Name	R.SARALA	ID	MED120883353
Age & Gender	55Year(s)/FEMALE	Visit Date	3/12/2022 12:00:00 AM
Ref Doctor Name	MediWheel	1	

EYE SCREENING

	Right Eye	Left Eye
DISTANT VISION	6/6	6/6
NEAR VISION	N8	N8
COLOUR VISION	Normal	Normal

IMPRESSION :

✤ Normal Study with specs.

Name	R.SARALA	ID	MED120883353
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USG ABDOMEN / PELVIS

REPORT :-

LIVER:

The liver is normal in size 14.3cm, shape and has smooth margins and **shows diffuse fatty changes.** Portal and hepatic veins are normal. No evidence of any focal lesion seen. Intrahepatic biliary radicles are not dilated.

GALL BLADDER:

The gall bladder is **contracted**.

COMMON BILE DUCT:

The CBD is normal in caliber. No evidence of calculus is seen.

SPLEEN:

The spleen is normal in size (8.3cm) and shows homogenous echotexture. No evidence of focal lesion is noted.

PANCREAS:

The pancreas is normal in size, shape and shows normal echotexture. No evidence of solid or cystic mass lesion is noted.

KIDNEYS:

Both kidneys are normal in size, shape and position and normal parenchymal echotexture and normal central echocomplex. Right kidney measures 8.7 x 5.0 cm Left kidney measures 9.3 x 5.0 cm No calculus or hydronephrosis

ASCITES:

There is no ascites seen.

URINARY BLADDER:

The urinary bladder is well distended and shows normal outline.

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The thickness of the wall of Urinary bladder is essentially normal. No evidence of calculus is seen. No evidence of any space occupying lesion or diverticulum is noted.

SONOGRAPHY OF PELVIS

Uterus and ovaries are atrophic (postmenopausal status)

BOTH ILIAC FOSSA : Appears normal. No mass / collection.

IMPRESSION :

➢ GRADE I FATTY LIVER

DR. P.T. PRABAKARAN, M.B.B.S., M.D.R.D.,

CONSULTANT RADI OLOGI ST

Name	R.SARALA	Customer ID	MED120883353
Age & Gender	55Y/F	Visit Date	Mar 12 2022 10:50AM
Ref Doctor	MediWheel	-	

X - RAY CHEST PA VIEW

Prominence of bilateral perihilar bronchovascular markings is noted.

Rest of the lung fields appear normal.

Cardiac size is within normal limits.

Bilateral domes of diaphragm and costophrenic angles are normal.

Visualised bones and soft tissues appear normal.

Sugg: Clinical correlation.

DR. PRAJNA SHENOY

DR. H.K. ANAND

DR. POOJA B.P DR. SHWETHA S CONSULTANT RADIOLOGISTS

Name	: Mrs. R.SARALA	Register On	:	12/03/2022 11:57 AM
PID No.	: MED120883353	Collection On	:	12/03/2022 12:28 PM
SID No.	: 132204497	Report On	:	13/03/2022 12:49 PM
Age / Sex	: 55 Year(s) / Female	Printed On	:	15/03/2022 12:58 PM
Ref. Dr	: MediWheel	Туре	:	OP

	Observed Value	11	Diele vieel Defense on Interval
Investigation	Observed Value	<u>Unit</u>	Biological Reference Interval
IMMUNOHAEMATOLOGY			
BLOOD GROUPING AND Rh TYPING (Blood /Agglutination)	'A1' 'Positive'		
INTERPRETATION: Reconfirm the Blood grou	p and Typing before blo	od transfusion	
BIOCHEMISTRY			
BUN / Creatinine Ratio	12.3		
Glucose Fasting (FBS) (Plasma - F/GOD- PAP)	120	mg/dL	Normal: < 100 Pre Diabetic: 100 - 125 Diabetic: >= 126
INTERPRETATION: Factors such as type, qua influence blood glucose level.	ntity and time of food in	take, Physical a	ctivity, Psychological stress, and drugs can
Glucose, Fasting (Urine) (Urine - F)	Negative		Negative
Glucose Postprandial (PPBS) (Plasma - PP/ GOD-PAP)	197	mg/dL	70 - 140
INTERPRETATION: Factors such as type, quantity and time of food glucose level. Fasting blood glucose level may Postprandial Insulin secretion, Insulin resistant medication during treatment for Diabetes.	be higher than Postprai	ndial glucose, be	ecause of physiological surge in
Urine Glucose(PP-2 hours) (Urine - PP)	Negative		Negative
Blood Urea Nitrogen (BUN) (Serum/ Agglutination)	7.4	mg/dL	7.0 - 21
Creatinine (Serum/Modified Jaffe)	0.6	mg/dL	0.6 - 1.1
INTERPRETATION: Elevated Creatinine value increased ingestion of cooked meat, consumin dysfunction and drugs such as cefoxitin, cefazo chemotherapeutic agent such as flucytosine et	g Protein/ Creatine supp blin, ACE inhibitors, ang	plements, Diabe	tic Ketoacidosis, prolonged fasting, renal
Uric Acid (Serum/Enzymatic)	6.2	mg/dL	2.6 - 6.0
Liver Function Test			
GGT(Gamma Glutamyl Transpeptidase) (Serum/Jaffe Kinetic)	16.0	U/L	< 38
Bilirubin(Total) (Serum/DCA with ATCS)	0.6	mg/dL	0.1 - 1.2
Bilirubin(Direct) (Serum/photometry)	0.1	mg/dL	0.0 - 0.3
Bilirubin(Indirect) (Serum/RIA)	0.50	mg/dL	0.1 - 1.0
SGOT/AST (Aspartate Aminotransferase) (Serum/Modified IFCC)	14.0	U/L	5 - 40
SGPT/ALT (Alanine Aminotransferase) (Serum/Modified IFCC)	10.0	U/L	5 - 41



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Investigation	Observed Value	<u>Unit</u>	Biological Reference Interval
Alkaline Phosphatase (SAP) (Serum/ Modified IFCC)	95.0	U/L	53 - 141
Total Protein (Serum/Phosphomolybdate/UV)	6.8	gm/dL	6.0 - 8.0
Albumin (Serum/Jaffe Kinetic / derived)	4.3	gm/dL	3.5 - 5.2
Globulin (Serum/RIA)	2.50	gm/dL	2.3 - 3.6
A : G RATIO (Serum/RIA)	1.72		1.1 - 2.2
Lipid Profile			
Cholesterol Total (Serum/CHOD-PAP with ATCS)	245	mg/dL	Optimal: < 200 Borderline: 200 - 239 High Risk: >= 240
Triglycerides (Serum/GPO-PAP with ATCS)	77	mg/dL	Optimal: < 150 Borderline: 150 - 199 High: 200 - 499 Very High: >= 500

INTERPRETATION: The reference ranges are based on fasting condition. Triglyceride levels change drastically in response to food, increasing as much as 5 to 10 times the fasting levels, just a few hours after eating. Fasting triglyceride levels show considerable diurnal variation too. There is evidence recommending triglycerides estimation in non-fasting condition for evaluating the risk of heart disease and screening for metabolic syndrome, as non-fasting sample is more representative of the usual+kcirculating level of triglycerides during most part of the day.

HDL Cholesterol (Serum/Immunoinhibition)	45.8	mg/dL	Optimal(Negative Risk Factor): >= 60 Borderline: 50 - 59 High Risk: < 50
LDL Cholesterol (Serum/Calculated)	183.8	mg/dL	Optimal: < 100 Above Optimal: 100 - 129 Borderline: 130 - 159 High: 160 - 189 Very High: >= 190
VLDL Cholesterol (Serum/Calculated)	15.4	mg/dL	< 30
Non HDL Cholesterol (Serum/Calculated)	199.2	mg/dL	Optimal: < 130 Above Optimal: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very High: >= 220

INTERPRETATION: 1.Non-HDL Cholesterol is now proven to be a better cardiovascular risk marker than LDL Cholesterol. 2.It is the sum of all potentially atherogenic proteins including LDL, IDL, VLDL and chylomicrons and it is the "new bad cholesterol" and is a co-primary target for cholesterol lowering therapy.





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Investigation Total Cholesterol/HDL Cholesterol Ratio (Serum/Calculated)	Observed Value 5.3	<u>Unit</u>	Biological Reference Interval Optimal: < 3.3 Low Risk: 3.4 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0 High Risk: > 11.0
Triglyceride/HDL Cholesterol Ratio (TG/HDL) (Serum/Calculated)	1.7		Optimal: < 2.5 Mild to moderate risk: 2.5 - 5.0 High Risk: > 5.0
LDL/HDL Cholesterol Ratio (Serum/ Calculated)	4		Optimal: 0.5 - 3.0 Borderline: 3.1 - 6.0 High Risk: > 6.0
Glycosylated Haemoglobin (HbA1c)			
HbA1C (Whole Blood/HPLC)	7.2 (Rechecked)	%	Normal: 4.5 - 5.6 Prediabetes: 5.7 - 6.4 Diabetic: >= 6.5

INTERPRETATION: If Diabetes - Good control : 6.1 - 7.0 %, Fair control : 7.1 - 8.0 %, Poor control >= 8.1 %

Remark: Please correlate clinically, Repeat test with fresh sample if necessarry.

Estimated Average Glucose (Whole Blood) 159.94 mg/dL

INTERPRETATION: Comments

HbA1c provides an index of Average Blood Glucose levels over the past 8 - 12 weeks and is a much better indicator of long term glycemic control as compared to blood and urinary glucose determinations.

Conditions that prolong RBC life span like Iron deficiency anemia, Vitamin B12 & Folate deficiency, hypertriglyceridemia,hyperbilirubinemia,Drugs, Alcohol, Lead Poisoning, Asplenia can give falsely elevated HbA1C values. Conditions that shorten RBC survival like acute or chronic blood loss, hemolytic anemia, Hemoglobinopathies, Splenomegaly,Vitamin E ingestion, Pregnancy, End stage Renal disease can cause falsely low HbA1c.

HAEMATOLOGY

Complete Blood Count With - ESR

Absolute Eosinophil Count (AEC) (Blood/ Automated Blood cell Counter)	0.66	10^3 / µl	0.04 - 0.44
Absolute Lymphocyte Count (Blood/ Automated Blood cell Counter)	2.88	10^3 / µl	1.5 - 3.5
PCT (Blood)	0.26	%	0.18 - 0.28
MPV (Blood/Automated Blood cell Counter)	8.4	fL	8.0 - 13.3
Absolute Basophil count (Blood/Automated Blood cell Counter)	0.02	10^3 / µl	< 0.2
Absolute Monocyte Count (Blood/Automated Blood cell Counter)	0.71	10^3 / µl	< 1.0
Absolute Neutrophil count (Blood/ Automated Blood cell Counter)	7.15	10^3 / µl	1.5 - 6.6
RDW-CV (Blood)	13.6	%	11.5 - 16.0



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Investigation	Observed Value	Unit	Biological Reference Interval	
RDW-SD (Blood)	52.7	fL	39 - 46	
Haemoglobin (Blood/Automated Blood cell Counter)	12.0	g/dL	12.5 - 16.0	
PCV (Packed Cell Volume) / Haematocrit (Blood/Automated Blood cell Counter)	36.5	%	37 - 47	
RBC Count (Blood/Automated Blood cell Counter)	3.7	mill/cu.mm	4.2 - 5.4	
MCV (Mean Corpuscular Volume) (Blood/ Automated Blood cell Counter)	97.5	fL	78 - 100	
MCH (Mean Corpuscular Haemoglobin) (Blood/Automated Blood cell Counter)	32.2	pg	27 - 32	
MCHC (Mean Corpuscular Haemoglobin concentration) (Blood/Automated Blood cell Counter)	33.1	g/dL	32 - 36	
Platelet Count (Blood/Automated Blood cell Counter)	306	10^3 / µl	150 - 450	
Total WBC Count (TC) (Blood/Automated Blood cell Counter)	11400	cells/cu.mm	4000 - 11000	
Diferential Leucocyte Count				
Neutrophils (Blood)	62.6	%	40 - 75	
Lymphocytes (Blood)	25.4	%	20 - 45	
Eosinophils (Blood)	5.7	%	01 - 06	
Monocytes (Blood)	6.2	%	01 - 10	
Basophils (Blood)	0.1	%	00 - 02	
INTERPRETATION: Tests done on Automater microscopically.	d Five Part cell counter.	All abnormal resu	ults are reviewed and confirmed	
ESR (Erythrocyte Sedimentation Rate) (Blood/Automated ESR analyser)	10	mm/hr	< 30	
<u>Immunology</u> <u>THYROID PROFILE / TFT</u>				
T3 (Triiodothyronine) - Total (Serum/ Chemiluminescent Immunometric Assay (CLIA))	0.67	ng/ml	0.4 - 1.81	
INTERPRETATION: Comment : Total T3 variation can be seen in other condition like pregnancy, drugs, nephrosis etc. In such cases, Free T3 is recommended as it is Metabolically active.				
T4 (Tyroxine) - Total (Serum/ Chemiluminescent Immunometric Assay (CLIA))	6.18	µg/dl	4.2 - 12.0	

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Investigation	Observed Value	<u>Unit</u>	Biological Reference Interval
INTERPRETATION: Comment :			
Total T4 variation can be seen in other condition it is Metabolically active.	on like pregnancy, drugs,	nephrosis etc. I	n such cases, Free T4 is recommended as
TSH (Thyroid Stimulating Hormone) (Serum /Chemiluminescent Immunometric Assay (CLIA))	n 1.80	µIU/mL	0.35 - 5.50
INTERPRETATION:			
Reference range for cord blood - upto 20			
1 st trimester: 0.1-2.5			
2 nd trimester 0.2-3.0			
3 rd trimester : 0.3-3.0 (Indian Thyroid Society Guidelines)			
Comment :			
1.TSH reference range during pregnancy depe	ends on lodine intake. TP	O status, Serun	n HCG concentration, race, Ethnicity and
BMI.			
2.TSH Levels are subject to circadian variation variation can be of the order of 50%,hence time	.		

3.Values&lt;0.03 µIU/mL need to be clinically correlated due to presence of rare TSH variant in some individuals.

Urine Analysis - Routine

BIOCHEMISTRY

Urine Sugar (Urine)

Negative

INTERPRETATION:

Comments:

Reference Range for Glucose is not established for body fluids. Physician to correlate clinically.

Clinical Pathology

Colour (Urine) pH (Urine)	Pale Yellow 6.0		Yellow to Amber 4.5 - 8.0
Specific Gravity (Urine) Urine Protein / Albumin (Urine)	1.010 Positive(+)		1.002 - 1.035 Negative
Ketone (Urine)	Negative		Negative
Bilirubin (Serum)	Negative	mg/dL	Negative
Urobilinogen (Urine)	Normal	5.1	Normal
Pus Cells (Urine)	5-6	/hpf	NIL
Epithelial Cells (Urine)	2-3	/hpf	NIL
RBCs (Urine)	8-10	/hpf	NIL



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Investigation	Observed Value	<u>Unit</u>	Biological Reference Interval
Casts (Urine)	Nil	/hpf	NIL
Urine Crystals (Stool)	Nil	/hpf	NIL
Others (Urine)	Nil		

INTERPRETATION: Note: Done with Automated Urine Analyser & microscopy

-- End of Report --



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