Patient Ref. No. 666000003348288

CLIENT CODE : CA00010147 - MEDIWHEEL

CLIENT'S NAME AND ADDRESS :

MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED
F701A, LADO SARAI, NEW DELHI,
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Email : customercare.ddrc@srl.in

PATIENT NAME : VIPIN DILEEP PATIENT ID : **DILEM1002934177**

ACCESSION NO : **4177WB000973** AGE : 30 Years SEX : Male ABHA NO :

DRAWN : RECEIVED : 10/02/2023 10:13 REPORTED : 11/02/2023 11:58

REFERRING DOCTOR : DR.ANTO 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		

PHYSICAL EXAMINATION

PHYSICAL EXAMINATION	COMPLETED		

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Test Report Status **Final**	Results		Units
MEDIWHEEL HEALTH CHEKUP BELOW 40(M)TMT			
BUN/CREAT RATIO			
BUN/CREAT RATIO	12	5 - 15	
CREATININE, SERUM			
CREATININE	0.99	18 - 60 yrs : 0.9 - 1.3	mg/dL
GLUCOSE, POST-PRANDIAL, PLASMA			
GLUCOSE, POST-PRANDIAL, PLASMA	117	Diabetes Mellitus : > or = 200. Impaired Glucose tolerance/ Prediabetes : 140 - 199. Hypoglycemia : < 55.	mg/dL
GLUCOSE FASTING,FLUORIDE PLASMA			
GLUCOSE, FASTING, PLASMA	102	Diabetes Mellitus : > or = 126. Impaired fasting Glucose/ Prediabetes : 101 - 125. Hypoglycemia : < 55.	mg/dL
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD			
GLYCOSYLATED HEMOGLOBIN (HBA1C)	5.1	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	99.7	< 116.0	mg/dL
LIPID PROFILE, SERUM			
CHOLESTEROL	188	Desirable : < 200 Borderline : 200-239 High : >or= 240	mg/dL
TRIGLYCERIDES	45	Normal : < 150 High : 150-199 Hypertriglyceridemia : 200-499 Very High : > 499	mg/dL
HDL CHOLESTEROL	50	General range : 40-60	mg/dL

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Test Report Status **Final**	Results			Units
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	**138**	**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	9.0		< or = 30.0	mg/dL
CHOL/HDL RATIO	3.8		3.30 - 4.40	
LDL/HDL RATIO	2.7		0.5 - 3.0	

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Test Report Status **Final**	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**

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Test Report Status **Final**	Results	Units

	LDL-C (mg/dl)	Non-HDL (mg/dl)	LDL-C (mg/dl)	Non-HDL (mg/dl)
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	0.39		General Range : < 1.1	mg/dL
BILIRUBIN, DIRECT	0.19		General Range : < 0.3	mg/dL
BILIRUBIN, INDIRECT	0.20		0.00 - 1.00	mg/dL
TOTAL PROTEIN	6.8		Ambulatory : 6.4 - 8.3 Recumbant : 6 - 7.8	g/dL
ALBUMIN	4.7		20-60yrs : 3.5 - 5.2	g/dL
GLOBULIN	2.1		2.0 - 4.1	g/dL
ALBUMIN/GLOBULIN RATIO	**2.2**	**High**	1.0 - 2.0	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	18		Adults : < 40	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)	26		Adults : < 45	U/L
ALKALINE PHOSPHATASE	83		Adult(<60yrs) : 40 - 130	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)	20		Adult (male) : < 60	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	6.5		Adults : 3.4-7	mg/dL

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP	B			

METHOD : GEL CARD METHOD

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Test Report Status **Final**	Results			Units
RH TYPE	POSITIVE			
BLOOD COUNTS,EDTA WHOLE BLOOD				
HEMOGLOBIN	14.4		13.0 - 17.0	g/dL
RED BLOOD CELL COUNT	4.68		4.5 - 5.5	mil/µL
WHITE BLOOD CELL COUNT	**3.70**	**Low**	4.0 - 10.0	thou/µL
PLATELET COUNT	268		150 - 410	thou/µL
Comments				
RECHECKED				
RBC AND PLATELET INDICES				
HEMATOCRIT	42.0		40 - 50	%
MEAN CORPUSCULAR VOL	89.6		83 - 101	fL
MEAN CORPUSCULAR HGB.	30.7		27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION	34.3		31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH	**14.2**	**High**	11.6 - 14.0	%
MENTZER INDEX	19.2			
MEAN PLATELET VOLUME	7.5		6.8 - 10.9	fL
WBC DIFFERENTIAL COUNT				
SEGMENTED NEUTROPHILS	49		40 - 80	%
LYMPHOCYTES	**42**	**High**	20 - 40	%
MONOCYTES	03		2 - 10	%
EOSINOPHILS	06		1 - 6	%
BASOPHILS	00		< 1 - 2	%
ABSOLUTE NEUTROPHIL COUNT	**1.81**	**Low**	2.0 - 7.0	thou/µL
ABSOLUTE LYMPHOCYTE COUNT	1.55		1 - 3	thou/µL
ABSOLUTE MONOCYTE COUNT	**0.11**	**Low**	0.20 - 1.00	thou/µL
ABSOLUTE EOSINOPHIL COUNT	0.22		0.02 - 0.50	thou/µL
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	1.2			
ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD				
SEDIMENTATION RATE (ESR)	05		0 - 14	mm at 1 hr
SUGAR URINE - POST PRANDIAL				

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Test Report Status **Final**	Results	Units
SUGAR URINE - POST PRANDIAL	NOT DETECTED	NOT DETECTED	
THYROID PANEL, SERUM			
T3	93.44	20-50 yrs : 60-181	ng/dL
T4	7.30	3.2 - 12.6	µg/dl
TSH 3RD GENERATION	3.870	18-49 yrs : 0.4 - 4.2	µIU/mL

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.

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Test Report Status **Final**	Results		Units
PHYSICAL EXAMINATION, URINE			
COLOR	PALE YELLOW		
APPEARANCE	CLEAR		
CHEMICAL EXAMINATION, URINE			
PH	5.0	4.7 - 7.5	
SPECIFIC GRAVITY	1.020	1.003 - 1.035	
PROTEIN	NOT DETECTED	NOT DETECTED	
GLUCOSE	NOT DETECTED	NOT DETECTED	
KETONES	NOT DETECTED	NOT DETECTED	
BLOOD	NOT DETECTED	NOT DETECTED	
BILIRUBIN	NOT DETECTED	NOT DETECTED	
UROBILINOGEN	NORMAL	NORMAL	
NITRITE	NOT DETECTED	NOT DETECTED	
MICROSCOPIC EXAMINATION, URINE			
RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
WBC	1-2	0-5	/HPF
EPITHELIAL CELLS	1-2	0-5	/HPF
CASTS	NOT DETECTED		
CRYSTALS	NOT DETECTED		
BACTERIA	NOT DETECTED	NOT DETECTED	

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Test Report Status **Final**	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

BLOOD UREA NITROGEN (BUN), SERUM

BLOOD UREA NITROGEN	11	Adult(<60 yrs) : 6 to 20	mg/dL

SUGAR URINE - FASTING

SUGAR URINE - FASTING	NOT DETECTED	NOT DETECTED

PHYSICAL EXAMINATION,STOOL

COLOUR	BROWN
CONSISTENCY	SEMI FORMED

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Test Report Status **Final**	Results		Units
MUCUS	NOT DETECTED	NOT DETECTED	
VISIBLE BLOOD	ABSENT	ABSENT	
MICROSCOPIC EXAMINATION,STOOL			
PUS CELLS	0-2		/hpf
RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
CYSTS	NOT DETECTED	NOT DETECTED	
OVA	NOT DETECTED		

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Test Report Status **Final**	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%.

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CLIENT CODE : CA00010147 - MEDIWHEEL

CLIENT'S NAME AND ADDRESS :

MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED
F701A, LADO SARAI, NEW DELHI,
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Email : customercare.ddrc@srl.in

PATIENT NAME : VIPIN DILEEP PATIENT ID : **DILEM1002934177**

ACCESSION NO : **4177WB000973** AGE : 30 Years SEX : Male ABHA NO :

DRAWN : RECEIVED : 10/02/2023 10:13 REPORTED : 11/02/2023 11:58

REFERRING DOCTOR : DR.ANTO CLIENT PATIENT ID :

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6. **Rota Virus Immunoassay**: This test is recommended in severe gastroenteritis in infants & children associated with watery diarrhoea, vomitting& abdominal cramps. Adults are also affected. It is highly contagious in nature.

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Patient Ref. No. 666000003348288

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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

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