CLIENT CODE : CA00010147
CLIENT'S NAME AND ADDRESS :
MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED
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SOUTH DELHI, DELHI,
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Tel : 93334 93334, Fax : CIN - U85190MH2006PTC161480
Email : customercare.ddrc@srl.in

PATIENT NAME : MR AJI V V   PATIENT ID :   **MRAJM1308744182**

ACCESSION NO :   **4182VH006062**   AGE :   48 Years   SEX : Male

DRAWN :   RECEIVED : 13/08/2022 09:23   REPORTED :   13/08/2022 14:17

REFERRING DOCTOR : SELF   CLIENT PATIENT ID :

Test Report Status	Results	Biological Reference Interval	Units

MEDIWHEEL HEALTH CHECKUP ABOVE 40(M)TMT

* TREADMILL TEST

TREADMILL TEST	REPORT GIVEN

DENTAL CHECK UP

DENTAL CHECK UP	REPORT GIVEN

OPTHAL

OPTHAL	REPORT GIVEN

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MEDIWHEEL HEALTH CHECKUP ABOVE 40(M)TMT

* SERUM BLOOD UREA NITROGEN

BLOOD UREA NITROGEN	8		6 - 20	mg/dL

* BUN/CREAT RATIO

BUN/CREAT RATIO	10.7			

CREATININE, SERUM

CREATININE	**0.75**	Low	0.9 - 1.3	mg/dL

* GLUCOSE, POST-PRANDIAL, PLASMA

GLUCOSE, POST-PRANDIAL, PLASMA	138		Diabetes Mellitus : > or = 200 mg/dL. Impaired Glucose tolerance/ Prediabetes : 140 to 199 mg/dL. Hypoglycemia : < 55 mg/dL.	mg/dL

GLUCOSE, FASTING, PLASMA

GLUCOSE, FASTING, PLASMA	92		Diabetes Mellitus : > or = 126 mg/dL. Impaired fasting Glucose/ Prediabetes : 101 to 125 mg/dL. Hypoglycemia : < 55 mg/dL.	mg/dL

* GLYCOSYLATED HEMOGLOBIN, EDTA WHOLE BLOOD

GLYCOSYLATED HEMOGLOBIN (HBA1C)	5.2		Normal : 4.0 - 5.6 %. Non-diabetic level : < 5.7%. 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			mg/dL

* CORONARY RISK PROFILE (LIPID PROFILE), SERUM

CHOLESTEROL	171		Desirable: <200 BorderlineHigh : 200-239 High : > or = 240	mg/dL
TRIGLYCERIDES	**165**	High	Normal: < 150 Borderline high: 150 - 199 High: 200 - 499 Very High: >/= 500	mg/dL
HDL CHOLESTEROL	**36**	Low	< 40 Low > or = 60 High	mg/dL

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Test Report Status	Results			Units
DIRECT LDL CHOLESTEROL	**118**	High	Adult Optimal : < 100 Near optimal : 100 - 129 Borderline high : 130 - 159 High : 160 - 189 Very high : > or = 190	mg/dL
NON HDL CHOLESTEROL	135			mg/dL
CHOL/HDL RATIO	4.8			
LDL/HDL RATIO	**3.3**	High	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
VERY LOW DENSITY LIPOPROTEIN	33.0		Desirable value : 10 - 35	mg/dL
* LIVER FUNCTION TEST WITH GGT				
BILIRUBIN, TOTAL	0.68		< 1.1	mg/dL
BILIRUBIN, DIRECT	0.23		< or = 0.30	mg/dL
BILIRUBIN, INDIRECT	0.45		0.00 - 0.60	mg/dL
TOTAL PROTEIN	7.3		6.4 - 8.3	g/dL
ALBUMIN	4.7		3.5 - 5.2	g/dL
GLOBULIN	2.6		2.0 - 4.0 Neonates - Pre Mature: 0.29 - 1.04	g/dL
ALBUMIN/GLOBULIN RATIO	1.8		1.00 - 2.00	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	14		< 40	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)	13		< 41	U/L
ALKALINE PHOSPHATASE	66		40 - 129	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)	14		8 - 61	U/L
TOTAL PROTEIN, SERUM				
TOTAL PROTEIN	7.3		6.6 - 8.7	g/dL
URIC ACID, SERUM				
URIC ACID	5.2		3.5 - 7.2	mg/dL
ABO GROUP & RH TYPE, EDTA WHOLE BLOOD				
ABO GROUP	TYPE O			
RH TYPE	POSITIVE			
* BLOOD COUNTS				
HEMOGLOBIN	15.4		13.0 - 17.0	g/dL
RED BLOOD CELL COUNT	**2.67**	Low	4.5 - 5.5	mil/µL
WHITE BLOOD CELL COUNT	6.34		4.0 - 10.0	thou/µL

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PLATELET COUNT	150	150 - 410	thou/µL
* RBC AND PLATELET INDICES			
HEMATOCRIT	**25.4**	Low 40 - 50	%
MEAN CORPUSCULAR VOL	95.0	83 - 101	fL
MEAN CORPUSCULAR HGB.	**57.7**	High 27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION	**60.7**	High 31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH	13.8	11.6 - 14.0	%
MEAN PLATELET VOLUME	7.9	6.8 - 10.9	fL
* WBC DIFFERENTIAL COUNT - NLR			
SEGMENTED NEUTROPHILS	50	40 - 80	%
ABSOLUTE NEUTROPHIL COUNT	3.17	2.0 - 7.0	thou/µL
LYMPHOCYTES	39	20 - 40	%
ABSOLUTE LYMPHOCYTE COUNT	2.47	1 - 3	thou/µL
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	1.3		
EOSINOPHILS	4	1 - 6	%
ABSOLUTE EOSINOPHIL COUNT	0.25	0.02 - 0.50	thou/µL
MONOCYTES	7	2 - 10	%
ABSOLUTE MONOCYTE COUNT	0.44	0.20 - 1.00	thou/µL
BASOPHILS	0	0 - 1	%
ABSOLUTE BASOPHIL COUNT	0.00		thou/µL
* ERYTHRO SEDIMENTATION RATE, BLOOD			
SEDIMENTATION RATE (ESR)	4	0 - 14	mm at 1 hr
STOOL: OVA & PARASITE	RESULT PENDING		
* SUGAR URINE - POST PRANDIAL			
SUGAR URINE - POST PRANDIAL	NOT DETECTED	NOT DETECTED	
URINALYSIS			
COLOR	PALE YELLOW		
APPEARANCE	CLEAR		
PH	6.0		
SPECIFIC GRAVITY	1.013		
GLUCOSE	NEGATIVE	NOT DETECTED	
PROTEIN	NEGATIVE	NOT DETECTED	
KETONES	NEGATIVE	NOT DETECTED	

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BLOOD	NOT DETECTED	NOT DETECTED	
BILIRUBIN	NOT DETECTED	NOT DETECTED	
UROBILINOGEN	NORMAL	NORMAL	
NITRITE	NEGATIVE	NOT DETECTED	
WBC	0-1	0-5	/HPF
EPITHELIAL CELLS	0-1	0-5	/HPF
RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
CASTS	NEGATIVE		
CRYSTALS	NEGATIVE		
REMARKS	NIL		
PROSTATE SPECIFIC ANTIGEN, SERUM			
PROSTATE SPECIFIC ANTIGEN	0.420	< 0.01 - 4.00	ng/mL
* THYROID PANEL, SERUM			
T3	74.42	60.0 - 181.0	ng/dL
T4	6.10	4.5 - 10.9	µg/dl
TSH 3RD GENERATION	1.670	0.550 - 4.780	µIU/mL

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

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

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(Ref: Tietz 4th Edition & ADA 2012 Guidelines)
GLYCOSYLATED HEMOGLOBIN, EDTA WHOLE BLOOD-
Glycosylated hemoglobin (GHb) has been firmly established as an index of long-term blood glucose concentrations and as a measure of the risk for the development of complications in patients with diabetes mellitus. Formation of GHb is essentially irreversible, and the concentration in the blood depends on both the life span of the red blood cell (average 120 days) and the blood glucose concentration. Because the rate of formation of GHb is directly proportional to the concentration of glucose in the blood, the GHb concentration represents the integrated values for glucose over the preceding 6-8 weeks.
Any condition that alters the life span of the red blood cells has the potential to alter the GHb level. Samples from patients with hemolytic anemias will exhibit decreased glycated hemoglobin values due to the shortened life span of the red cells. This effect will depend upon the severity of the anemia. Samples from patients with polycythemia or post-splenectomy may exhibit increased glycated hemoglobin values due to a somewhat longer life span of the red cells.
Glycosylated hemoglobins results from patients with HbSS, HbCC, and HbSC and HbD must be interpreted with caution, given the pathological processes, including anemia, increased red cell turnover, transfusion requirements, that adversely impact HbA1c as a marker of long-term glycemic control. In these conditions, alternative forms of testing such as glycated serum protein (fructosamine) should be considered.
"Targets should be individualized; More or less stringent glycemic goals may be appropriate for individual patients. Goals should be individualized based on duration of diabetes, age/life expectancy, comorbid conditions, known CVD or advanced microvascular complications, hypoglycemia unawareness, and individual patient considerations.''

References
1. Tietz Textbook of Clinical Chemistry and Molecular Diagnostics, edited by Carl A Burtis, Edward R.Ashwood, David E Bruns, 4th Edition, Elsevier publication, 2006, 879-884.
2. Forsham PH. Diabetes Mellitus:A rational plan for management. Postgrad Med 1982, 71,139-154.
3. Mayer TK, Freedman ZR: Protein glycosylation in Diabetes Mellitus: A review of laboratory measurements and their clinical utility. Clin Chim Acta 1983, 127, 147-184.
CORONARY RISK PROFILE (LIPID PROFILE), SERUM-
Serum cholesterol is a blood test that can provide valuable information for the risk of coronary artery disease This test can help determine your risk of the build up of plaques in your arteries that can lead to narrowed or blocked arteries throughout your body (atherosclerosis). High cholesterol levels usually don't cause any signs or symptoms, so a cholesterol test is an important tool. High cholesterol levels often are a significant risk factor for heart disease and important for diagnosis of hyperlipoproteinemia, atherosclerosis, hepatic and thyroid diseases.

Serum Triglyceride are a type of fat in the blood. When you eat, your body converts any calories it doesn't need into triglycerides, which are stored in fat cells. High triglyceride levels are associated with several factors, including being overweight, eating too many sweets or drinking too much alcohol, smoking, being sedentary, or having diabetes with elevated blood sugar levels. Analysis has proven useful in the diagnosis and treatment of patients with diabetes mellitus, nephrosis, liver obstruction, other diseases involving lipid metabolism, and various endocrine disorders. In conjunction with high density lipoprotein and total serum cholesterol, a triglyceride determination provides valuable information for the assessment of coronary heart disease risk.It is done in fasting state.

High-density lipoprotein (HDL) cholesterol. This is sometimes called the ""good"" cholesterol because it helps carry away LDL cholesterol, thus keeping arteries open and blood flowing more freely.HDL cholesterol is inversely related to the risk for cardiovascular disease. It increases following regular exercise, moderate alcohol consumption and with oral estrogen therapy. Decreased levels are associated with obesity, stress, cigarette smoking and diabetes mellitus.

SERUM LDL The small dense LDL test can be used to determine cardiovascular risk in individuals with metabolic syndrome or established/progressing coronary artery disease, individuals with triglyceride levels between 70 and 140 mg/dL, as well as individuals with a diet high in trans-fat or carbohydrates. Elevated sdLDL levels are associated with metabolic syndrome and an 'atherogenic lipoprotein profile', and are a strong, independent predictor of cardiovascular disease.
Elevated levels of LDL arise from multiple sources. A major factor is sedentary lifestyle with a diet high in saturated fat. Insulin-resistance and pre-diabetes have also been implicated, as has genetic predisposition. Measurement of sdLDL allows the clinician to get a more comprehensive picture of lipid risk factors and tailor treatment accordingly. Reducing LDL levels will reduce the risk of CVD and MI.

Non HDL Cholesterol - Adult treatment panel ATP III suggested the addition of Non-HDL Cholesterol as an indicator of all atherogenic lipoproteins (mainly LDL and VLDL). 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.

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Gout
Lesch nyhan syndrome.
Type 2 DM.
Metabolic syndrome.

Causes of decreased levels
• Low Zinc Intake
• OCP's
• Multiple Sclerosis

Nutritional tips to manage increased Uric acid levels
• Drink plenty of fluids
• Limit animal proteins
• High Fibre foods
• Vit C Intake
• Antioxidant rich foods
ABO GROUP & RH TYPE, EDTA WHOLE BLOOD-
Blood group is identified by antigens and antibodies present in the blood. Antigens are protein molecules found on the surface of red blood cells. Antibodies are found in plasma. To determine blood group, red cells are mixed with different antibody solutions to give A,B,O or AB.

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

The test is performed by both forward as well as reverse grouping methods.
BLOOD COUNTS-
The cell morphology is well preserved for 24hrs. However after 24-48 hrs a progressive increase in MCV and HCT is observed leading to a decrease in MCHC. A direct smear is recommended for an accurate differential count and for examination of RBC morphology.
RBC AND PLATELET INDICES-
The cell morphology is well preserved for 24hrs. However after 24-48 hrs a progressive increase in MCV and HCT is observed leading to a decrease in MCHC. A direct smear is recommended for an accurate differential count and for examination of RBC morphology.
WBC DIFFERENTIAL COUNT - NLR-
The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR < 3.3, COVID-19 patients tend to show mild disease.
(Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients ; A.-P. Yang, et al.; International Immunopharmacology 84 (2020) 106504
This ratio element is a calculated parameter and out of NABL scope.
ERYTHRO SEDIMENTATION RATE, BLOOD-
Erythrocyte sedimentation rate (ESR) is a non - specific phenomena and is clinically useful in the diagnosis and monitoring of disorders associated with an increased production of acute phase reactants. The ESR is increased in pregnancy from about the 3rd month and returns to normal by the 4th week post partum. ESR is influenced by age, sex, menstrual cycle and drugs (eg. corticosteroids, contraceptives). It is especially low (0 -1mm) in polycythaemia, hypofibrinogenemia or congestive cardiac failure and when there are abnormalities of the red cells such as poikilocytosis, spherocytosis or sickle cells.

Reference :
1. Nathan and Oski's Haematology of Infancy and Childhood, 5th edition
2. Paediatric reference intervals. AACC Press, 7th edition. Edited by S. Soldin.
3. The reference for the adult reference range is "Practical Haematology by Dacie and Lewis, 10th Edition"
SUGAR URINE - POST PRANDIAL-METHOD: DIPSTICK/BENEDICT'S TEST
URINALYSIS-Routine urine analysis assists in screening and diagnosis of various metabolic, urological, kidney and liver disorders
Protein: Elevated proteins can be an early sign of kidney disease. Urinary protein excretion can also be temporarily elevated by strenuous exercise, orthostatic proteinuria, dehydration, urinary tract infections and acute illness with fever
Glucose: Uncontrolled diabetes mellitus can lead to presence of glucose in urine. Other causes include pregnancy, hormonal disturbances, liver disease and certain medications.
Ketones: Uncontrolled diabetes mellitus can lead to presence of ketones in urine. Ketones can also be seen in starvation, frequent vomiting, pregnancy and strenuous exercise.
Blood: Occult blood can occur in urine as intact erythrocytes or haemoglobin, which can occur in various urological, nephrological and bleeding disorders.
Leukocytes: An increase in leukocytes is an indication of inflammation in urinary tract or kidneys. Most common cause is bacterial urinary tract infection.
Nitrite: Many bacteria give positive results when their number is high. Nitrite concentration during infection increases with length of time the urine specimen is retained in bladder prior to collection.
pH: The kidneys play an important role in maintaining acid base balance of the body. Conditions of the body producing acidosis/ alkalosis or ingestion of certain type of food can affect the pH of urine.
Specific gravity: Specific gravity gives an indication of how concentrated the urine is. Increased specific gravity is seen in conditions like dehydration, glycosuria and proteinuria while decreased specific gravity is seen in excessive fluid intake, renal failure and diabetes insipidus.
Bilirubin: In certain liver diseases such as biliary obstruction or hepatitis, bilirubin gets excreted in urine.
Urobilinogen: Positive results are seen in liver diseases like hepatitis and cirrhosis and in cases of hemolytic anemia
PROSTATE SPECIFIC ANTIGEN, SERUM-
Prostate Specific Antigen (PSA) is a single-chain glycoprotein normally found in the cytoplasm of the epithelial cells lining the acini and ducts of the prostate gland. PSA is

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detected in the serum of males 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 serum of males without prostate tissue (because of radical prostatectomy or cystoprostatectomy) or in the serum of most females.

The fact that PSA is unique to prostate tissue makes it a suitable marker for monitoring men with cancer of the prostate. PSA is also useful for determining possible recurrence after therapy when used in conjunction with other diagnostic indices. PSA levels increase in men with cancer of the prostate. After radical prostatectomy PSA levels routinely fall to a very low level, which may not be seen in patients undergoing radiation therapy. Monitoring PSA levels appears to be useful in detecting residual disease and early recurrence of tumor. Therefore, serial PSA levels can help determine the success of prostatectomy and the need for further treatment, such as radiation, endocrine or chemotherapy and in the monitoring of the effectiveness of therapy.

PSA levels should not be interpreted as absolute evidence of the presence or the absence of malignant disease. Before treatment, patients with confirmed prostate carcinoma frequently have levels of PSA within the range observed in healthy individuals. Elevated levels of PSA can be observed in the patients with nonmalignant diseases. Measurement of PSA should always be used in conjunction with other diagnostic procedures, including information from the patient's clinical evaluation. The concentration of total PSA in a given specimen determined with assays from different manufacturers can vary due to differences in assay methods, calibration, and reagent specificity. Values obtained with different assay method cannot be used interchangeably.

Heterophilic antibodies in human serum can react with reagent immunoglobulins, interfering with in vitro immunoassays. Patients routinely exposed to animals or to animal serum products can be prone to this interference and anomalous values may be observed. 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 levels persisting upto 3 weeks.
THYROID PANEL, SERUM-
Triiodothyronine T3 , is a thyroid hormone. It affects almost every physiological process in the body, including growth, development, metabolism, body temperature, and heart rate. Production of T3 and its prohormone thyroxine (T4) is activated by thyroid-stimulating hormone (TSH), which is released from the pituitary gland. Elevated concentrations of T3, and T4 in the blood inhibit the production of TSH.
Thyroxine T4, Thyroxine's principal function is to stimulate the metabolism of all cells and tissues in the body. Excessive secretion of thyroxine in the body is hyperthyroidism, and deficient secretion is called hypothyroidism. Most of the thyroid hormone in blood is bound to transport proteins. Only a very small fraction of the circulating hormone is free and biologically active.
In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hypothyroidism, TSH levels are low.
Below mentioned are the guidelines for Pregnancy related reference ranges for Total T4, TSH & Total T3

Levels in Pregnancy	TOTAL T4 (µg/dL)	TSH3G (µIU/mL)	TOTAL T3 (ng/dL)
First Trimester	6.6 - 12.4	0.1 - 2.5	81 - 190
2nd Trimester	6.6 - 15.5	0.2 - 3.0	100 - 260
3rd Trimester	6.6 - 15.5	0.3 - 3.0	100 - 260

Below mentioned are the guidelines for age related reference ranges for T3 and T4.

T3 (ng/dL)	T4 (µg/dL)
New Born: 75 - 260	1-3 day: 8.2 - 19.9
.	1 Week: 6.0 - 15.9

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

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

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8800465156

DDRC SRL DIAGNOSTICS
ASTER SQUARE BUILDING, ULLOOR,
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KERALA, INDIA
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Email : customercare.ddrc@srl.in

PATIENT NAME : MR AJI V V

PATIENT ID :   MRAJM1308744182

ACCESSION NO :   **4182VH006062**   AGE :   48 Years   SEX : Male

DRAWN :   RECEIVED :   13/08/2022 09:23   REPORTED :   13/08/2022 14:17

REFERRING DOCTOR : SELF   CLIENT PATIENT ID :

Test Report Status	Results	Units

MEDIWHEEL HEALTH CHECKUP ABOVE 40(M)TMT

* ECG WITH REPORT

REPORT
REPORT GIVEN

* USG ABDOMEN AND PELVIS

REPORT
REPORT GIVEN

* CHEST X-RAY WITH REPORT

REPORT
REPORT GIVEN

End Of Report
Please visit www.srlworld.com for related Test Information for this accession
TEST MARKED WITH '*' ARE OUTSIDE THE NABL ACCREDITED SCOPE OF THE LABORATORY.

BABU K MATHEW
HOD -BIOCHEMISTRY

DR.VAISHALI RAJAN
HOD - HAEMATOLOGY

PADMANABHAN NAIR
HOD - HORMONES

Scan to View Details

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COLOUR DOPPLER
ULTRASOUND SCANNING
ECHO

DDRC SRL
Diagnostic Services
INDIA'S LEADING DIAGNOSTICS NETWORK

RADIOLOGY DIVISION

Acc no:4182VH006062	Name: Mr. Aji V V	Age:48 y	Sex: Male	Date: 13.08.2

US SCAN WHOLE ABDOMEN

LIVER is normal in size (12.1 cm). Margins are regular. **Hepatic parenchyma shows increased echogenicity**. No focal lesions seen. No dilatation of intrahepatic biliary radicles. CBD is not dilated. Portal vein is normal in caliber (8.8 mm).

GALL BLADDER is partially distended and grossly normal. No pericholecystic fluid seen.

SPLEEN is normal in size (7.5 cm) and parenchymal echotexture. No focal lesion seen.

PANCREAS Head and body visualized, appears normal in size and parenchymal echotexture. Pancreatic duct is not dilated.

RIGHT KIDNEY is normal in size (9.8 x 4.2 cm) and shows normal parenchymal echotexture. Cortico medullary differentiation is maintained. Parenchymal thickness is normal. No echogenic focus with shadowing suggestive of renal calculi seen. No dilatation of pelvicalyceal system seen. Ureter is not dilated. Perinephric spaces are normal.

LEFT KIDNEY is normal in size (10.4 x 4.5 cm) and shows normal parenchymal echotexture. Cortico medullary differentiation is maintained. Parenchymal thickness is normal. No echogenic focus with shadowing suggestive of renal calculi seen. No dilatation of pelvicalyceal system seen. Ureter is not dilated. Perinephric spaces are normal.

PARAAORTIC AREA (upper part visualized) No retroperitoneal lymphadenopathy or mass seen.

URINARY BLADDER is distended, normal in wall thickness, lumen clear.

PROSTATE is normal in size (vol - 14.3 cc) and shows normal echotexture. No focal lesion seen.
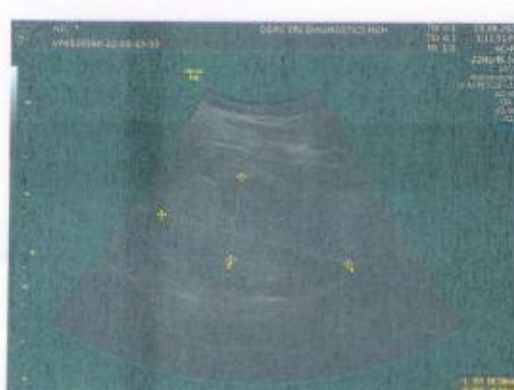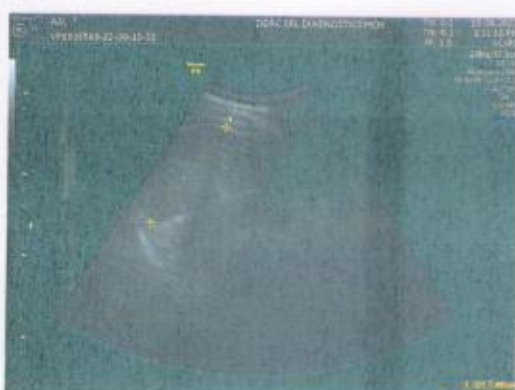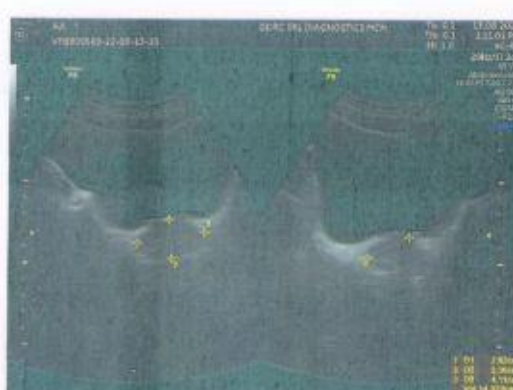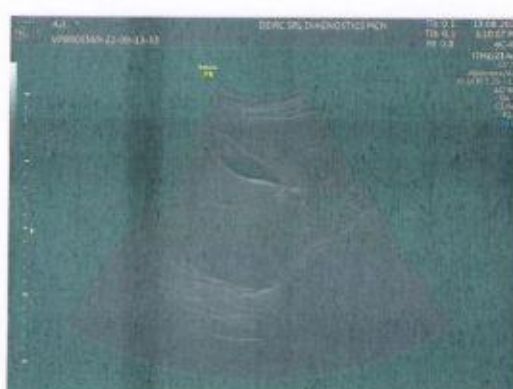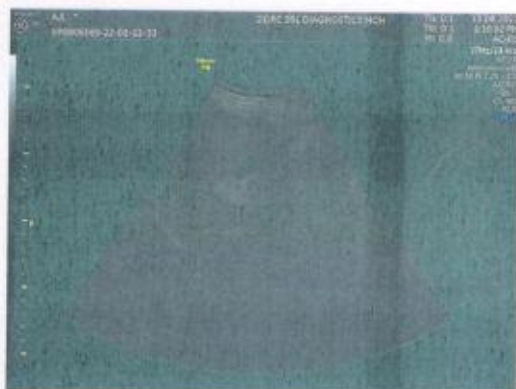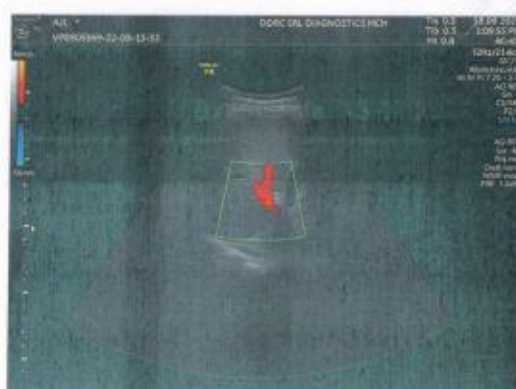
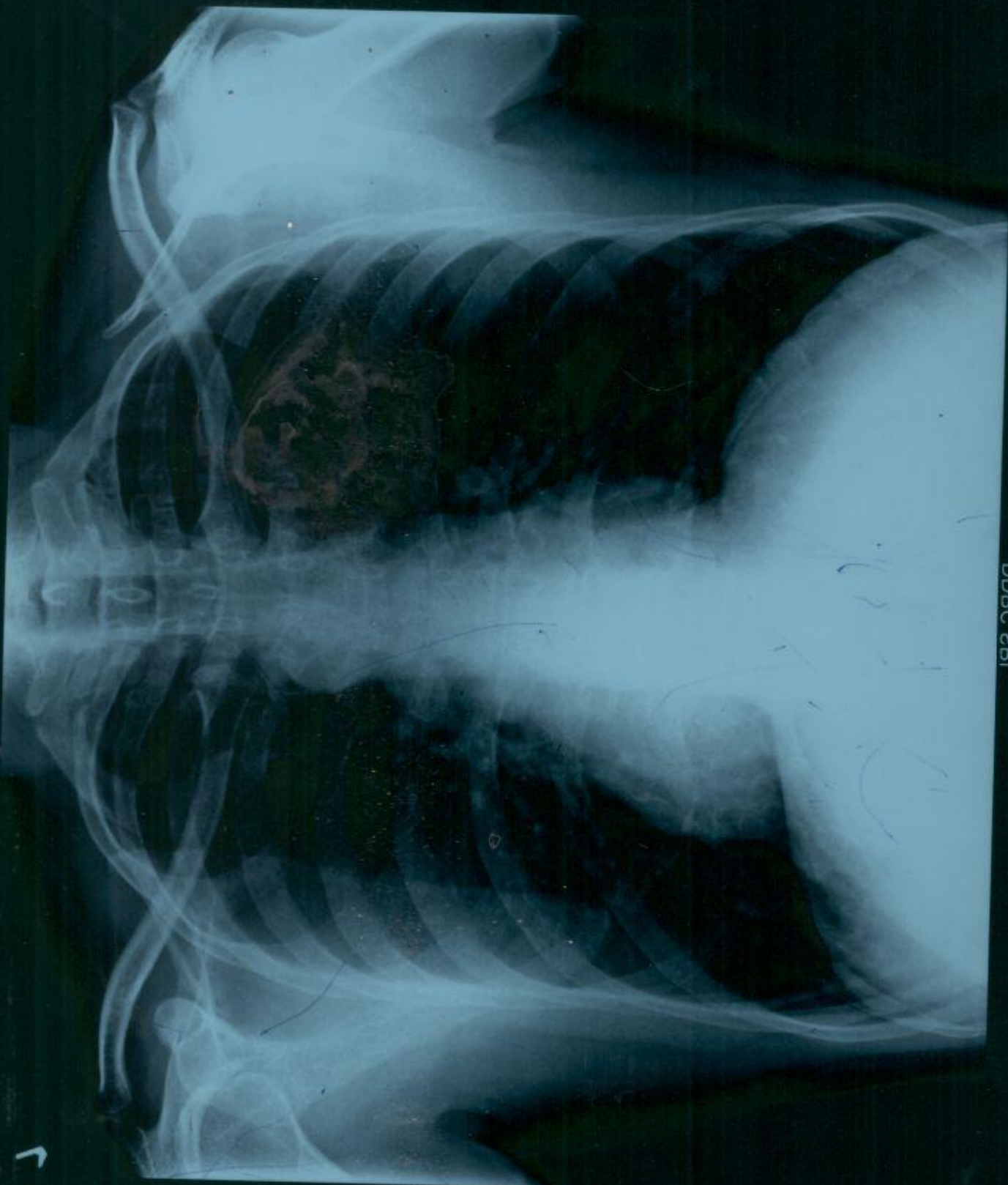No ascites or pleural effusion.

Gaseous distension of bowel loops noted.

CONCLUSION:-

➢ **Grade I / II fatty liver** - *suggest LFT correlation.*

Dr. Nisha Unni MD , DNB (RD)
Consultant radiologist.

Diagnosis Information:

ale
8Years
cm

mmHg

kg

R   : 68   bpm
     : 91   ms
R   : 131   ms
RS   : 87   ms
TQTc : 399/425 ms
QRS/T : 49/23/67 °
V5/SV1 : 0.929/0.832 mV

Report Confirmed by:

mr.

V1

V2

V3

V4

V6

Standard

ID: 006062   13-08-2022   10:44:35 AM

Standard   L 1   L II   L III   Inspiration   L III Inspiration

I   aVR   V1   V4

II   aVL   V2   V5

III   aVF   V3   V6
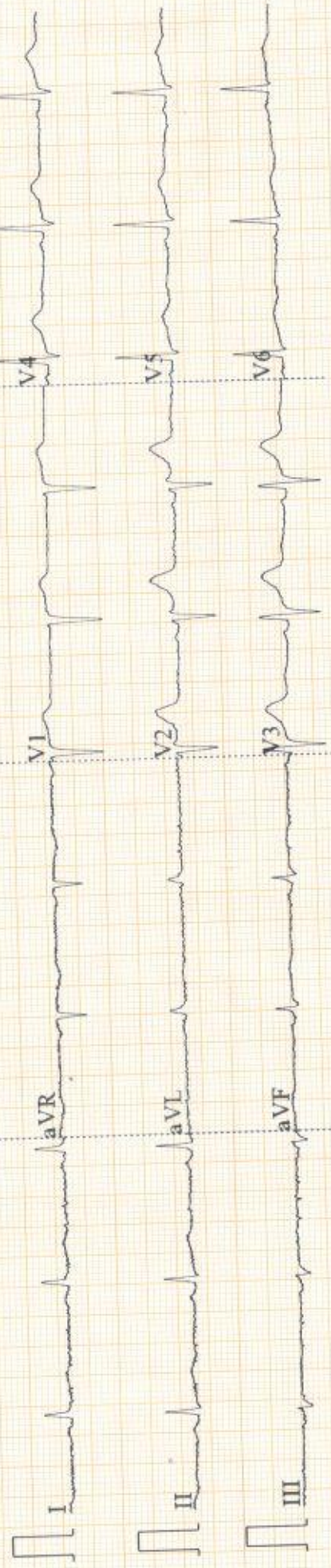
0.5~35Hz AC50 25mm/s 10mm/mV ♥64   V1.0 SEMIP V1.7 DDRCSRL

DDRC SRL

Patient Details   Date: 13-Aug-22   Time: 1:39:36 PM

Name: AJI V V   ID: 4182VH006062

Age: 48 y   Sex: M   Height: 173 cms   Weight: 62 Kgs

Clinical History: NIL

Medications: NIL

Test Details

Protocol: Bruce   Pr.MHR: 172 bpm   THR: 154 (90 % of Pr.MHR) bpm

Total Exec. Time: 9 m 41 s   Max. HR: 183 (106% of Pr.MHR)bpm   Max. Mets: 13.50

Max. BP: 170 / 80 mmHg   Max. BP x HR: 31110 mmHg/min   Min. BP x HR: 7920 mmHg/min

Test Termination Criteria: THR ATTAINED

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	0 : 11	1.0	0	0	0	120 / 80	0.00 I	0.00 II
Standing	0 : 0	1.0	0	0	0	120 / 80	0.00 I	0.00 II
Hyperventilation	0 : 28	1.0	0	0	100	120 / 80	-0.21 I	1.42 V3
1	3 : 0	4.6	1.7	10	105	130 / 80	-1.91 aVR	-3.54 V2
2	3 : 0	7.0	2.5	12	121	150 / 80	-2.76 I	-2.83 I
3	3 : 0	10.2	3.4	14	133	160 / 80	-1.06 III	3.54 V3
Peak Ex	0 : 41	13.5	4.2	16	183	170 / 80	-2.34 II	-2.83 V1
Recovery(1)	1 : 0	1.8	1	0	126	160 / 80	-0.64 II	5.31 V2
Recovery(2)	1 : 0	1.0	0	0	114	160 / 80	-0.42 aVR	5.66 V3
Recovery(3)	1 : 0	1.0	0	0	99	160 / 80	-0.21 I	3.18 V3
Recovery(4)	1 : 0	1.0	0	0	100	160 / 80	-0.42 II	2.12 V3
Recovery(5)	0 : 14	1.0	0	0	103	140 / 80	-0.21 I	1.77 V4
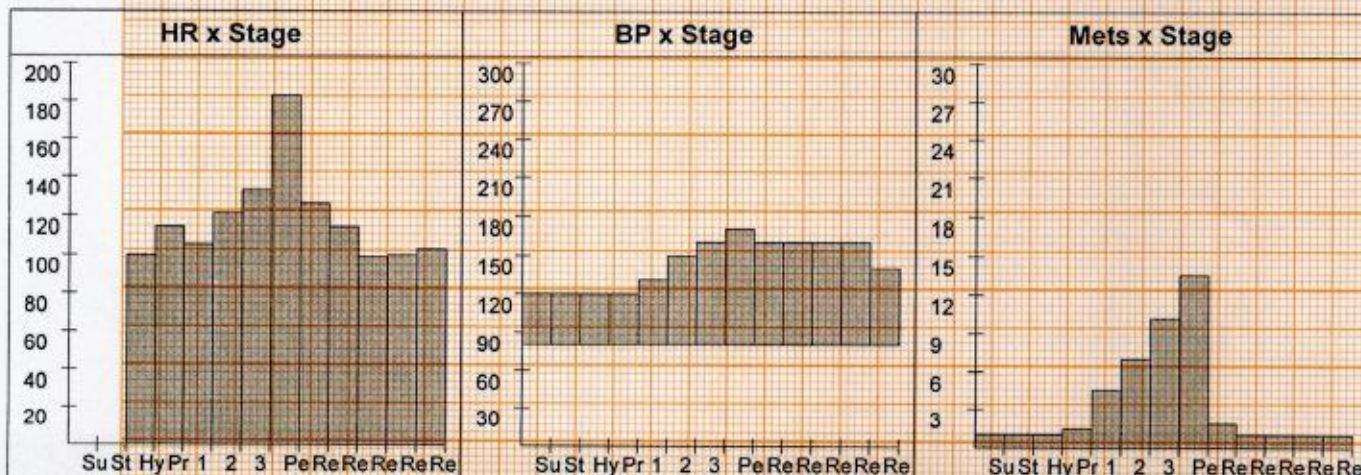
HR x Stage   BP x Stage   Mets x Stage

DDRC SRL

Patient Details	Date: 13-Aug-22	Time: 1:39:36 PM	

Name: AJI V V   **ID:** 4182VH006062

Age: 48 y	Sex: M	Height: 173 cms	Weight: 62 Kgs

Interpretation

The patient exercised according to the Bruce protocol for 9 m 41 s achieving a
work level of Max. METS : 13.50. Resting heart rate initially 0 bpm, rose to a
max. heart rate of 183 (106% of Pr.MHR) bpm. Resting blood Pressure 120 /
80 mmHg, rose to a maximum blood pressure of 170 / 80 mmHg.
NO ANGINA/ARRHYTHMIAS/SOB
GOOD EFFORT TOLERANCE
NO SIGNIFICANT ST CHANGES
TEST IS NEGATIVE FOR INDUCIBLE ISCHEMIA

Ref. Doctor: MEDIWHEEL

Doctor: DR.J.PRABAKARAN

(Summary Report edited by user)

DDRC SRL DIAGNOSTICS (P) LTD. TRIVANDRUM, KOTTAYAM, COCHIN, CALICUT.

AJI V V (48 M)
Protocol: Bruce
Exec Time : 0 m 0 s

ID: 4182VH006062
Stage: Supine
Stage Time : 0 m 5 s

Date: 13-Aug-22
Speed: 0 mph
HR: 97 bpm

B.P: 120 / 80
Grade: 0 %
(THR: 154 bpm)

		I		aVR		V1		V4				ST Level (mm)
			-0.2		0.0		0.8		0.6			ST Slope (mV / s)
			0.0		-0.4		1.1		1.1			
		II		aVL		V2		V5				
			0.0		0.0		1.1		0.4			
			0.7		0.0		0.7		0.7			
		III		aVF		V3		V6				
			0.0		0.0		0.8		0.2			
			0.4		0.4		1.1		0.7			

Chart Speed: 25 mm/sec
Schiller Spandan V 4.7

Filter: 35 Hz
Iso = R - 60 ms   J = R + 60 ms

Mains Filt: ON
Post J = J + 60 ms

Amp: 5 mm
Linked Median

AJI V V (48 M)
Protocol: Bruce
Exec Time : 0 m 0 s

ID: 4182VH006062
Stage: Standing
Stage Time : 0 m 5 s

Date: 13-Aug-22
Speed: 0 mph
HR: 97 bpm

B.P: 120 / 80
Grade: 0 %
(THR: 154 bpm)

I

II

III

aVR

aVL

aVF

V1

V2

V3

V4

V5

V6

V5

				ST Level (mm)
I	aVR	V1	V4	
	-0.2	0.0	0.8	0.6
	0.0	-0.4	1.1	1.1 ST Slope (mV / s)
II	aVL	V2	V5	
	0.0	0.0	1.1	0.4
	0.7	0.0	0.7	0.7
III	aVF	V3	V6	
	0.0	0.0	0.8	0.2
	0.4	0.4	1.1	0.7

Chart Speed: 25 mm/sec
Schiller Spandan V 4.7

Filter: 35 Hz
Iso = R - 60 ms   J = R + 60 ms

Mains Filt: ON
Post J = J + 60 ms

Amp: 5 mm
Linked Median

DDRC SRL

AJI V V (48 M)
Protocol: Bruce
Exec Time : 0 m 0 s

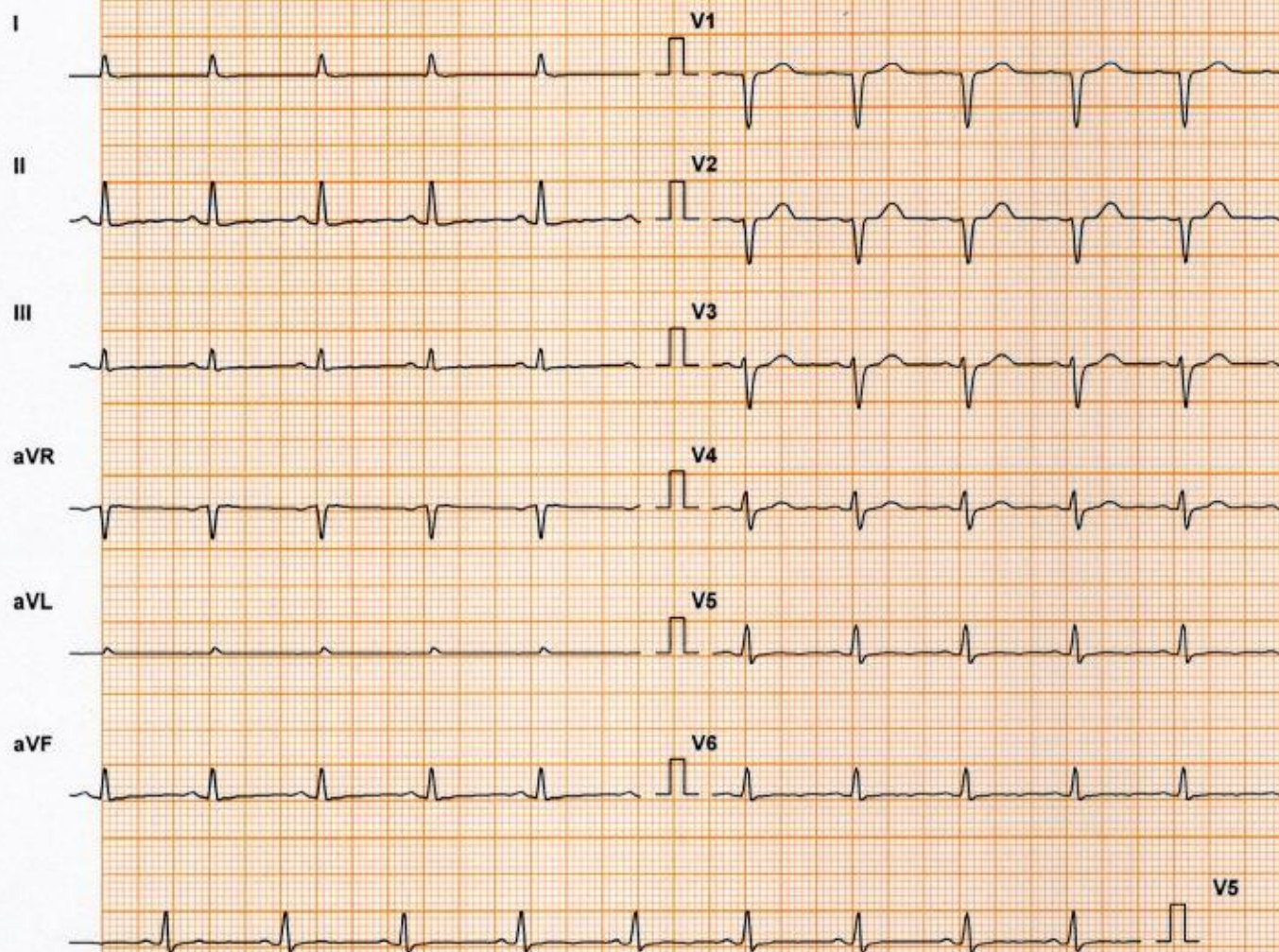ID: 4182VH006062
Stage: Hyperventilation
Stage Time : 0 m 22 s

Date: 13-Aug-22
Speed: 0 mph
HR: 116 bpm

B.P: 120 / 80
Grade: 0 %
(THR: 154 bpm)

I	aVR		V1		V4		ST Level (mm)
	0.0		-0.2		1.1		
	0.7		-0.7		0.7		ST Slope (mV / s)
II	aVL		V2		V5		
	0.4		-0.2		1.1		0.4
	1.1		0.0		0.7		0.7
III	aVF		V3		V6		
	0.4		0.6		0.6		0.4
	0.4		1.1		0.7		0.7

ST Level (mm) column values: I 0.0 / V4 0.4, II 0.4 / V5 0.4, III 0.4 / V6 0.4

Chart Speed: 25 mm/sec
Filter: 35 Hz
Mains Filt: ON
Amp: 5 mm

Schiller Spandan V 4.7
Iso = R - 60 ms   J = R + 60 ms
Post J = J + 60 ms
Linked Median

AJI V V (48 M)

Protocol: Bruce

Exec Time : 2 m 54 s

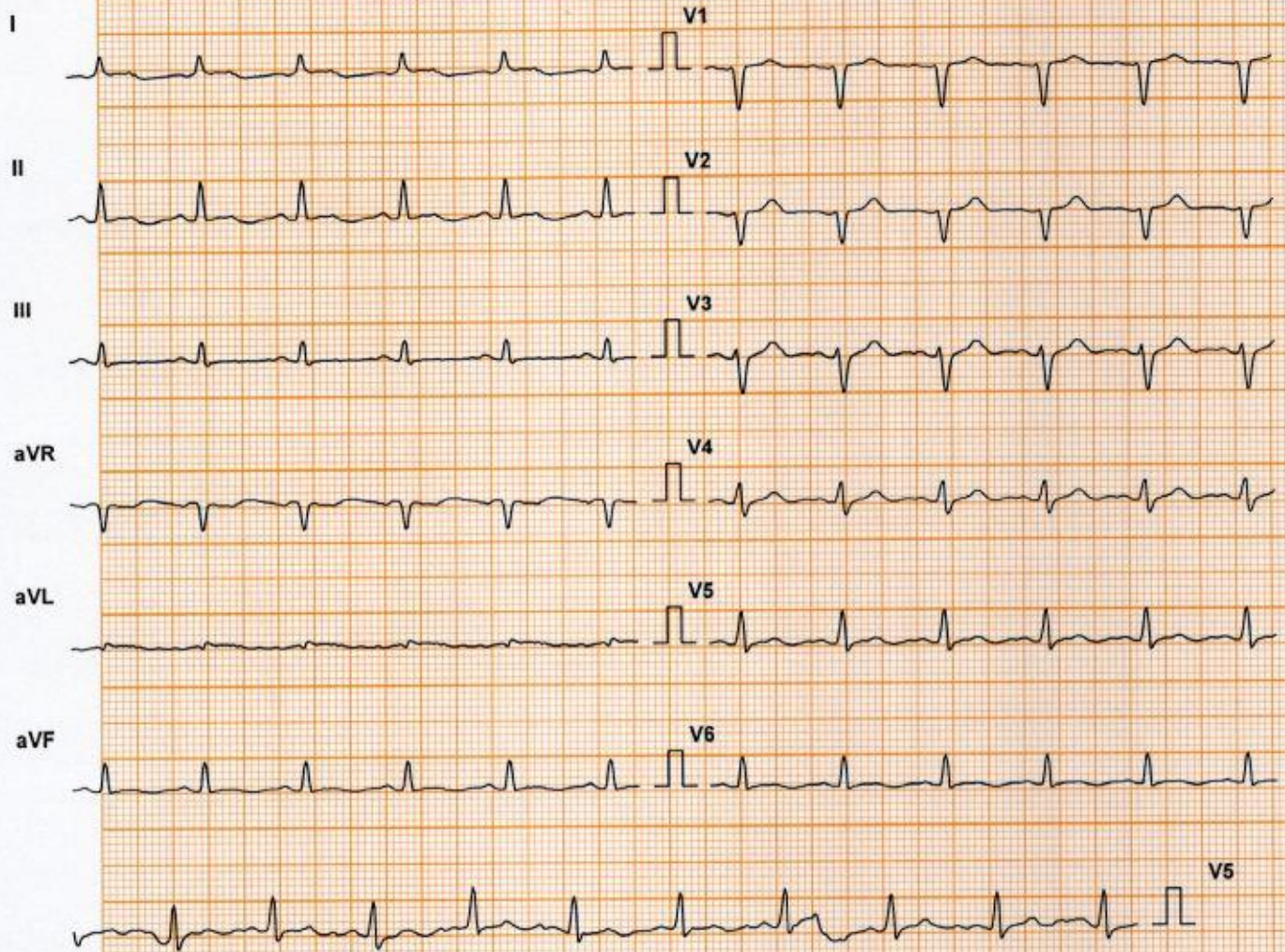ID: 4182VH006062

Stage: 1

Stage Time : 2 m 54 s

Date: 13-Aug-22

Speed: 1.7 mph

HR: 103 bpm

B.P: 130 / 80

Grade: 10 %

(THR: 154 bpm)

			ST Level (mm)	ST Slope (mV / s)
I	0.8	0.7		
aVR	-0.8	-0.7		
V1	1.5	1.1		
V4	1.1	1.4		
II	0.8	0.7		
aVL	0.4	0.4		
V2	1.7	1.4		
V5	0.6	0.7		
III	0.0	0.4		
aVF	0.6	0.7		
V3	1.7	1.8		
V6	0.4	0.7		

Chart Speed: 25 mm/sec

Schiller Spandan V 4.7

Filter: 35 Hz

Iso = R - 60 ms   J = R + 60 ms

Mains Filt: ON

Post J = J + 60 ms

Amp: 5 mm

Linked Median

DDRC SRL

I	aVR		V1		V4		ST Level (mm)
		0.0		0.2		1.1	0.2
		0.7		-0.7		1.1	1.4 ST Slope (mV / s)
II	aVL		V2		V5		
		0.0		0.0		1.3	0.2
		1.1		0.0		1.1	1.4
III	aVF		V3		V6		
		0.0		0.0		1.1	-0.2
		0.4		0.7		1.4	0.4

AJI V V (48 M)
Protocol: Bruce
Exec Time : 8 m 54 s

ID: 4182VH006062
Stage: 3
Stage Time : 2 m 54 s

Date: 13-Aug-22
Speed: 3.4 mph
HR: 131 bpm

B.P: 160 / 80
Grade: 14 %
(THR: 154 bpm)

I

II

III

aVR

aVL

aVF

V1

V2

V3

V4

V5

V6

V5

			ST Level (mm)
I	aVR -0.2 / 0.7	V1 0.2 / -0.7	V4 1.7 / 2.1	ST Slope (mV / s)
II	aVL -0.4 / 1.1	V2 -0.2 / 0.0	V5 2.1 / 2.5	0.2 / 1.4
III	aVF -0.2 / 0.4	V3 -0.2 / 0.7	V6 2.3 / 3.2	-0.4 / 0.7

Chart Speed: 25 mm/sec
Schiller Spandan V 4.7

Filter: 35 Hz
Iso = R - 60 ms   J = R + 60 ms

Mains Filt: ON
Post J = J + 60 ms

Amp: 5 mm
Linked Median

AJI V V (48 M)
Protocol: Bruce
Exec Time : 9 m 35 s

ID: 4182VH006062

Stage: Peak Ex

Stage Time : 0 m 35 s

Date: 13-Aug-22

Speed: 4.2 mph

HR: 167 bpm

B.P: 170 / 80

Grade: 16 %

(THR: 154 bpm)

I

II

III

aVR

aVL

aVF

V1

V2

V3

V4

V5

V6

V5

I		aVR		V1		V4		
		aVR	-1.1	V1	1.5	V4	3.0	-0.4 ST Level (mm)
			-0.4		-0.7		-0.4	1.4 ST Slope (mV / s)
II		aVL		V2		V5		
		aVL	-2.3	V2	0.0	V5	1.1	-1.1
			1.4		-0.4		2.8	1.4
III		aVF		V3		V6		
		aVF	-1.1	V3	0.2	V6	0.2	-0.4
			1.4		1.4		0.4	1.1

ST Level value in III row aVR = -1.1 / 1.4

Chart Speed: 25 mm/sec

Schiller Spandan V 4.7

Filter: 35 Hz

Iso = R - 60 ms   J = R + 60 ms

Mains Filt: ON

Post J = J + 60 ms

Amp: 5 mm

Linked Median

AJI V V (48 M)

Protocol: Bruce

Exec Time : 9 m 41 s

ID: 4182VH006062

Stage: Recovery(1)

Stage Time : 0 m 54 s

Date: 13-Aug-22

Speed: 1 mph

HR: 126 bpm

B.P: 160 / 80

Grade: 0 %

(THR: 154 bpm)

I

II

III

aVR

aVL

aVF

V1

V2

V3

V4

V5

V6

V5

I		aVR		V1		V4		
	0.2		-0.4		2.1		2.3	ST Level (mm)
	0.7		-1.8		2.5		3.9	ST Slope (mV / s)
II		aVL		V2		V5		
	0.8		0.0		3.0		1.3	
	2.8		0.0		3.5		2.5	
III		aVF		V3		V6		
	0.4		0.4		3.6		0.6	
	1.8		2.1		5.0		2.1	

Chart Speed: 25 mm/sec

Schiller Spandan V 4.7

Filter: 35 Hz

Iso = R - 60 ms   J = R + 60 ms

Mains Filt: ON

Post J = J + 60 ms

Amp: 5 mm

Linked Median

AJI V V (48 M)
Protocol: Bruce
Exec Time : 9 m 41 s

ID: 4182VH006062
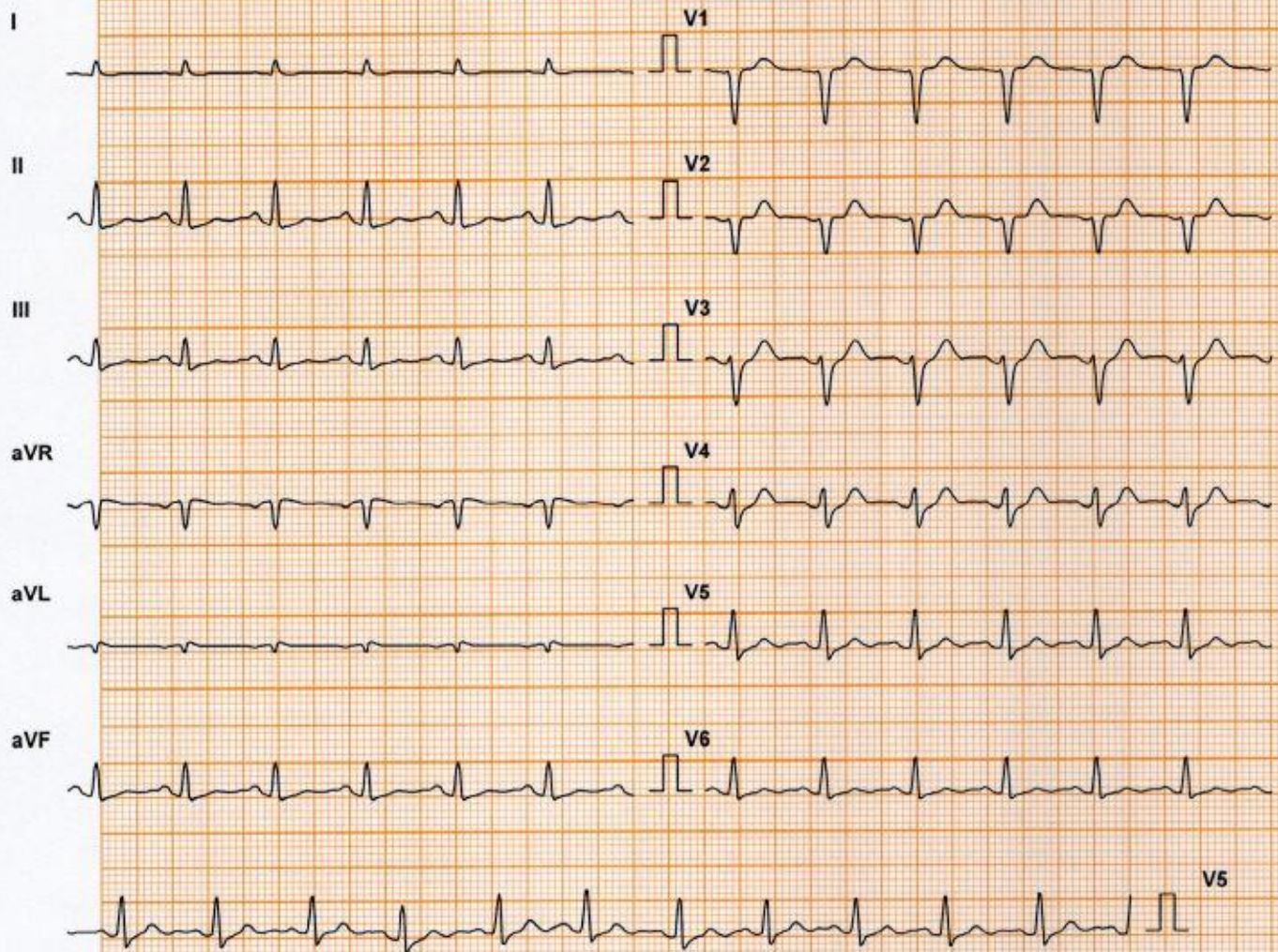Stage: Recovery(2)
Stage Time : 0 m 54 s

Date: 13-Aug-22
Speed: 0 mph
HR: 116 bpm

B.P: 160 / 80
Grade: 0 %
(THR: 154 bpm)

I		aVR		V1		V4			
	0.0		0.0		1.7		1.5	ST Level (mm)	
	0.4		-1.1		1.4		3.2	ST Slope (mV / s)	
II		aVL		V2		V5			
	0.0		-0.2		1.7		0.8		
	1.8		-0.4		1.4		2.1		
III		aVF		V3		V6			
	0.0		0.0		2.8		0.4		
	1.1		1.4		3.5		1.4		

Chart Speed: 25 mm/sec
Schiller Spandan V 4.7

Filter: 35 Hz
Iso = R - 60 ms   J = R + 60 ms

Mains Filt: ON
Post J = J + 60 ms

Amp: 5 mm
Linked Median

AJI V V (48 M)

Protocol: Bruce	ID: 4182VH006062	Date: 13-Aug-22	B.P: 160 / 80
	Stage: Recovery(3)	Speed: 0 mph	Grade: 0 %
Exec Time : 9 m 41 s	Stage Time : 0 m 54 s	**HR: 97 bpm**	(THR: 154 bpm)

I	aVR	V1	V4	
0.0	0.0	1.3	1.1	ST Level (mm)
0.0	-0.7	1.4	2.1	ST Slope (mV / s)
II	aVL	V2	V5	
0.0	0.0	0.8	0.6	
1.1	0.0	0.4	1.4	
III	aVF	V3	V6	
0.0	0.0	1.5	0.2	
0.7	1.1	1.8	1.1	

Chart Speed: 25 mm/sec	Filter: 35 Hz	Mains Filt: ON	Amp: 5 mm
Schiller Spandan V 4.7	Iso = R - 60 ms J = R + 60 ms	Post J = J + 60 ms	Linked Median

AJI V V (48 M)
Protocol: Bruce
Exec Time : 9 m 41 s

ID: 4182VH006062
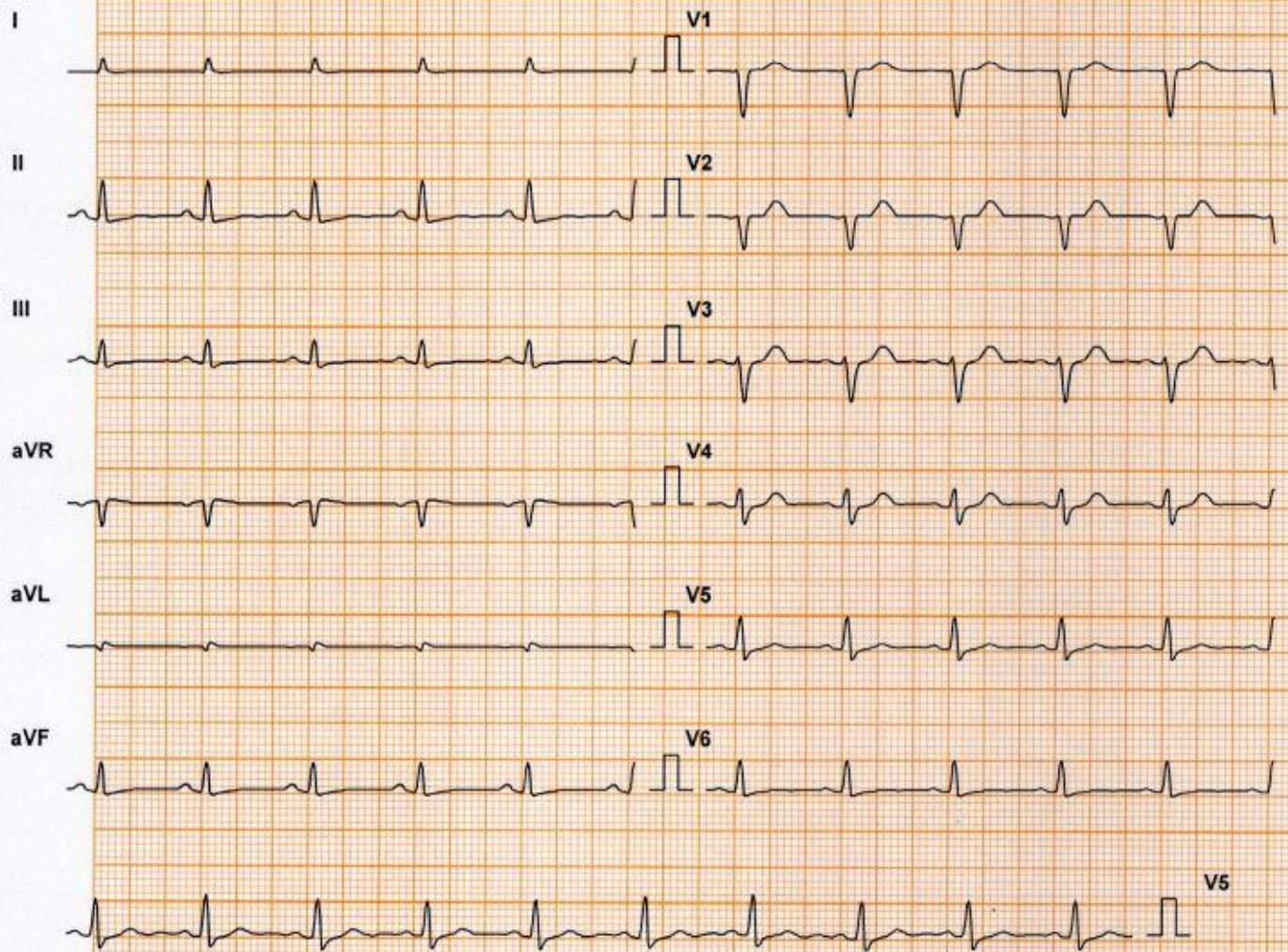Stage: Recovery(4)
Stage Time : 0 m 54 s

Date: 13-Aug-22
Speed: 0 mph
HR: 98 bpm

B.P: 160 / 80
Grade: 0 %
(THR: 154 bpm)

I

II

III

aVR

aVL

aVF

V1

V2

V3

V4

V5

V6

V5

I		aVR		V1		V4		
	-0.2		0.0		0.6		0.8	ST Level (mm)
	0.0		-0.7		0.7		1.4	ST Slope (mV / s)
II		aVL		V2		V5		
	-0.2		0.0		0.6		0.4	
	0.7		0.0		0.0		1.4	
III		aVF		V3		V6		
	0.0		-0.2		1.1		-0.2	
	0.7		0.7		1.4		0.7	

Chart Speed: 25 mm/sec
Schiller Spandan V 4.7

Filter: 35 Hz
Iso = R - 60 ms   J = R + 60 ms

Mains Filt: ON
Post J = J + 60 ms

Amp: 5 mm
Linked Median

AJI V V (48 M)

Protocol: Bruce			
Exec Time : 9 m 41 s			

ID: 4182VH006062

Stage: Recovery(5)

Stage Time : 0 m 8 s

Date: 13-Aug-22

Speed: 0 mph

HR: 101 bpm

B.P: 140 / 80

Grade: 0 %

(THR: 154 bpm)

I

II

III

aVR

aVL

aVF

V1

V2

V3

V4

V5

V6

V5

I	aVR	V1	V4	ST Level (mm)
	-0.2	0.0	0.6	1.1
	0.0	-0.7	0.7	1.8 ST Slope (mV / s)
II	aVL	V2	V5	
	-0.2	0.0	0.6	0.2
	0.7	0.0	0.0	1.1
III	aVF	V3	V6	
	0.0	0.0	1.3	0.0
	0.7	0.7	1.1	1.1

Chart Speed: 25 mm/sec

Schiller Spandan V 4.7

Filter: 35 Hz

Iso = R - 60 ms   J = R + 60 ms

Mains Filt: ON

Post J = J + 60 ms

Amp: 5 mm

Linked Median

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