**Patient Ref. No. 666000003362207**

**CLIENT CODE :** CA00010147 - MEDIWHEEL

**CLIENT'S NAME AND ADDRESS :**

MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED
F701A, LADO SARAI, NEW DELHI,
SOUTH DELHI, DELHI,
SOUTH DELHI 110030
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Cert. No. MC-2809

**PATIENT NAME : MANU MOHANAN** PATIENT ID : **MANUM110290403**

ACCESSION NO : **4036WB002020** AGE : 33 Years SEX : Male ABHA NO :

DRAWN : RECEIVED : 11/02/2023 10:54 REPORTED : 11/02/2023 13:55

**REFERRING DOCTOR :** DR. MEDIWHEEL CLIENT PATIENT ID :

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

**MEDIWHEEL HEALTH CHEKUP BELOW 40(M)TMT**

**OPTHAL**

| | |
|---|---|
| OPTHAL | COMPLETED |

*** TREADMILL TEST**

| | |
|---|---|
| TREADMILL TEST | COMPLETED |

*** PHYSICAL EXAMINATION**

| | |
|---|---|
| PHYSICAL EXAMINATION | COMPLETED |



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**CLIENT'S NAME AND ADDRESS :** ARCOFEMI HEALTHCARE LIMITED

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|---|---|---|---|
| **MEDIWHEEL HEALTH CHEKUP BELOW 40(M)TMT** | | | |
| *** BUN/CREAT RATIO** | | | |
| BUN/CREAT RATIO | 19.8 | 5 - 15 | |
| **CREATININE, SERUM** | | | |
| CREATININE | 0.89 | 18 - 60 yrs : 0.9 - 1.3 | mg/dL |
| **GLUCOSE, POST-PRANDIAL, PLASMA** | RESULT PENDING | | |
| **GLUCOSE FASTING,FLUORIDE PLASMA** | | | |
| GLUCOSE, FASTING, PLASMA | 88 | Diabetes Mellitus : > or = 126.<br>Impaired fasting Glucose/ Prediabetes : 101 - 125.<br>Hypoglycemia : < 55. | mg/dL |
| **GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD** | | | |
| GLYCOSYLATED HEMOGLOBIN (HBA1C) | 5.7 | Normal : 4.0 - 5.6%.<br>Non-diabetic level : < 5.7%.<br>Diabetic : >6.5%<br><br>Glycemic control goal<br>More stringent goal : < 6.5 %.<br>General goal : < 7%.<br>Less stringent goal : < 8%.<br><br>Glycemic targets in CKD :-<br>If eGFR > 60 : < 7%.<br>If eGFR < 60 : 7 - 8.5%. | % |
| **LIPID PROFILE, SERUM** | | | |
| CHOLESTEROL | **251** **High** | Desirable : < 200<br>Borderline : 200-239<br>High : >or= 240 | mg/dL |
| TRIGLYCERIDES | **212** **High** | Normal : < 150<br>High : 150-199<br>Hypertriglyceridemia : 200-499<br>Very High : > 499 | mg/dL |
| HDL CHOLESTEROL | 39 | General range : 40-60 | mg/dL |
| DIRECT LDL CHOLESTEROL | **192** **High** | Optimum : < 100<br>Above Optimum : 100-139<br>Borderline High : 130-159<br>High : 160-189<br>Very High : >or= 190 | mg/dL |



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|---|---|---|---|---|
| NON HDL CHOLESTEROL | **212** | **High** | Desirable: Less than 130<br>Above Desirable: 130 - 159<br>Borderline High: 160 - 189<br>High: 190 - 219<br>Very high: > or = 220 | mg/dL |
| VERY LOW DENSITY LIPOPROTEIN | **42.4** | **High** | < or = 30.0 | mg/dL |
| CHOL/HDL RATIO | **6.4** | **High** | 3.30 - 4.40 | |
| LDL/HDL RATIO | **4.9** | **High** | 0.5 - 3.0 | |



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|---|---|---|

**Interpretation(s)**

1) Cholesterol levels help assess the patient risk status and to follow the progress of patient under treatment to lower serum cholesterol concentrations.

2) Serum Triglyceride (TG) are a type of fat and a major source of energy for the body. Both quantity and composition of the diet impact on plasma triglyceride concentrations. Elevations in TG levels are the result of overproduction and impaired clearance. High TG are associated with increased risk for CAD (Coronary artery disease) in patients with other risk factors, such as low HDL-C, some patient groups with elevated apolipoprotein B concentrations, and patients with forms of LDL that may be particularly atherogenic.

3)HDL-C plays a crucial role in the initial step of reverse cholesterol transport, this considered to be the primary atheroprotective function of HDL

4) LDL -C plays a key role in causing and influencing the progression of atherosclerosis and, in particular, coronary sclerosis.The majority of cholesterol stored in atherosclerotic plaques originates from LDL, thus LDL-C value is the most powerful clinical predictor.

5)Non HDL cholesterol: Non-HDL-C measures the cholesterol content of all atherogenic lipoproteins, including LDL hence it is a better marker of risk in both primary and secondary prevention studies. Non-HDL-C also covers, to some extent, the excess ASCVD risk imparted by the sdLDL, which is significantly more atherogenic than the normal large buoyant particles, an elevated non-HDL-C indirectly suggests greater proportion of the small, dense variety of LDL particles

Serum lipid profile is measured for cardiovascular risk prediction.Lipid Association of India recommends LDL-C as primary target and Non HDL-C as co-primary treatment target.

**Risk Stratification for ASCVD (Atherosclerotic cardiovascular disease) by Lipid Association of India**

| **Risk Category** | |
|---|---|
| Extreme risk group | A.CAD with > 1 feature of high risk group |
| | B. CAD with > 1 feature of Very high risk group or recurrent ACS (within 1 year) despite LDL-C < or = 50 mg/dl or polyvascular disease |
| Very High Risk | 1. Established ASCVD 2. Diabetes with 2 major risk factors or evidence of end organ damage 3. Familial Homozygous Hypercholesterolemia |
| High Risk | 1. Three major ASCVD risk factors. 2. Diabetes with 1 major risk factor or no evidence of end organ damage. 3. CKD stage 3B or 4. 4. LDL >190 mg/dl 5. Extreme of a single risk factor. 6. Coronary Artery Calcium - CAC >300 AU. 7. Lipoprotein a >/= 50mg/dl 8. Non stenotic carotid plaque |
| Moderate Risk | 2 major ASCVD risk factors |
| Low Risk | 0-1 major ASCVD risk factors |
| **Major ASCVD (Atherosclerotic cardiovascular disease) Risk Factors** | |
| 1. Age > or = 45 years in males and > or = 55 years in females | 3. Current Cigarette smoking or tobacco use |
| 2. Family history of premature ASCVD | 4. High blood pressure |
| 5. Low HDL | |

**Newer treatment goals and statin initiation thresholds based on the risk categories proposed by LAI in 2020.**

| Risk Group | Treatment Goals | Consider Drug Therapy |
|---|---|---|



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|---|---|---|

| | LDL-C (mg/dl) | Non-HDL (mg/dl) | LDL-C (mg/dl) | Non-HDL (mg/dl) |
|---|---|---|---|---|
| Extreme Risk Group Category A | <50 (Optional goal < OR = 30 ) | < 80 (Optional goal <OR = 60) | >OR = 50 | >OR = 80 |
| Extreme Risk Group Category B | <OR = 30 | <OR = 60 | > 30 | >60 |
| Very High Risk | <50 | <80 | >OR= 50 | >OR= 80 |
| High Risk | <70 | <100 | >OR= 70 | >OR= 100 |
| Moderate Risk | <100 | <130 | >OR= 100 | >OR= 130 |
| Low Risk | <100 | <130 | >OR= 130* | >OR= 160 |

*After an adequate non-pharmacological intervention for at least 3 months.

**References:** Management of Dyslipidaemia for the Prevention of Stroke: Clinical Practice Recommendations from the Lipid Association of India. Current Vascular Pharmacology, 2022, 20, 134-155.

**LIVER FUNCTION TEST WITH GGT**

| | | | | |
|---|---|---|---|---|
| BILIRUBIN, TOTAL | 0.50 | | General Range : < 1.1 | mg/dL |
| BILIRUBIN, DIRECT | 0.16 | | General Range : < 0.3 | mg/dL |
| BILIRUBIN, INDIRECT | 0.34 | | 0.00 - 1.00 | mg/dL |
| TOTAL PROTEIN | 7.2 | | Ambulatory : 6.4 - 8.3<br>Recumbant : 6 - 7.8 | g/dL |
| ALBUMIN | 4.9 | | 20-60yrs : 3.5 - 5.2 | g/dL |
| GLOBULIN | 2.3 | | 2.0 - 4.1 | g/dL |
| ALBUMIN/GLOBULIN RATIO | **2.1** | **High** | 1.0 - 2.0 | RATIO |
| ASPARTATE AMINOTRANSFERASE (AST/SGOT) | 25 | | Adults : < 40 | U/L |
| ALANINE AMINOTRANSFERASE (ALT/SGPT) | 28 | | Adults : < 45 | U/L |
| ALKALINE PHOSPHATASE | 72 | | Adult(<60yrs) : 40 - 130 | U/L |
| GAMMA GLUTAMYL TRANSFERASE (GGT) | 37 | | Adult (male) : < 60 | U/L |

**TOTAL PROTEIN, SERUM**

| | | | | |
|---|---|---|---|---|
| TOTAL PROTEIN | 7.2 | | Ambulatory : 6.4 - 8.3<br>Recumbant : 6 - 7.8 | g/dL |

**URIC ACID, SERUM**

| | | | | |
|---|---|---|---|---|
| URIC ACID | 6.9 | | Adults : 3.4-7 | mg/dL |

**ABO GROUP & RH TYPE, EDTA WHOLE BLOOD**

| | |
|---|---|
| ABO GROUP | TYPE A |
| RH TYPE | NEGATIVE |



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| Test Report Status **Preliminary** | Results | | | Units |
|---|---|---|---|---|
| **BLOOD COUNTS,EDTA WHOLE BLOOD** | | | | |
| HEMOGLOBIN | 15.3 | | 13.0 - 17.0 | g/dL |
| RED BLOOD CELL COUNT | 5.45 | | 4.5 - 5.5 | mil/µL |
| WHITE BLOOD CELL COUNT | 6.20 | | 4.0 - 10.0 | thou/µL |
| PLATELET COUNT | 195 | | 150 - 410 | thou/µL |
| **RBC AND PLATELET INDICES** | | | | |
| HEMATOCRIT | 44.5 | | 40 - 50 | % |
| MEAN CORPUSCULAR VOL | **82.0** | **Low** | 83 - 101 | fL |
| MEAN CORPUSCULAR HGB. | 28.0 | | 27.0 - 32.0 | pg |
| MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION | 34.4 | | 31.5 - 34.5 | g/dL |
| RED CELL DISTRIBUTION WIDTH | **11.5** | **Low** | 11.6 - 14.0 | % |
| MENTZER INDEX | 15.1 | | | |
| **WBC DIFFERENTIAL COUNT** | | | | |
| SEGMENTED NEUTROPHILS | **36** | **Low** | 40 - 80 | % |
| LYMPHOCYTES | **59** | **High** | 20 - 40 | % |
| MONOCYTES | **00** | **Low** | 2 - 10 | % |
| EOSINOPHILS | 05 | | 1 - 6 | % |
| BASOPHILS | 00 | | 0 - 2 | % |
| ABSOLUTE NEUTROPHIL COUNT | 2.23 | | 2.0 - 7.0 | thou/µL |
| ABSOLUTE LYMPHOCYTE COUNT | **3.66** | **High** | 1.0 - 3.0 | thou/µL |
| ABSOLUTE MONOCYTE COUNT | **0** | **Low** | 0.2 - 1.0 | thou/µL |
| ABSOLUTE EOSINOPHIL COUNT | 0.31 | | 0.02 - 0.50 | thou/µL |
| ABSOLUTE BASOPHIL COUNT | **00** | **Low** | 0.02 - 0.10 | thou/µL |
| NEUTROPHIL LYMPHOCYTE RATIO (NLR) | 0.6 | | | |
| **ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD** | | | | |
| SEDIMENTATION RATE (ESR) | 10 | | 0 - 14 | mm at 1 hr |
| **SUGAR URINE - POST PRANDIAL** | RESULT PENDING | | | |
| **THYROID PANEL, SERUM** | | | | |
| T3 | 106.76 | | 20-50 yrs : 60-181 | ng/dL |
| T4 | 8.00 | | 3.2 - 12.6 | µg/dl |
| TSH 3RD GENERATION | 2.600 | | 18-49 yrs : 0.4 - 4.2 | µIU/mL |



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**Interpretation(s)**

**Triiodothyronine T3** , **Thyroxine T4,** and **Thyroid Stimulating Hormone TSH** are thyroid hormones which affect almost every physiological process in the body, including growth, development, metabolism, body temperature, and heart rate.
Production of T3 and its prohormone thyroxine (T4) is activated by thyroid-stimulating hormone (TSH), which is released from the pituitary gland. Elevated concentrations of T3, and T4 in the blood inhibit the production of TSH.
Excessive secretion of thyroxine in the body is hyperthyroidism, and deficient secretion is called hypothyroidism.
In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hyperthyroidism, TSH levels are low.
Below mentioned are the guidelines for Pregnancy related reference ranges for Total T4, TSH & Total T3.Measurement of the serum TT3 level is a more sensitive test for the diagnosis of hyperthyroidism, and measurement of TT4 is more useful in the diagnosis of hypothyroidism.Most of the thyroid hormone in blood is bound to transport proteins. Only a very small fraction of the circulating hormone is free and biologically active. It is advisable to detect Free T3, FreeT4 along with TSH, instead of testing for albumin bound Total T3, Total T4**.**

| Sr. No. | TSH | Total T4 | FT4 | Total T3 | Possible Conditions |
|---|---|---|---|---|---|
| 1 | High | Low | Low | Low | (1) Primary Hypothyroidism (2) Chronic autoimmune Thyroiditis (3) Post Thyroidectomy (4) Post Radio-Iodine treatment |
| 2 | High | Normal | Normal | Normal | (1)Subclinical Hypothyroidism (2) Patient with insufficient thyroid hormone replacement therapy (3) In cases of Autoimmune/Hashimoto thyroiditis (4). Isolated increase in TSH levels can be due to Subclinical inflammation, drugs like amphetamines, Iodine containing drug and dopamine antagonist e.g. domperidone and other physiological reasons. |
| 3 | Normal/Low | Low | Low | Low | (1) Secondary and Tertiary Hypothyroidism |
| 4 | Low | High | High | High | (1) Primary Hyperthyroidism (Graves Disease) (2) Multinodular Goitre (3)Toxic Nodular Goitre (4) Thyroiditis (5) Over treatment of thyroid hormone (6) Drug effect e.g. Glucocorticoids, dopamine, T4 replacement therapy (7) First trimester of Pregnancy |
| 5 | Low | Normal | Normal | Normal | (1) Subclinical Hyperthyroidism |
| 6 | High | High | High | High | (1) TSH secreting pituitary adenoma (2) TRH secreting tumor |
| 7 | Low | Low | Low | Low | (1) Central Hypothyroidism (2) Euthyroid sick syndrome (3) Recent treatment for Hyperthyroidism |
| 8 | Normal/Low | Normal | Normal | High | (1) T3 thyrotoxicosis (2) Non-Thyroidal illness |
| 9 | Low | High | High | Normal | (1) T4 Ingestion (2) Thyroiditis (3) Interfering Anti TPO antibodies |

REF: 1. TIETZ Fundamentals of Clinical chemistry 2.Guidlines of the American Thyroid association duriing pregnancy and Postpartum, 2011.
**NOTE: It is advisable to detect Free T3,FreeT4 along with TSH, instead of testing for albumin bound Total T3, Total T4.**TSH is not affected by variation in thyroid - binding protein. TSH has a diurnal rhythm, with peaks at 2:00 - 4:00 a.m. And troughs at 5:00 - 6:00 p.m. With ultradian variations.

**PHYSICAL EXAMINATION, URINE**

| | | |
|---|---|---|
| COLOR | PALE YELLOW | |
| APPEARANCE | CLEAR | |

*** CHEMICAL EXAMINATION, URINE**

| | | |
|---|---|---|
| PH | 6.0 | 4.8 - 7.4 |



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| SPECIFIC GRAVITY | 1.020 | 1.015 - 1.030 | |
| PROTEIN | NOT DETECTED | NOT DETECTED | |
| GLUCOSE | NOT DETECTED | NOT DETECTED | |
| KETONES | NOT DETECTED | NOT DETECTED | |
| BLOOD | NOT DETECTED | NOT DETECTED | |
| BILIRUBIN | NOT DETECTED | NOT DETECTED | |
| UROBILINOGEN | NORMAL | NORMAL | |
| NITRITE | NOT DETECTED | NOT DETECTED | |
| **MICROSCOPIC EXAMINATION, URINE** | | | |
| RED BLOOD CELLS | **0 - 1** | NOT DETECTED | /HPF |
| WBC | 3-5 | 0-5 | /HPF |
| EPITHELIAL CELLS | 0-1 | 0-5 | /HPF |
| CASTS | NOT DETECTED | | |
| CRYSTALS | NOT DETECTED | | |
| BACTERIA | NOT DETECTED | NOT DETECTED | |
| YEAST | NOT DETECTED | NOT DETECTED | |



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**Interpretation(s)**

The following table describes the probable conditions, in which the analytes are present in urine

| Presence of | Conditions |
|---|---|
| Proteins | Inflammation or immune illnesses |
| Pus (White Blood Cells) | Urinary tract infection, urinary tract or kidney stone, tumors or any kind of kidney impairment |
| Glucose | Diabetes or kidney disease |
| Ketones | Diabetic ketoacidosis (DKA), starvation or thirst |
| Urobilinogen | Liver disease such as hepatitis or cirrhosis |
| Blood | Renal or genital disorders/trauma |
| Bilirubin | Liver disease |
| Erythrocytes | Urological diseases (e.g. kidney and bladder cancer, urolithiasis), urinary tract infection and glomerular diseases |
| Leukocytes | Urinary tract infection, glomerulonephritis, interstitial nephritis either acute or chronic, polycystic kidney disease, urolithiasis, contamination by genital secretions |
| Epithelial cells | Urolithiasis, bladder carcinoma or hydronephrosis, ureteric stents or bladder catheters for prolonged periods of time |
| | |
| Granular Casts | Low intratubular pH, high urine osmolality and sodium concentration, interaction with Bence-Jones protein |
| Hyaline casts | Physical stress, fever, dehydration, acute congestive heart failure, renal diseases |
| Calcium oxalate | Metabolic stone disease, primary or secondary hyperoxaluria, intravenous infusion of large doses of vitamin C, the use of vasodilator naftidrofuryl oxalate or the gastrointestinal lipase inhibitor orlistat, ingestion of ethylene glycol or of star fruit (Averrhoa carambola) or its juice |
| Uric acid | arthritis |
| Bacteria | Urinary infectionwhen present in significant numbers & with pus cells. |
| Trichomonas vaginalis | Vaginitis, cervicitis or salpingitis |

**BLOOD UREA NITROGEN (BUN), SERUM**

| | | | |
|---|---|---|---|
| BLOOD UREA NITROGEN | 18 | Adult(<60 yrs) : 6 to 20 | mg/dL |

**SUGAR URINE - FASTING**

| | | |
|---|---|---|
| SUGAR URINE - FASTING | NOT DETECTED | NOT DETECTED |



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**PATIENT NAME : MANU MOHANAN** PATIENT ID : **MANUM110290403**

ACCESSION NO : **4036WB002020** AGE : 33 Years SEX : Male ABHA NO :

DRAWN : RECEIVED : 11/02/2023 10:54 REPORTED : 11/02/2023 13:55

**REFERRING DOCTOR :** DR. MEDIWHEEL CLIENT PATIENT ID :

| Test Report Status **Preliminary** | Results | Units |
|---|---|---|

**MEDIWHEEL HEALTH CHEKUP BELOW 40(M)TMT**

*** ECG WITH REPORT**

**REPORT**
COMPLETED

*** USG ABDOMEN AND PELVIS**

**REPORT**
COMPLETED

*** CHEST X-RAY WITH REPORT**

**REPORT**
COMPLETED

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

**PRASEEDA S NAIR**
**BIOCHEMIST**

**DR.KRIPA ELIZABETH JOHN**
**CONSULTANT PATHOLOGIST**

**K.MEERA BHAI**
**SENIOR BIOCHEMIST**



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