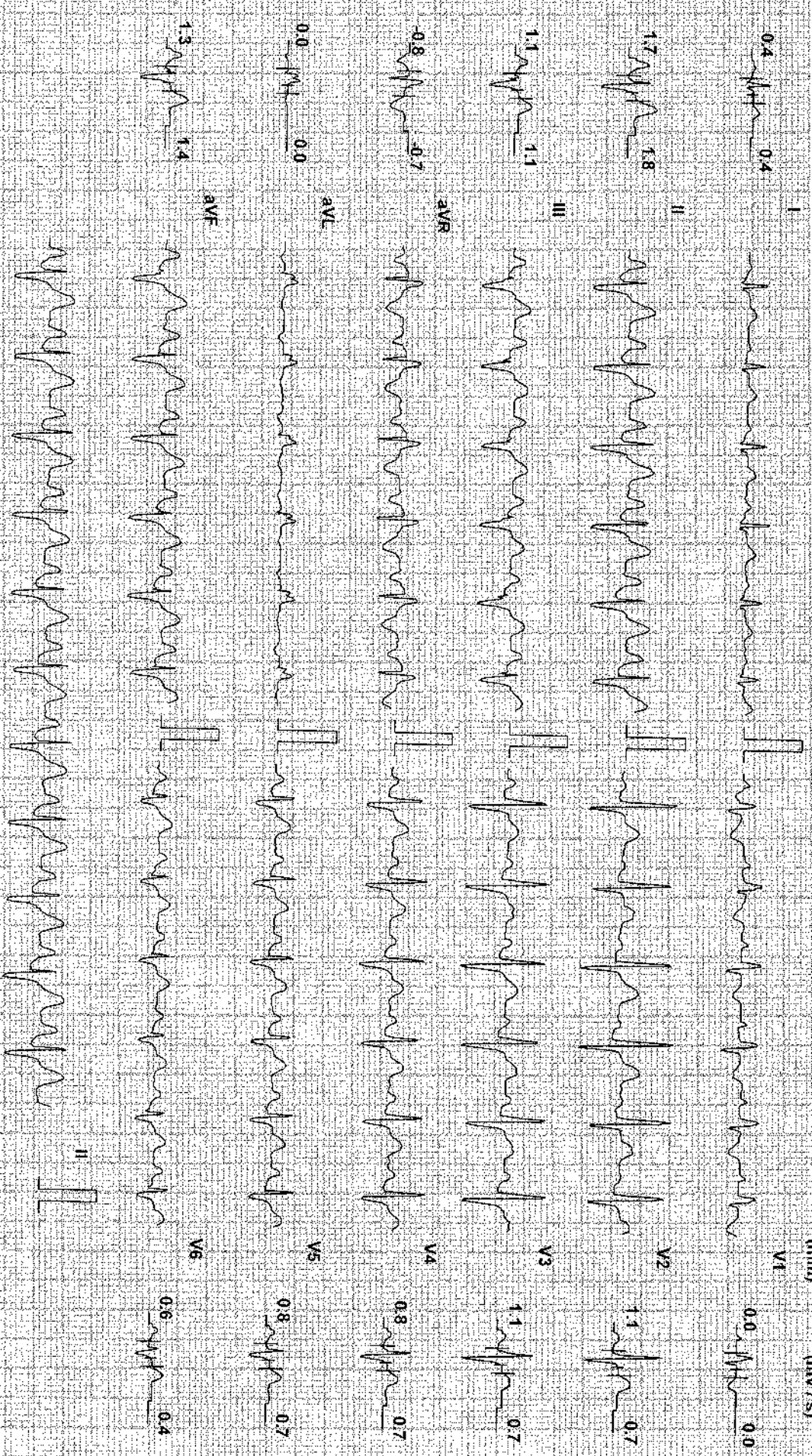


Chart Speed: 25 mm/sec
Schiller Standard V47

Filter: 35 Hz

Mains Filtr: ON

Amp: 10 mm

60 = R - 60 ms

J = R - 60 ms

Pd_{ST} = J + 60 ms

Mr. PRENAM (32 M)

ID: 2192

Date: 13-Mar-23

Exec Time : 11 m 1 s Stage Time : 1 m 0 s

HR: 112 bpm

Protocol: Bruce

Stage: Recovery(5)

Speed: 0 mph

Grade: 0 %

(THR: 169 bpm)

B.P: 120 / 80

ST Level (mm) ST Slope (mV/s)

ST Level (mm) ST Slope (mV/s)

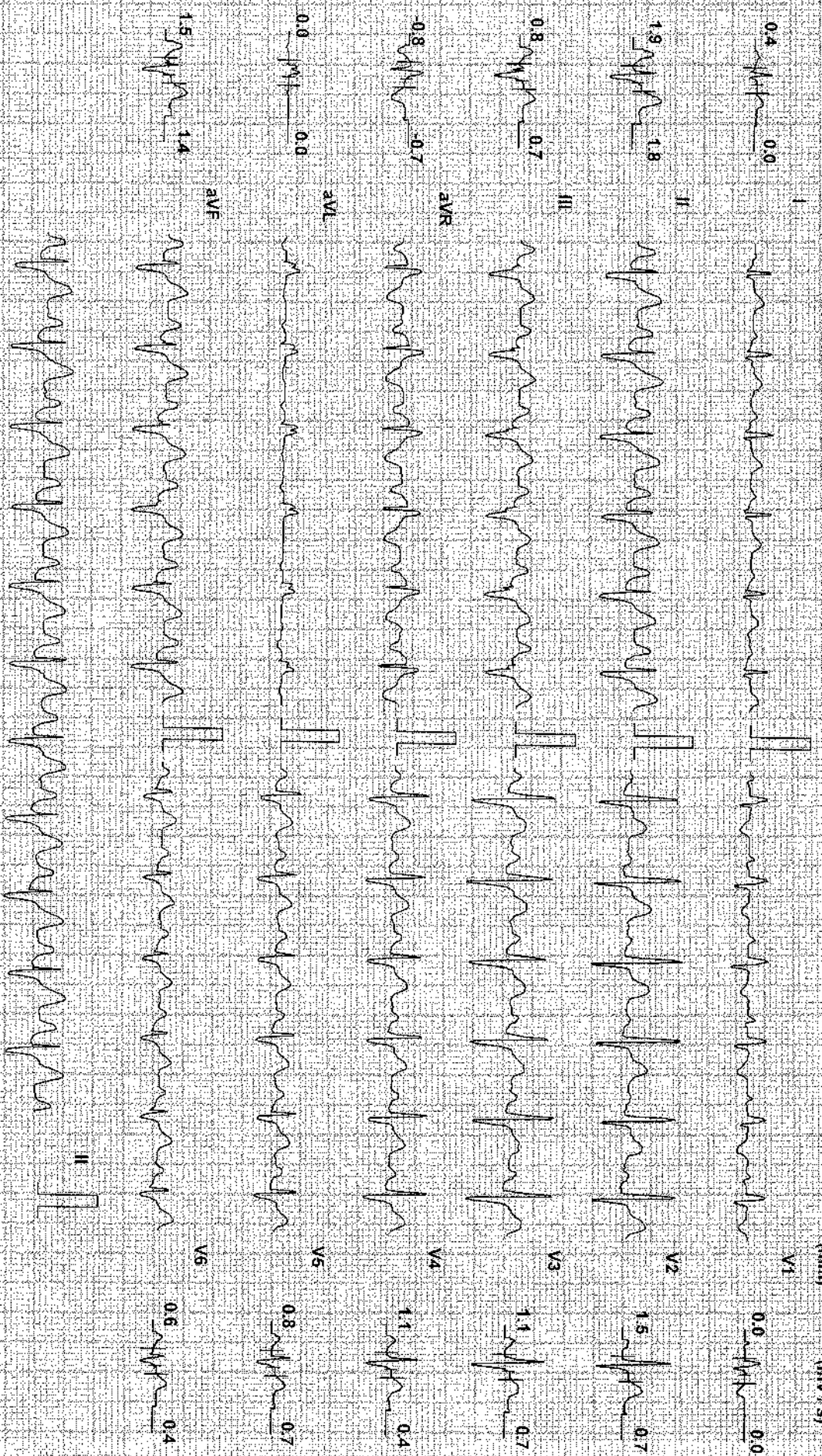


Chart Speed: 25 mm/sec
Schiller Spandax V.4.7

Filter: 35 Hz

Mains-Filt: ON

Amp: 10 mm

ISO = R: 60 ms

J = R: 60 ms

POST = J: 60 ms

DDRC Hospital

Patient Details

Date: 13-Mar-23

Time: 11:14:32 AM

Name: Mr. PRENAM ID: 2192

Age: 32 y

Sex: M

Height: 173 cms

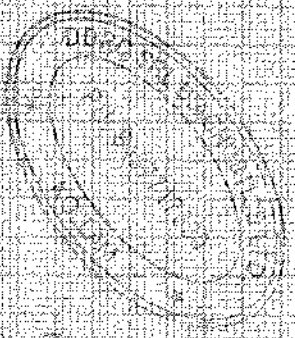
Weight: 70 Kgs

Interpretation

The Patient exercised according to the Bruce Protocol for 11 m 03s achieving a work level of
Maximum Mets: 13.50 Resting heart rate initially 83 bpm, Rose to a maximum heart rate
164 (87% of Pr. MHR) bpm. Resting Blood pressure 110/80 mmHg, Rose to maximum blood
pressure of 140/80 mmHg

No angina, arrhythmias or significant ST-T changes, signs
of LV dysfunction during exercise or at recovery

ECG negative for possible myocardial ischemia



Signature of the doctor

Ref. Doctor: _____

Doctor: SSN