



NE

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. <u>BEENA THOMAS</u>
2. Mark of Identification	:	(Mole/Scar/any other (specify location)):
3. Age/Date of Birth	:	<u>05-05-1972</u> Gender: <input checked="" type="checkbox"/> F/M
4. Photo ID Checked	:	(Passport/Election Card/PAN Card/Driving Licence/Company ID)

PHYSICAL DETAILS:

a. Height <u>167</u> (cms)	b. Weight <u>71</u> (Kgs)	c. Girth of Abdomen <u>80</u> (cms)
d. Pulse Rate <u>70</u> (/Min)	e. Blood Pressure:	Systolic Diastolic
	1 st Reading	<u>120</u> <u>80</u>
	2 nd Reading	

FAMILY HISTORY:

Relation	Age if Living	Health Status	If deceased, age at the time and cause
Father			<u>77 CABG, Paralysis</u>
Mother			
Brother(s)		<u>NS</u>	
Sister(s)			

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

Tobacco in any form	Sedative	Alcohol
<u>—</u>	<u>—</u>	<u>—</u>

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. HTIV Y/N
- b. Have you undergone/been advised any surgical procedure? 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? Carbis Sy. 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

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

H. breast cysts operated

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

CONFIDENTIAL COMMENTS FROM MEDICAL EXAMINER

- Was the examinee co-operative? Y/N
- Is there anything about the examinee'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;

Medical consult

➤ 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 :

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

Seal of Medical Examiner :

Name & Seal of DDRC SRL Branch :



Date & Time :

03/02/2023

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Subject: Photo from Beena Thomas

From: Beena Mathews <beena.mathews@gmail.com>

Date: 01/02/2023, 8:48 AM

To: medicalexecutives.ddrc@srl.in

—IMG-20230118-WA0049.jpg—



The image shows a Government of India ID card. At the top left is the State Emblem of India. To the right, it says 'ಭಾರತ ಸರ್ಕಾರ' (Government of India) and 'Government of India'. Below this, the cardholder's name is 'ಬೀನಾ ಥಾಮಸ್' (Beena Thomas). Her husband's name is 'ಗಂಡ : ಬಿನೋಯ್ ಥಾಮಸ್' (Husband : Binoy Thomas). Her date of birth is 'ಜನ್ಮ ದಿನಾಂಕ / DOB : 05/05/1972' and her gender is 'ಸ್ತ್ರೀ / Female'. A QR code is located on the right side. At the bottom, the card number '3356 5917 2822' is displayed, followed by the text 'ಆಧಾರ್ - ಶ್ರೀಸಾಮಾನ್ಯನ ಅಧಿಕಾರ' (Aadhaar - Shri Samanyana Adhikara).

—Attachments:—

IMG-20230118-WA0049.jpg

140 KB



PATIENT NAME : BEENA THOMAS**REF. DOCTOR : DR. MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED****CODE/NAME & ADDRESS : CA00010147 -**
 MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED
 F701A, LADO SARAI, NEW DELHI,SOUTH DELHI,
 DELHI,
 SOUTH DELHI 110030
 8800465156
ACCESSION NO : **4126WB000061**

PATIENT ID : BEENF0505724126

CLIENT PATIENT ID:
ABHA NO :

AGE/SEX : 50 Years Female

DRAWN :

RECEIVED : 01/02/2023 08:52:19

REPORTED : 01/02/2023 19:14:11

Test Report Status	<u>Preliminary</u>	Results	Biological Reference Interval	Units
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MEDIWHEEL HEALTH CHECKUP ABOVE 40(F)TMT**OPHAL**

OPHAL

TEST COMPLETED



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 KERALA, INDIA
 Tel : 93334 93334
 Email : customercare.ddrc@srl.in
**Patient Ref. No. 66600003233902**

PATIENT NAME : BEENA THOMAS**REF. DOCTOR : DR. MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED**
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MEDIWHEEL HEALTH CHECKUP ABOVE 40(F)TMT**TREADMILL TEST**

TREADMILL TEST

TEST COMPLETED

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**Patient Ref. No. 666000003233902**

CIN : U85190MH2006PTC161480

(Refer to "CONDITIONS OF REPORTING" overleaf)

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MEDIWHEEL HEALTH CHECKUP ABOVE 40(F)TMT
ECG WITH REPORT
REPORT

TEST COMPLETED

MAMMOGRAPHY -BOTH
REPORT

TEST COMPLETED

USG ABDOMEN AND PELVIS
REPORT

TEST COMPLETED

CHEST X-RAY WITH REPORT
REPORT

TEST COMPLETED

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HAEMATOLOGY - CBC**MEDIWHEEL HEALTH CHECKUP ABOVE 40(F)TMT****BLOOD COUNTS, EDTA WHOLE BLOOD**

HEMOGLOBIN	13.1	12.0 - 15.0	g/dL
METHOD : NON CYANMETHHEMOGLOBIN			
RED BLOOD CELL COUNT	4.24	3.8 - 4.8	mil/ μ L
METHOD : IMPEDANCE			
WHITE BLOOD CELL COUNT	6.32	4.0 - 10.0	thou/ μ L
METHOD : IMPEDANCE			
PLATELET COUNT	239	150 - 410	thou/ μ L
METHOD : IMPEDANCE			


RBC AND PLATELET INDICES

HEMATOCRIT	39.4	36 - 46	%
METHOD : CALCULATED			
MEAN CORPUSCULAR VOL	93.0	83 - 101	fL
METHOD : DERIVED FROM IMPEDANCE MEASURE			
MEAN CORPUSCULAR HGB.	30.9	27.0 - 32.0	pg
METHOD : CALCULATED			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION	33.2	31.5 - 34.5	g/dL
METHOD : CALCULATED			
RED CELL DISTRIBUTION WIDTH	15.3	12.0 - 18.0	%
MENTZER INDEX	21.9		
MEAN PLATELET VOLUME	8.6	6.8 - 10.9	fL
METHOD : DERIVED FROM IMPEDANCE MEASURE			

WBC DIFFERENTIAL COUNT

SEGMENTED NEUTROPHILS	48	40 - 80	%
METHOD : DHSS FLOWCYTOMETRY			
LYMPHOCYTES	37	20 - 40	%
METHOD : DHSS FLOWCYTOMETRY			
MONOCYTES	8	2 - 10	%
METHOD : DHSS FLOWCYTOMETRY			
EOSINOPHILS	7 High	1 - 6	%
METHOD : DHSS FLOWCYTOMETRY			

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DR. NILIA THERESA DAVIS, MBBS
MD (PATH)
(Reg No - TCMC:45470)
CONSULTANT PATHOLOGIST


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BASOPHILS		0	0 - 2	%
METHOD : IMPEDANCE				
ABSOLUTE NEUTROPHIL COUNT		3.03	2.0 - 7.0	thou/ μ L
METHOD : CALCULATED				
ABSOLUTE LYMPHOCYTE COUNT		2.34	1 - 3	thou/ μ L
METHOD : CALCULATED				
ABSOLUTE MONOCYTE COUNT		0.51	0.20 - 1.00	thou/ μ L
METHOD : CALCULATED				
ABSOLUTE EOSINOPHIL COUNT		0.44	0.02 - 0.50	thou/ μ L
METHOD : CALCULATED				
ABSOLUTE BASOPHIL COUNT		0.00	0.00 - 0.10	thou/ μ L
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		1.3		
ERYTHROCYTE SEDIMENTATION RATE (ESR), WHOLE BLOOD				
SEDIMENTATION RATE (ESR)		05	0 - 20	mm at 1 hr
METHOD : WESTERGREN METHOD				

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MEDIWHEEL HEALTH CHECKUP ABOVE 40(F)TMT**SUGAR URINE - POST PRANDIAL**

SUGAR URINE - POST PRANDIAL	NOT DETECTED	NOT DETECTED
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SUGAR URINE - FASTING

SUGAR URINE - FASTING	NOT DETECTED	NOT DETECTED
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Interpretation(s)

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, Vasculitides, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Tissue injury, Pregnancy, Estrogen medication, Aging.

Finding a very accelerated ESR (>100 mm/hour) in patients with ill-defined symptoms directs the physician to search for a systemic disease (Paraproteinemias, Disseminated malignancies, connective tissue disease, severe infections such as bacterial endocarditis).

In pregnancy BRI in first trimester is 0-48 mm/hr(62 if anemic) and in second trimester (0-70 mm/hr(95 if anemic). ESR returns to normal 4th week post partum.

Decreased in: Polycythemia vera, Sickle cell anemia

LIMITATIONS

False elevated ESR : Increased fibrinogen, Drugs(Vitamin A, Dextran etc), Hypercholesterolemia

False Decreased : Poikilocytosis,(SickleCells,spherocytes),Microcytosis, Low fibrinogen, Very high WBC counts, Drugs(Quinine, salicylates)


REFERENCE :

1. Nathan and Oski's Haematology of Infancy and Childhood, 5th edition; 2. Paediatric reference intervals. AACC Press, 7th edition. Edited by S. Soldin; 3. The reference for the adult reference range is "Practical Haematology by Dacie and Lewis, 10th edition.

SUGAR URINE - POST PRANDIAL-METHOD: DIPSTICK/BENEDICT'S TEST

SUGAR URINE - FASTING-METHOD: DIPSTICK/BENEDICT'S TEST

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IMMUNOHAEMATOLOGY**MEDIWHEEL HEALTH CHECKUP ABOVE 40(F)TMT****ABO GROUP & RH TYPE, EDTA WHOLE BLOOD**

ABO GROUP	A
METHOD : GEL CARD METHOD	
RH TYPE	POSITIVE

Interpretation(s)



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.

Page 7 Of 17


DR.HARI SHANKAR, MBBS MD
 (Reg No - TCMC:62092)
HEAD - Biochemistry &
Immunology

DR.SMITHA PAULSON,MD
 (PATH),DPB
 (Reg No - TCMC:35960)
LAB DIRECTOR & HEAD-
HISTOPATHOLOGY & CYTOLOGY


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BIO CHEMISTRY**MEDIWHEEL HEALTH CHECKUP ABOVE 40(F)TMT****BLOOD UREA NITROGEN (BUN), SERUM**

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

BUN/CREAT RATIO

BUN/CREAT RATIO	11.9		
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CREATININE, SERUM

CREATININE	0.92	18 - 60 yrs : 0.6 - 1.1	mg/dL
METHOD : JAFFE KINETIC METHOD			

GLUCOSE, POST-PRANDIAL, PLASMA

GLUCOSE, POST-PRANDIAL, PLASMA	82	Diabetes Mellitus : > or = 200. mg/dL Impaired Glucose tolerance/ Prediabetes : 140 - 199. Hypoglycemia : < 55.	
METHOD : HEXOKINASE			

GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

GLYCOSYLATED HEMOGLOBIN (HBA1C)	5.7	Normal : 4.0 - 5.6%. Non-diabetic level : < 5.7%. Diabetic : >6.5%	%
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Glycemic control goal
 More stringent goal : < 6.5 %.
 General goal : < 7%.
 Less stringent goal : < 8%.

Glycemic targets in CKD :-
 If eGFR > 60 : < 7%.
 If eGFR < 60 : 7 - 8.5%.
 < 116.0

MEAN PLASMA GLUCOSE	116.9 High		mg/dL
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LIVER FUNCTION TEST WITH GGT

BILIRUBIN, TOTAL	0.50	General Range : < 1.1	mg/dL
METHOD : DIAZO METHOD			

BILIRUBIN, DIRECT	0.20	General Range : < 0.3	mg/dL
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METHOD : DIAZO METHOD			
BILIRUBIN, INDIRECT	0.31	0.00 - 0.60	mg/dL
TOTAL PROTEIN	6.4	Ambulatory : 6.4 - 8.3 Recumbant : 6 - 7.8	g/dL
ALBUMIN	4.3	20-60yrs : 3.5 - 5.2	g/dL
GLOBULIN	2.1	2.0 - 4.0 Neonates - Pre Mature: 0.29 - 1.04	g/dL
ALBUMIN/GLOBULIN RATIO	2.0	1.00 - 2.00	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	12	Adults : < 33	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)	8	Adults : < 34	U/L
METHOD : IFCC WITHOUT PDP			
ALKALINE PHOSPHATASE	56	Adult (<60yrs) : 35 - 105	U/L
METHOD : IFCC			
GAMMA GLUTAMYL TRANSFERASE (GGT)	12	Adult (female) : < 40	U/L
TOTAL PROTEIN, SERUM			
TOTAL PROTEIN	6.4	Ambulatory : 6.4 - 8.3 Recumbant : 6 - 7.8	g/dL
METHOD : BIURET			
URIC ACID, SERUM			
URIC ACID	3.7	Adults : 2.4-5.7	mg/dL
METHOD : SPECTROPHOTOMETRY			
GLUCOSE FASTING, FLUORIDE PLASMA			
GLUCOSE, FASTING, PLASMA	107	Diabetes Mellitus : > or = 126. mg/dL Impaired fasting Glucose/ Prediabetes : 101 - 125. Hypoglycemia : < 55.	
METHOD : HEXOKINASE			

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)


DR. SMITHA PAULSON, MD
 (PATH), DPB
 (Reg No - TCMC:35960)
 LAB DIRECTOR & HEAD-
 HISTOPATHOLOGY & CYTOLOGY


DR. HARI SHANKAR, MBBS MD
 (Reg No - TCMC:62092)
 HEAD - Biochemistry &
 Immunology

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 Tel : 93334 93334
 Email : customercare.ddrc@srl.in

Patient Ref. No. 666000003233902

CIN : U85190MH2006PTC161480

(Refer to "CONDITIONS OF REPORTING" overleaf)

PATIENT NAME : **BEENA THOMAS**REF. DOCTOR : **DR. MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED**

CODE/NAME & ADDRESS : CA00010147 -

 MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED
 F701A, LADO SARAI, NEW DELHI,SOUTH DELHI,
 DELHI,
 SOUTH DELHI 110030
 8800465156
ACCESSION NO : **4126WB000061**PATIENT ID : **BEENF0505724126**CLIENT PATIENT ID:
ABHA NO :

AGE/SEX : 50 Years Female

DRAWN :

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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 Glycosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc. Additional test HbA1c GLYCOSYLATED HEMOGLOBIN (HbA1c), EDTA WHOLE BLOOD-Used For:

1. Evaluating the long-term control of blood glucose concentrations in diabetic patients.
2. Diagnosing diabetes.
3. Identifying patients at increased risk for diabetes (prediabetes).

The ADA recommends measurement of HbA1c (typically 3-4 times per year for type 1 and poorly controlled type 2 diabetic patients, and 2 times per year for well-controlled type 2 diabetic patients) to determine whether a patient's metabolic control has remained continuously within the target range.

1. eAG (Estimated average glucose) converts percentage HbA1c to mg/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 addition are reported to interfere with some assay methods, falsely increasing results.
 - IV. Interference of hemoglobinopathies in HbA1c estimation is seen in
 - a. Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.
 - b. Heterozygous state detected (D10 is corrected for HbS & HbC trait.)
 - c. HbF > 25% on alternate platform (Boronate affinity chromatography) is recommended for testing of HbA1c. Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy
- 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, Waldenström'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 SclerosisGLUCOSE 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 so that 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; sulfonyleureas, 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 Glycosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.



DR. SMITHA PAULSON, MD
 (PATH), DPB
 (Reg No - TCMC:35960)
 LAB DIRECTOR & HEAD-
 HISTOPATHOLOGY & CYTOLOGY



DR. HARI SHANKAR, MBBS MD
 (Reg No - TCMC:62092)
 HEAD - Biochemistry &
 Immunology

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CODE/NAME & ADDRESS : CA00010147 -
 MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED
 F701A, LADO SARAI, NEW DELHI, SOUTH DELHI,
 DELHI,
 SOUTH DELHI 110030
 8800465156

ACCESSION NO : **4126WB000061**
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CLIENT PATIENT ID:
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AGE/SEX : 50 Years Female
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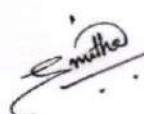
BIOCHEMISTRY - LIPID**MEDIWHEEL HEALTH CHECKUP ABOVE 40(F)TMT****LIPID PROFILE, SERUM**

CHOLESTEROL	212	Desirable : < 200 Borderline : 200-239 High : >or= 240	mg/dL
METHOD : CHOD-POD			
TRIGLYCERIDES	111	Normal : < 150 High : 150-199 Hypertriglyceridemia : 200-499 Very High : > 499	mg/dL
HDL CHOLESTEROL	49	General range : 40-60	mg/dL
METHOD : DIRECT ENZYME CLEARANCE			
DIRECT LDL CHOLESTEROL	137	Optimum : < 100 Above Optimum : 100-139 Borderline High : 130-159 High : 160-189 Very High : >or= 190	mg/dL
NON HDL CHOLESTEROL	163 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	22.2	Desirable value : 10 - 35	mg/dL
CHOL/HDL RATIO	4.3	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	2.8	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	

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.

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DR.HARI SHANKAR, MBBS MD
 (Reg No - TCMC:62092)
HEAD - Biochemistry & Immunology

DR.SMITHA PAULSON,MD
 (PATH),DPB
 (Reg No - TCMC:35960)
LAB DIRECTOR & HEAD- HISTOPATHOLOGY & CYTOLOGY


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 MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED
 F701A, LADO SARAI, NEW DELHI,SOUTH DELHI,
 DELHI,
 SOUTH DELHI 110030
 8800465156

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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)
Extreme Risk Group Category A	<50 (Optional goal < OR = 30)	< 80 (Optional goal <OR = 60)	>OR = 50	>OR = 80



DR.HARI SHANKAR, MBBS MD
 (Reg No - TCMC:62092)
 HEAD - Biochemistry & Immunology



DR.SMITHA PAULSON,MD
 (PATH),DPB
 (Reg No - TCMC:35960)
 LAB DIRECTOR & HEAD- HISTOPATHOLOGY & CYTOLOGY

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 Email : customercare.ddrc@srl.in


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CODE/NAME & ADDRESS : CA00010147 - MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED F701A, LADO SARAI, NEW DELHI,SOUTH DELHI, DELHI, SOUTH DELHI 110030 8800465156	ACCESSION NO : 4126WB000061 PATIENT ID : BEENF0505724126 CLIENT PATIENT ID: ABHA NO :	AGE/SEX : 50 Years Female DRAWN : RECEIVED : 01/02/2023 08:52:19 REPORTED : 02/02/2023 13:48:48
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HISTOPATHOLOGY**MEDIWHEEL HEALTH CHECKUP ABOVE 40(F)TMT****CYTOLOGY - CS (PAP SMEAR)**


CYTOLOGY - CS (PAP SMEAR)

CYTOLOGY NO : CY/549/2023**NATURE OF SPECIMEN** : Pap smear.**GROSS SPECIMEN** : 2 smears stained.**MICROSCOPY**: Satisfactory smear shows superficial and intermediate squamous cells, in a background of lactobacilli and neutrophils. No atypical cells seen.**IMPRESSION** : Negative for intraepithelial lesion or malignancy.**Interpretation(s)**

CYTOLOGY - CS (PAP SMEAR)-METHOD: STAINING- MICROSCOPY

Specimens sent for biopsy will be preserved in the Lab only for 30 days after despatch of reports.They will be discarded after this period. Slides/blocks of tissues will be issued only on written request from the concerned medical officer. Slides / Blocks and Reports will be preserved only for a period of 10 years.Generally Slides will be made available only a day after giving the request.Only two copies of the report will be given . Additional copies will be given only on production of a letter from the concerned doctor. Special stains & tests will be done wherever necessary to assist diagnosis and will be charged extra.

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DR.NISHA G,MBBS MD(PATH),
 (Reg No - TCMC:45399)
CONSULTANT PATHOLOGIST


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 KERALA, INDIA
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 Email : customercare.ddrc@srl.in
**Patient Ref. No. 666000003233902**

CIN : U85190MH2006PTC161480

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 MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED
 F701A, LADO SARAI, NEW DELHI, SOUTH DELHI,
 DELHI,
 SOUTH DELHI 110030
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ACCESSION NO : 4126WB000061**PATIENT ID : BEENF0505724126****CLIENT PATIENT ID:
ABHA NO :****AGE/SEX : 50 Years Female****DRAWN :****RECEIVED : 01/02/2023 08:52:19****REPORTED : 02/02/2023 13:48:48**

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SPECIALISED CHEMISTRY - HORMONE**MEDIWHEEL HEALTH CHECKUP ABOVE 40(F)TMT****THYROID PANEL, SERUM**

T3	95.92	80 - 200	ng/dL
METHOD : ELECTROCHEMILUMINESCENCE			
T4	7.69	5.1 - 14.1	µg/dl
METHOD : ELECTROCHEMILUMINESCENCE			
TSH 3RD GENERATION	0.744	Non-Pregnant : 0.4-4.2	µIU/mL

Pregnant Trimester-wise :

1st : 0.1 - 2.5

2nd : 0.2 - 3

3rd : 0.3 - 3

METHOD : ELECTROCHEMILUMINESCENCE

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


DR. SMITHA PAULSON, MD
 (PATH), DPB
 (Reg No - TCMC:35960)
 LAB DIRECTOR & HEAD-
 HISTOPATHOLOGY & CYTOLOGY


DR. HARI SHANKAR, MBBS MD
 (Reg No - TCMC:62092)
 HEAD - Biochemistry &
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 MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED
 F701A, LADO SARAI, NEW DELHI, SOUTH DELHI,
 DELHI,
 SOUTH DELHI 110030
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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. Guidelines of the American Thyroid association during pregnancy and Postpartum, 2011.

NOTE: It is advisable to detect Free T3, Free T4 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.



DR. SMITHA PAULSON, MD
 (PATH), DPB
 (Reg No - TCMC:35960)
 LAB DIRECTOR & HEAD-
 HISTOPATHOLOGY & CYTOLOGY



DR. HARI SHANKAR, MBBS MD
 (Reg No - TCMC:62092)
 HEAD - Biochemistry &
 Immunology

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CLINICAL PATH - URINALYSIS
MEDIWHEEL HEALTH CHECKUP ABOVE 40(F)TMT
PHYSICAL EXAMINATION, URINE

COLOR	PALE YELLOW
APPEARANCE	CLEAR

CHEMICAL EXAMINATION, URINE

PH	7.0	4.8 - 7.4
SPECIFIC GRAVITY	1.005 Low	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

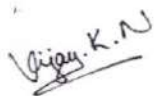
MICROSCOPIC EXAMINATION, URINE

RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
WBC	1-2	0-5	/HPF
EPITHELIAL CELLS	2-3	0-5	/HPF
CASTS	NOT DETECTED		
CRYSTALS	NOT DETECTED		
BACTERIA	NOT DETECTED	NOT DETECTED	
YEAST	NOT DETECTED	NOT DETECTED	

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


DR. VIJAY K N, MBBS MD(PATH)
 (Reg No - KMC:91816)
HEAD-HAEMATOLOGY & CLINICAL PATHOLOGY


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 SOUTH DELHI 110030
 8800465156
ACCESSION NO : 4126WB000061**PATIENT ID : BEENF0505724126****CLIENT PATIENT ID:
ABHA NO :****AGE/SEX : 50 Years Female****DRAWN :****RECEIVED : 01/02/2023 08:52:19****REPORTED : 02/02/2023 13:48:48**

Test Report Status	Preliminary	Results	Units
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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 infection when present in significant numbers & with pus cells.
Trichomonas vaginalis	Vaginitis, cervicitis or salpingitis

Page 18 Of 19

Vijay K.N

DR. VIJAY K N, MBBS MD (PATH)
 (Reg No - KMC:91816)
**HEAD-HAEMATOLOGY & CLINICAL
 PATHOLOGY**



View Details



View Report

PERFORMED AT :
 DDRC SRL DIAGNOSTICS
 DDRC SRL Tower, G-131, Panampilly Nagar,
 PANAMPALLY NAGAR, 682036
 KERALA, INDIA
 Tel : 93334 93334
 Email : customercare.ddrc@srl.in
**Patient Ref. No. 66600003233902**

CIN : U85190MH2006PTC161480

(Refer to "CONDITIONS OF REPORTING" overleaf)

PATIENT NAME : BEENA THOMAS**REF. DOCTOR : DR. MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED**

CODE/NAME & ADDRESS : CA00010147 - MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED F701A, LADO SARAI, NEW DELHI,SOUTH DELHI, DELHI, SOUTH DELHI 110030 8800465156	ACCESSION NO : 4126WB000061 PATIENT ID : BEENF0505724126 CLIENT PATIENT ID: ABHA NO :	AGE/SEX : 50 Years Female DRAWN : RECEIVED : 01/02/2023 08:52:19 REPORTED : 02/02/2023 13:48:48
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Test Report Status	Preliminary	Results	Units
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CLINICAL PATH - STOOL ANALYSIS

MEDIWHEEL HEALTH CHECKUP ABOVE 40(F)TMT	RESULT PENDING
PHYSICAL EXAMINATION,STOOL	RESULT PENDING
CHEMICAL EXAMINATION,STOOL	RESULT PENDING
MICROSCOPIC EXAMINATION,STOOL	RESULT PENDING

Page 19 Of 19



View Details



View Report

PERFORMED AT :

DDRC SRL DIAGNOSTICS
 DDRC SRL Tower, G-131,Panampilly Nagar,
 PANAMPALLY NAGAR, 682036
 KERALA, INDIA
 Tel : 93334 93334
 Email : customercare.ddrc@srl.in

**Patient Ref. No. 66600003233902**

CIN : U85190MH2006PTC161480

(Refer to "CONDITIONS OF REPORTING" overleaf)

Date...01.02.2023

OPHTHALMOLOGY REPORT

This is to certify that I have examined

Mr / Ms : Beena Thomas.....Aged...50.....and his / her

visual standards is as follows :

Visual Acuity:

For far vision

R:6/9p.....

EPUR L R 6/6p
L 6/6p

L:6/9p.....

For near vision

R:NA.....

EPUR R NB
L NB

L:NA.....

Color Vision :Normal.....

.....

Nannu Elizabeth

Nannu Elizabeth

(Optometrist)



NAME: MRS BEENA THOMAS	STUDY DATE 01/02/2023
AGE / SEX : 50 YRS / F	REPORTING DATE 01/02/2023
REFERRED BY :MEDIWHEEL	ACC NO : 4126WB000061

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**

Navneet
Dr. NAVNEET KAUR, MBBS,MD
Consultant Radiologist.



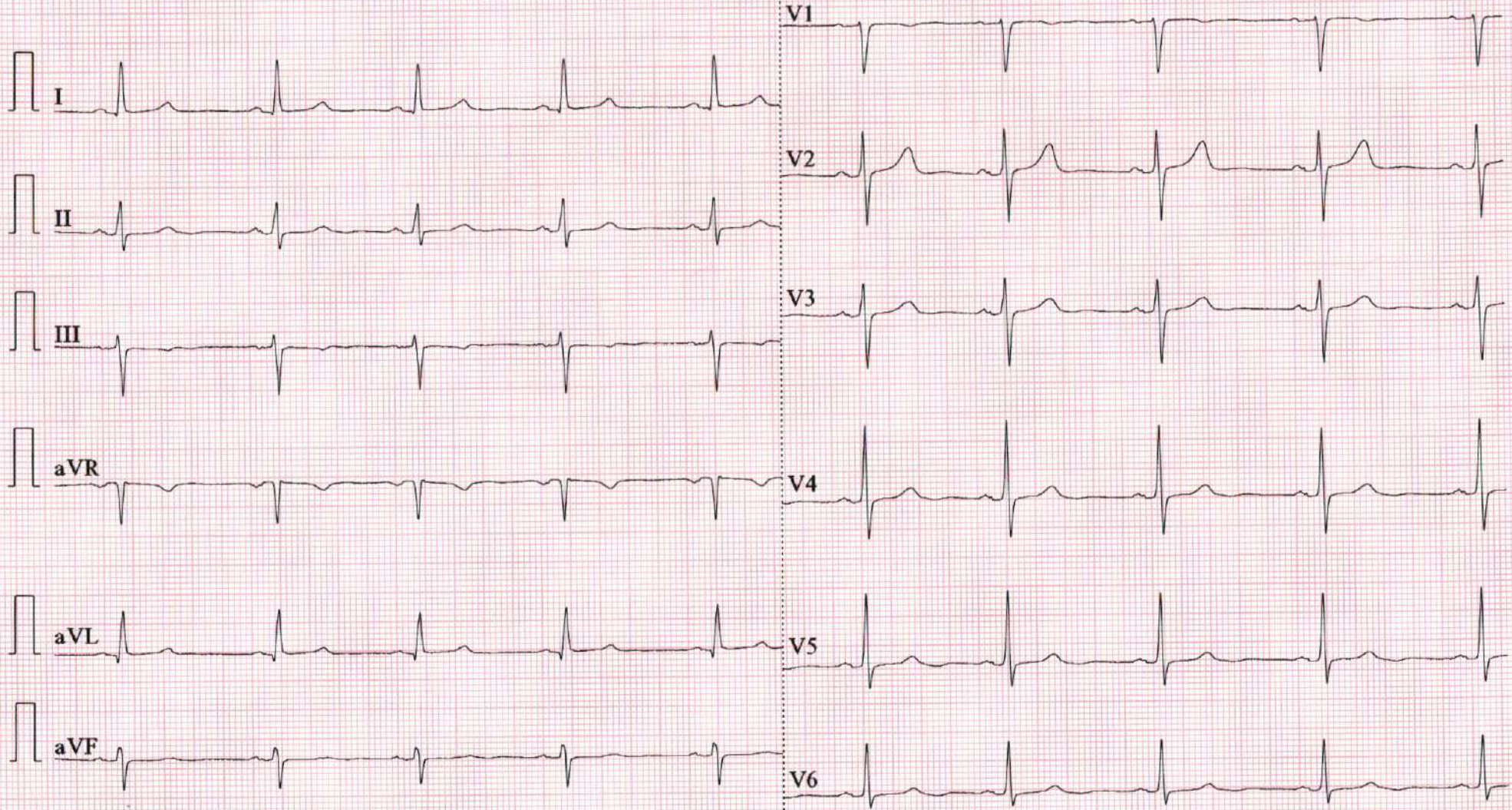
ID: 000061
BEENA THOMAS
Female 50Years

01-02-2023 10:21:45 AM
HR : 57 bpm
P : 95 ms
PR : 154 ms
QRS : 91 ms
QT/QTc : 440/431 ms
P/QRS/T : -8/-14/12 °
RV5/SV1 : 1.211/0.848 mV

Diagnosis Information:

Within normal limits
Dr. George Thomas MD,FCSI,FIAE
Cardiologist

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





NAME	MRS BEENA THOMAS	AGE	50YRS
SEX	FEMALE	DATE	February 1, 2023
REFERRAL	MEDIWHEEL ARCOFEMI	ACC NO	4126WB000061

MAMMOGRAPHY

Technique: Bilateral MLO and CC views

Clinical details: Screening mammography . Status post lumpectomy right breast (?breast cyst).

Findings:

- Both breasts show ACR type C composition.
- Post operative changes are seen in the right breast in the form of volume loss and surgical clips in situ.
- Left breast parenchymal architecture is preserved.
- No evidence of micro/macro calcifications seen in breast.
- The skin, nipple-areola complex and retro-areolar zone are normal.
- The retro-mammary clear zone and underlying pectoralis muscle appear normal.

ULTRASOUND SCREENING:

RIGHT BREAST

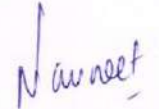
- Heterogeneously dense composition with prominent echogenic fibroglandular parenchyma.
- Few small breasts cysts are seen , largest measuring 6.4 x 3.3 mm at 12 o' clock location about 3 cm away from the nipple.
- Linear echogenic foci are seen in retroareolar location (surgical clips)
- Mild retro-areolar ductal prominence is seen (maximum caliber 2.8 mm). No definite intra ductal contents /internal vascularity seen.
- No evidence of axillary lymphadenopathy

LEFT BREAST

- Heterogeneously dense composition with prominent echogenic fibroglandular parenchyma.
- Few cysts are seen in left breast , largest measuring 9.2 x 5.7 mm at 3 o' clock location about 2 cm away from the nipple.
- An oval hypoechoic lesion measuring 6.9 x 4.9mm is seen in retroareolar location about 3mm deep to skin surface . No calcification /internal vascularity seen in the lesion. Another 12 x 7 mm oval hypoechoic lesion is seen at 6 o' clock location about 1cm away from nipple and at a depth 8 mm from the skin surface.
- Mild retroareolar ductal prominence is seen (maximum caliber 2.3 mm). Few of the ducts show avascular intra ductal debris.
- No evidence of axillary lymphadenopathy

IMPRESSION:

- ✚ *Bilateral fibrocystic disease (BIRADS II).*
- ✚ *Mild retroareolar ductal prominence (L>R) with intra ductal debris in few of the ducts(BIRADS III)*
- ✚ *Oval hypoechoic left breast lesions ?fibroadenoma (BIRADS III).*
- ✚ *Post operative changes in right breast with surgical clips in situ.*



Dr. NAVNEET KAUR MBBS . MD
 Consultant Radiologist

ACR BIRADS Category

0	More information is needed to give a final mammogram report
I	Your mammogram is normal.
II	Your mammogram shows only minor abnormalities that are not suspicious for cancer. No additional testing is needed.
III	Your mammogram shows minor abnormalities that are probably benign. The radiologist may recommend follow-up testing to make sure the suspicious area has not changed.
IV	Your mammogram shows a suspicious change, and a biopsy should probably be performed.
V	Your mammogram shows a worrisome change. A biopsy is strongly recommended.
VI	Known biopsy - proven malignancy; Surgical excision when clinically appropriate.

For Emergency Call: 9496005127.Thanks for referral. Your feedback will be appreciated.
 (Please bring relevant investigation reports during all visits)





NAME	MRS BEENA THOMAS	AGE	50 YRS
SEX	FEMALE	DATE	February 1, 2023
REFERRAL	MEDIWHEEL ARCOFEMI	ACC NO	4126WB000061

USG ABDOMEN AND PELVIS

LIVER Measures ~ 10.6 cm. Normal echopattern.
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 ~ 8.7 cm, normal to visualized extent. Splenic vein normal.

PANCREAS Normal to visualized extent. PD is not dilated.

KIDNEYS RK: 9.8 x 3.9 cm, appears normal in size and echotexture.
LK: 9.9 x 3.9 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.

UTERUS Anteverted, measures [11.3 x 3.8 x 6.1 cm] and echopattern.
No focal lesion seen.
ET - 6.1 mm with IUCD in situ.

OVARIES RT OV: 1.9 x 1.3 x 1.5 cm [volume ~ 2.1 cc].
LT OV: 3 x 0.9 x 1.5 cm [volume ~ 2.3 cc].

NODES/FLUID Nil to visualized extent.

BOWEL Visualized bowel loops appear normal.

IMPRESSION ➔ **No significant abnormality in the present study**

Kindly correlate clinically.

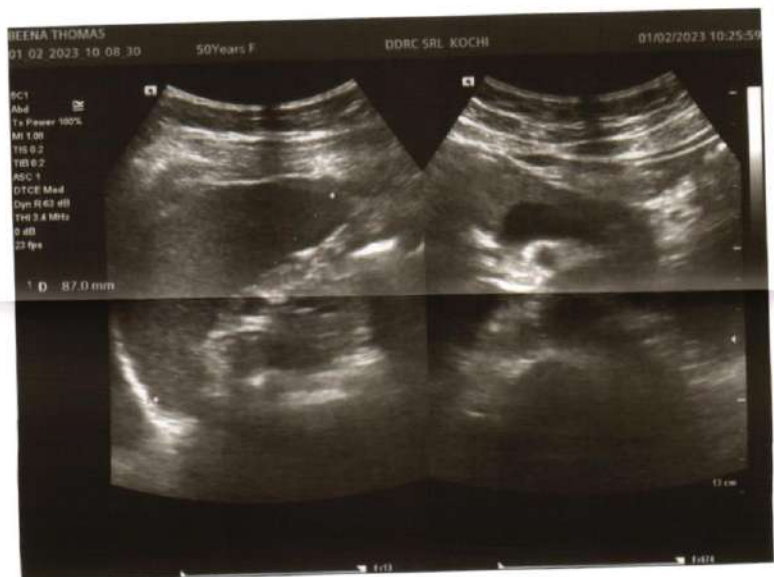
Navneet

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.





BEENA THOMAS

01/02/2023 10:08:30

50Years F

DDRC SRL KOCHI

01/02/2023 10:25:23

SC1
Abd
Tx Power: 100%
MR 1.00
TIS 0.2
TIB 0.2
ASC 1
DTCE Med
Dgn R 63 dB
THI 3.4 MHz
0 dB
22 fps



- 1 D 98.3 mm
- 2 D 39.9 mm
- 3 D 99.9 mm
- 4 D 39.1 mm

BEENA THOMAS

01/02/2023 10:08:30

50Years F

DDRC SRL KOCHI

01/02/2023 10:24:01

SC1
Abd
Tx Power: 100%
MR 1.01
TIS 0.2
TIB 0.2
ASC 1
DTCE Med
Dgn R 63 dB
THI 3.4 MHz
0 dB
19 fps



- 1 D 106.5 mm

DDRC SRL DIAGNOSTIC SERVICE PVT LTD

Test Report

BEENA THOMAS (50 F)

ID: WB000061

Date: 01-Feb-23

Exec Time : 0 m 0 s

Stage Time : 1 m 26 s

HR: 62 bpm

Protocol: Bruce

Stage: Supine

Speed: 0 mph

Grade: 0 %

(THR: 144 bpm)

B.P: 130 / 80

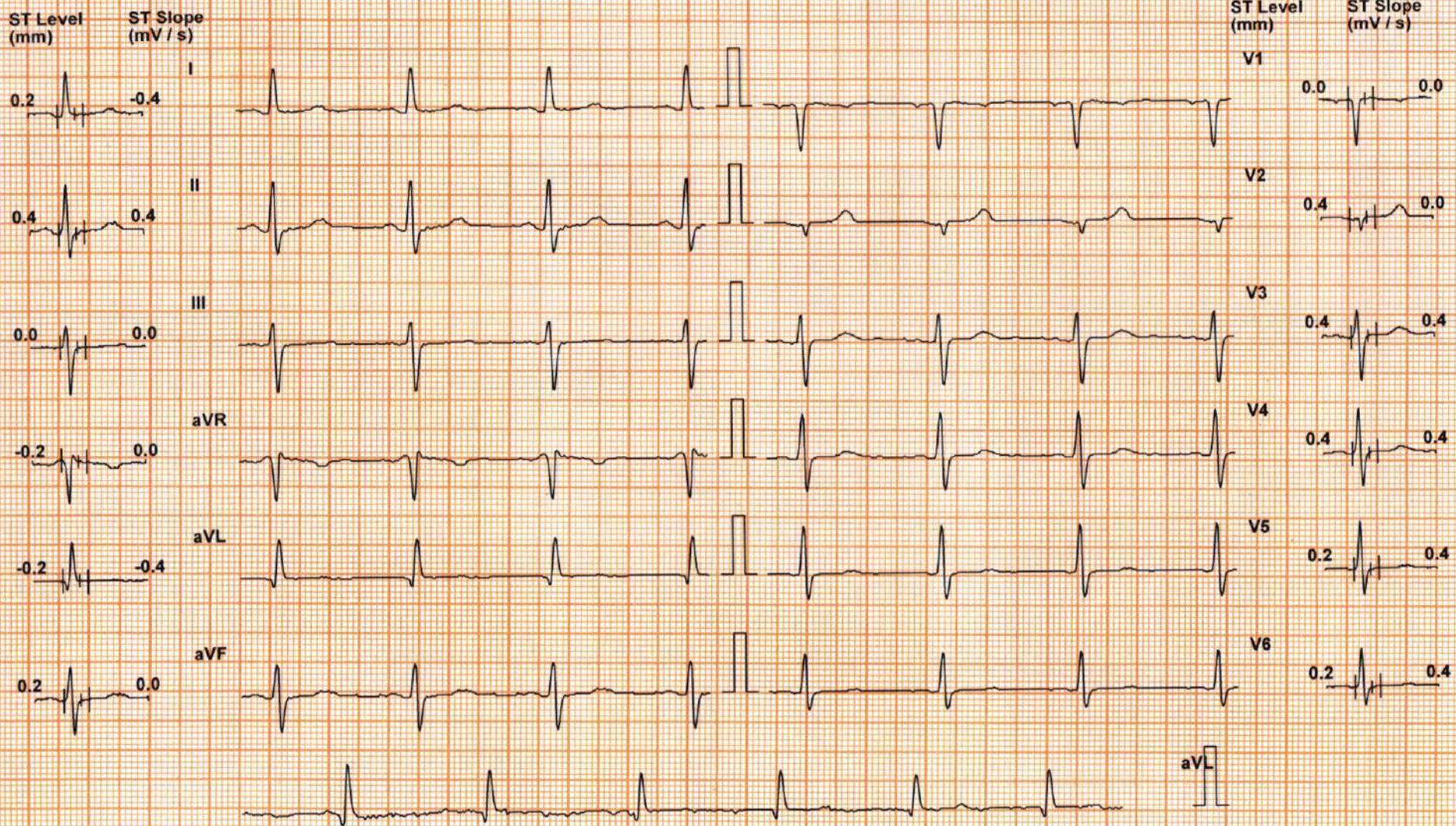


Chart Speed: 25 mm/sec

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

BEENA THOMAS (50 F)

ID: WB000061

Date: 01-Feb-23

Exec Time : 0 m 0 s

Stage Time : 0 m 17 s HR: 60 bpm

Protocol: Bruce

Stage: Standing

Speed: 0 mph

Grade: 0 %

(THR: 144 bpm)

B.P: 130 / 80

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



I



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

V1



V2



V3



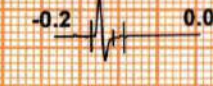
V4



V5



V6



II



III



aVR



aVL



aVF



Chart Speed: 25 mm/sec

Filter: 35 Hz

Mains Filtr: 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

BEENA THOMAS (50 F)

ID: WB000061

Date: 01-Feb-23

Exec Time : 2 m 54 s

Stage Time : 2 m 54 s

HR: 100 bpm

Protocol: Bruce

Stage: 1

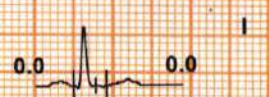
Speed: 1.7 mph

Grade: 10 %

(THR: 144 bpm)

B.P: 140 / 80

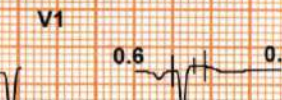
ST Level (mm) ST Slope (mV/s)



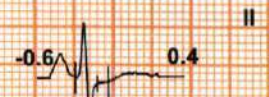
I



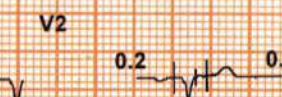
ST Level (mm) ST Slope (mV/s)



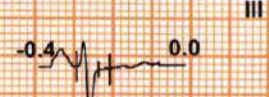
V1



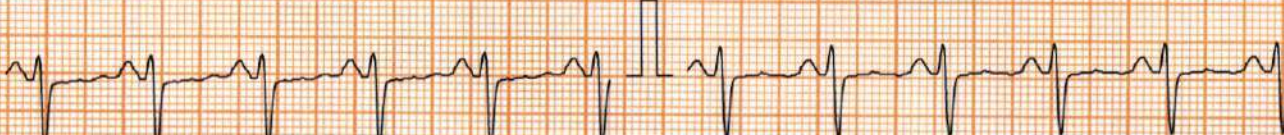
II



V2



III



V3



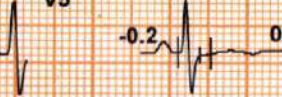
aVR



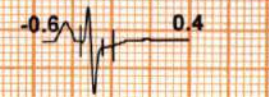
V4



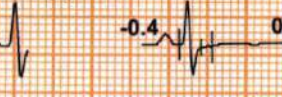
aVL



V5



aVF



V6



aVL

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

BEENA THOMAS (50 F)

ID: WB000061

Date: 01-Feb-23

Exec Time : 5 m 54 s Stage Time : 2 m 54 s HR: 112 bpm

Protocol: Bruce

Stage: 2

Speed: 2.5 mph

Grade: 12 %

(THR: 144 bpm)

B.P: 150 / 80

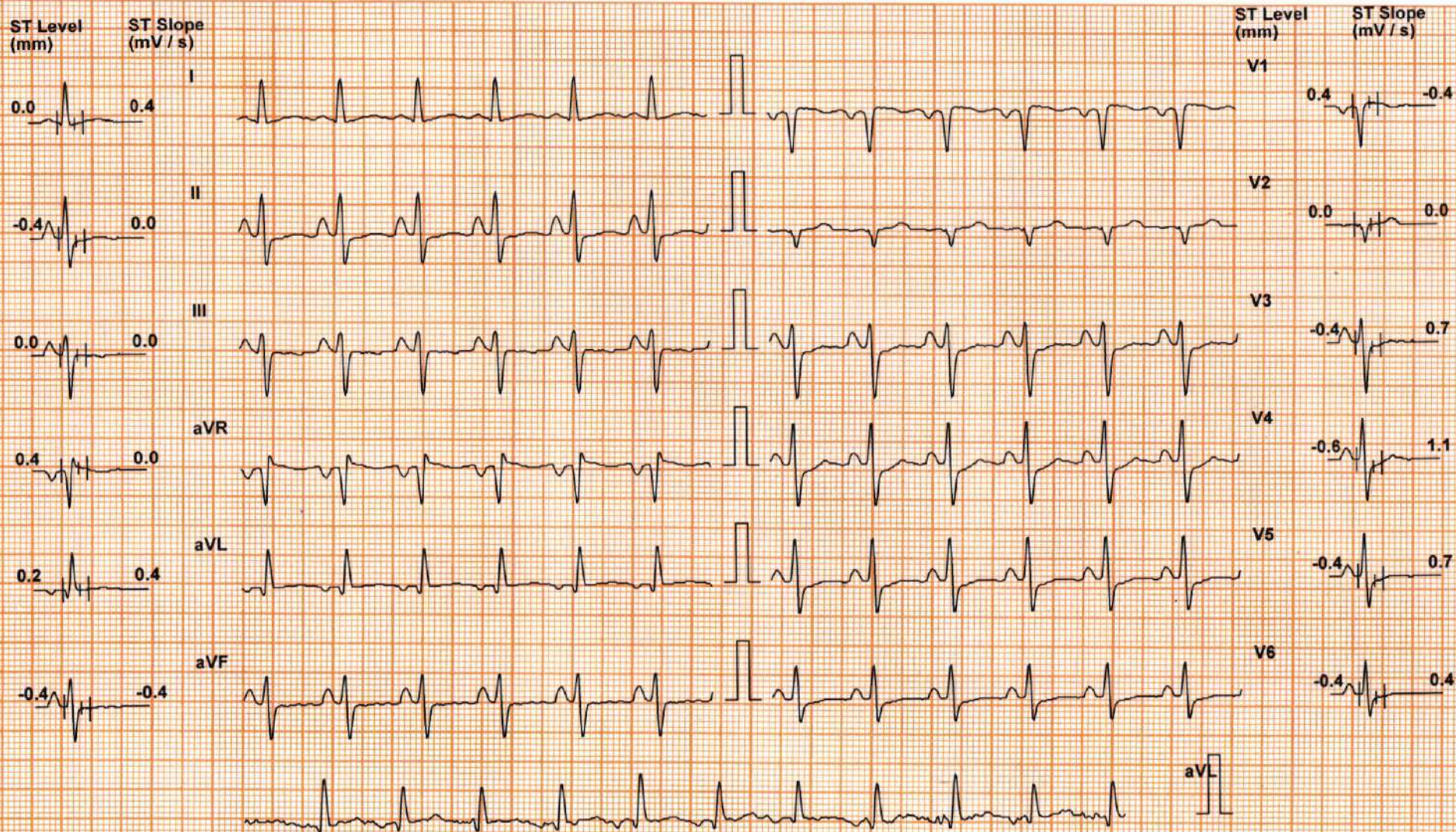


Chart Speed: 25 mm/sec

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

BEENA THOMAS (50 F)

ID: WB000061

Date: 01-Feb-23

Exec Time : 8 m 54 s Stage Time : 2 m 54 s HR: 135 bpm

Protocol: Bruce

Stage: 3

Speed: 3.4 mph

Grade: 14 %

(THR: 144 bpm)

B.P: 160 / 80

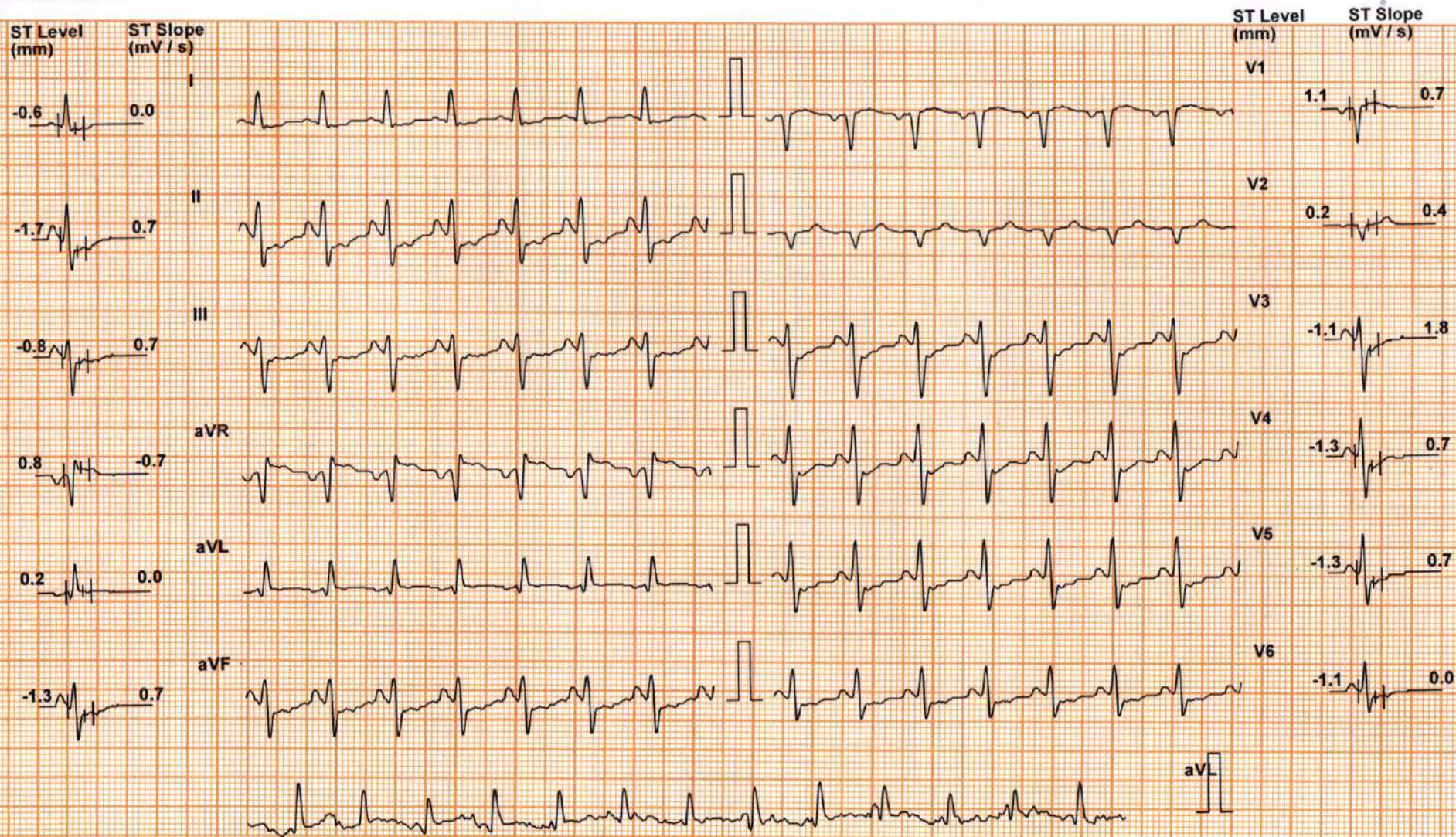


Chart Speed: 25 mm/sec

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

BEENA THOMAS (50 F)

ID: WB000061

Date: 01-Feb-23

Exec Time : 9 m 26 s

Stage Time : 0 m 26 s

HR: 142 bpm

Protocol: Bruce

Stage: Peak Ex

Speed: 4.2 mph

Grade: 16 %

(THR: 144 bpm)

B.P: 170 / 80

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

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

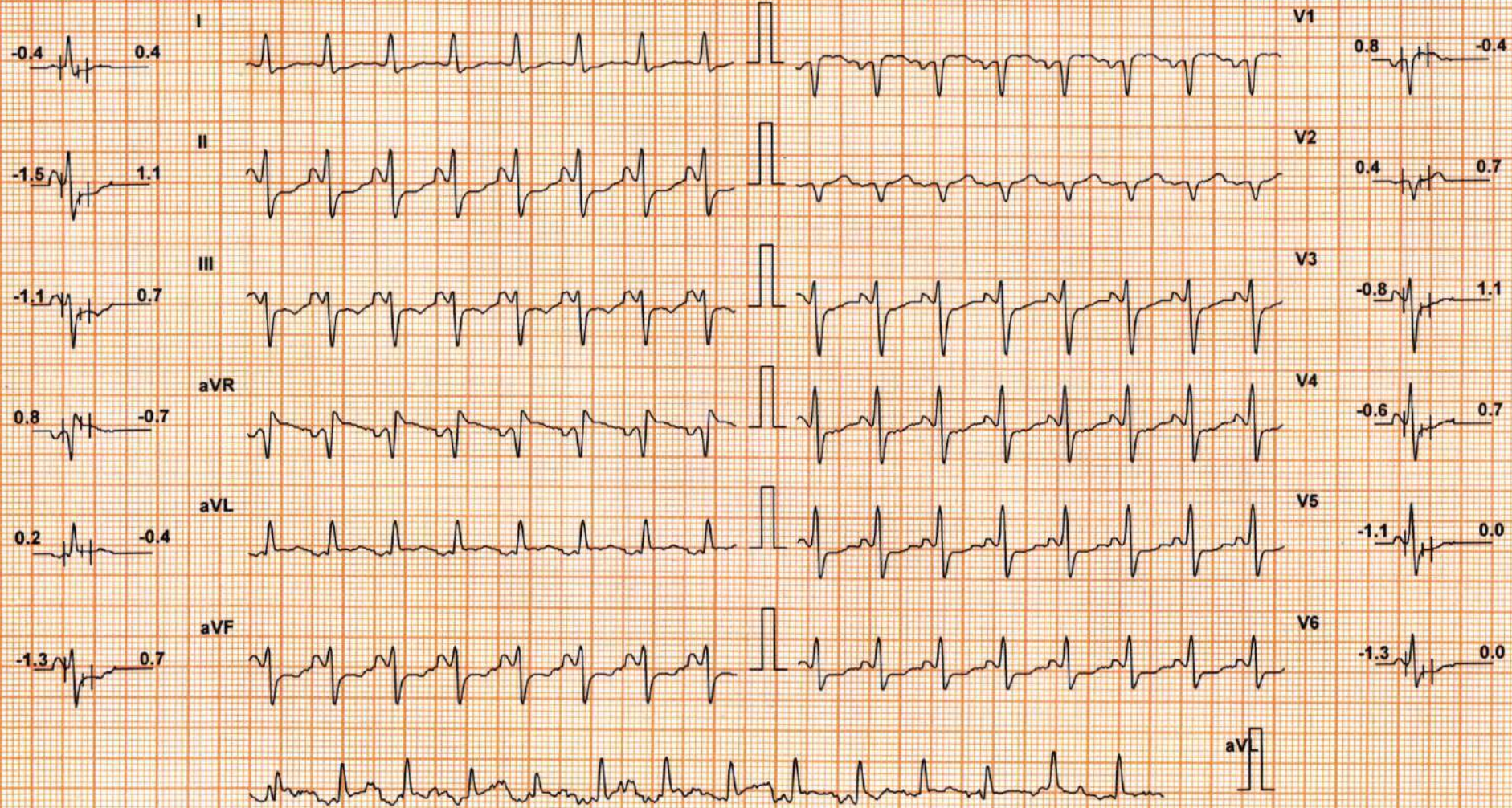


Chart Speed: 25 mm/sec

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

BEENA THOMAS (50 F)

ID: WB000061

Date: 01-Feb-23

Exec Time : 9 m 32 s

Stage Time : 0 m 54 s

HR: 100 bpm

Protocol: Bruce

Stage: Recovery(1)

Speed: 1 mph

Grade: 0 %

(THR: 144 bpm)

B.P: 180 / 80

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

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

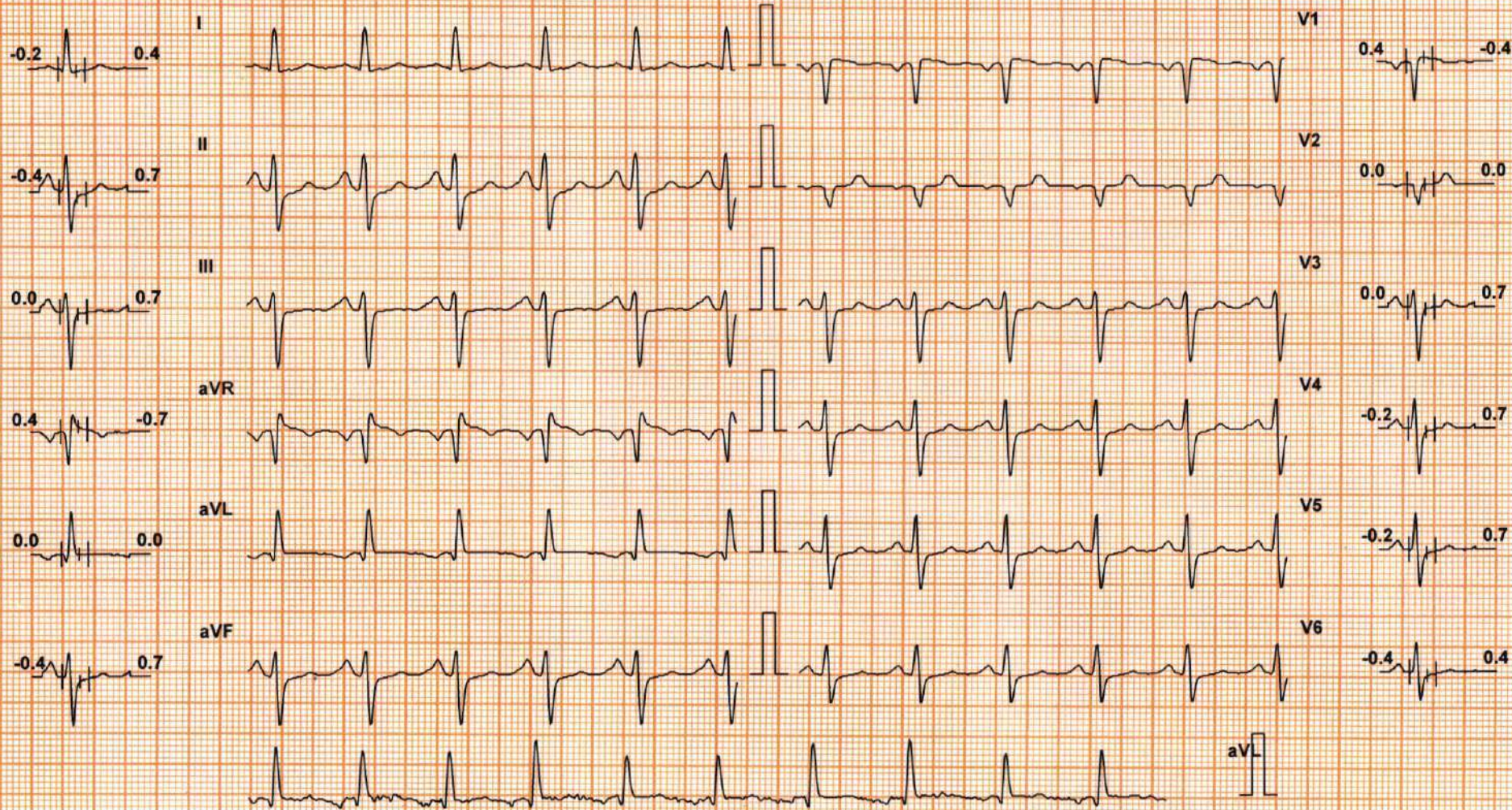


Chart Speed: 25 mm/sec

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

BEENA THOMAS (50 F)

ID: WB000061

Date: 01-Feb-23

Exec Time : 9 m 32 s

Stage Time : 0 m 54 s

HR: 86 bpm

Protocol: Bruce

Stage: Recovery(2)

Speed: 0 mph

Grade: 0 %

(THR: 144 bpm)

B.P: 160 / 80

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

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

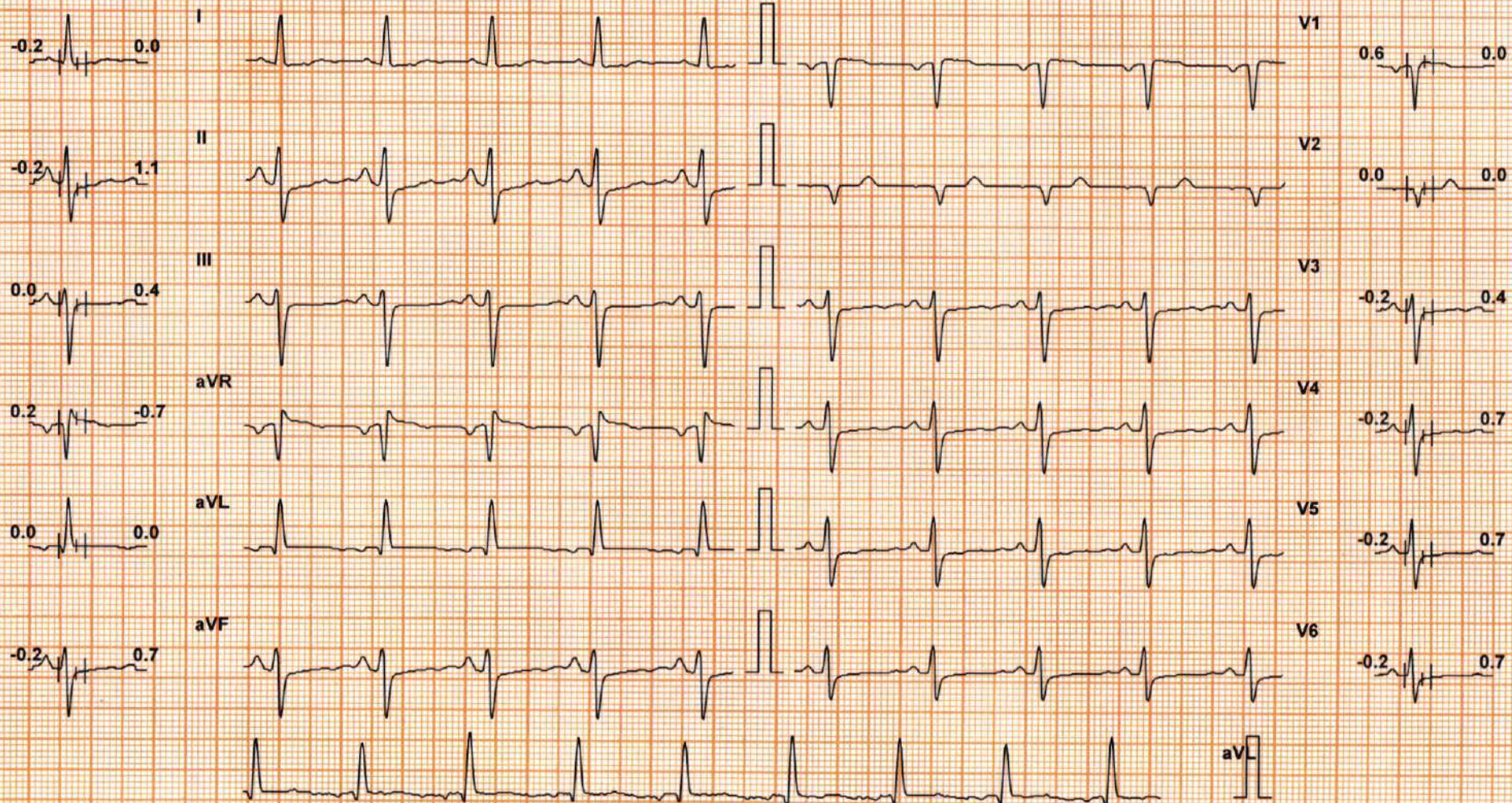


Chart Speed: 25 mm/sec

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

BEENA THOMAS (50 F)

ID: WB000061

Date: 01-Feb-23

Exec Time : 9 m 32 s Stage Time : 0 m 54 s HR: 86 bpm

Protocol: Bruce

Stage: Recovery(3)

Speed: 0 mph

Grade: 0 %

(THR: 144 bpm)

B.P: 160 / 80

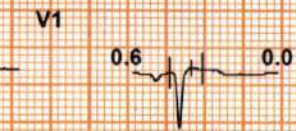
ST Level (mm) ST Slope (mV/s)



I



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



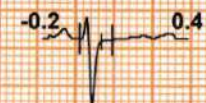
V2



II



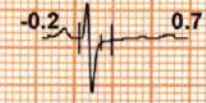
V3



III



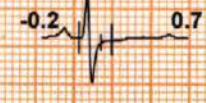
V4



aVR



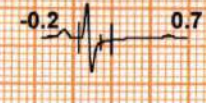
V5



aVL



V6



aVF



aVL



Chart Speed: 25 mm/sec

Filter: 35 Hz

Mains Filtr: 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:** 01-Feb-23 **Time:** 10:49:28
Name: BEENA THOMAS **ID:** WB000061
Age: 50 y **Sex:** F **Height:** 167 cms **Weight:** 71 Kgs
Clinical History: HTN

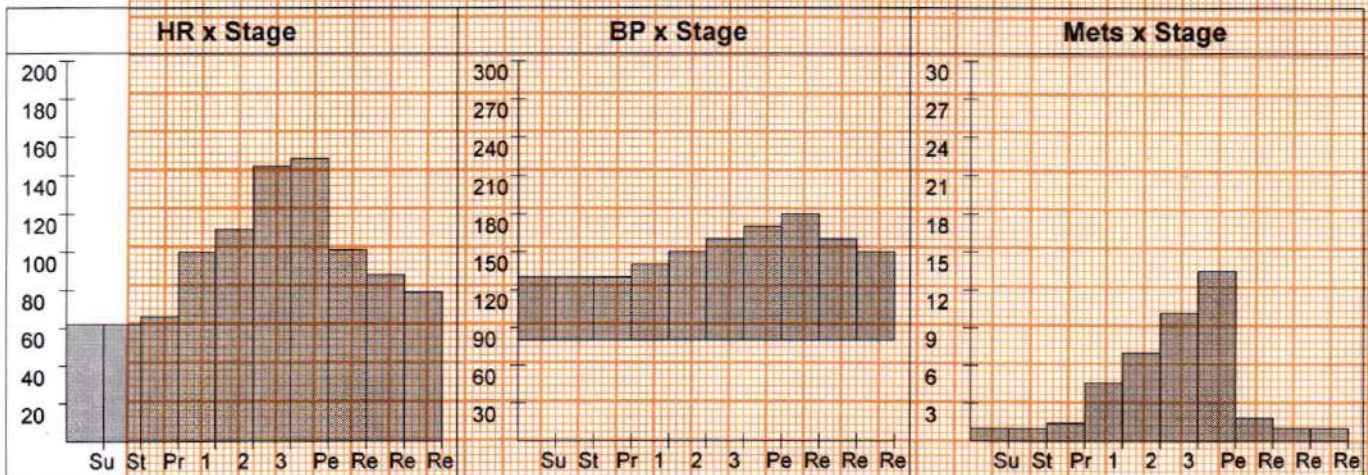
Medications: T.Corbis

Test Details

Protocol: Bruce **Pr.MHR:** 170 bpm **THR:** 144 (85 % of Pr.MHR) bpm
Total Exec. Time: 9 m 32 s **Max. HR:** 149 (88% of Pr.MHR)bpm **Max. Mets:** 13.50
Max. BP: 180 / 80 mmHg **Max. BP x HR:** 26820 mmHg/min **Min. BP x HR:** 4960 mmHg/min
Test Termination Criteria: Target HR 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	1 : 32	1.0	0	0	62	130 / 80	-0.42 III	1.06 II
Standing	0 : 23	1.0	0	0	62	130 / 80	-0.21 II	1.06 V3
1	3 : 0	4.6	1.7	10	100	140 / 80	-0.85 II	1.42 II
2	3 : 0	7.0	2.5	12	112	150 / 80	-1.49 II	1.77 V4
3	3 : 0	10.2	3.4	14	145	160 / 80	-2.12 II	-3.18 II
Peak Ex	0 : 32	13.5	4.2	16	149	170 / 80	-4.67 II	5.66 aVF
Recovery(1)	1 : 0	1.8	1	0	101	180 / 80	-3.40 II	4.95 V3
Recovery(2)	1 : 0	1.0	0	0	88	160 / 80	-0.64 II	1.42 II
Recovery(3)	0 : 31	1.0	0	0	79	150 / 80	-0.64 II	1.06 II



DDRC SRL DIAGNOSTIC SERVICE PVT LTD

Patient Details

Date: 01-Feb-23

Time: 10:49:28

Name: BEENA THOMAS ID: WB000061

Age: 50 y

Sex: F

Height: 167 cms

Weight: 71 Kgs

Interpretation

The patient exercised according to the Bruce protocol for 9 m 32 s achieving a work level of Max. METS : 13.50. Resting heart rate initially 62 bpm, rose to a max. heart rate of 149 (88% of Pr.MHR) bpm. Resting blood Pressure 130 / 80 mmHg, rose to a maximum blood pressure of 180 / 80 mmHg, No Angina, No Arrhythmia.

- Non-significant ST changes noted
- Test negative for inducible ischaemia


DR GEORGE THOMAS
MD, FCSI, FIAE
CARDIOLOGIST



Ref. Doctor: MEDIWHEEL

Doctor: -----

(Summary Report edited by user)