



INDIA'S LEADING DIAGNOSTICS NET WORK

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

PATIENT NAME : ATHIRA K

PATIENT ID : ATHIF0802964071

ACCESSION NO : 4071VK006061 **AGE :** 26 Years **SEX :** Female

DRAWN : **RECEIVED :** 26/11/2022 12:25 **REPORTED :** 26/11/2022 17:21

REFERRING DOCTOR : SELF

CLIENT PATIENT ID :

Test Report Status	Final	Results	Biological Reference Interval	Units
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MEDIWHEEL HEALTH CHECKUP BELOW 40(F)TMT

TREADMILL TEST

TREADMILL TEST REPORTED

OPHTHAL

OPHTHAL REPORTED

PHYSICAL EXAMINATION

PHYSICAL EXAMINATION REPORTED



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MEDIWHEEL HEALTH CHECKUP BELOW 40(F)TMT
SERUM BLOOD UREA NITROGEN

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

BUN/CREAT RATIO	16.9		
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CREATININE, SERUM

CREATININE	0.59	18 - 60 yrs : 0.6 - 1.1	mg/dL
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GLUCOSE, POST-PRANDIAL, PLASMA

GLUCOSE, POST-PRANDIAL, PLASMA	93	Diabetes Mellitus : > or = 200. Impaired Glucose tolerance/ Prediabetes : 140 - 199. Hypoglycemia : < 55.	mg/dL
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GLUCOSE, FASTING, PLASMA

GLUCOSE, FASTING, PLASMA	85	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)	5.2	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%.

MEAN PLASMA GLUCOSE	102.5	< 116.0	mg/dL
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LIPID PROFILE, SERUM

CHOLESTEROL	175	Desirable : < 200 Borderline : 200-239 High : >or= 240	mg/dL
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TRIGLYCERIDES	60	Normal : < 150 High : 150-199 Hypertriglyceridemia : 200-499	mg/dL
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HDL CHOLESTEROL	61	General range : 40-60	mg/dL
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DIRECT LDL CHOLESTEROL	108	Optimum : < 100 Above Optimum : 100-139 Borderline High : 130-159 High : 160-189 Very High : >or= 190	mg/dL
NON HDL CHOLESTEROL	114	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
CHOL/HDL RATIO	2.9	Low 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	1.8	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
VERY LOW DENSITY LIPOPROTEIN	12.0	Desirable value : 10 - 35	mg/dL
LIVER FUNCTION TEST WITH GGT			
BILIRUBIN, TOTAL	0.54	General Range : < 1.1	mg/dL
BILIRUBIN, DIRECT	0.20	General Range : < 0.2	mg/dL
BILIRUBIN, INDIRECT	0.34	0.00 - 0.60	mg/dL
TOTAL PROTEIN	6.8	Ambulatory : 6.4 - 8.3 Recumbant : 6 - 7.8	g/dL
ALBUMIN	4.4	20-60yrs : 3.5 - 5.2	g/dL
GLOBULIN	2.3	2.0 - 4.0 Neonates - Pre Mature: 0.29 - 1.04	g/dL
ALBUMIN/GLOBULIN RATIO	1.8	1.0 - 2.0	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	12	Adults : < 33	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)	11	Adults : < 34	U/L
ALKALINE PHOSPHATASE	67	Adult (<60yrs) : 35 - 105	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)	13	5 - 36	U/L
TOTAL PROTEIN, SERUM			
TOTAL PROTEIN	6.8	Ambulatory : 6.4 - 8.3 Recumbant : 6 - 7.8	g/dL
URIC ACID, SERUM			
URIC ACID	4.7	Adults : 2.4-5.7	mg/dL
ABO GROUP & RH TYPE, EDTA WHOLE BLOOD			





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ABO GROUP		TYPE O	
RH TYPE		NEGATIVE	
BLOOD COUNTS,EDTA WHOLE BLOOD			
HEMOGLOBIN		13.3	12.0 - 15.0 g/dL
RED BLOOD CELL COUNT		4.62	3.8 - 4.8 mil/ μ L
WHITE BLOOD CELL COUNT		8.32	4.0 - 10.0 thou/ μ L
PLATELET COUNT		234	150 - 410 thou/ μ L
RBC AND PLATELET INDICES			
HEMATOCRIT		39.7	36 - 46 %
MEAN CORPUSCULAR VOL		85.8	83 - 101 fL
MEAN CORPUSCULAR HGB.		28.9	27.0 - 32.0 pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION		33.6	31.5 - 34.5 g/dL
RED CELL DISTRIBUTION WIDTH		13.4	11.6 - 14.0 %
MENTZER INDEX		18.6	
MEAN PLATELET VOLUME		9.4	6.8 - 10.9 fL
WBC DIFFERENTIAL COUNT			
SEGMENTED NEUTROPHILS		59	40 - 80 %
LYMPHOCYTES		36	20 - 40 %
MONOCYTES		02	2 - 10 %
EOSINOPHILS		03	1 - 6 %
ABSOLUTE NEUTROPHIL COUNT		4.91	2.0 - 7.0 thou/ μ L
ABSOLUTE LYMPHOCYTE COUNT		3.00	1.0 - 3.0 thou/ μ L
ABSOLUTE MONOCYTE COUNT		0.17	Low 0.2 - 1.0 thou/ μ L
ABSOLUTE EOSINOPHIL COUNT		0.25	0.02 - 0.50 thou/ μ L
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		1.6	
ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD			
SEDIMENTATION RATE (ESR)		06	0 - 20 mm at 1 hr
SUGAR URINE - POST PRANDIAL			
SUGAR URINE - POST PRANDIAL		NOT DETECTED	NOT DETECTED
THYROID PANEL, SERUM			
T3		144.90	80 - 200 ng/dL
T4		10.83	5.1 - 14.1 μ g/dL





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TSH 3RD GENERATION **<0.005** **Low** Non-Pregnant : 0.4-4.2 μ IU/mL

Pregnant Trimester-wise :
1st : 0.1 - 2.5
2nd : 0.2 - 3
3rd : 0.3 - 3

Comments

*Kindly correlate clinically.
*Kindly inform lab within 2days if not clinically correlating.

PHYSICAL EXAMINATION, URINE

COLOR PALE YELLOW
APPEARANCE **CLOUDY**

CHEMICAL EXAMINATION, URINE

PH	6.5	4.8 - 7.4
SPECIFIC GRAVITY	1.010	Low 1.015 - 1.030
PROTEIN	DETECTED (SMALL)	NOT DETECTED
GLUCOSE	NORMAL	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

WBC	2-3	0-5	/HPF
EPITHELIAL CELLS	3-5	0-5	/HPF
CASTS	NIL		
CRYSTALS	NIL		
BACTERIA	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



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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:

- 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 patient's 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 platform (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).



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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.

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'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

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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: 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

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	TOTAL T4 (µg/dL)	TSH3G (µIU/mL)	TOTAL T3 (ng/dL)
Pregnancy			
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

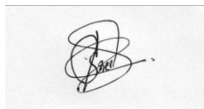
NOTE: TSH concentrations in apparently normal euthyroid subjects are known to be highly skewed, with a strong tailed distribution towards higher TSH values. This is well documented in the pediatric population including the infant age group.
Kindly note: Method specific reference ranges are appearing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

Reference:

- Burtis C.A., Ashwood E. R. Bruns D.E. Teitz textbook of Clinical Chemistry and Molecular Diagnostics, 4th Edition.
- Gowenlock A.H. Varley's Practical Clinical Biochemistry, 6th Edition.
- Behrman R.E. Kilegman R.M., Jenson H. B. Nelson Text Book of Pediatrics, 17th Edition

****End Of Report****

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Scan to View Details



Scan to View Report

ATHIRA (26 F)

ID: 1992

Date: 26-Nov-22

Exec Time : 0 m 0 s

Stage Time : 0 m 17 s

HR: 83 bpm

Protocol: Bruce

Stage: Supine

Speed: 0 mph

Grade: 0 %

(THR: 175 bpm)

B.P: 110 / 70

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

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

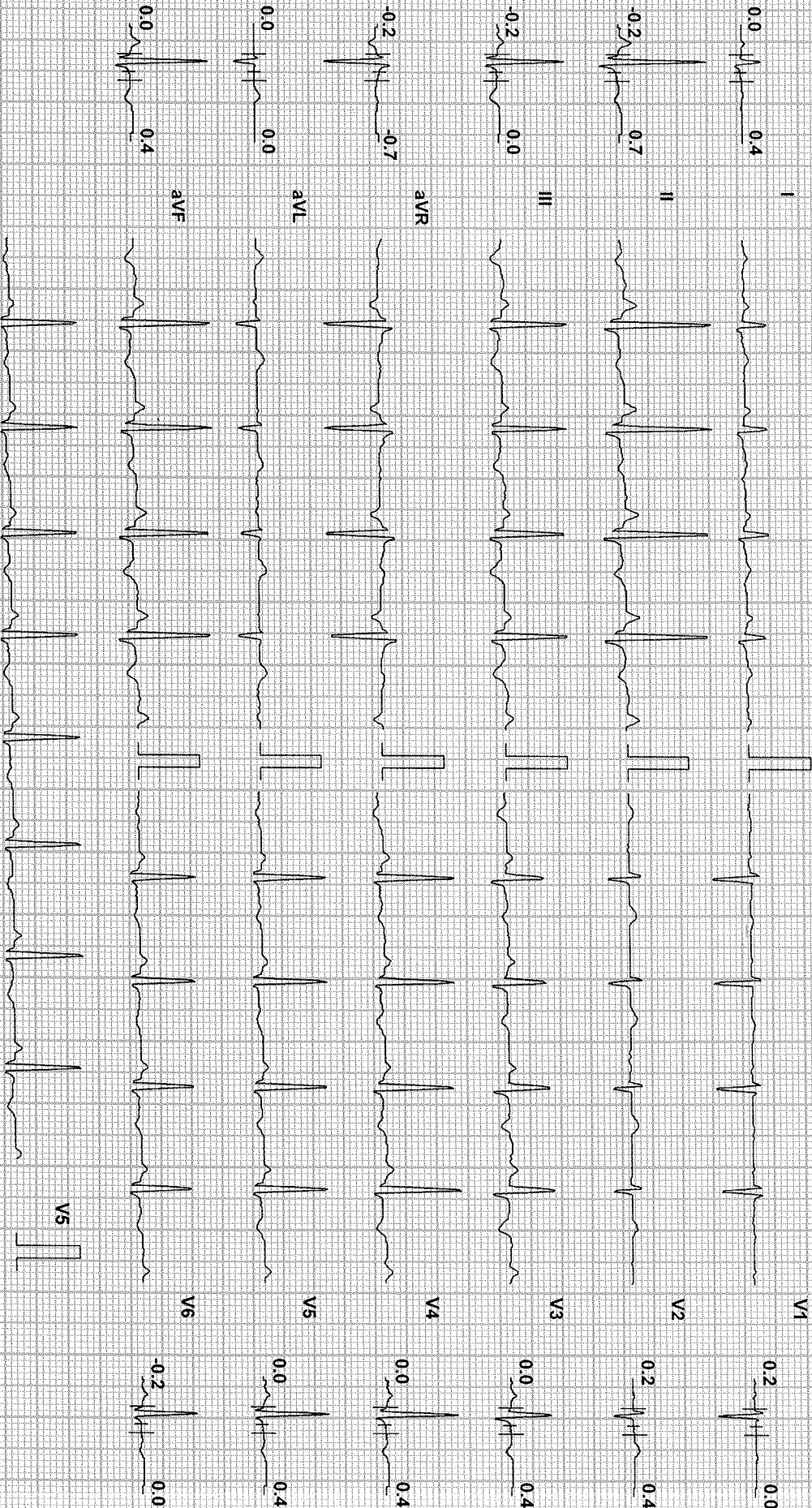


Chart Speed: 25 mm/sec
Schiller Spanden V.4.7

Filter: 35 Hz

Mains Filtr: ON

Amp: 10 mm

ISO = R - 60 ms

J = R + 60 ms

Post J = J + 60 ms

DDRC Hospital

ATHIRA (26 F)

ID: 1992

Date: 26-Nov-22

Exec Time : 0 m 0 s

Stage Time : 0 m 24 s

HR: 90 bpm

Protocol: Bruce

Stage: Standing

Speed: 0 mph

Grade: 0 %

(THR: 175 bpm)

B.P: 110 / 70

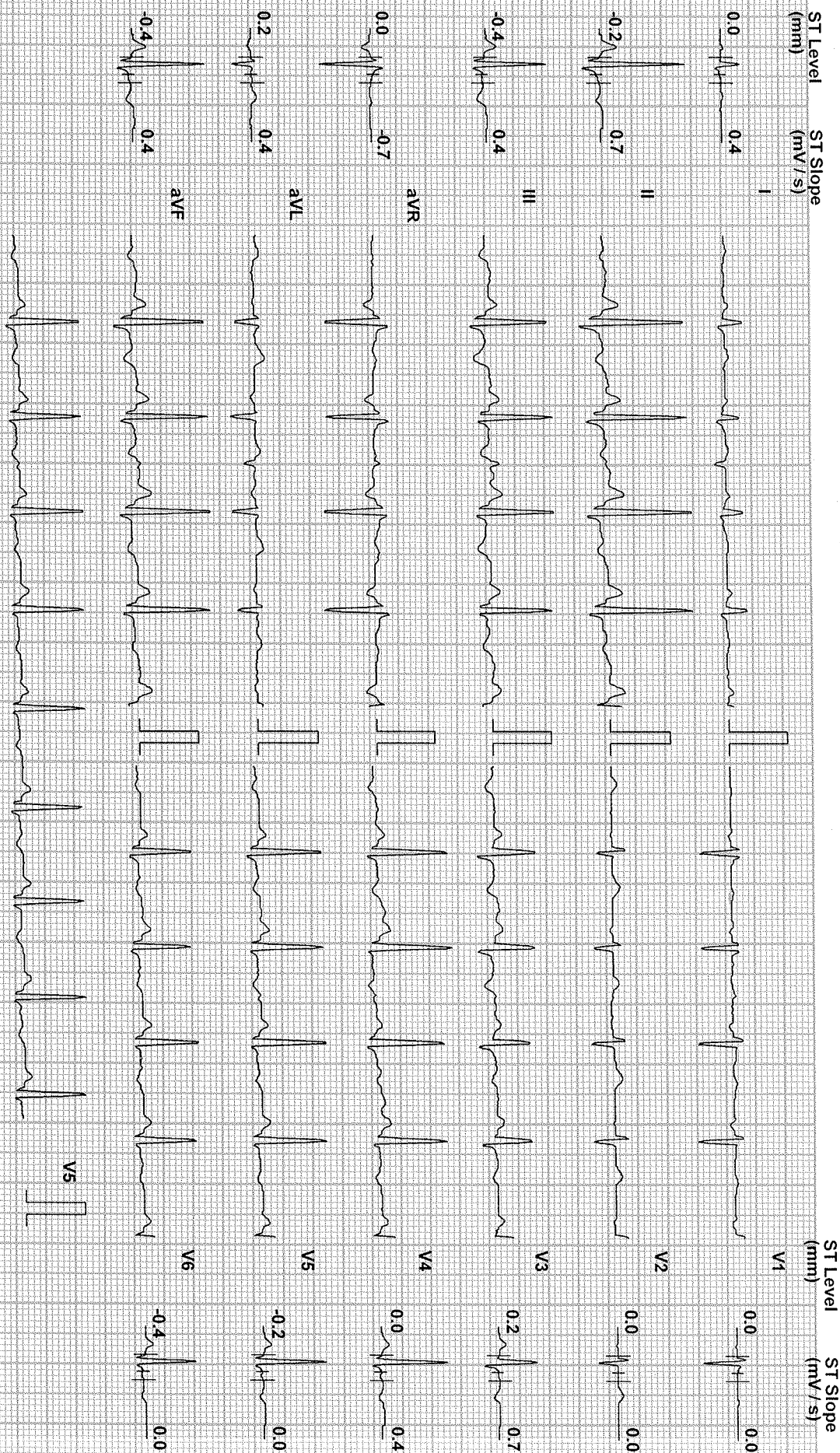


Chart Speed: 25 mm/sec

Filter: 35 Hz

Mains Fil: ON

Amp: 10 mm

ISO = R - 60 ms

J = R + 60 ms

Post J = J + 60 ms

Schiller Spandan V4.7

ATHIRA (26 F)

ID: 1992

Date: 26-Nov-22

Exec Time : 0 m 0 s

Stage Time : 0 m 17 s **HR: 86 bpm**

Protocol: Bruce

Stage: Hyperventilation

Speed: 0 mph

Grade: 0 %

(THR: 175 bpm)

B.P: 110 / 70

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

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

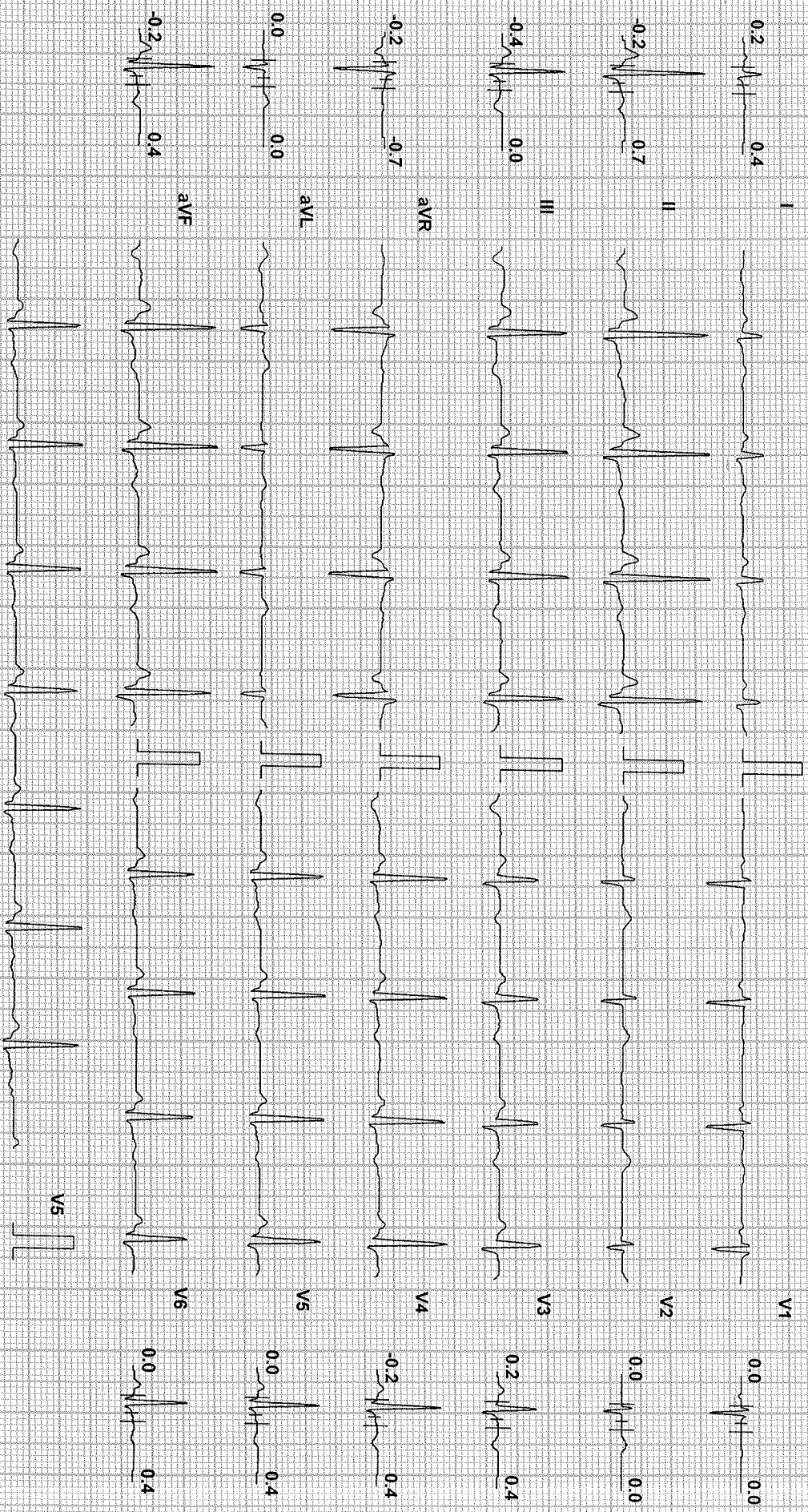


Chart Speed: 25 mm/sec
Schlitz Spanden V47

Filter: 35 Hz

Mains Fil: ON

Amp: 10 mm

Iso = R - 60 ms

J = R + 60 ms

Post J = J + 60 ms

ATHIRA (26 F)

Protocol: Bruce

ID: 1992

Stage: 1

DDRC Hospital

Date: 26-Nov-22

Speed: 1.7 mph

Exec Time : 3 m 0 s

Grade: 10 %

Stage Time : 3 m 0 s

(THR: 175 bpm)

HR: 136 bpm

B.P: 110 / 70

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

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

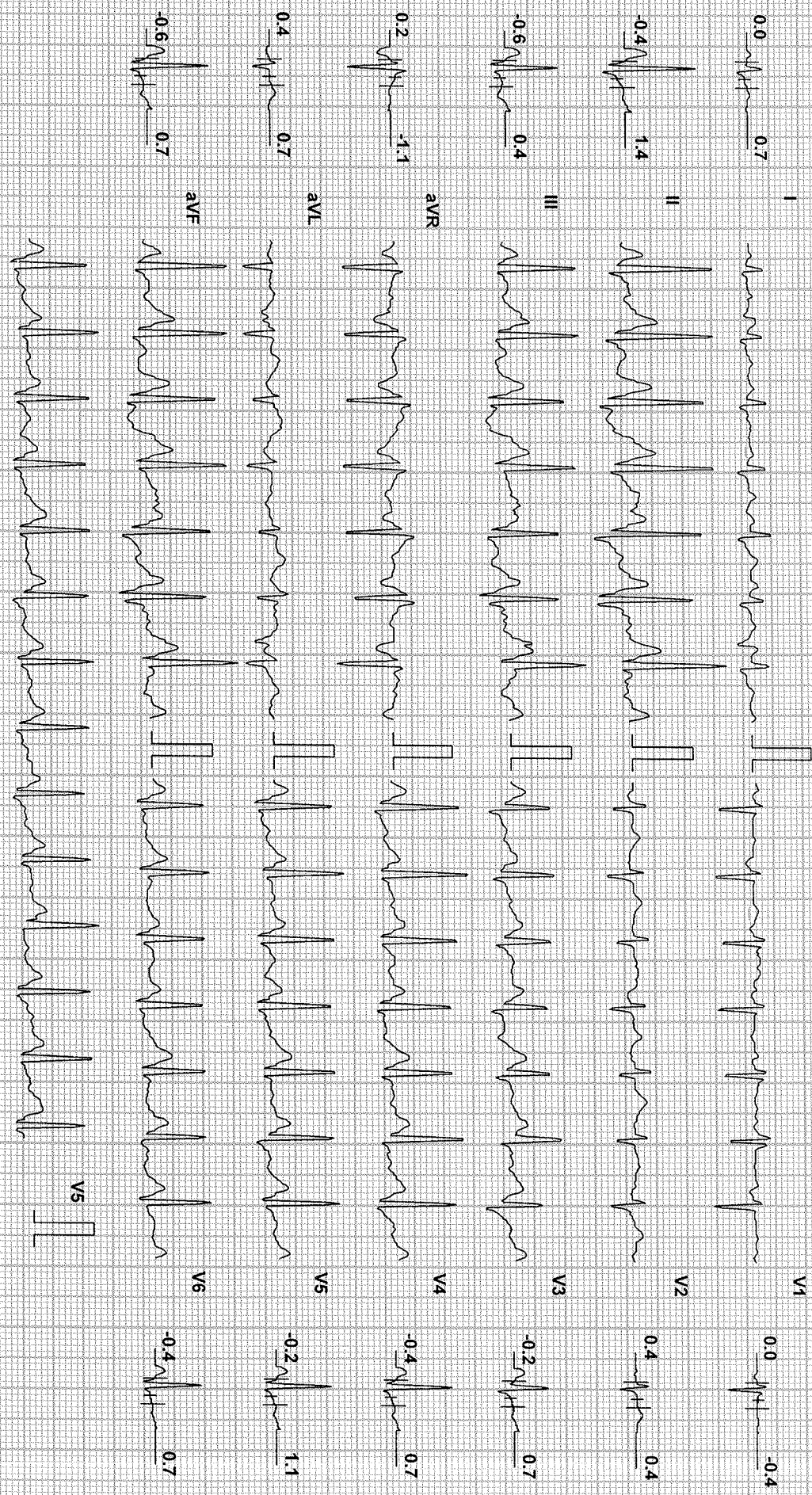


Chart Speed: 25 mm/sec
Schiller Spanden V.4.7

Filter: 35 Hz

Mains Fil: ON

Amp: 10 mm

ISO = R - 60 ms

J = R + 60 ms

Post J = T + 60 ms

ATHIRA (26 F)

ID: 1992

Date: 26-Nov-22

Exec Time : 6 m 0 s

Stage Time : 3 m 0 s

HR: 148 bpm

Protocol: Bruce

Stage: 2

Speed: 2.5 mph

Grade: 12 %

(THR: 175 bpm)

B.P: 110 / 70

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

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

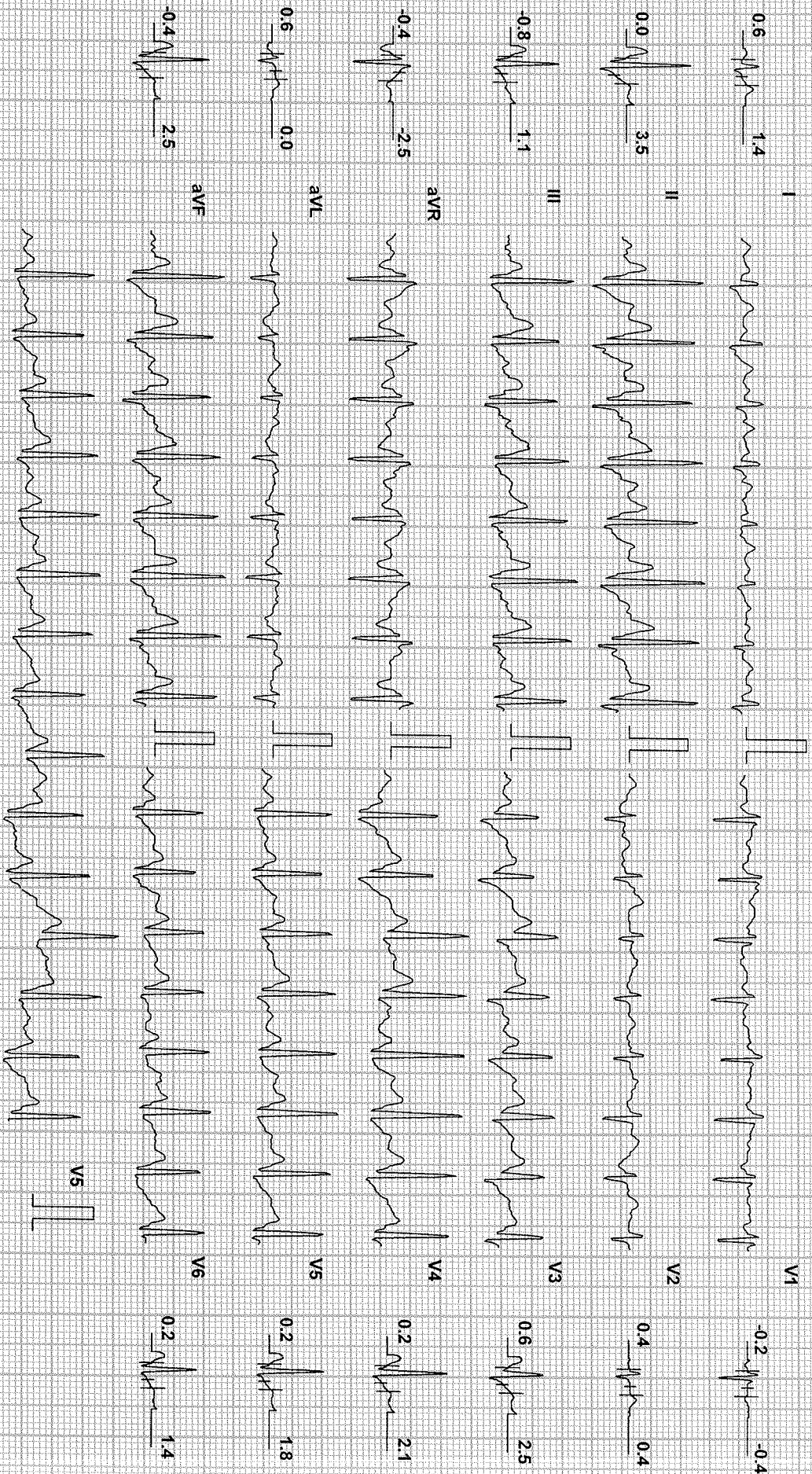


Chart Speed: 25 mm/sec
Schiller Spandan V4.7

Filter: 35 Hz

Mains Fil: ON

Amp: 10 mm

Iso = R - 60 ms

J = R + 60 ms

Post J = J + 60 ms

ATHIRA (26 F)

ID: 1992

Date: 26-Nov-22

Exec Time : 8 m 54 s Stage Time : 2 m 54 s HR: 173 bpm

Protocol: Bruce

Stage: 3

Speed: 3.4 mph

Grade: 14 % (THR: 175 bpm) B.P: 130 / 70

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

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

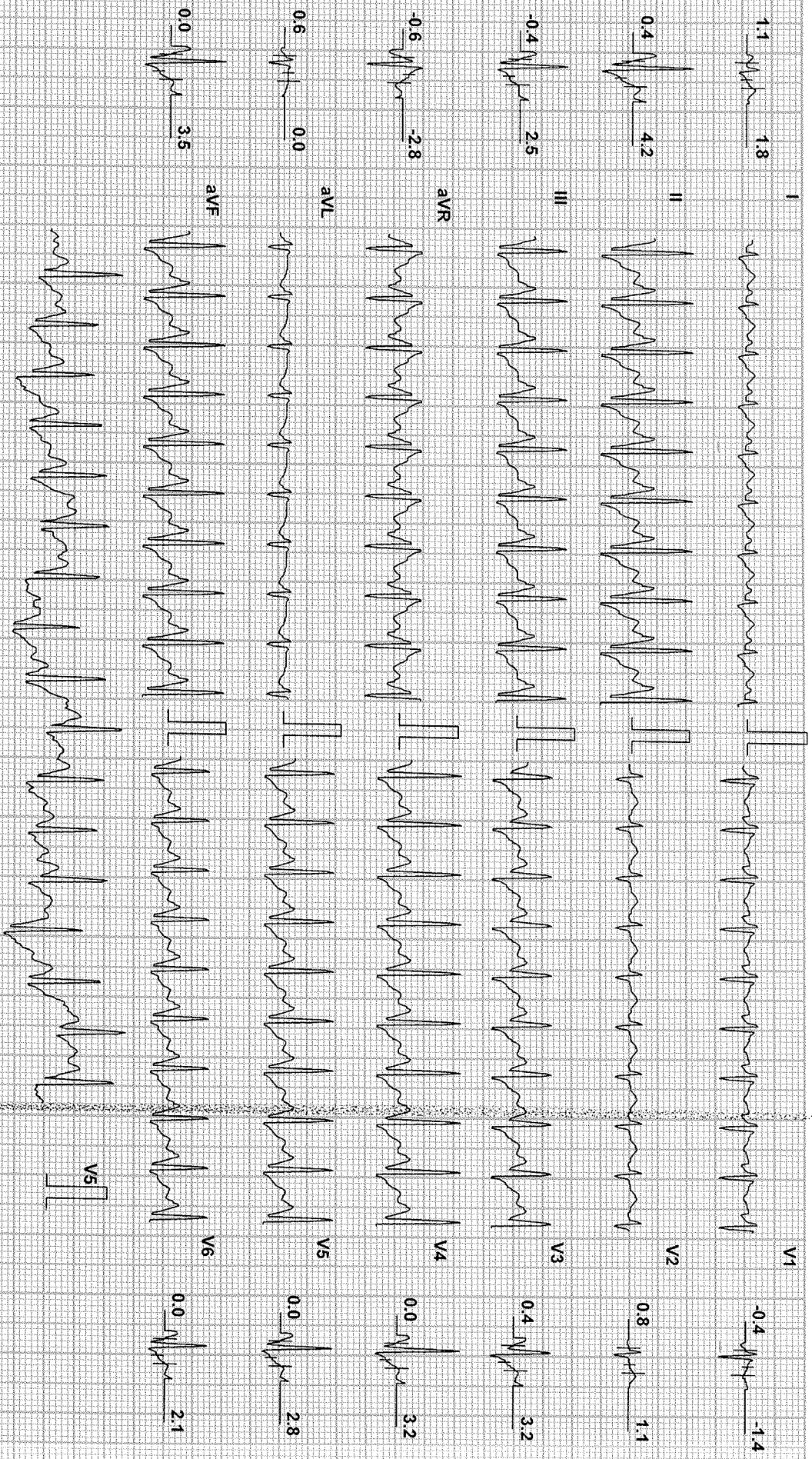


Chart Speed: 25 mm/sec
Schiller Spandan V4.7

Filter: 35 Hz

Mains Filtr: ON

Amp: 10 mm

ISO = R - 60 ms

J = R + 60 ms

Post J = J + 60 ms

Linked Median