



Lab No. : JAD/20-03-2023/SR7428884  
 Patient Name : ARIJIT MITRA  
 Age : 29 Y O M O D  
 Gender : M

Lab Add. : Newtown, Kolkata-700156  
 Ref Dr. : Dr.MEDICAL OFFICER  
 Collection Date: 20/Mar/2023 09:33AM  
 Report Date : 20/Mar/2023 02:37PM



Test Name	Result	Unit	Bio Ref. Interval	Method
<b>ALKALINE PHOSPHATASE , GEL SERUM</b>				
ALKALINE PHOSPHATASE	112	U/L	46-116 U/L	IFCC standardization
<b>SODIUM, BLOOD , GEL SERUM</b>				
SODIUM,BLOOD	138	mEq/L	132 - 146 mEq/L	ISE INDIRECT
<b>*CHLORIDE, BLOOD , .</b>				
CHLORIDE,BLOOD	104	mEq/L	99-109 mEq/L	ISE INDIRECT
<b>GLUCOSE, FASTING , BLOOD, NAF PLASMA</b>				
GLUCOSE,FASTING	88	mg/dL	Impaired Fasting-100-125 .-Diabetes- >= 126.-Fasting is defined as no caloric intake for at least 8 hours.	Gluc Oxidase Trinder

In the absence of unequivocal hyperglycemia, diagnosis requires two abnormal test results from the same sample or in two separate test samples.

Reference :  
 ADA Standards of Medical Care in Diabetes – 2020. Diabetes Care Volume 43, Supplement 1.

<b>BILIRUBIN (DIRECT) , GEL SERUM</b>				
BILIRUBIN (DIRECT)	0.20	mg/dL	<0.2 mg/dL	Vanadate oxidation
<b>CREATININE, BLOOD , GEL SERUM</b>				
CREATININE, BLOOD	0.86	mg/dL	0.7-1.3 mg/dL	Jaffe, alkaline picrate, kinetic
<b>PHOSPHORUS-INORGANIC, BLOOD , GEL SERUM</b>				
PHOSPHORUS-INORGANIC,BLOOD	2.9	mg/dL	2.4-5.1 mg/dL	Phosphomolybdate/UV
<b>POTASSIUM, BLOOD , GEL SERUM</b>				
POTASSIUM,BLOOD	3.90	mEq/L	3.5-5.5 mEq/L	ISE INDIRECT
<b>BILIRUBIN (TOTAL) , GEL SERUM</b>				
BILIRUBIN (TOTAL)	1.00	mg/dL	0.3-1.2 mg/dL	Vanadate oxidation

□

  
**Dr NEEPA CHOWDHURY**  
 MBBS MD (Biochemistry)  
 Consultant Biochemist

Lab No. : SR7428884      Name : ARIJIT MITRA      Age/G : 29 Y 0 M 0 D / M      Date : 20-03-2023

**SGOT/AST , GEL SERUM**

SGOT/AST      **68**      U/L      13-40 U/L      Modified IFCC

**TO CORRELATE CLINICALLY**

**UREA,BLOOD**

**17.1**      mg/dL      19-49 mg/dL      Urease with GLDH

**CALCIUM, BLOOD**

CALCIUM,BLOOD      **8.40**      mg/dL      8.7-10.4 mg/dL      Arsenazo III

ESTIMATED TWICE

**TO CORRELATE CLINICALLY**

**SUGGESTED FOLLOW-UP**

**GLUCOSE, PP , BLOOD, NAF PLASMA**

GLUCOSE,PP      **84\***      mg/dL      Impaired Glucose Tolerance-140 to 199.  
 Gluc Oxidase Trinder  
 Diabetes>= 200.

**\*Note: Blood glucose level is maintained by a very complex integrated mechanism involving critical interplay of release of hormones and action of enzymes on key metabolic pathways resulting in a smooth transition normally from a high level of glucose influx following meal / glucose intake to a basal level after 2 – 3 hrs or so. Excluding alimentary hypoglycaemia, renal glycosuria, hereditary fructose intolerance and Galactosemia , the possible causes of post prandial reactive hypoglycaemia (PRH) include high insulin sensitivity, exaggerated response of insulin and glucagon like peptide 1(GLP-1), defects in counter-regulation, very lean and /or anxious individuals, after massive weight reduction etc.**

The test should be performed as described by the WHO, using a glucose load containing the equivalent of 75-g anhydrous glucose dissolved in water. In the absence of unequivocal hyperglycemia, diagnosis requires two abnormal test results from the same sample or in two separate test samples.

Reference :  
 ADA Standards of Medical Care in Diabetes – 2020. Diabetes Care Volume 43, Supplement 1.

**LIPID PROFILE , GEL SERUM**

CHOLESTEROL-TOTAL	166	mg/dL	Desirable: < 200 mg/dL Borderline high: 200-239 mg/dL High: > or =240 mg/dL	Enzymatic
TRIGLYCERIDES	109	mg/dL	Normal:: < 150, BorderlineHigh::150-199, High:: 200-499, VeryHigh::>500	GPO-Trinder
HDL CHOLESTEROL	43	mg/dl	< 40 - Low 40-59- Optimum 60 - High	Elimination/catalase
LDL CHOLESTEROL DIRECT	<b>119</b>	mg/dL	OPTIMAL : <100 mg/dL, Near optimal/ above optimal : 100-129 mg/dL, Borderline high : 130-159 mg/dL, High : 160-189 mg/dL, Very high : >=190 mg/dL	Elimination / Catalase

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VLDL	4	mg/dl	< 40 mg/dl Calculated
CHOL HDL Ratio	3.9		LOW RISK 3.3-4.4 AVERAGE RISK 4.47-7.1 MODERATE RISK 7.1-11.0 HIGH RISK >11.0 Calculated

Reference: National Cholesterol Education Program. Executive summary of the third report of The National Cholesterol Education Program (NCEP) Expert Panel on detection, evaluation, and treatment of high blood cholesterol in adults (Adult Treatment Panel III). JAMA. May 16 2001;285(19):2486-97.

**TOTAL PROTEIN [BLOOD] ALB:GLO RATIO , .**

TOTAL PROTEIN	7.70	g/dL	5.7-8.2 g/dL	BIURET METHOD
ALBUMIN	4.2	g/dL	3.2-4.8 g/dL	BCG Dye Binding
GLOBULIN	<b>3.50</b>	g/dl	1.8-3.2 g/dl	Calculated
AG Ratio	1.20		1.0 - 2.5	Calculated

[PDF Attached](#)

**GLYCATED HAEMOGLOBIN (HBA1C) , EDTA WHOLE BLOOD**

GLYCATED HEMOGLOBIN (HBA1C)	4.7	%	***FOR BIOLOGICAL REFERENCE INTERVAL DETAILS , PLEASE REFER TO THE BELOW MENTIONED REMARKS/NOTE WITH ADDITIONAL CLINICAL INFORMATION ***
HbA1c (IFCC)	28.0	mmol/mol	HPLC

**Clinical Information and Laboratory clinical interpretation on Biological Reference Interval:**

Low risk / Normal / non-diabetic : <5.7% (NGSP) / < 39 mmol/mol (IFCC)  
 Pre-diabetes/High risk of Diabetes : 5.7%- 6.4% (NGSP) / 39 - < 48 mmol/mol (IFCC)  
 Diabetics-HbA1c level : >= 6.5% (NGSP) / > 48 mmol/mol (IFCC)

**Analyzer used : Bio-Rad-VARIANT TURBO 2.0**

**Method : HPLC Cation Exchange**

**Recommendations for glycemc targets**

- Ø Patients should use self-monitoring of blood glucose (SMBG) and HbA1c levels to assess glycemc control.
- Ø The timing and frequency of SMBG should be tailored based on patients' individual treatment, needs, and goals.
- Ø Patients should undergo HbA1c testing at least twice a year if they are meeting treatment goals and have stable glycemc control.
- Ø If a patient changes treatment plans or does not meet his or her glycemc goals, HbA1c testing should be done quarterly.
- Ø For most adults who are not pregnant, HbA1c levels should be <7% to help reduce microvascular complications and macrovascular disease . Action suggested >8% as it indicates poor control.
- Ø Some patients may benefit from HbA1c goals that are stringent.

**Result alterations in the estimation has been established in many circumstances, such as after acute/ chronic blood loss, for example, after surgery, blood transfusions, hemolytic anemia, or high erythrocyte turnover; vitamin B<sub>12</sub>/ folate deficiency, presence of chronic renal or liver disease; after administration of high-dose vitamin E / C; or erythropoietin treatment.**

**Reference: Glycated hemoglobin monitoring BMJ 2006; 333:586-8**

**References:**

1. Chamberlain JJ, Rhinehart AS, Shaefer CF, et al. Diagnosis and management of diabetes: synopsis of the 2016 American Diabetes Association Standards of Medical Care in Diabetes. Ann Intern Med. Published online 1 March 2016. doi:10.7326/M15-3016.
2. Mosca A, Goodall I, Hoshino T, Jeppsson JO, John WG, Little RR, Miedema K, Myers GL, Reinauer H, Sacks DB, Weykamp CW. International Federation of Clinical Chemistry and Laboratory Medicine, IFCC Scientific Division. Global standardization of glycated hemoglobin measurement: the position of the IFCC Working Group. Clin Chem Lab Med. 2007;45(8):1077-1080.

**SGPT/ALT , GEL SERUM**

SGPT/ALT	<b>106</b>	U/L	7-40 U/L	Modified IFCC
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**TO CORRELATE CLINICALLY**

**URIC ACID, URINE, SPOT URINE**

URIC ACID, SPOT URINE ESTIMATED TWICE	<b>32.00</b>	mg/dL	37-92 mg/dL	URICASE
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**Dr. SUPARBA CHAKRABARTI**  
MBBS, MD(BIOCHEMISTRY)  
Consultant Biochemist



Lab No. : SR7428884      Name : ARIJIT MITRA      Age/G : 29 Y 0 M 0 D / M      Date : 20-03-2023

**CBC WITH PLATELET (THROMBOCYTE) COUNT , EDTA WHOLE BLOOD**

HEMOGLOBIN	13.9	g/dL	13 - 17	PHOTOMETRIC
WBC	9.6	*10 <sup>3</sup> /μL	4 - 10	DC detection method
RBC	<b>4.36</b>	*10 <sup>6</sup> /μL	4.5 - 5.5	DC detection method
PLATELET (THROMBOCYTE) COUNT	188	*10 <sup>3</sup> /μL	150 - 450*10 <sup>3</sup> /μL	DC detection method/Microscopy

**DIFFERENTIAL COUNT**

NEUTROPHILS	80	%	40 - 80 %	Flowcytometry/Microscopy
LYMPHOCYTES	<b>12</b>	%	20 - 40 %	Flowcytometry/Microscopy
MONOCYTES	05	%	2 - 10 %	Flowcytometry/Microscopy
EOSINOPHILS	03	%	1 - 6 %	Flowcytometry/Microscopy
BASOPHILS	00	%	0-0.9%	Flowcytometry/Microscopy

**CBC SUBGROUP**

HEMATOCRIT / PCV	42.8	%	40 - 50 %	Calculated
MCV	98.2	fl	83 - 101 fl	Calculated
MCH	31.9	pg	27 - 32 pg	Calculated
MCHC	32.5	gm/dl	31.5-34.5 gm/dl	Calculated
RDW - RED CELL DISTRIBUTION WIDTH	<b>15.1</b>	%	11.6-14%	Calculated
PDW-PLATELET DISTRIBUTION WIDTH	26.6	fL	8.3 - 25 fL	Calculated
MPV-MEAN PLATELET VOLUME	12.2		7.5 - 11.5 fl	Calculated

**DR. NEHA GUPTA**  
**MD, DNB (Pathology)**  
**Consultant Pathologist**



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**BLOOD GROUP ABO+RH [GEL METHOD] , EDTA WHOLE BLOOD**

ABO	O	Gel Card
RH	POSITIVE	Gel Card

**TECHNOLOGY USED: GEL METHOD**

**ADVANTAGES :**

- Gel card allows simultaneous forward and reverse grouping.
- Card is scanned and record is preserved for future reference.
- Allows identification of Bombay blood group.
- Daily quality controls are run allowing accurate monitoring.

**Historical records check not performed.**

**ESR (ERYTHROCYTE SEDIMENTATION RATE) , EDTA WHOLE BLOOD**

1stHour	04	mm/hr	0.00 - 20.00 mm/hr	Westergren
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**URINE ROUTINE ALL, ALL , URINE**

**PHYSICAL EXAMINATION**

COLOUR	PALE YELLOW
APPEARANCE	SLIGHTLY HAZY

**CHEMICAL EXAMINATION**

pH	5.0	4.6 - 8.0	Dipstick (triple indicator method)
SPECIFIC GRAVITY	1.015	1.005 - 1.030	Dipstick (ion concentration method)
PROTEIN	NOT DETECTED	NOT DETECTED	Dipstick (protein error of pH indicators)/Manual
GLUCOSE	NOT DETECTED	NOT DETECTED	Dipstick (glucose-oxidase-peroxidase method)/Manual
KETONES (ACETOACETIC ACID, ACETONE)	NOT DETECTED	NOT DETECTED	Dipstick (Legals test)/Manual
BLOOD	NOT DETECTED	NOT DETECTED	Dipstick (pseudoperoxidase reaction)
BILIRUBIN	NEGATIVE	NEGATIVE	Dipstick (azo-diazo reaction)/Manual
UROBILINOGEN	NEGATIVE	NEGATIVE	Dipstick (diazonium ion reaction)/Manual
NITRITE	NEGATIVE	NEGATIVE	Dipstick (Griess test)
LEUCOCYTE ESTERASE	NEGATIVE	NEGATIVE	Dipstick (ester hydrolysis reaction)

**MICROSCOPIC EXAMINATION**

LEUKOCYTES (PUS CELLS)	0-1	/hpf	0-5	Microscopy
EPITHELIAL CELLS	0-1	/hpf	0-5	Microscopy
RED BLOOD CELLS	NOT DETECTED	/hpf	0-2	Microscopy
CAST	NOT DETECTED		NOT DETECTED	Microscopy
CRYSTALS	NOT DETECTED		NOT DETECTED	Microscopy
BACTERIA	NOT DETECTED		NOT DETECTED	Microscopy
YEAST	NOT DETECTED		NOT DETECTED	Microscopy

**Note:**

1. All urine samples are checked for adequacy and suitability before examination.
2. Analysis by urine analyzer of dipstick is based on reflectance photometry principle. Abnormal results of chemical examinations are confirmed by manual methods.
3. The first voided morning clean-catch midstream urine sample is the specimen of choice for chemical and microscopic analysis.
4. Negative nitrite test does not exclude urinary tract infections.
5. Trace proteinuria can be seen in many physiological conditions like exercise, pregnancy, prolonged recumbency etc.
6. False positive results for glucose, protein, nitrite, urobilinogen, bilirubin can occur due to use of certain drugs, therapeutic dyes, ascorbic acid, cleaning agents used in urine collection container.
7. Discrepancy between results of leukocyte esterase and blood obtained by chemical methods with corresponding pus cell and red blood cell count by microscopy can

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**Suraksha**  
DIAGNOSTICS

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occur due to cell lysis.

8. Contamination from perineum and vaginal discharge should be avoided during collection, which may falsely elevate epithelial cell count and show presence of bacteria and/or yeast in the urine.

□

**Dr. PANKTI PATEL**  
MBBS , MD (PATHOLOGY)  
CONSULTANT PATHOLOGIST



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**URIC ACID, BLOOD , GEL SERUM**

URIC ACID,BLOOD	5.80	mg/dL	3.5-7.2 mg/dL	Uricase/Peroxidase
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**THYROID PANEL (T3, T4, TSH) , GEL SERUM**

T3-TOTAL (TRI IODOTHYRONINE)	1.02	ng/ml	0.60-1.81 ng/ml	CLIA
T4-TOTAL (THYROXINE)	8.3	µg/dL	3.2-12.6 µg/dL	CLIA
TSH (THYROID STIMULATING HORMONE)	<b>9.23</b>	µIU/mL	0.55-4.78 µIU/mL	CLIA

**Suggested follow up with ft4 reports and to correlate clinically**

Serum TSH levels exhibit a diurnal variation with the peak occurring during the night and the nadir, which approximates to 50% of the peak value, occurring between 1000 and 1600 hours.[1,2]

**References:**

- Bugalho MJ, Domingues RS, Pinto AC, Garrao A, Catarino AL, Ferreira T, Limbert E and Sobrinho L. Detection of thyroglobulin mRNA transcripts in peripheral blood of individuals with and without thyroid glands: evidence for thyroglobulin expression by blood cells. *Eur J Endocrinol* 2001;145:409-13.
- Bellantone R, Lombardi CP, Bossola M, Ferrante A,Princi P, Boscherini M et al. Validity of thyroglobulin mRNA assay in peripheral blood of postoperative thyroid carcinoma patients in predicting tumor recurrence varies according to the histologic type: results of a prospective study. *Cancer* 2001;92:2273-9.

**BIOLOGICAL REFERENCE INTERVAL: [ONLY FOR PREGNANT MOTHERS]**

Trimester specific TSH LEVELS during pregnancy:

- FIRST TRIMESTER: 0.10 – 3.00 µ IU/mL
- SECOND TRIMESTER: 0.20 -3.50 µ IU/mL
- THIRD TRIMESTER : 0.30 -3.50 µ IU/mL

**References:**

- Erik K. Alexander, Elizabeth N. Pearce, Gregory A. Brent, Rosalind S. Brown, Herbert Chen, Chrysoula Dosiou, William A. Grobman, Peter Laurberg, John H. Lazarus, Susan J. Mandel, Robin P. Peeters, and Scott Sullivan. *Thyroid*. Mar 2017.315-389. <http://doi.org/10.1089/thy.2016.0457>
- Kalra S, Agarwal S, Aggarwal R, Ranabir S. Trimester-specific thyroid-stimulating hormone: An indian perspective. *Indian J Endocr Metab* 2018;22:1-4.

**DR. ANANNYA GHOSH**  
**MBBS, MD (Biochemistry)**  
**Consultant Biochemist**

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Lab Add. :  
Ref Dr. : Dr.MEDICAL OFFICER  
Collection Date:  
Report Date : 20/Mar/2023 02:54PM



## X-RAY REPORT OF CHEST (PA) VIEW

### FINDINGS :

No active lung parenchymal lesion is seen.  
Both the hila are normal in size, density and position.  
Mediastinum is in central position. Trachea is in midline.  
Domes of diaphragm are smoothly outlined. Position is within normal limits.  
Lateral costo-phrenic angles are clear.  
The cardio-thoracic ratio is normal.  
Bony thorax reveals no definite abnormality.

### IMPRESSION :

Normal study.

□



Dr. J Sen  
MD Consultant, Radiologist

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Lab Add. :  
Ref Dr. : Dr.MEDICAL OFFICER  
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Report Date : 20/Mar/2023 04:57PM



**DEPARTMENT OF ULTRASONOGRAPHY**  
**REPORT ON EXAMINATION OF WHOLE ABDOMEN**

**LIVER**

Liver is normal in size with smooth margins. Parenchymal echotexture of both lobes are normal. No focal mass lesion is seen in liver. Intrahepatic biliary radicals are not dilated. Portal vein branches and hepatic veins are normal.

**PORTA**

Portal vein is normal in caliber measures 10 mm. Common bile duct is not dilated (3 mm). No intraluminal calculus or soft tissue is seen in CBD.

**GALL BLADDER**

Gall bladder is normal in size, shape. No intraluminal calculus or mass is seen. Gall bladder wall is normal in thickness. No pericholecystic fluid collection noted.

**PANCREAS**

Pancreas is normal in size, shape and contour. Parenchymal echogenicity is normal and homogeneous. No focal mass or calcification seen. Main pancreatic duct is not dilated. No peripancreatic fluid collection or pseudocyst noted.

**SPLEEN**

Spleen is normal in size (106 mm), shape, position. Echotexture is normal. No focal lesion is noted. Splenic vein at splenic hilum is normal in caliber. No collateral seen.

**KIDNEYS**

Both the kidneys are normal in size, shape and position. Cortical echogenicity and cortical thickness of both kidneys are normal. Cortico-medullary differentiation is maintained. No calculus, mass or hydronephrosis is seen in either kidneys.

Right kidney measures : 87 mm      Left kidney measures : 92 mm.

**URETERS**

Ureters are not dilated.

**URINARY BLADDER**

Urinary bladder is distended, wall thickness appeared normal. No intraluminal calculi / mass could

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Report Date : 20/Mar/2023 04:57PM



be detected.

**PROSTATE**

Prostate is normal in size. Echotexture appears within normal limits. No focal lesion is seen.

It measures : 29 mm x 26 mm x 22 mm.

Approximate weight - 9 gms.

**RETROPERITONEUM & PERITONEUM**

The aorta and IVC are normal. No enlarged lymph nodes are noted in the retroperitoneum. No free fluid is seen in peritoneum.

**IMPRESSION:-** Normal study.

**Kindly note:-**

\* ***Ultrasound is not the modality of choice to rule out subtle bowel lesion.***

\* ***Please Intimate us for any typing mistakes and send the report for correction within 7 days.***

\* ***The science of Radiological diagnosis is based on the interpretation of various shadows produced by both the normal and abnormal tissues and are not always conclusive. Further biochemical and radiological investigation & clinical correlation is required to enable the clinician to reach the final diagnosis.***

**The report and films are not valid for medico-legal purpose.**

**Patient Identity not verified**

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Dr. J Sen  
MD Consultant, Radiologist

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Age : 29 Y 0 M 0 D  
Gender : M

Lab Add. :  
Ref Dr. : Dr.MEDICAL OFFICER  
Collection Date:  
Report Date : 20/Mar/2023 03:56PM



### E.C.G. REPORT

DATA	
HEART RATE	88 Bpm
PR INTERVAL	138 Ms
QRS DURATION	82 Ms
QT INTERVAL	318 Ms
QTC INTERVAL	398 Ms
AXIS	Normal
P WAVE	38 Degree
QRS WAVE	60 Degree
T WAVE	24 Degree
<b>IMPRESSION</b>	<b>: Normal sinus rhythm.</b>

**Dr Pulak Ghosh Dastidar**  
MBBS, PGDC, Fellowship in Diabetes  
Management (CMC VELLORE)

**Patient Data**

Sample ID: C02135000824  
 Patient ID: SR7428884  
 Name:  
 Physician:  
 Sex:  
 DOB:

**Analysis Data**

Analysis Performed: 20/MAR/2023 13:59:14  
 Injection Number: 9430U  
 Run Number: 219  
 Rack ID: 0007  
 Tube Number: 4  
 Report Generated: 20/MAR/2023 14:21:23  
 Operator ID: ASIT

Comments:

Peak Name	NGSP %	Area %	Retention Time (min)	Peak Area
A1a	---	1.0	0.156	15437
A1b	---	0.7	0.216	10940
F	---	0.8	0.268	12331
LA1c	---	1.6	0.399	23473
A1c	4.7	---	0.510	55655
P3	---	3.1	0.787	46696
P4	---	1.2	0.870	17273
Ao	---	87.7	0.996	1302145

Total Area: 1,483,951

**HbA1c (NGSP) = 4.7 %**    HbA1c (IFCC) = 28 mmol/mol

