NEP

DDRC SRL
Diagnostic Services
INDIA'S LEADING DIAGNOSTICS NET WORK

MEDICAL EXAMINATION REPORT (MER)

If the examinee is suffering from an acute life threatening situation, you may be obliged to disclose the result of the medical examination to the examinee.

1. Name of the examinee	:	Mr./~~Mrs./Ms.~~ Joseph Jerry Lopez.
2. Mark of Identification	:	(Mole/Scar/any other (specify location)): Mole on left wrist.
3. Age/Date of Birth	:	45, 12/11/1977 Gender: M ~~F~~/M
4. Photo ID Checked	:	(Passport/Election Card/PAN Card/Driving Licence/Company ID)

PHYSICAL DETAILS:

a. Height .....168..... (cms) b. Weight .....74..... (Kgs) c. Girth of Abdomen .....78.... (cms)

d. Pulse Rate .....70..... (/Min) e. Blood Pressure: Systolic 130 Diastolic 80

1st Reading		
2nd Reading		

FAMILY HISTORY:

Relation	Age if Living	Health Status	If deceased, age at the time and cause
Father		NS	
Mother	73	PTCA	
Brother(s)		/NS	
Sister(s)			

HABITS & ADDICTIONS: Does the examinee consume any of the following?

Tobacco in any form	Sedative	Alcohol
—	—	✓

PERSONAL HISTORY

a. Are you presently in good health and entirely free from any mental or Physical impairment or deformity. If No, please attach details. Y/N

b. Have you undergone/been advised any surgical procedure? Hernia Y/N

c. During the last 5 years have you been medically examined, received any advice or treatment or admitted to any hospital? Y/N

d. Have you lost or gained weight in past 12 months? Y/N

Have you ever suffered from any of the following?

- Psychological Disorders or any kind of disorders of the Nervous System? Y/N
- Any disorders of Respiratory system? Y/N
- Any Cardiac or Circulatory Disorders? Y/N
- Enlarged glands or any form of Cancer/Tumour? Y/N
- Any Musculoskeletal disorder? Y/N
- Any disorder of Gastrointestinal System? Y/N
- Unexplained recurrent or persistent fever, and/or weight loss Y/N
- Have you been tested for HIV/HBsAg / HCV before? If yes attach reports Y/N
- Are you presently taking medication of any kind? Y/N

DDRC SRL Diagnostics Private Limited
Corp. Office: DDRC SRL Tower, G- 131, Panampilly Nagar, Ernakulam - 682 036
Ph No. 0484-2318223, 2318222, e-mail: info@ddrcsrl.com, web: www.ddrcsrl.com
Regd. Office: 4th Floor, Prime Square, Plot No.1, Gaiwadi Industrial Estate, S.V. Road, Goregaon (West), Mumbai – 400062.

- Any disorders of Urinary System? Y/N
- Any disorder of the Eyes, Ears, Nose, Throat or Mouth & Skin Y/N

FOR FEMALE CANDIDATES ONLY NA

a. Is there any history of diseases of breast/genital organs? Y/N

b. Is there any history of abnormal PAP Smear/Mammogram/USG of Pelvis or any other tests? (If yes attach reports) Y/N

c. Do you suspect any disease of Uterus, Cervix or Ovaries? Y/N

d. Do you have any history of miscarriage/ abortion or MTP Y/N

e. For Parous Women, were there any complication during pregnancy such as gestational diabetes, hypertension etc Y/N

f. Are you now pregnant? If yes, how many months? Y/N

CONFIDENTAIL COMMENTS FROM MEDICAL EXAMINER

- Was the examinee co-operative? Y/N
- Is there anything about the examine's health, lifestyle that might affect him/her in the near future with regard to his/her job? Y/N
- Are there any points on which you suggest further information be obtained? Y/N
- Based on your clinical impression, please provide your suggestions and recommendations below;

NS

.....

.....

- Do you think he/she is MEDICALLY FIT or UNFIT for employment.

FIT

MEDICAL EXAMINER'S DECLARATION

I hereby confirm that I have examined the above individual after verification of his/her identity and the findings stated above are true and correct to the best of my knowledge.

Name & Signature of the Medical Examiner :

Seal of Medical Examiner :

Dr. GEORGE THOMAS
MD, FCSI, FIAE
MEDICAL EXAMINER
Reg: 86614

Name & Seal of DDRC SRL Branch :

DDRC SRL DIAGNOSTICS PVT. LTD. KADAVIL BUILDINGS PANAMPILLY NAGAR KOCHI-36

Date & Time : 15/03/2023

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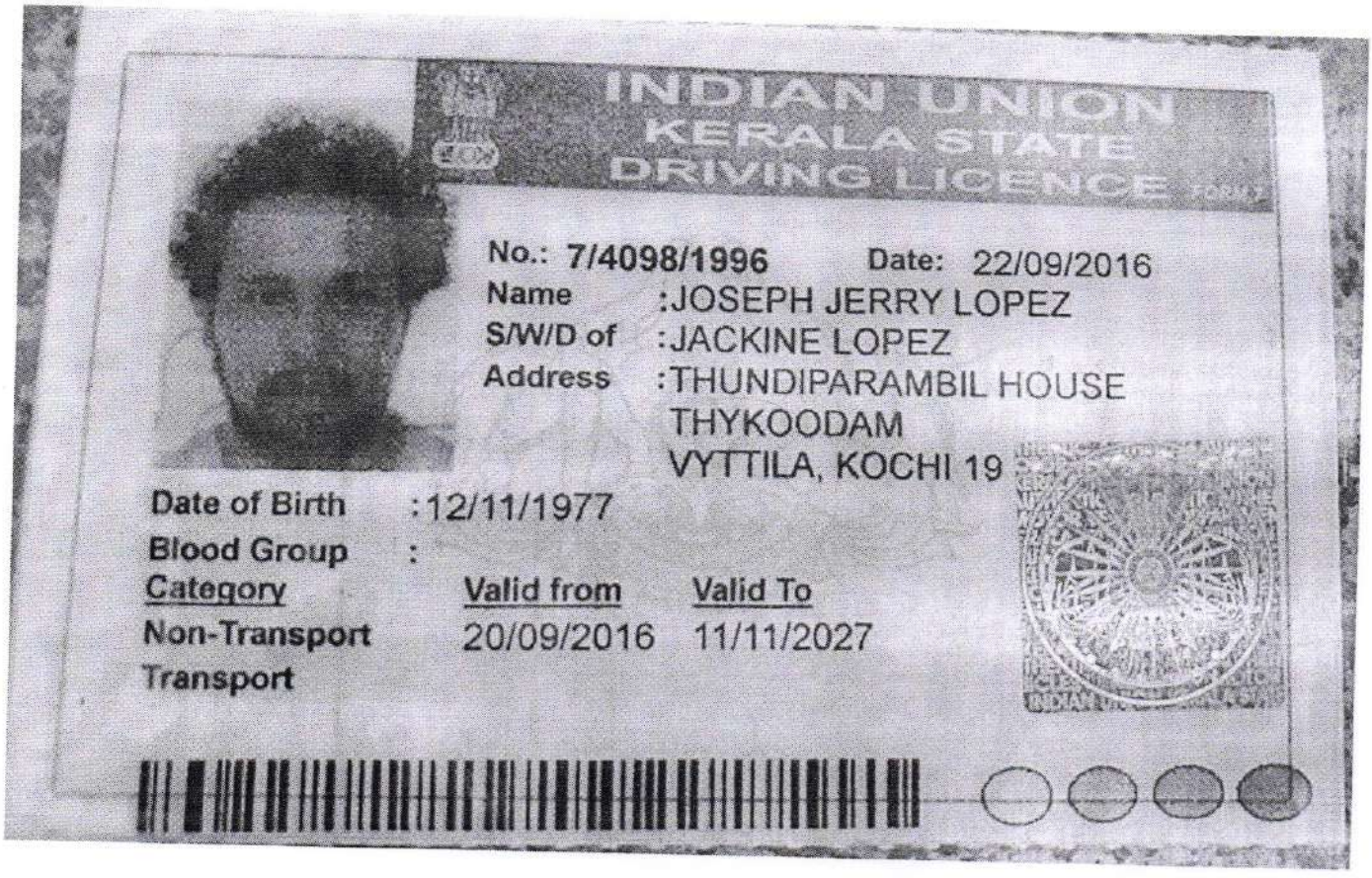
Subject: DDRC
From: Jerry Lopez <jjlopez005@gmail.com>
Date: 13/03/2023, 8:29 AM
To: anicia.pa@srl.in

PHOTO-2022-05-10-16-27-51.jpg



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Attachments:

PHOTO-2022-05-10-16-27-51.jpg 81.3 KB

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LABORATORY SERVICES

Patient Ref. No. 666000003724973

DDRC SRL
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INDIA'S LEADING DIAGNOSTICS NETWORK

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

PATIENT NAME : MR. JOSEPH JERRY LOPEZ PATIENT ID : **JOSEM1303784126**

ACCESSION NO : **4126WC004302** AGE : 45 Years SEX : Male ABHA NO :

DRAWN : RECEIVED : 13/03/2023 08:56 REPORTED : 13/03/2023 17:11

REFERRING DOCTOR : DR. MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED CLIENT PATIENT ID :

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

MEDIWHEEL HEALTH CHECKUP ABOVE 40(M)TMT

TREADMILL TEST

TREADMILL TEST	TEST COMPLETED		

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MEDIWHEEL HEALTH CHECKUP ABOVE 40(M)TMT			
BLOOD UREA NITROGEN (BUN), SERUM			
BLOOD UREA NITROGEN METHOD : UREASE - UV	**24**	**High** Adult(<60 yrs) : 6 to 20	mg/dL
BUN/CREAT RATIO			
BUN/CREAT RATIO	20.1		
CREATININE, SERUM			
CREATININE METHOD : JAFFE KINETIC METHOD	1.19	18 - 60 yrs : 0.9 - 1.3	mg/dL
GLUCOSE, POST-PRANDIAL, PLASMA			
GLUCOSE, POST-PRANDIAL, PLASMA METHOD : HEXOKINASE	89	Diabetes Mellitus : > or = 200. Impaired Glucose tolerance/ Prediabetes : 140 - 199. Hypoglycemia : < 55.	mg/dL
GLUCOSE FASTING,FLUORIDE PLASMA			
GLUCOSE, FASTING, PLASMA METHOD : HEXOKINASE	96	Diabetes Mellitus : > or = 126. Impaired fasting Glucose/ Prediabetes : 101 - 125. Hypoglycemia : < 55.	mg/dL
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD			
GLYCOSYLATED HEMOGLOBIN (HBA1C)	5.2	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%.	%
MEAN PLASMA GLUCOSE	102.5	< 116.0	mg/dL
LIPID PROFILE, SERUM			
CHOLESTEROL	202	Desirable : < 200 Borderline : 200-239 High : >or= 240	mg/dL

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METHOD : CHOD-POD			
TRIGLYCERIDES	142	Normal : < 150 High : 150-199 Hypertriglyceridemia : 200-499 Very High : > 499	mg/dL
HDL CHOLESTEROL	46	General range : 40-60	mg/dL
METHOD : DIRECT ENZYME CLEARANCE			
DIRECT LDL CHOLESTEROL	136	Optimum : < 100 Above Optimum : 100-139 Borderline High : 130-159 High : 160-189 Very High : >or= 190	mg/dL
NON HDL CHOLESTEROL	**156** **High**	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
VERY LOW DENSITY LIPOPROTEIN	28.4	Desirable value : 10 - 35	mg/dL
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	3.0	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	

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(Refer to " CONDITIONS OF REPORTING " Overleaf)

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Test Report Status **Preliminary**	Results	Units

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 METHOD : DIAZO METHOD	0.48	General Range : < 1.1	mg/dL
BILIRUBIN, DIRECT METHOD : DIAZO METHOD	0.19	General Range : < 0.3	mg/dL
BILIRUBIN, INDIRECT	0.29	0.00 - 0.60	mg/dL
TOTAL PROTEIN	6.7	Ambulatory : 6.4 - 8.3 Recumbant : 6 - 7.8	g/dL
ALBUMIN	4.2	20-60yrs : 3.5 - 5.2	g/dL
GLOBULIN	2.5	2.0 - 4.0 Neonates - Pre Mature: 0.29 - 1.04	g/dL
ALBUMIN/GLOBULIN RATIO	1.6	1.00 - 2.00	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	16	Adults : < 40	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT) METHOD : IFCC WITHOUT PDP	22	Adults : < 45	U/L
ALKALINE PHOSPHATASE METHOD : IFCC	57	Adult(<60yrs) : 40 -130	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)	17	Adult (Male) : < 60	U/L

TOTAL PROTEIN, SERUM

TOTAL PROTEIN METHOD : BIURET	6.7	Ambulatory : 6.4 - 8.3 Recumbant : 6 - 7.8	g/dL

URIC ACID, SERUM

URIC ACID	5.8	Adults : 3.4-7	mg/dL

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Test Report Status **Preliminary**	Results		Units
METHOD : SPECTROPHOTOMETRY			
ABO GROUP & RH TYPE, EDTA WHOLE BLOOD			
ABO GROUP METHOD : GEL CARD METHOD	B		
RH TYPE	POSITIVE		
BLOOD COUNTS,EDTA WHOLE BLOOD			
HEMOGLOBIN METHOD : NON CYANMETHEMOGLOBIN	14.0	13.0 - 17.0	g/dL
RED BLOOD CELL COUNT METHOD : IMPEDANCE	4.75	4.5 - 5.5	mil/µL
WHITE BLOOD CELL COUNT METHOD : IMPEDANCE	7.90	4.0 - 10.0	thou/µL
PLATELET COUNT METHOD : IMPEDANCE	210	150 - 410	thou/µL
RBC AND PLATELET INDICES			
HEMATOCRIT METHOD : CALCULATED	41.9	40 - 50	%
MEAN CORPUSCULAR VOL METHOD : DERIVED FROM IMPEDANCE MEASURE	88.1	83 - 101	fL
MEAN CORPUSCULAR HGB. METHOD : CALCULATED	29.4	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION METHOD : CALCULATED	33.3	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH	14.4	12.0 - 18.0	%
MENTZER INDEX	18.6		
MEAN PLATELET VOLUME METHOD : DERIVED FROM IMPEDANCE MEASURE	8.9	6.8 - 10.9	fL
WBC DIFFERENTIAL COUNT			
SEGMENTED NEUTROPHILS METHOD : DHSS FLOWCYTOMETRY	60	40 - 80	%
LYMPHOCYTES METHOD : DHSS FLOWCYTOMETRY	29	20 - 40	%
MONOCYTES METHOD : DHSS FLOWCYTOMETRY	6	2 - 10	%
EOSINOPHILS METHOD : DHSS FLOWCYTOMETRY	5	1 - 6	%

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BASOPHILS METHOD : IMPEDANCE	0	0 - 2	%
ABSOLUTE NEUTROPHIL COUNT METHOD : CALCULATED	4.74	2.0 - 7.0	thou/µL
ABSOLUTE LYMPHOCYTE COUNT METHOD : CALCULATED	2.29	1 - 3	thou/µL
ABSOLUTE MONOCYTE COUNT METHOD : CALCULATED	0.47	0.20 - 1.00	thou/µL
ABSOLUTE EOSINOPHIL COUNT METHOD : CALCULATED	0.40	0.02 - 0.50	thou/µL
ABSOLUTE BASOPHIL COUNT	0.00	0.00 - 0.10	thou/µL
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	2.1		
ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD			
SEDIMENTATION RATE (ESR) METHOD : WESTERGREN METHOD	10	0 - 14	mm at 1 hr
SUGAR URINE - POST PRANDIAL			
SUGAR URINE - POST PRANDIAL	NOT DETECTED	NOT DETECTED	
PROSTATE SPECIFIC ANTIGEN, SERUM			
PROSTATE SPECIFIC ANTIGEN METHOD : ECLIA	0.856	Age Specific :- <49yrs : <2.5 50-59yrs : <3.5 60-69yrs : <4.5 >70yrs : <6.5	ng/mL
THYROID PANEL, SERUM			
T3 METHOD : ELECTROCHEMILUMINESCENCE	83.40	80 - 200	ng/dL
T4 METHOD : ELECTROCHEMILUMINESCENCE	5.86	5.1 - 14.1	µg/dl
TSH 3RD GENERATION METHOD : ELECTROCHEMILUMINESCENCE	2.880	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.Guidlines of the American Thyroid association duriing 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	5.0	4.8 - 7.4

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DDRC SRL Diagnostic Services
INDIA'S LEADING DIAGNOSTICS NETWORK

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MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED
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PATIENT NAME : MR. JOSEPH JERRY LOPEZ PATIENT ID : **JOSEM1303784126**

ACCESSION NO : **4126WC004302** AGE : 45 Years SEX : Male ABHA NO :

DRAWN : RECEIVED : 13/03/2023 08:56 REPORTED : 13/03/2023 17:11

REFERRING DOCTOR : DR. MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED CLIENT PATIENT ID :

Test Report Status **Preliminary**	Results		Units
SPECIFIC GRAVITY	1.020	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	
LEUKOCYTE ESTERASE	NOT DETECTED	NOT DETECTED	
MICROSCOPIC EXAMINATION, URINE			
RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
WBC	1-2	0-5	/HPF
EPITHELIAL CELLS	0-1	0-5	/HPF
CASTS	NOT DETECTED		
CRYSTALS	NOT DETECTED		
BACTERIA	NOT DETECTED	NOT DETECTED	
YEAST	NOT DETECTED	NOT DETECTED	

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REFERRING DOCTOR : DR. MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED CLIENT PATIENT ID :

Test Report Status **Preliminary**	Results	Units

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 infectionwhen present in significant numbers & with pus cells.
Trichomonas vaginalis	Vaginitis, cervicitis or salpingitis

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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Test Report Status **Preliminary**	Results	Units

Interpretation(s)

Stool routine analysis is only a screening test for disorders of gastrointentestinal 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 antidiarrheal 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 :

1. **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.
2. **Fecal Calprotectin**: It is a marker of intestinal inflammation. This test is done to differentiate Inflammatory Bowel Disease (IBD) from Irritable Bowel Syndrome (IBS).
3. **Fecal Occult Blood Test(FOBT):** This test is done to screen for colon cancer & to evaluate possible cause of unexplained anaemia.
4. **Clostridium Difficile Toxin Assay**: This test is strongly recommended in healthcare associated bloody or waterydiarrhoea, due to overuse of broad spectrum antibiotics which alter the normal GI flora.
5. **Biofire (Film Array) GI PANEL:** In patients of Diarrhoea, Dysentry, 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%.
6. **Rota Virus Immunoassay**: This test is recommended in severe gastroenteritis in infants & children associated with watery

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ACCESSION NO : **4126WC004302** AGE : 45 Years SEX : Male ABHA NO :

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Test Report Status	**Preliminary**	Results	Units

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

Interpretation(s)
BLOOD UREA NITROGEN (BUN), SERUM-Causes of Increased levels include Pre renal (High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal), Renal Failure, Post Renal (Malignancy, Nephrolithiasis, Prostatism)
Causes of decreased level include Liver disease, SIADH.
CREATININE, SERUM-Higher than normal level may be due to:
- Blockage in the urinary tract
- Kidney problems, such as kidney damage or failure, infection, or reduced blood flow
- Loss of body fluid (dehydration)
- Muscle problems, such as breakdown of muscle fibers
- Problems during pregnancy, such as seizures (eclampsia)), or high blood pressure caused by pregnancy (preeclampsia)

Lower than normal level may be due to:
- Myasthenia Gravis
- Muscular dystrophy

GLUCOSE, POST-PRANDIAL, PLASMA-High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glyosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.Additional test HbA1c
GLUCOSE FASTING,FLUORIDE PLASMA-**TEST DESCRIPTION**
Normally, the glucose concentration in extracellular fluid is closely regulated so that a source of energy is readily available to tissues and sothat no glucose is excreted in the urine.
Increased in
Diabetes mellitus, Cushing' s syndrome (10 – 15%), chronic pancreatitis (30%). Drugs:corticosteroids,phenytoin, estrogen, thiazides.
Decreased in
Pancreatic islet cell disease with increased insulin,insulinoma,adrenocortical insufficiency, hypopituitarism,diffuse liver disease, malignancy (adrenocortical, stomach,fibrosarcoma), infant of a diabetic mother, enzyme deficiency diseases(e.g., galactosemia),Drugs- insulin, ethanol, propranolol; sulfonylureas,tolbutamide, and other oral hypoglycemic agents.
NOTE: While random serum glucose levels correlate with home glucose monitoring results (weekly mean capillary glucose values), there is wide fluctuation within individuals.Thus, glycosylated hemoglobin(HbA1c) levels are favored to monitor glycemic control.
High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glyosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD-**Used For**:

1.Evaluating the long-term control of blood glucose concentrations in diabetic patients.
2.Diagnosing diabetes.
3.Identifying patients at increased risk for diabetes (prediabetes).
The ADA recommends measurement of HbA1c (typically 3-4 times per year for type 1 and poorly controlled type 2 diabetic patients, and 2 times per year for well-controlled type 2 diabetic patients) to determine whether a 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
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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CLIENT'S NAME AND ADDRESS :

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PATIENT NAME : MR. JOSEPH JERRY LOPEZ PATIENT ID : **JOSEM1303784126**

ACCESSION NO : **4126WC004302** AGE : 45 Years SEX : Male ABHA NO :

DRAWN : RECEIVED : 13/03/2023 08:56 REPORTED : 13/03/2023 17:11

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Test Report Status **Preliminary**	Results	Units

Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma, Waldenstrom'''''''s disease
Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage),Burns,Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome,Protein-losing enteropathy etc.
URIC ACID, SERUM-**Causes of Increased levels:**-Dietary(High Protein Intake,Prolonged Fasting,Rapid weight loss),Gout,Lesch nyhan syndrome,Type 2 DM,Metabolic syndrome
Causes of decreased levels-Low Zinc intake,OCP,Multiple Sclerosis
ABO GROUP & RH TYPE, EDTA WHOLE BLOOD-
Blood group is identified by antigens and antibodies present in the blood. Antigens are protein molecules found on the surface of red blood cells. Antibodies are found in plasma. To determine blood group, red cells are mixed with different antibody solutions to give A,B,O or AB.

Disclaimer: "Please note, as the results of previous ABO and Rh group (Blood Group) for pregnant women are not available, please check with the patient records for availability of the same."

The test is performed by both forward as well as reverse grouping methods.
BLOOD COUNTS,EDTA WHOLE BLOOD-The cell morphology is well preserved for 24hrs. However after 24-48 hrs a progressive increase in MCV and HCT is observed leading 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 :
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-- PSA is detected in the male patients 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 patients without prostate tissue (because of radical prostatectomy or cystoprostatectomy) and also in the female patient.
- It a suitable marker for monitoring of patients with Prostate Cancer and it is better to be used in conjunction with other diagnostic procedures.
- Serial PSA levels can help determine the success of prostatectomy and the need for further treatment, such as radiation, endocrine or chemotherapy and useful in detecting residual disease and early recurrence of tumor.
- Elevated levels of PSA can be also observed in the patients with non-malignant diseases like Prostatitis and Benign Prostatic Hyperplasia.
- 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 (false positive) levels persisting up to 3 weeks.
- As per American urological guidelines, PSA screening is recommended for early detection of Prostate cancer above the age of 40 years. Following Age specific reference range can be used as a guide lines-

Age of male	Reference range (ng/ml)
40-49 years	0-2.5
50-59 years	0-3.5

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Test Report Status **Preliminary**	Results	Units

60-69 years 0-4.5
70-79 years 0-6.5

(* conventional reference level (< 4 ng/ml) is already mentioned in report,which covers all agegroup with 95% prediction interval)

References- Teitz ,textbook of clinical chemiistry, 4th edition) 2.Wallach's Interpretation of Diagnostic Tests
SUGAR URINE - FASTING-METHOD: DIPSTICK/BENEDICT'S TEST

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(Refer to " CONDITIONS OF REPORTING " Overleaf)

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MEDIWHEEL HEALTH CHECKUP ABOVE 40(M)TMT

ECG WITH REPORT

REPORT

TEST COMPLETED

USG ABDOMEN AND PELVIS

REPORT

TEST COMPLETED

CHEST X-RAY WITH REPORT

REPORT

TEST COMPLETED

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

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HEAD - Biochemistry & Immunology

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(Reg No - KMC:91816)
HEAD-HAEMATOLOGY & CLINICAL PATHOLOGY

DR.SMITHA PAULSON,MD (PATH),DPB
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LAB DIRECTOR & HEAD-HISTOPATHOLOGY & CYTOLOGY

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Date. 13/03/2023

OPHTHALMOLOGY REPORT

This is to certify that I have examined

Mr / Ms : Joseph Jeery Lopes **Aged** 45 **and his / her visual standards is as follows :**

Visual Acuity:

For far vision

R: 6/6

L : 6/6

For near vision

R : N8

L : N8

c PG < R N6 / L N6

Color Vision : Normal

Nannu Elizabeth

(Optometrist)

ID: 4302
JOSEPH JERRY LOPEZ
Male 45Years

13-03-2023 09:55:47 AM

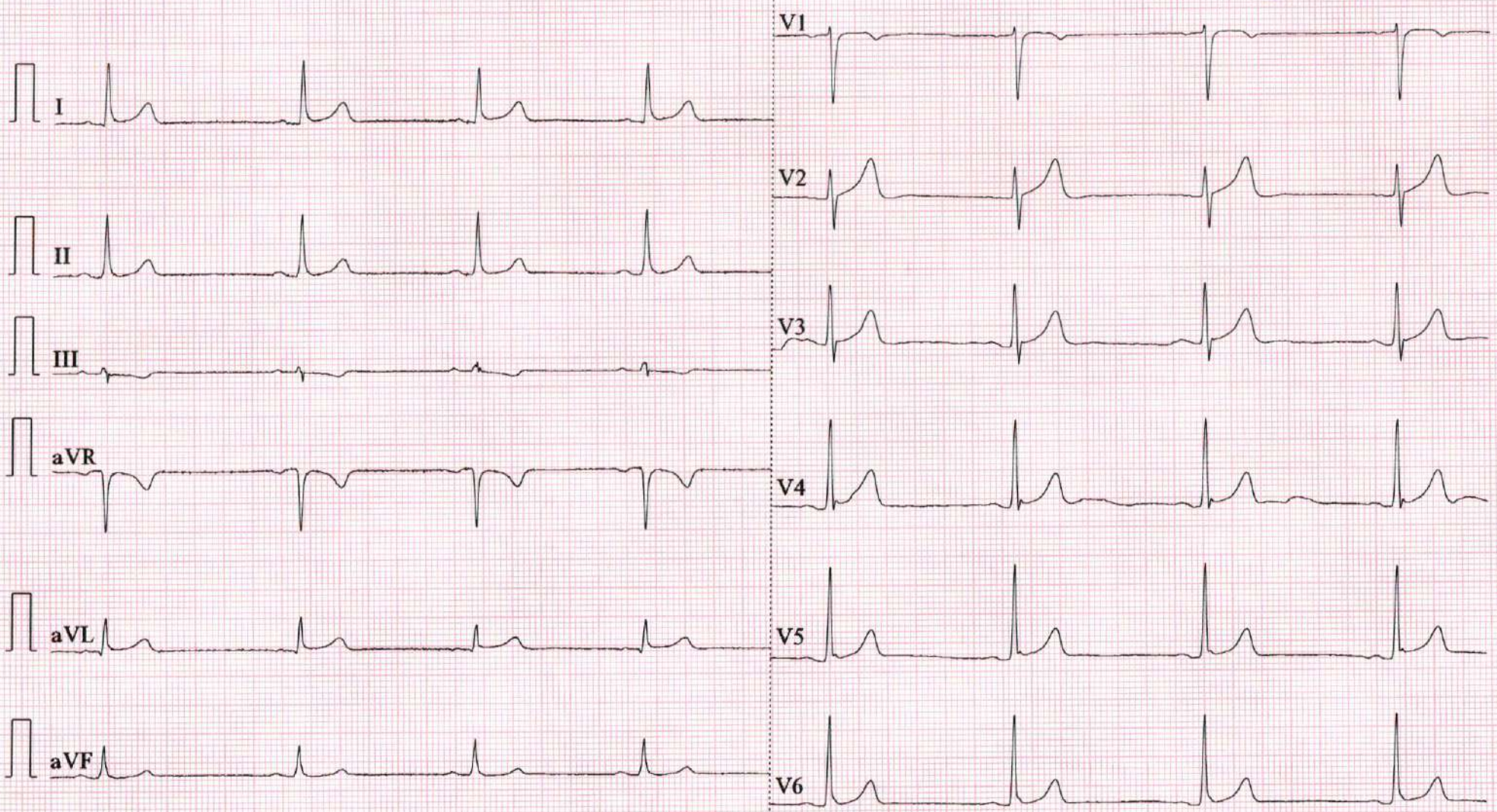
HR	: 46	bpm
P	: 98	ms
PR	: 165	ms
QRS	: 96	ms
QT/QTc	: 410/361	ms
P/QRS/T	: 68/25/19	°
RV5/SV1	: 1.637/1.141	mV

Diagnosis Information:
- Sinus bradycardia
- T inversion in III

Technician : ALEENA
Ref-Phys. : MEDIWHEEL
Report Confirmed by:

DR GEORGE THOMAS
MD,FCSI, FIAE
CARDIOLOGIST

DDRC SRL KOCHI-36



0.67~100Hz AC50 25mm/s 10mm/mV 2*5.0s ♥46 V2.2 SEMIP V1.81 DDRCSRL DIAGNOSTICS P NAGAR

DDRC SRL
Diagnostic Services
INDIA'S LEADING DIAGNOSTICS NETWORK

NAME: MR JOSEPH JERRY LOPEZ	STUDY DATE 13/03/2023
AGE / SEX : 45 YRS / M	REPORTING DATE 13/03/2023
REFERRED BY : MEDIWHEEL ARCOFEMI	ACC NO : 4126WC004302

X - RAY - CHEST PA VIEW

- Both the lung fields are clear.
- B/L hila and mediastinal shadows are normal.
- Cardiac silhouette appears normal.
- Cardio – thoracic ratio is normal.
- Bilateral CP angles and domes of diaphragm appear normal.

IMPRESSION: NORMAL STUDY

Kindly correlate clinically

Dr. NAVNEET KAUR, MBBS,MD
Consultant Radiologist.

DDRC SRL DIAGNOSTICS PVT LTD. KADAV PANAMPILLY NAGAR KOCHI-36

DDRC SRL
Diagnostic Services
INDIA'S LEADING DIAGNOSTICS NETWORK

NAME	**MR JOSEPH JERRY LOPEZ**	**AGE**	**45 YRS**
SEX	**MALE**	**DATE**	**March 13, 2023**
REFERRAL	**MEDIWHEEL ARCOFEMI**	**ACC NO**	**4126WC004302**

USG ABDOMEN AND PELVIS

LIVER Measures ~ 15.7 cm. Normal echotexture.
Smooth margins and no obvious focal lesion within.
No IHBR dilatation. Portal vein normal in caliber .

GB No calculus within gall bladder. Normal GB wall caliber.

SPLEEN Measures ~ 9 cm, normal to visualized extent. Splenic vein normal.

PANCREAS Normal to visualized extent. PD is not dilated.

KIDNEYS RK: 9.8 x 4.7 cm, appears normal in size and echotexture
LK: 10.5 x 5.5 cm, appears normal in size and echotexture.
No focal lesion / calculus within.
Maintained corticomedullary differentiation and normal parenchymal thickness.
No hydroureteronephrosis.

BLADDER Normal wall caliber, no internal echoes/calculus within.

PROSTATE Normal in volume and echopattern.

NODES/FLUID Nil to visualized extent.

BOWEL Visualized bowel loops appear normal.

IMPRESSION

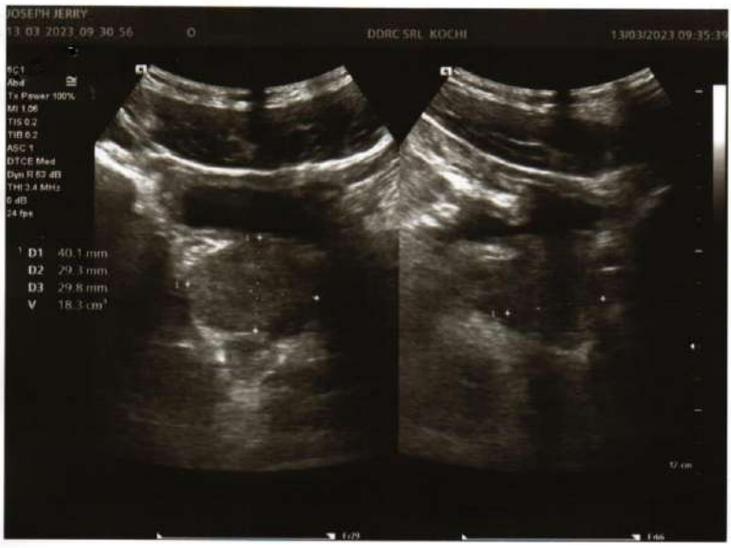
- ***Mild hepatomegaly .***

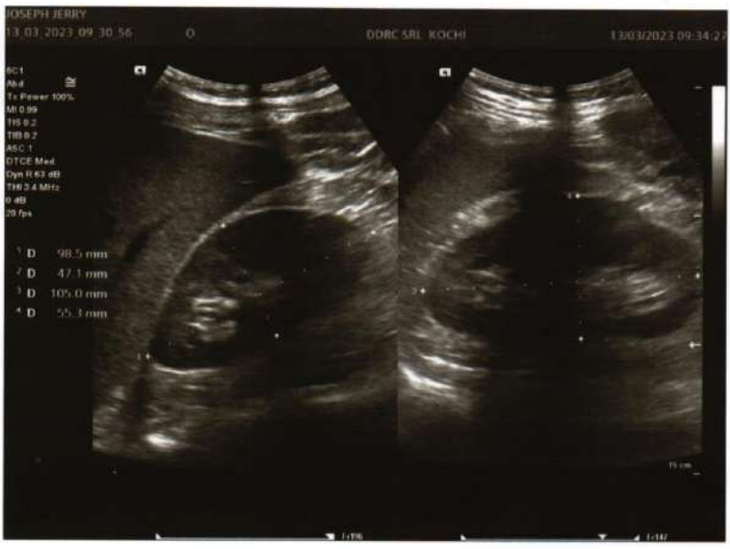
Kindly correlate clinically.

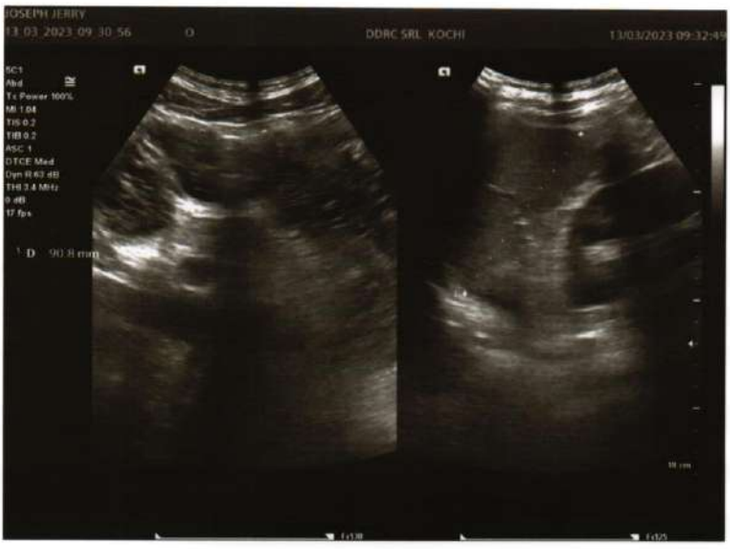
Dr. NAVNEET KAUR MBBS . MD
Consultant Radiologist

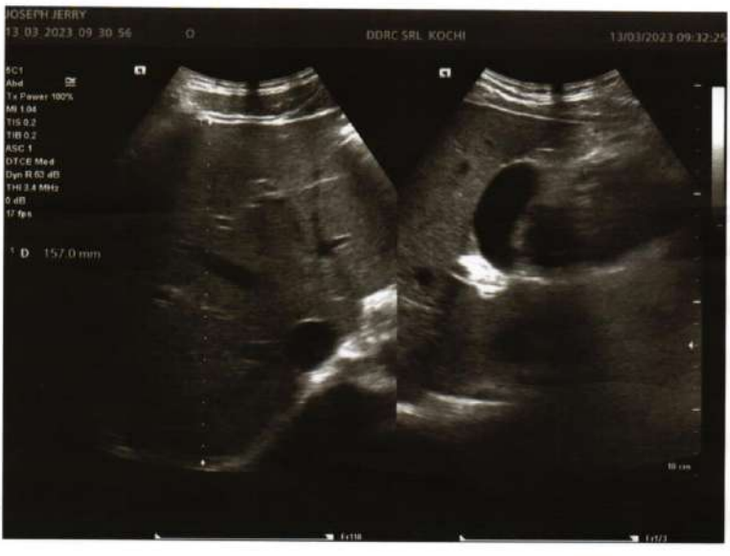
Thank you for referral. Your feedback will be appreciated.

NOTE: This report is only a professional opinion based on the real time image finding and not a diagnosis by itself. It has to be correlated and interpreted with clinical and other investigation findings. Review scan is advised, If this ultrasound opinion and other clinical findings / reports don't correlate.


JOSEPH JERRY
13.03.2023 09:30:56
DDRC SRL KOCHI
13/03/2023 09:35:39
D1 40.1 mm
D2 29.3 mm
D3 29.8 mm
V 18.3 cm³


JOSEPH JERRY
13.03.2023 09:30:56
DDRC SRL KOCHI
13/03/2023 09:34:27
D 98.5 mm
D 47.1 mm
D 105.0 mm
D 55.1 mm


JOSEPH JERRY
13.03.2023 09:30:56
DDRC SRL KOCHI
13/03/2023 09:32:49
D 90.8 mm


JOSEPH JERRY
13.03.2023 09:30:56
DDRC SRL KOCHI
13/03/2023 09:32:25
D 157.0 mm

DDRC SRL DIAGNOSTIC SERVICE PVT LTD

Test Report

JOSEPH JERRY LOPEZ (45 M) ID: WC004302 Date: 13-Mar-23 Exec Time : 0 m 0 s Stage Time : 1 m 21 s ***HR: 57 bpm***

Protocol: Bruce Stage: Supine Speed: 0 mph Grade: 0 % (THR: 148 bpm) B.P: 110 / 70

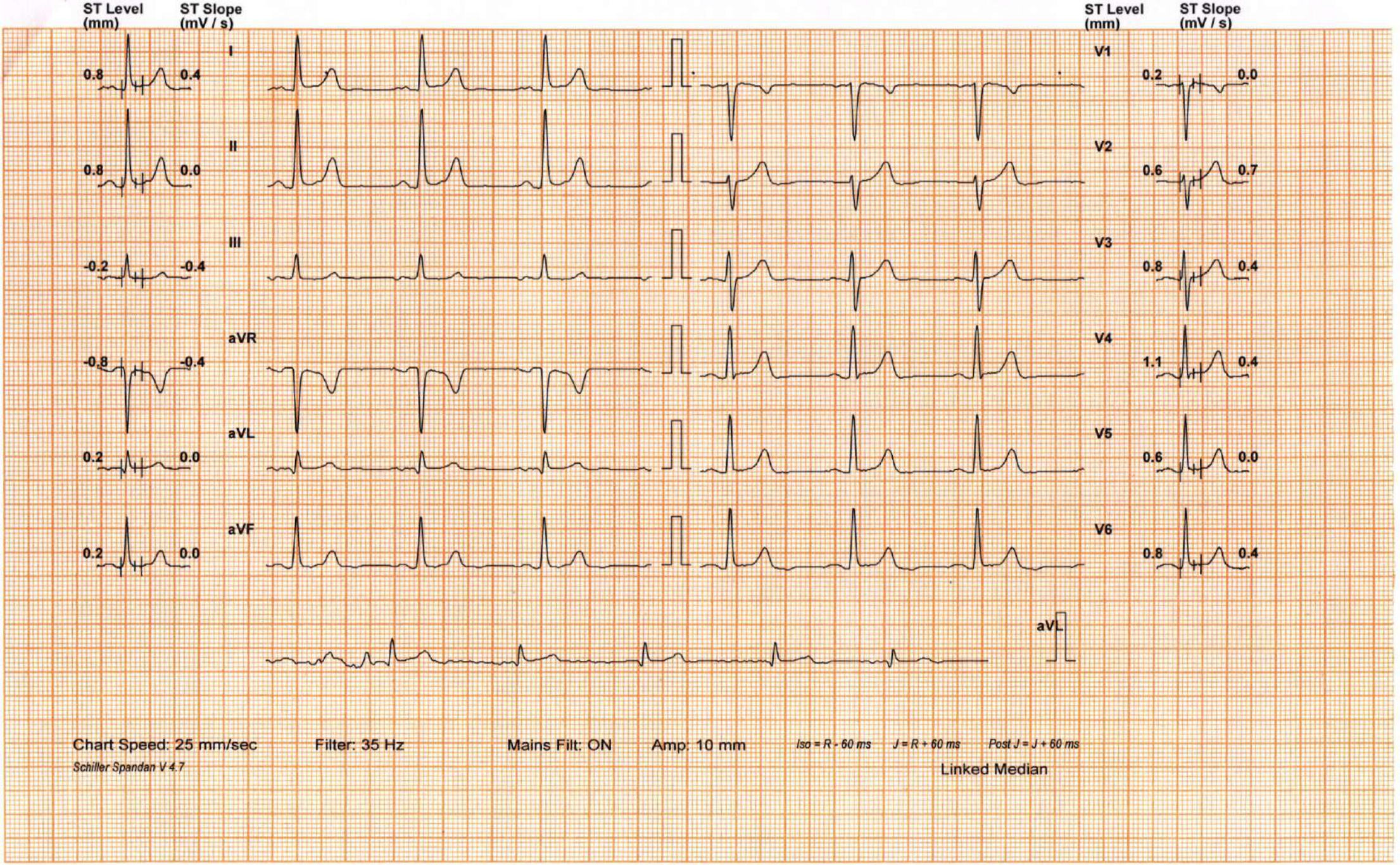


Chart Speed: 25 mm/sec Filter: 35 Hz Mains Filt: ON Amp: 10 mm *Iso = R - 60 ms* *J = R + 60 ms* *Post J = J + 60 ms*

Schiller Spandan V 4.7

Linked Median

DDRC SRL DIAGNOSTIC SERVICE PVT LTD

Test Report

JOSEPH JERRY LOPEZ (45 M) ID: WC004302 Date: 13-Mar-23 Exec Time : 0 m 0 s Stage Time : 0 m 25 s ***HR: 47 bpm***

Protocol: Bruce Stage: Standing Speed: 0 mph Grade: 0 % (THR: 148 bpm) B.P: 110 / 70

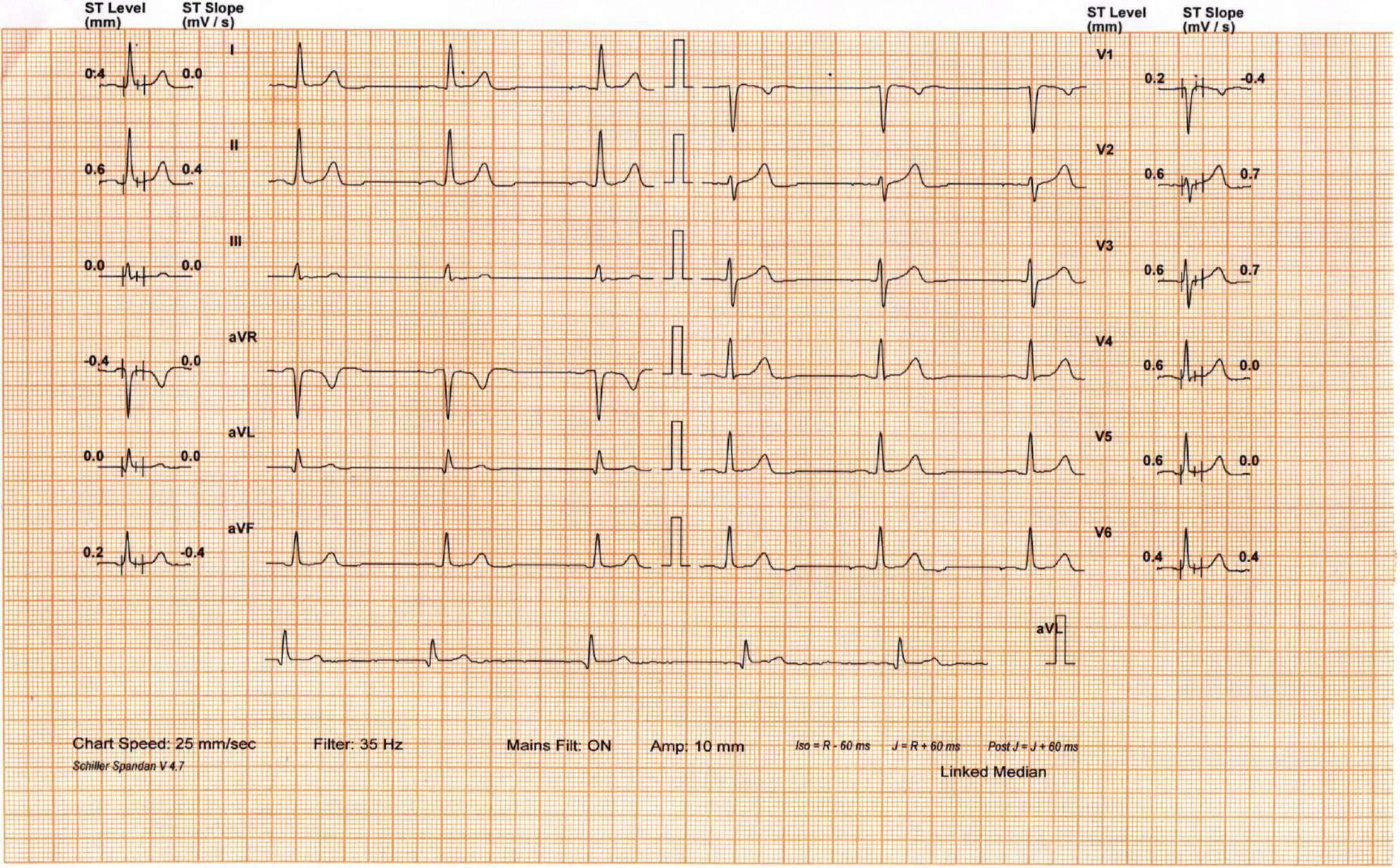


Chart Speed: 25 mm/sec Filter: 35 Hz Mains Filt: ON Amp: 10 mm *Iso = R - 60 ms* *J = R + 60 ms* *Post J = J + 60 ms*

Schiller Spandan V 4.7

Linked Median

DDRC SRL DIAGNOSTIC SERVICE PVT LTD

Test Report

JOSEPH JERRY LOPEZ (45 M) ID: WC004302 Date: 13-Mar-23 Exec Time : 2 m 54 s Stage Time : 2 m 54 s ***HR: 82 bpm***

Protocol: Bruce Stage: 1 Speed: 1.7 mph Grade: 10 % (THR: 148 bpm) B.P: 120 / 70

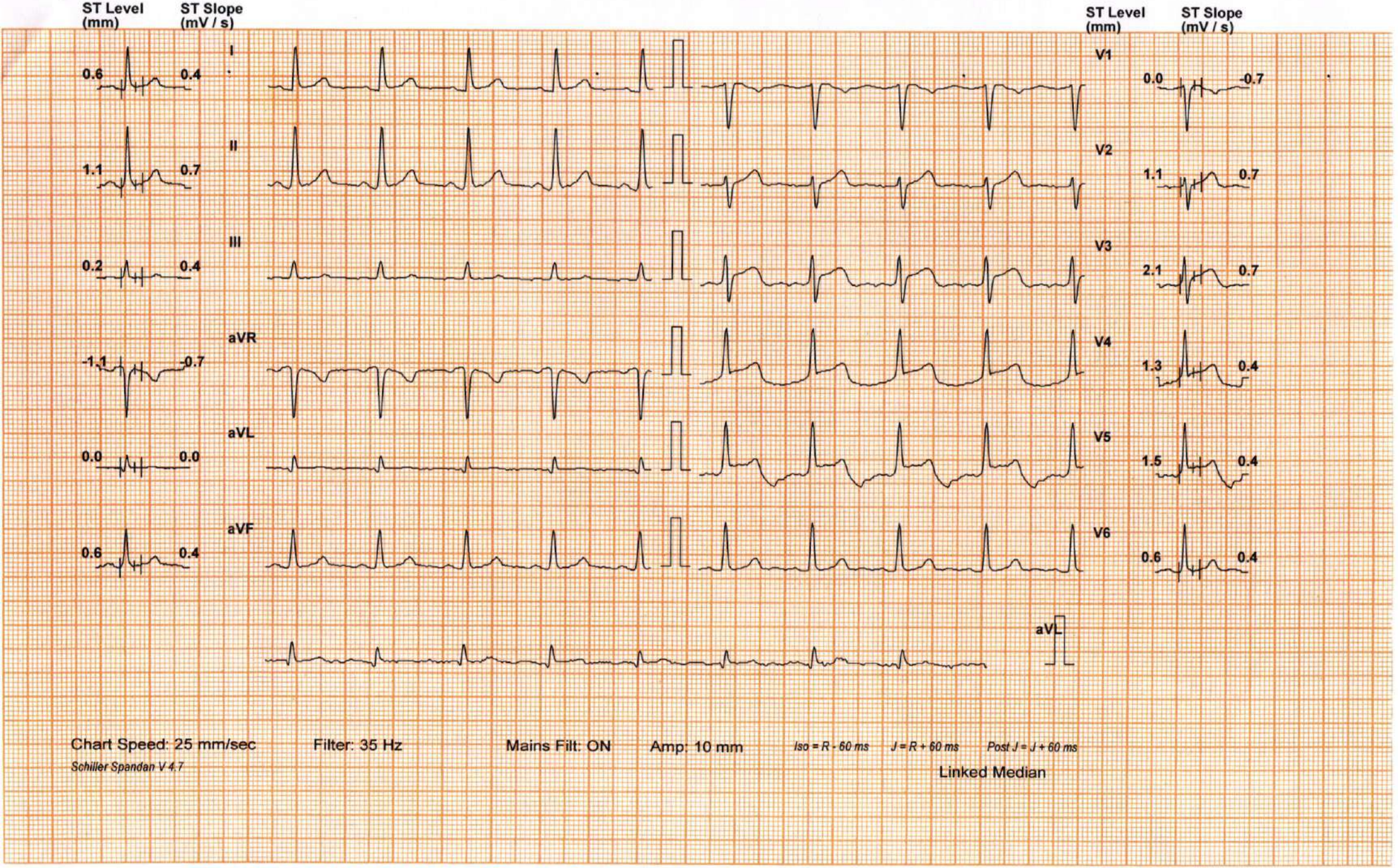


Chart Speed: 25 mm/sec Filter: 35 Hz Mains Filt: ON Amp: 10 mm *Iso = R - 60 ms* *J = R + 60 ms* *Post J = J + 60 ms*

Schiller Spandan V 4.7

Linked Median

DDRC SRL DIAGNOSTIC SERVICE PVT LTD

Test Report

JOSEPH JERRY LOPEZ (45 M) ID: WC004302 Date: 13-Mar-23 Exec Time : 5 m 54 s Stage Time : 2 m 54 s ***HR: 99 bpm***

Protocol: Bruce Stage: 2 Speed: 2.5 mph Grade: 12 % (THR: 148 bpm) B.P: 130 / 70

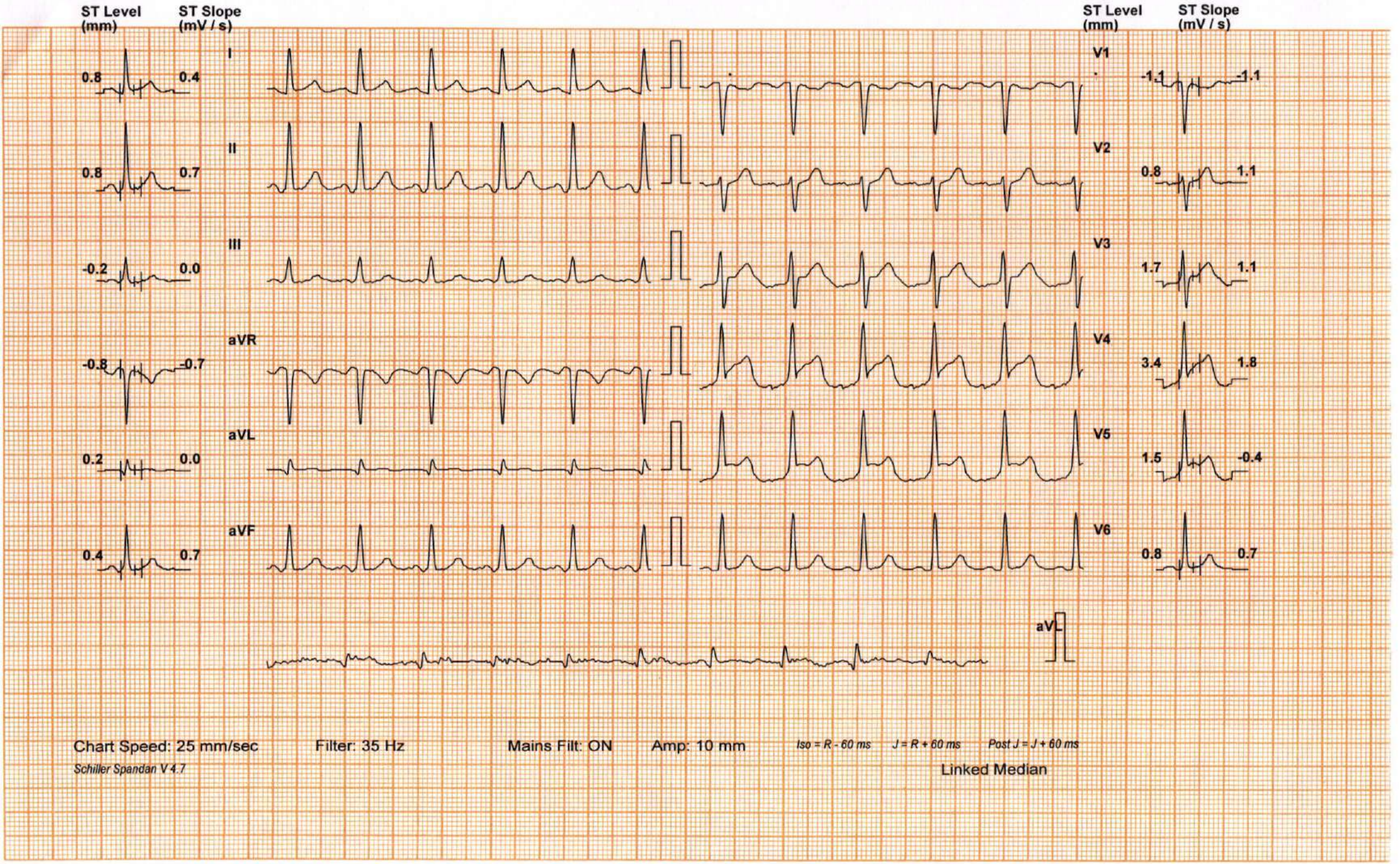


Chart Speed: 25 mm/sec Filter: 35 Hz Mains Filt: ON Amp: 10 mm *Iso = R - 60 ms* *J = R + 60 ms* *Post J = J + 60 ms*

Schiller Spandan V 4.7

Linked Median

DDRC SRL DIAGNOSTIC SERVICE PVT LTD

Test Report

JOSEPH JERRY LOPEZ (45 M) ID: WC004302 Date: 13-Mar-23 Exec Time : 8 m 54 s Stage Time : 2 m 54 s ***HR: 103 bpm***

Protocol: Bruce Stage: 3 Speed: 3.4 mph Grade: 14 % (THR: 148 bpm) B.P: 140 / 70

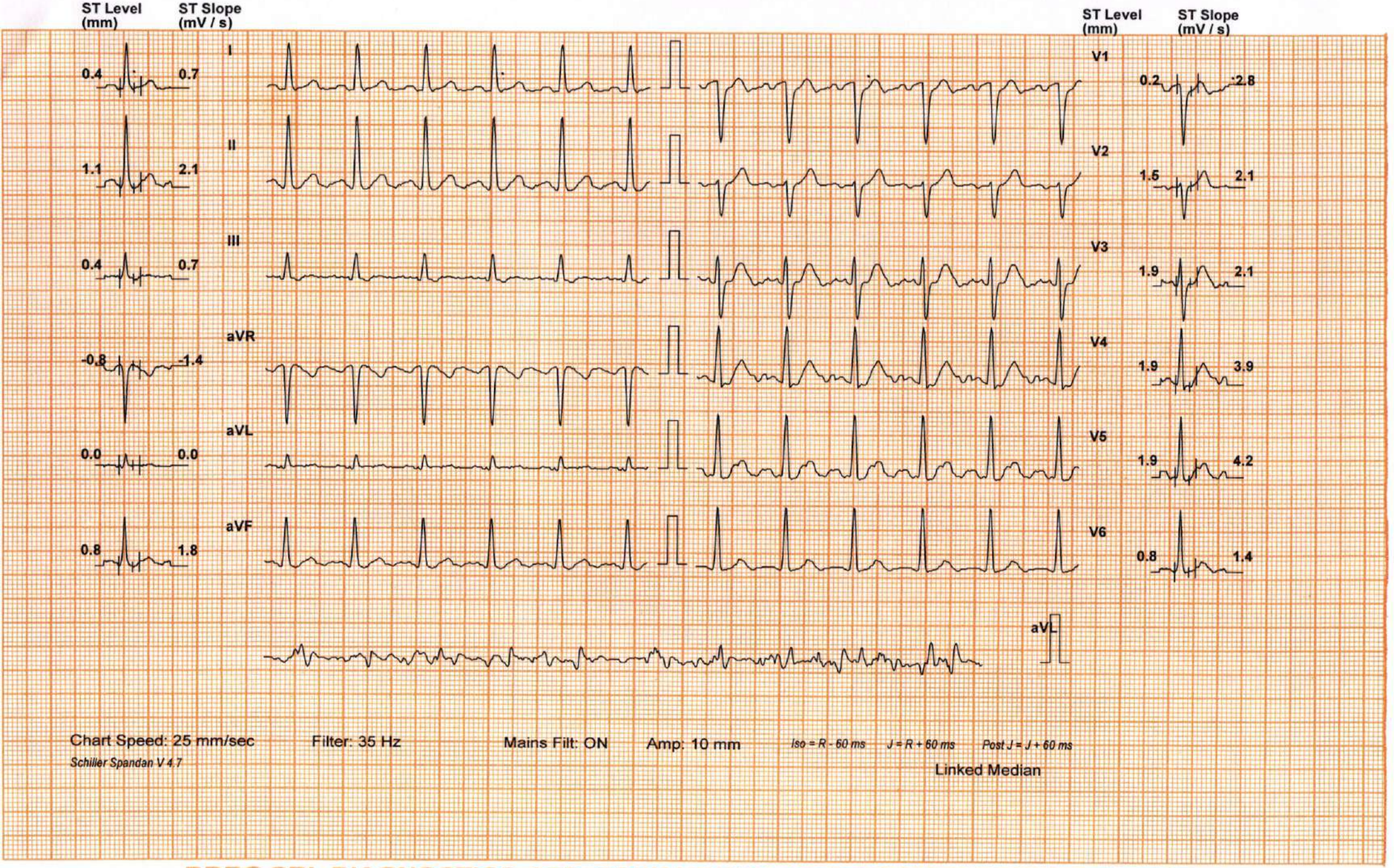


Chart Speed: 25 mm/sec Filter: 35 Hz Mains Filt: ON Amp: 10 mm *Iso = R - 60 ms* *J = R + 60 ms* *Post J = J + 60 ms*

Schiller Spandan V 4.7

Linked Median

DDRC SRL DIAGNOSTIC SERVICE PVT LTD

Test Report

JOSEPH JERRY LOPEZ (45 M) ID: WC004302 Date: 13-Mar-23 Exec Time : 10 m 54 s Stage Time : 1 m 54 s ***HR: 117 bpm***

Protocol: Bruce Stage: Peak Ex Speed: 4.2 mph Grade: 16 % (THR: 148 bpm) B.P: 150 / 70

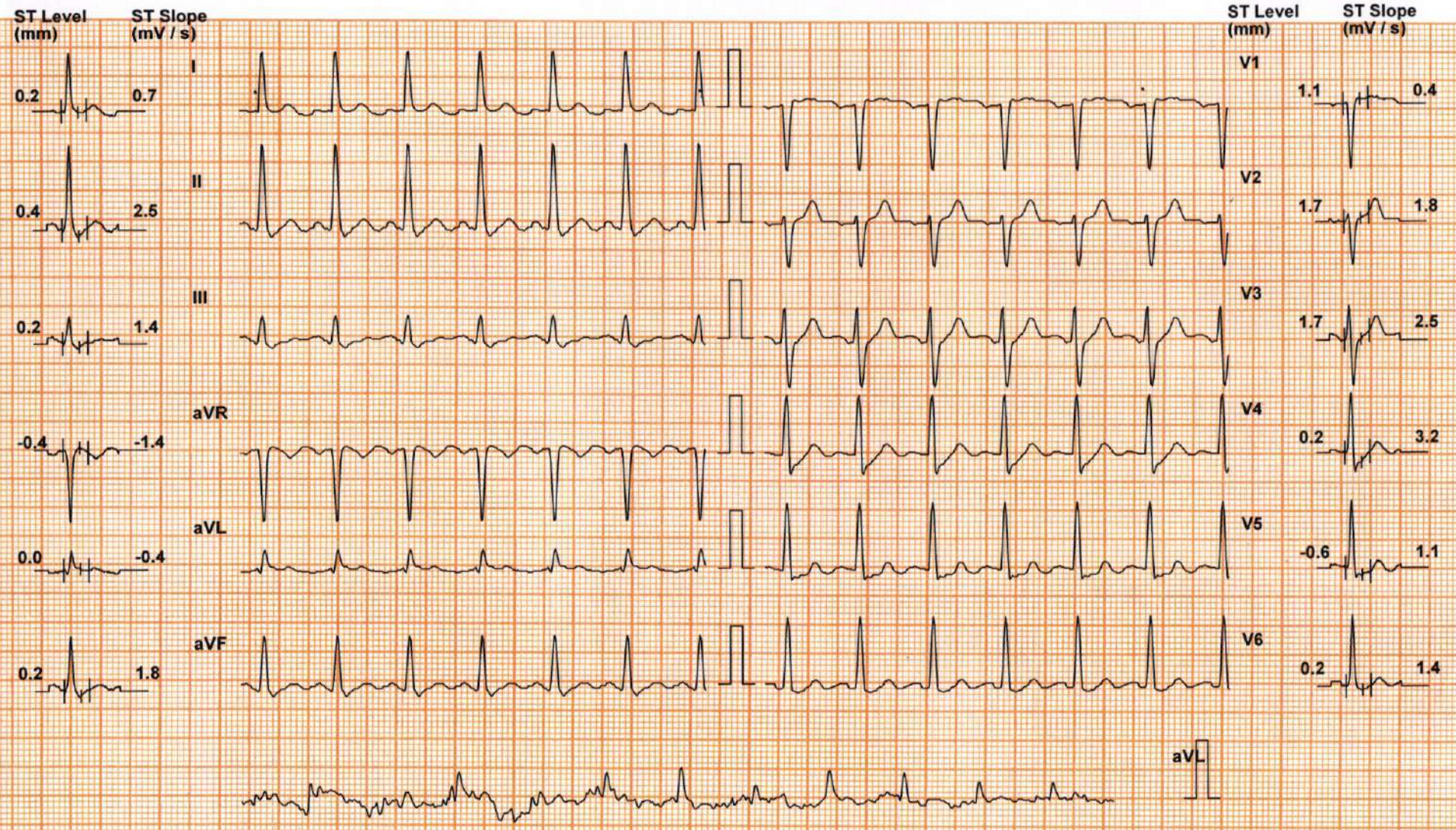


Chart Speed: 25 mm/sec Filter: 35 Hz Mains Filt: ON Amp: 10 mm *Iso = R - 60 ms* *J = R + 60 ms* *Post J = J + 60 ms*

Schiller Spandan V 4.7

Linked Median

DDRC SRL DIAGNOSTIC SERVICE PVT LTD

Test Report

JOSEPH JERRY LOPEZ (45 M) ID: WC004302 Date: 13-Mar-23 Exec Time : 11 m 0 s Stage Time : 0 m 54 s ***HR: 78 bpm***

Protocol: Bruce Stage: Recovery(1) Speed: 1 mph Grade: 0 % (THR: 148 bpm) B.P: 170 / 70

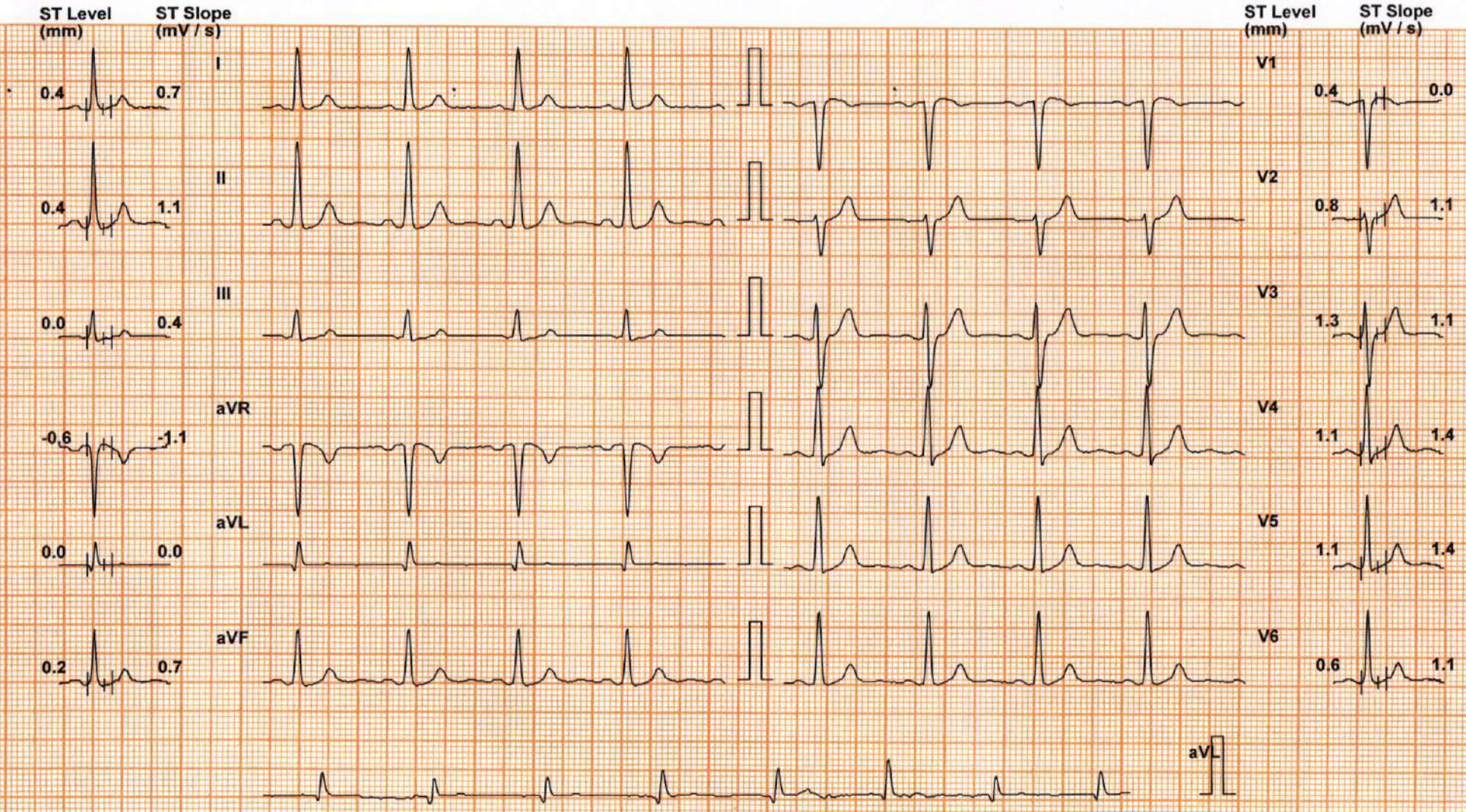


Chart Speed: 25 mm/sec Filter: 35 Hz Mains Filt: ON Amp: 10 mm *Iso = R - 60 ms* *J = R + 60 ms* *Post J = J + 60 ms*

Schiller Spandan V 4.7

Linked Median

DDRC SRL DIAGNOSTIC SERVICE PVT LTD

Test Report

JOSEPH JERRY LOPEZ (45 M) ID: WC004302 Date: 13-Mar-23 Exec Time : 11 m 0 s Stage Time : 0 m 54 s ***HR: 62 bpm***

Protocol: Bruce Stage: Recovery(2) Speed: 0 mph Grade: 0 % (THR: 148 bpm) B.P: 150 / 70

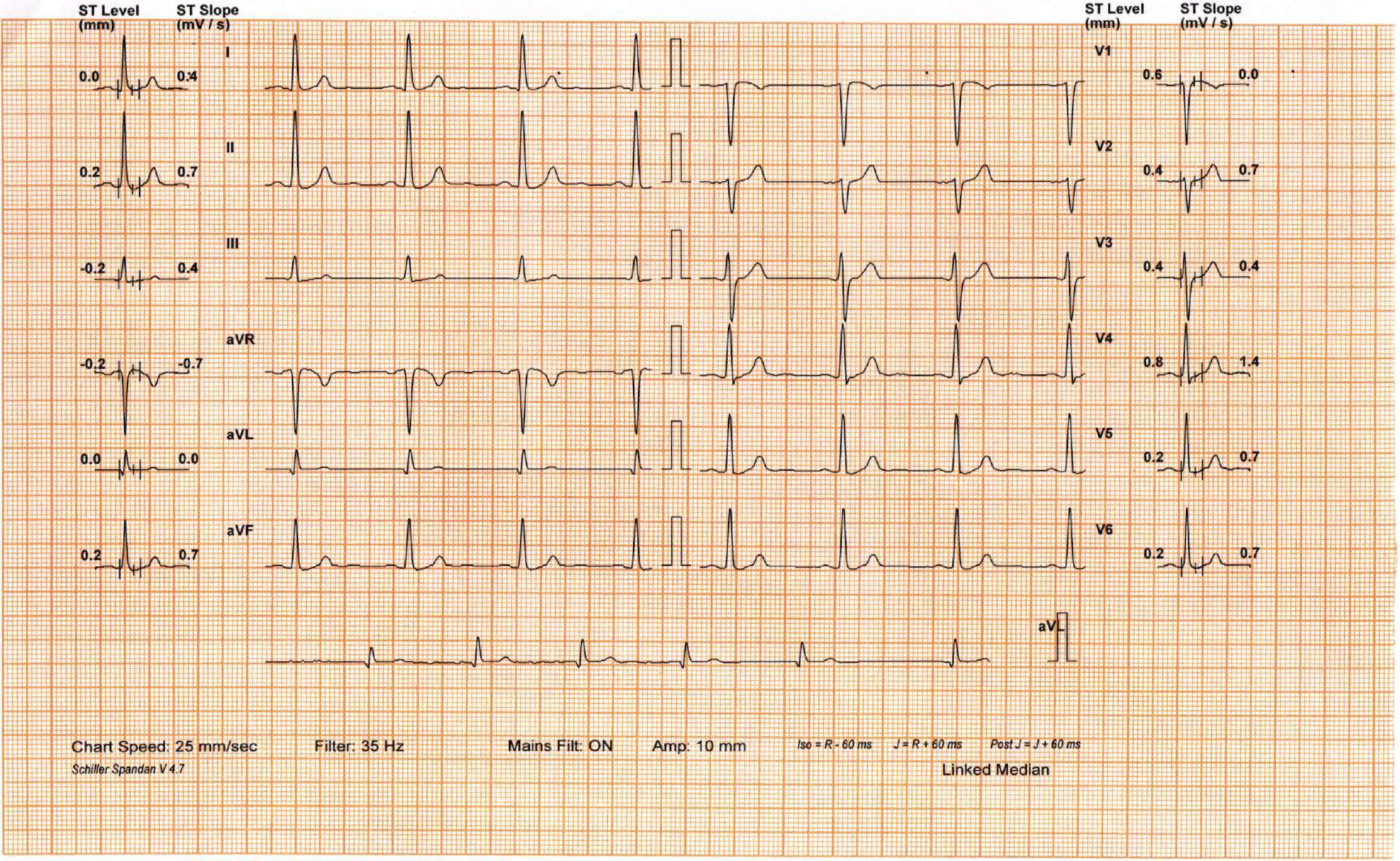


Chart Speed: 25 mm/sec Filter: 35 Hz Mains Filt: ON Amp: 10 mm *Iso = R - 60 ms* *J = R + 60 ms* *Post J = J + 60 ms*

Schiller Spandan V 4.7

Linked Median

DDRC SRL DIAGNOSTIC SERVICE PVT LTD

Test Report

JOSEPH JERRY LOPEZ (45 M) ID: WC004302 Date: 13-Mar-23 Exec Time : 11 m 0 s Stage Time : 0 m 54 s ***HR: 62 bpm***

Protocol: Bruce Stage: Recovery(3) Speed: 0 mph Grade: 0 % (THR: 148 bpm) B.P: 150 / 70

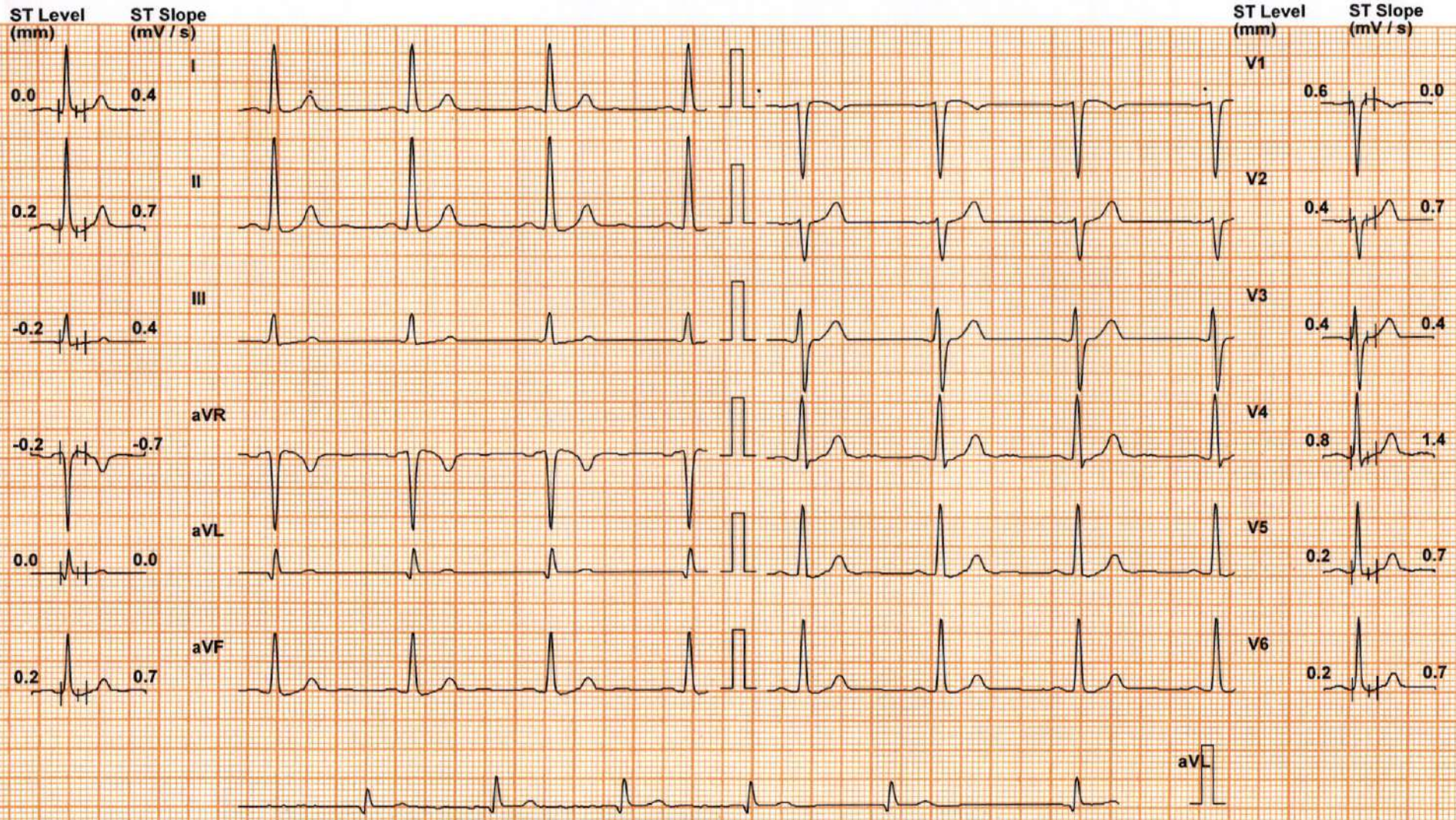


Chart Speed: 25 mm/sec Filter: 35 Hz Mains Filt: ON Amp: 10 mm *Iso = R - 60 ms* *J = R + 60 ms* *Post J = J + 60 ms*

Schiller Spandan V 4.7

Linked Median

DDRC SRL DIAGNOSTIC SERVICE PVT LTD

Patient Details **Date: 13-Mar-23** **Time: 09:55:18**

Name: JOSEPH JERRY LOPEZ ID: WC004302

Age: 45 y **Sex: M** **Height: -- cms** **Weight: -- Kgs**

Clinical History: NIL

Medications:

Test Details

Protocol: Bruce **Pr.MHR:** 175 bpm **THR:** 148 (85 % of Pr.MHR) bpm

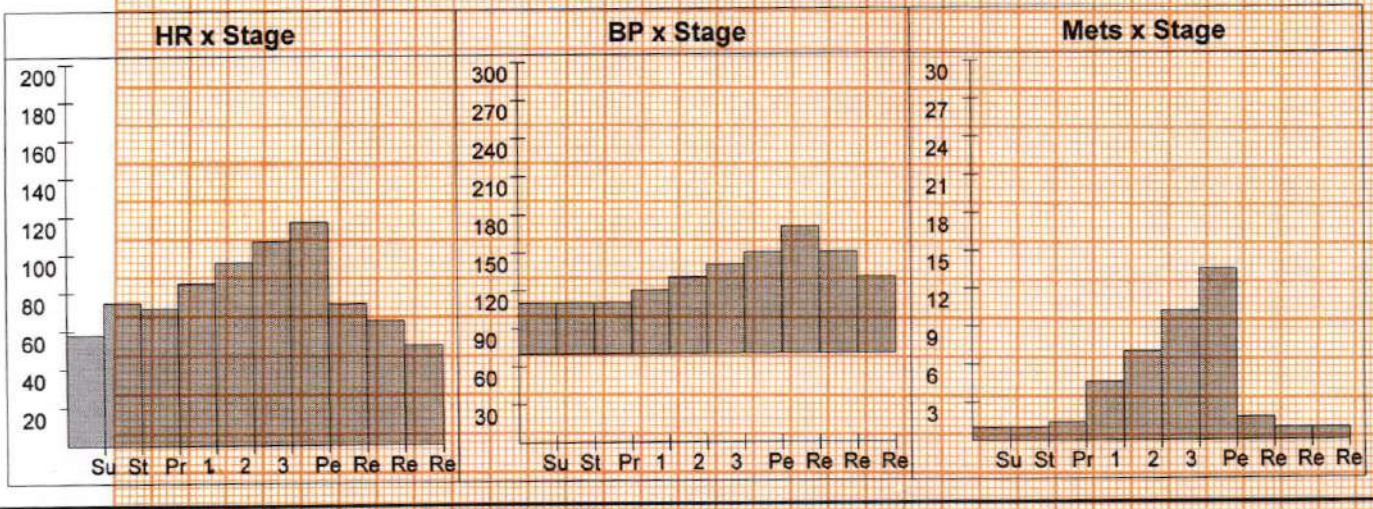
Total Exec. Time: 11 m 0 s **Max. HR:** 117 (67% of Pr.MHR)bpm **Max. Mets:** 13.50

Max. BP: 170 / 70 mmHg **Max. BP x HR:** 19890 mmHg/min **Min. BP x HR:** 3640 mmHg/min

Test Termination Criteria: Fatigue

Protocol Details

Stage Name	Stage Time (min : sec)	Mets	Speed (mph)	Grade (%)	Heart Rate (bpm)	Max. BP (mm/Hg)	Max. ST Level (mm)	Max. ST Slope (mV/s)
Supine	1 : 27	1.0	0	0	58	110 / 70	-1.91 III	3.89 V6
Standing	0 : 31	1.0	0	0	75	110 / 70	-1.70 III	1.06 V2
1	3 : 0	4.6	1.7	10	85	120 / 70	-1.91 V5	3.89 V1
2	3 : 0	7.0	2.5	12	96	130 / 70	-1.49 V5	4.25 V4
3	3 : 0	10.2	3.4	14	107	140 / 70	-1.06 aVR	3.54 V3
Peak Ex	2 : 0	13.5	4.2	16	117	150 / 70	-1.70 V4	3.89 V5
Recovery(1)	1 : 0	1.8	1	0	74	170 / 70	-1.06 aVR	3.18 V3
Recovery(2)	1 : 0	1.0	0	0	65	150 / 70	-0.64 aVR	1.77 V3
Recovery(3)	0 : 41	1.0	0	0	52	130 / 70	-0.42 III	1.77 V3



DDRC SRL DIAGNOSTIC SERVICE PVT LTD

Patient Details **Date:** 13-Mar-23 **Time:** 09:55:18

Name: JOSEPH JERRY LOPEZ ID: WC004302

Age: 45 y **Sex:** M **Height:** -- cms **Weight:** -- Kgs

Interpretation

The patient exercised according to the Bruce protocol for 11 m 0 s achieving a work level of Max. METS : 13.50. Resting heart rate initially 58 bpm, rose to a max. heart rate of 117 (67% of Pr.MHR) bpm. Resting blood Pressure 110 / 70 mmHg, rose to a maximum blood pressure of 170 / 70 mmHg.No Angina,No Arrhythmia

No significant ST changes
Test negative for inducible ischemia

Dr. George Thomas MD,FCSI,FIAE
Cardiologist

Ref. Doctor: MEDIWHEEL **Doctor:** ------

(Summary Report edited by user)