


To: **KIMS Hospital Enterprises Pvt Ltd-Hyderabad**  
1-112/86,  
Survey No : 55/EE,Kondapur, Serilingampally,  
Telangana  
Hyderabad - 500084  
Contact: 9573151558



Sample ID 2470006948  
Patient ID 1002497048  
Collected on 07/11/2024  
Reported on -  
Referred by **Dr. Shilpi Reddy**




**Understand Your Report In Detail**




Scan QR code

**Patient Name: Mrs. Y SNEHA** **Patient DOB: 21/12/1995**

**EVICO DUO PE+ : Dual Marker Screening**

A. Common Aneuploidies Screening		
Conditions (Disorder)	Final Adjusted Risk (at term)	Interpretation
T21 (Down syndrome)	1: 258	Intermediate Risk 
T18 (Edwards' syndrome)	1: 88518	Low Risk 
T13 (Patau syndrome)	1: 100000	Low Risk 

Marker	Multiple Of Median (MoM)
Free β-hCG	5.43 
PAPP-A	0.44
PLGF	0.82
UTPI	0.66

**Suggestions**

- In view of intermediate risk (Risk between 1:251 to 1:1000), further counselling is recommended.
- Latest guidelines suggest further evaluation of intermediate risk patients by the following options as indicated:
  - a) Integrated screening with detailed Genetic Sonogram (Detection rate: 92-95%), ref: Kypros Nicolaides et al, Fetal Diagn Ther 2014;35:174-184.
  - b) Non- Invasive Prenatal Testing/ Screening (NIPT) (Detection rate: >99%), ref: ISPD guidelines 2015.
  - c) Definitive testing through Fetal Karyotyping.

In view of free bHCG MoMs observed in the mother, kindly consider correlation with fetal growth and well being scan at 28 - 30 weeks.

**B. Pre-eclampsia Screening**

**Final Adjusted Risk** 1: 2617 **Low Risk** 

**Interpretation** 

**Reference:**Ultrasound Obstet Gynecol 2018; 52: 186 - 195, K. H. Nicolaides et.al (Fetal Medicine Foundation (UK) 2018)

**C. SGA/IUGR**

In the view of maternal history, patient demographics and observed biochemical MoM values, there appears to be **low predisposition to SGA/IUGR.**

**Reference:**Ultrasound Obstet Gynecol 2021; 57: 52-61, K. H. Nicolaides et.al (Fetal Medicine Foundation (UK) 2021)

**D. Fetal Macrosomia**

In the view of maternal history, patient demographics and observed biochemical MoM values, there appears to be **low predisposition to Fetal Macrosomia..**

**Reference:**Ultrasound Obstet Gynecol 2016; 47: 332-339, K. H. Nicolaides et.al (Fetal Medicine Foundation (UK) 2016)

**Note:** All the above assessments have been calculated based on the clinical information provided in the test requisition form.

MoM: Multiple of Median , SGA: Small for Gestation Age, IUGR: Intrauterine Growth Restriction

Patient name : Mrs. Y SNEHA

Sample ID : 2470006948

**EVIC**Screen™ is an evidence based Comprehensive prenatal screening program curated by Lilac Insights in accordance with the Fetal Medicine Foundation (UK) guidelines for First Trimester Screening to determine the probability of **most common chromosomal aneuploidies** in a pregnancy as well as the common pregnancy disorders such as **pre-eclampsia, fetal macrosomia, IUGR/SGA**. It utilizes

- Hormonal values from the pregnancies measured on Fetal Medicine Foundation (UK) accredited analyzers and reagents
- Robust indigenous medians from over 10 lac+ pregnancies for different gestation age & maternal age screened at Lilac Insights
- Risk predictions from evidence based algorithms developed and validated through large international studies carried by Fetal Medicine Foundation (UK)

**UKNEQAS: United Kingdom National External Quality Assessment Service**

**RIQAS: Randox International Quality Assessment Scheme**



The Risk Assessment Performed Using  
CE-marked Antenatal Risk Evaluation Software  
Certified by the British Standards Institute  
(BSI)- ISO 13485:2016

### Ongoing Pregnancy Details

No. of fetuses : 1  
EDD : 18/05/2025  
Age at Term : 29.4 Years  
GA is Based on : CRL 61.1mm at 07/11/2024  
LMP Date : 04/08/2024  
Certainty : Regular  
Smoking : None  
Assisted Reproduction : No

Parity : Nulliparous  
Height : 152.0 cm  
Weight : 51.70 Kg  
Ethnicity : Asian

### Previous Pregnancy Details

<b>Aneuploidies</b>	<b>Pre-eclampsia</b>	<b>Other</b>
<input type="checkbox"/> Down syndrome	<input type="checkbox"/> PE in previous pregnancy	<input type="checkbox"/> Insulin dependent diabetes
<input type="checkbox"/> Patau syndrome	<input type="checkbox"/> Pat. mother had PE	<input type="checkbox"/> Chronic hypertension
<input type="checkbox"/> Edwards' syndrome		
<input type="checkbox"/> NTD syndrome		

EDD: Estimated Due Date | GA: Gestation Age | LMP: Last Menstrual Period | FHR: Fetal Heart Rate | NTD: Neural Tube Defect | PE: Pre-eclampsia | DOB: Date of Birth | CRL: Crown Rump Length | free-β-hCG: free-Beta Human Chorionic Gonadotropin | NT: Nuchal Translucency | NB: Nasal Bone | PAPP-A: Pregnancy-associated Plasma Protein-A | MAP: Mean Arterial Pressure | UTPI: Uterine Artery Pulsatility Index | PLGF: Placental Growth Factor | AFP: Alpha-Fetoprotein

Sample Type: Serum

Method: Time-resolved Fluoroimmunoassay

Risk assessment: Algorithm validated by SURUSS 2003, N.J Wald

### Specimen Details

Pregnancy Type: Singleton  
Sample ID: 2470006948  
Collected On: 07/11/2024  
Received On: 08/11/2024  
Scan by: Dr. KEERTHI  
Scan Date: 07/11/2024  
CRL : 61.1 mm

Patient ID: 1002497048  
GA at Coll Date: 12 W 4 D  
Registered On: 08/11/2024  
GA at Scan Date: 12 W 4 D

Parameter	Concentration	Units	Corr. Mom
Free-β-hCG	216.00	ng/mL	5.43
PAPP-A	1870.00	mU/L	0.44
PLGF	55.56	pg/mL	0.82
NT	1.32	mm	0.94
NB	Present		
MAP	82.67	mmHg	1.00
UTPI	1.13	--	0.66

### Detailed Risk Assessment

Disorder	Aneuploidies			Pre-eclampsia
	Trisomy 21 (Down Syndrome)	Trisomy 18 (Edwards' Syndrome)	Trisomy 13 (Patau Syndrome)	PE before 34 weeks (Early PE)
Cut-off	1:250	1:100	1:100	1: 100
Age/ Apriori risk	1:1029	1:9257	1:27795	--
Final risk (at term)	1:258	1:88518	1:100000	1: 2617
Result	● Intermediate Risk	● Low Risk	● Low Risk	● Low Risk

## Prenatal Screening Background

Every pregnant woman carries a certain degree of risk that her fetus/baby may have certain chromosomal defect/ abnormalities. Diagnosis of these fetal chromosomal abnormalities requires confirmatory testing through analysis of amniocytes or Chorionic Villous Samples (CVS). However, amniocentesis and CVS procedures carry some degree of risk for miscarriage or other pregnancy complications (Tabor and Alfirevic, 2010). Therefore, in routine practice, prenatal screening tests are offered to a pregnant woman to provide her a personalised risk for the most common chromosomal abnormalities (T21-Down syndrome, T18- Edwards' syndrome, T13- Patau syndrome) using her peripheral blood sample. Based on this risk assessment, if the risk is high or intermediate, you can take informed decision of opting for invasive procedure such as amniocentesis or CVS followed by confirmatory diagnostic test(s), as per discussion with your clinician.

### PRENATAL SCREENING TESTS ARE NOT CONFIRMATORY TESTS. THEY ARE LIKELIHOOD ASSESSMENT TESTS.

You may get your prenatal screening result as either of the following:-

#### High Risk

A High Risk Result does not mean that the pregnancy is affected with the condition. It means that the likelihood of the pregnancy having a condition is higher than the cut-off (Most commonly used cut-off is 1:250 and this represents the risk of pregnancy loss from confirmatory testing through CVS or amniocentesis).

#### Low Risk

A Low Risk result does not mean that the pregnancy is not affected with a condition. It means that the likelihood of the pregnancy having a condition is lower than the cut-off.

#### Intermediate Risk

An intermediate Risk result means that the pregnancy has an equivocal or a borderline risk of being affected with a condition. In this case, you may want to choose a second stage screening modality like an Integrated Screening Test that is done between 16 to 20 weeks of pregnancy or a Non-invasive Prenatal Screening Test between 12 to 20 weeks of pregnancy before taking a decision on an invasive confirmatory testing. This will help you improve the sensitivity of the screening test keeping an invasive test a last option were you to come as a high risk in the second stage screening test.

## Significance Of Multiple Of Medians (MoMs)

Prenatal screening involves assessing the likelihood of specific pregnancy-related conditions by analyzing various markers, including hormonal levels, biophysical measurements, and ultrasound findings. Hormones, particularly those produced by the fetus or placenta, not only provide insights into the risk of chromosomal abnormalities but also signal potential issues with placental function. This, in turn, can lead to complications such as pre-eclampsia, intrauterine growth restriction (IUGR), and fetal macrosomia.

In addition to hormonal markers, various other biophysical and ultrasound markers can also offer indications of possible placental impairment. Therefore, it is essential to consider both the reported multiples of the median (MoMs) for these markers and the available information about the pregnancy when interpreting the screening results. This comprehensive approach provides a more thorough understanding of the pregnancy's status and potential risks.

### Limitations of the Test:

As prenatal screening tests are not confirmatory diagnostic tests, the possibility of false positive or false negative results can not be denied. The results issued for this test does not eliminate the possibility that this pregnancy may be associated with other chromosomal or sub- chromosomal abnormalities, birth defects and other complications.

Nuchal Translucency is the most prominent marker in screening for Trisomy 13, 18, 21 in the first trimester and should be measured in accordance with the Fetal Medicine Foundation (UK) guidelines. Nuchal Translucency or Crown Rump Length measurement, if not performed as per FMF (UK) imaging guidelines may lead to erroneous risk assessments and Lilac Insights bears no responsibility for errors arising due to sonography measurements not performed as per these criteria defined by international bodies such as FMF (UK), ISUOG.

It is assumed that the details provided along with the sample are correct. The manner in which this information is used to guide patient care is the responsibility of the healthcare provider, including advising for the need for genetic counselling or additional diagnostic testing like amniocentesis or Chorionic Villus Sampling. Any diagnostic test should be interpreted in the context of all available clinical findings. As with any medical test, there is always a chance of failure or error in sample analysis though extensive measures are taken to avoid these errors.

#### Note:

- Quality of the Down syndrome screening program (Biochemical values, MoMs and Risk assessments) is monitored by UKNEQAS on an ongoing basis.
- This interpretation assumes that patient and specimen details are accurate and correct.
- Lilac Insights does not bear responsibility for ultrasound measurements like CRL,NT,NB etc. We strongly recommend that ultrasound measurements are performed as per FMF (UK)/ISUOG practice guidelines.
- It must be clearly understood that the results represent risk and not diagnostic outcomes. Increased risk does not mean that the baby is affected and further tests must be performed before a firm diagnosis can be made. A Low Risk result does not exclude the possibility of Down syndrome or other abnormalities, as the risk assessment does not detect all affected pregnancies.
- Each sample received at Lilac Insights' processing centre is handled with the utmost sensitivity and care. All samples received on Sundays and National holidays are stored as per specific guidelines for the respective specimens and processed on the next day.
- PE risk stratification is done using a cut-off of 1:100 as per ASPRE study.

For more information, visit our website at: [www.lilacinsights.com/faq-pns](http://www.lilacinsights.com/faq-pns)