DDRC SRL
Diagnostic Services
INDIA'S LEADING DIAGNOSTICS NETWORK

LABORATORY SERVICES

4031V1001529
SHIYANA

X - RAY

ECG

MOTION

TMT.

4031V1001533
ARUN

MOTION

We voluntarily refused to take the above mentioned tests.

Shiyana

Shiyana Sebastian.

Arun

Arun Joseph

DDRC SRL DIAGNOSTICS PRIVATE LTD.
Wellness Centre
MEXA Tower
Mavoor Road
Eranhippalam
Calicut-673 006

Patient Ref. No. 666000001624095

CLIENT CODE : CA00010147

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

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

PATIENT NAME : JOSEPH ARUN PATIENT ID : **JOSEM2109904031**

ACCESSION NO : **4031VI001533** AGE : 32 Years SEX : Male ABHA NO :

DRAWN : RECEIVED : 21/09/2022 10:39 REPORTED : 22/09/2022 18:08

REFERRING DOCTOR : SELF CLIENT PATIENT ID :

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

MEDIWHEEL HEALTH CHEKUP BELOW 40(M)TMT

OPTHAL

OPTHAL	COMPLETED		

TREADMILL TEST

TREADMILL TEST	COMPLETED		

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MEDIWHEEL HEALTH CHEKUP BELOW 40(M)TMT				
LIVER PROFILE - EXTENDED				
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	30		Upto 40	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)	**48**	**High**	Upto 45	U/L
ALKALINE PHOSPHATASE	69		40 - 129	U/L
BILIRUBIN, TOTAL	**1.7**	**High**	0.0 - 1.2	mg/dL
BILIRUBIN, INDIRECT	**1.1**	**High**	0.00 - 1.00	mg/dL
TOTAL PROTEIN	7.8		6.4 - 8.3	g/dL
ALBUMIN	4.8		3.5 - 5.2	g/dL
GLOBULIN	3		2.0 - 4.1	g/dL
ALBUMIN/GLOBULIN RATIO	1.6		1.0 - 2.0	Ratio
HEPATITIS B SURFACE ANTIGEN	NON REACTIVE		NON REACTIVE	
BUN/CREAT RATIO				
BUN/CREAT RATIO	5.1		5 - 15	
CREATININE, SERUM				
CREATININE	**0.6**	**Low**	0.70 - 1.20	mg/dL
GLUCOSE, POST-PRANDIAL, PLASMA				
GLUCOSE, POST-PRANDIAL, PLASMA	**232**	**High**	Normal: < 140, Impaired Glucose Tolerance:140-199 Diabetic > or = 200	mg/dL
GLUCOSE, FASTING, PLASMA				
GLUCOSE, FASTING, PLASMA	**228**	**High**	74 - 99	mg/dL
CORONARY RISK PROFILE (LIPID PROFILE), SERUM				
CHOLESTEROL	195		Desirable: <200 BorderlineHigh : 200-239 High : > or = 240	mg/dL
TRIGLYCERIDES	91		Desirable: < 150 Borderline High: 150 - 199 High: 200 - 499 Very High : > or = 500	mg/dL
HDL CHOLESTEROL	**33**	**Low**	< 40 Low > or = 60 High	mg/dL

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DIRECT LDL CHOLESTEROL	**143**	**High**	Adult levels: Optimal < 100 Near optimal/above optimal: 100-129 Borderline high : 130-159 High : 160-189 Very high : = 190	mg/dL
NON HDL CHOLESTEROL	**162**	**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	**5.9**	**High**	3.30 - 4.40	
LDL/HDL RATIO	**4.3**	**High**	0.5 - 3.0	
VERY LOW DENSITY LIPOPROTEIN	18.2		< or = 30.0	mg/dL
LIVER FUNCTION TEST WITH GGT				
BILIRUBIN, DIRECT	**0.6**	**High**	0.0 - 0.2	mg/dL
TOTAL PROTEIN	7.8		6.4 - 8.3	g/dL
ALBUMIN	4.8		3.50 - 5.20	g/dL
GLOBULIN	3		2.0 - 4.1	g/dL
ALBUMIN/GLOBULIN RATIO	1.6		1.0 - 2.0	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	30		UPTO 40	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)	**49**	**High**	UP TO 45	U/L
ALKALINE PHOSPHATASE	69		40 - 129	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)	21		8 - 61	U/L
URIC ACID, SERUM				
URIC ACID	4.9		3.5 - 7.2	mg/dL
ABO GROUP & RH TYPE, EDTA WHOLE BLOOD				
ABO GROUP	TYPE A			
RH TYPE	POSITIVE			
BLOOD COUNTS				
HEMOGLOBIN	14.8		13.0 - 17.0	g/dL
RED BLOOD CELL COUNT	5.09		4.5 - 5.5	mil/µL
WHITE BLOOD CELL COUNT	6.10		4.0 - 10.0	thou/µL
PLATELET COUNT	196		150 - 410	thou/µL
RBC AND PLATELET INDICES				


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HEMATOCRIT	44.9	40 - 50	%
MEAN CORPUSCULAR VOL	88.1	83 - 101	fL
MEAN CORPUSCULAR HGB.	29.1	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION	33.0	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH	13.6	11.6 - 14.0	%
MEAN PLATELET VOLUME	8.7	6.8 - 10.9	fL
WBC DIFFERENTIAL COUNT - NLR			
SEGMENTED NEUTROPHILS	51	40 - 80	%
ABSOLUTE NEUTROPHIL COUNT	3.11	2.0 - 7.0	thou/µL
LYMPHOCYTES	**45** **High**	20 - 40	%
ABSOLUTE LYMPHOCYTE COUNT	2.74	1.0 - 3.0	thou/µL
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	1.1		
EOSINOPHILS	04	1 - 6	%
ABSOLUTE EOSINOPHIL COUNT	0.24	0.02 - 0.50	thou/µL
ERYTHRO SEDIMENTATION RATE, BLOOD			
SEDIMENTATION RATE (ESR)	14	0 - 14	mm at 1 hr
SUGAR URINE - POST PRANDIAL			
SUGAR URINE - POST PRANDIAL	**DETECTED (+)**	NOT DETECTED	
URINALYSIS			
COLOR	PALE YELLOW		
APPEARANCE	CLEAR		
PH	6.0	4.7 - 7.5	
SPECIFIC GRAVITY	1.015	1.003 - 1.035	
GLUCOSE	**DETECTED (TRACE)**	NOT DETECTED	
PROTEIN	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	
WBC	1-2	0-5	/HPF
EPITHELIAL CELLS	0-1	0-5	/HPF
RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
CASTS	NOT DETECTED		

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CRYSTALS	NOT DETECTED		
BACTERIA	NOT DETECTED	NOT DETECTED	
THYROID PANEL, SERUM			
T3	127.62	Male and Non-Pregnant : 70-204ng/dL Pregnant Trimester-wise 1st : 81-190 2nd : 100-260 3rd : 100-260	
T4	11.20	3.2 - 12.6	µg/dl
TSH 3RD GENERATION	2.760	0.35 - 5.50	µIU/mL

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-
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)
CORONARY RISK PROFILE (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).

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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.
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-
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-
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.
WBC DIFFERENTIAL COUNT - NLR-
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.
ERYTHRO SEDIMENTATION RATE, BLOOD-
Erythrocyte sedimentation rate (ESR) is a non - specific phenomena and is clinically useful in the diagnosis and monitoring of disorders associated with an increased production of acute phase reactants. The ESR is increased in pregnancy from about the 3rd month and returns to normal by the 4th week post partum. ESR is influenced by age, sex, menstrual cycle and drugs (eg. corticosteroids, contraceptives). It is especially low (0 -1mm) in polycythaemia, hypofibrinogenemia or congestive cardiac failure and when there are abnormalities of the red cells such as poikilocytosis, spherocytosis or sickle cells.

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
URINALYSIS-Routine urine analysis assists in screening and diagnosis of various metabolic, urological, kidney and liver disorders
Protein: Elevated proteins can be an early sign of kidney disease. Urinary protein excretion can also be temporarily elevated by strenuous exercise, orthostatic proteinuria, dehydration, urinary tract infections and acute illness with fever
Glucose: Uncontrolled diabetes mellitus can lead to presence of glucose in urine. Other causes include pregnancy, hormonal disturbances, liver disease and certain medications.
Ketones: Uncontrolled diabetes mellitus can lead to presence of ketones in urine. Ketones can also be seen in starvation, frequent vomiting, pregnancy and strenuous

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exercise.
Blood: Occult blood can occur in urine as intact erythrocytes or haemoglobin, which can occur in various urological, nephrological and bleeding disorders.
Leukocytes: An increase in leukocytes is an indication of inflammation in urinary tract or kidneys. Most common cause is bacterial urinary tract infection.
Nitrite: Many bacteria give positive results when their number is high. Nitrite concentration during infection increases with length of time the urine specimen is retained in bladder prior to collection.
pH: The kidneys play an important role in maintaining acid base balance of the body. Conditions of the body producing acidosis/ alkalosis or ingestion of certain type of food can affect the pH of urine.
Specific gravity: Specific gravity gives an indication of how concentrated the urine is. Increased specific gravity is seen in conditions like dehydration, glycosuria and proteinuria while decreased specific gravity is seen in excessive fluid intake, renal failure and diabetes insipidus.
Bilirubin: In certain liver diseases such as biliary obstruction or hepatitis, bilirubin gets excreted in urine.
Urobilinogen: Positive results are seen in liver diseases like hepatitis and cirrhosis and in cases of hemolytic anemia
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

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MEDIWHEEL HEALTH CHEKUP BELOW 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

SILPA BAS M T **LAB TECHNICIAN**	**REKHA** **MICROBIOLOGIST**	**DHANYA PRAKASH** **LAB TECHNICIAN**	**ALFA PV** **LAB TECHNICIAN**

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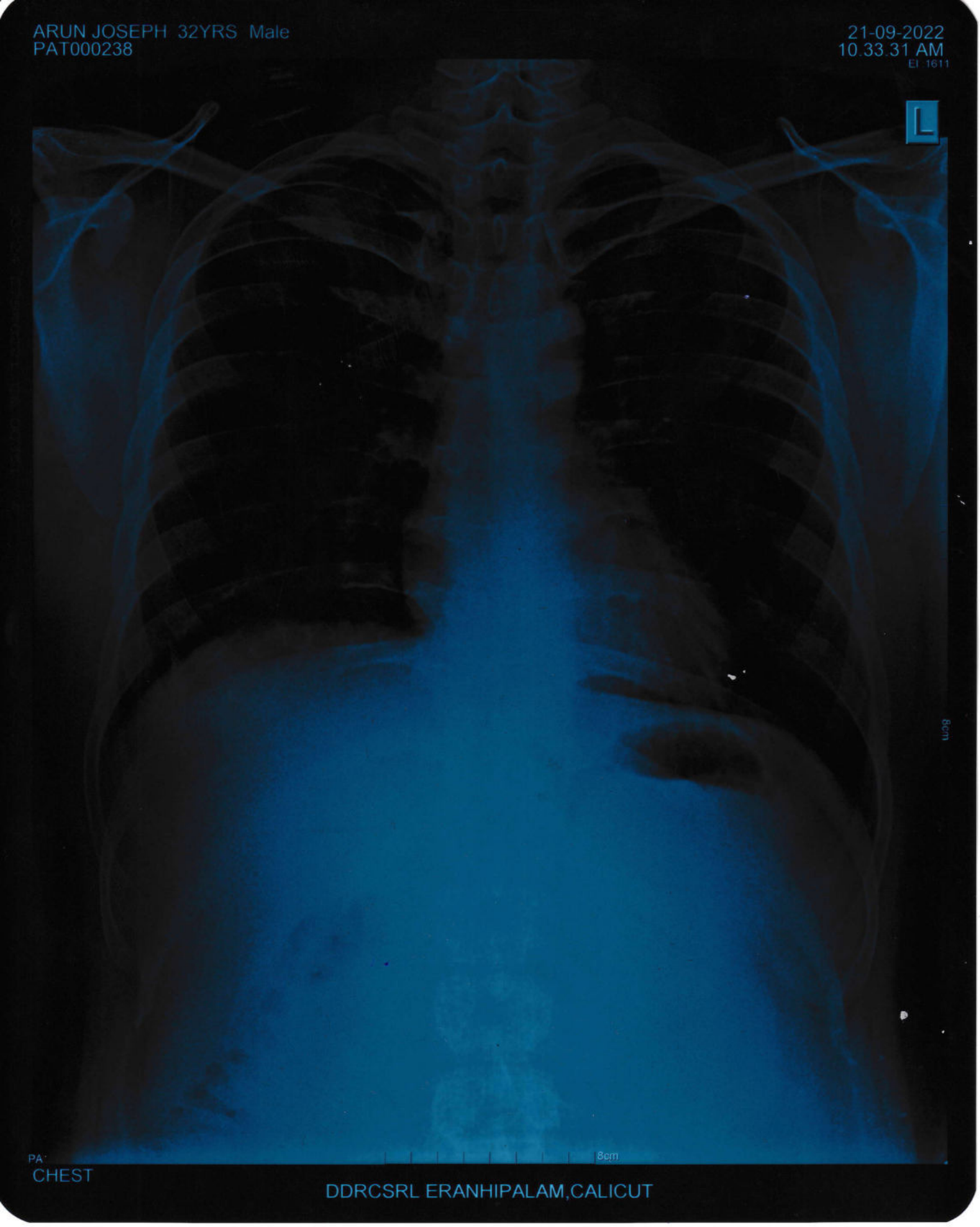
ARUN JOSEPH 32YRS Male
PAT000238
21-09-2022
10.33.31 AM
EI 1611
L
8cm
8cm
PA
CHEST
DDRCSRL ERANHIPALAM,CALICUT

your center
RADIOLOGY AND DIAGNOSTIC SERVICES

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+91 90610 60000
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www.yourcenter.in

Name	Mr. ARUN JOSEPH	Date	21/09/2022
Age/sex	32 Years/ Male	Patient ID	YCC116977
Ref. by	MEDICAL OFFICER		

USG-ABDOMEN/PELVIS

Observations:

LIVER: Normal in size (14.3 cm). **Parenchymal echogenicity appears diffusely raised.** Intra hepatic biliary radicles not dilated. No focal mass lesion identified.

PORTAL VEIN: Normal in caliber. No evidence of portal vein thrombosis.

CBD is normal in caliber. No evidence of intraluminal lesions.

GALL BLADDER: Normally distended. No calculi. No wall thickening/irregularity. Pericholecystic space appears normal.

SPLEEN: Normal in size (9.3 cm) with normal echopattern. No focal mass.

PANCREAS: Normal in size and echopattern. No focal mass noted. Pancreatic duct is not dilated. No calculi. No peripancreatic collection.

RIGHT KIDNEY: Normal in size (11.3 x 4.4 cm) , shape, position, axis and echopattern. Corticomedullary differentiation is maintained. No focal mass lesion. No calculi. No dilatation of pelvicalyceal system noted.

LEFT KIDNEY: Normal in size (11.4 x 4.8 cm), shape, position, axis and echopattern. Corticomedullary differentiation is maintained. No focal mass lesion. No calculi. No dilatation of pelvicalyceal system noted.

URINARY BLADDER: Well distended. No calculi. No wall thickening/irregularity.

PROSTATE: Normal in size and echotexture (Volume : 12 cc).

Retroperitoneum: No significant lymphadenopathy.

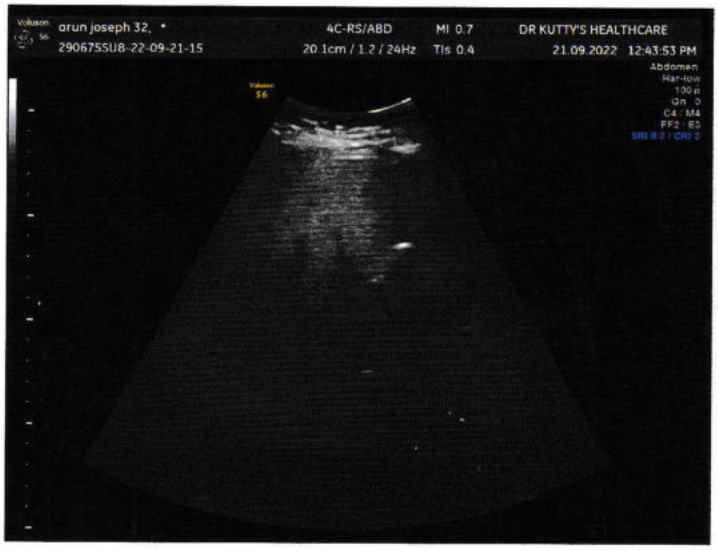
Bowel: No obvious bowel wall thickening/ mass lesion noted.

No ascites. No basal pleural effusion.

IMPRESSION

- **Grade I fatty infiltration of liver.**

Dr. AMAR S PRASAD MBBS MD RD
CONSULTANT RADIOLOGIST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4C-RS/ABD
20.1cm / 1.2 / 24Hz
MI 0.7
TIs 0.4
DR KUTTY'S HEALTHCARE
21.09.2022 12:43:53 PM
Abdomen


arun joseph 32, *
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4C-RS/ABD
20.1cm / 1.2 / 24Hz
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DR KUTTY'S HEALTHCARE
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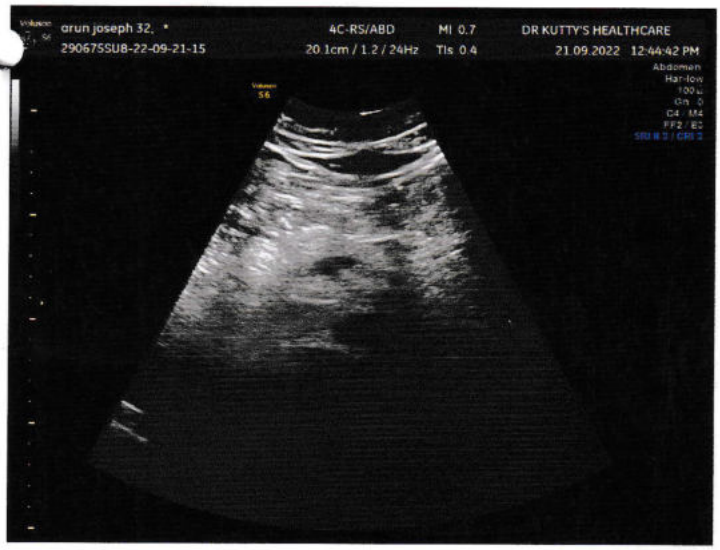
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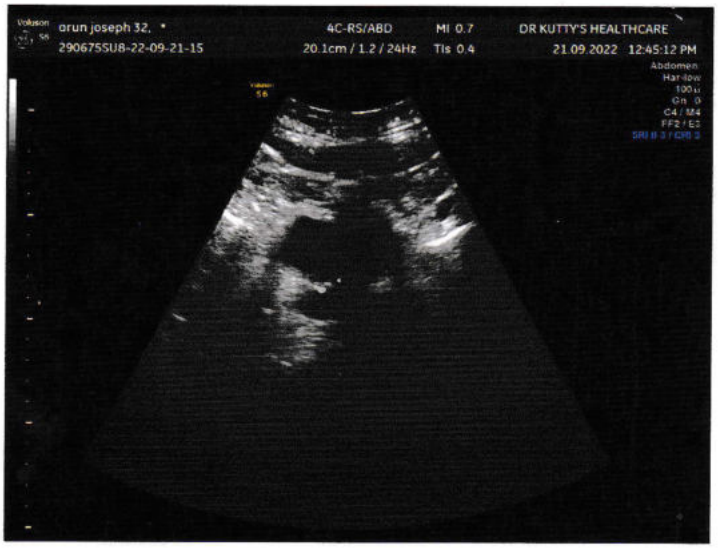
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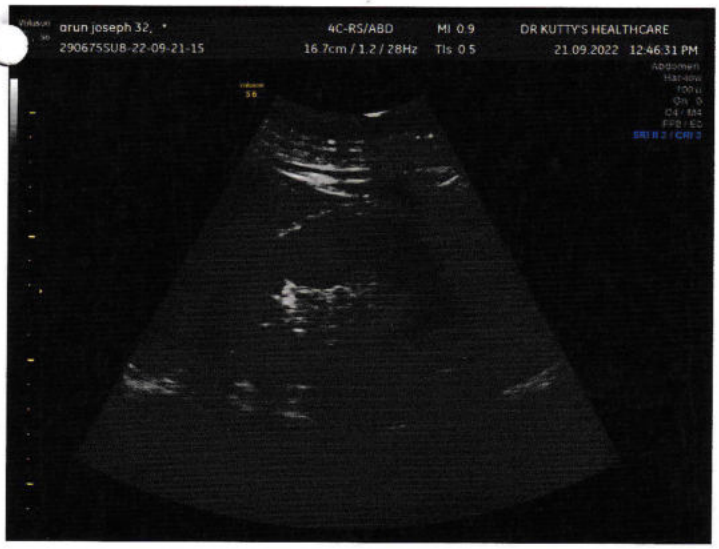
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16.7cm / 1.2 / 28Hz
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