A 52 year old man was referred to the diabetic clinic because of weight loss and persistent osmotic symptoms. He was diagnosed three years before presentation and was on diet therapy. His general practitioner was concerned that he had a “sinister cause” for his symptoms because his glycated haemoglobin (HbA1c) levels were “near normal” when repeated on several occasions (measured using the Menarini high performance liquid chromatography method, with a reference range of 4%–6%). He was in remission from Hodgkin’s disease. Initial clinical examination was unremarkable. Laboratory data were: haemoglobin 155 g/l, white cell count 4.81 × 10^9/l (normal differential count), platelet count 214 × 10^9/l; liver enzymes, renal function, and microalbuminuria screen were normal. Other results are shown in table 1.

**QUESTIONS**

1. What do the data demonstrate?
2. What is the differential diagnosis and what would you do next?
3. What is the pathophysiological basis of the discrepancies observed and how would you assess this man’s long term glycaemic control?

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**Diabetes**

**Low HbA1c levels in a poorly controlled diabetic**

**A R Vasudevan, S Ghosh, R Srivastava, LDKE Premawardhana**

Answers on p 421.

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**Neurology**

**A bed bound patient**

**G G Hanna, G V McDonnell**

Answers on p 421.

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**Table 1 Laboratory data**

<table>
<thead>
<tr>
<th>Date</th>
<th>Urine glucose</th>
<th>Random plasma glucose</th>
<th>HbA1c</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 1998</td>
<td>+++</td>
<td>9.9</td>
<td>2.8</td>
</tr>
<tr>
<td>September 1998</td>
<td>+++</td>
<td>16</td>
<td>3.1</td>
</tr>
<tr>
<td>March 1999</td>
<td>+++</td>
<td>11</td>
<td>3.5</td>
</tr>
<tr>
<td>November 1999</td>
<td>+++</td>
<td>16</td>
<td>4.3</td>
</tr>
</tbody>
</table>

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**Authors’ affiliations**

**Diabetes**

A R Vasudevan, S Ghosh, R Srivastava, LDKE Premawardhana, Department of Diabetes and Endocrinology, Caerphilly Miner’s Hospital, Gwent Healthcare NHS Trust, Caerphilly

Correspondence to: Dr LDKE Premawardhana, Department of Medicine, Caerphilly Miner’s Hospital, St Martin’s Road, Caerphilly CF83 2WW, UK; ldke.premawardhana@gwent.wales.nhs.uk Submitted 20 March 2002 Accepted 6 August 2002

**Neurology**

**A bed bound patient**

**G G Hanna, G V McDonnell**

Correspondence to: Dr Gavin V McDonnell, Department of Neurology, Ward 4E, Royal Victoria Hospital, Belfast, Co Antrim, Northern Ireland BT12 6BA, UK; hanna@doctors.org.uk Submitted 12 July 2002 Accepted 27 August 2002

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**Authors’ affiliations**

**Diabetes**

A R Vasudevan, S Ghosh, R Srivastava, LDKE Premawardhana, Department of Diabetes and Endocrinology, Caerphilly Miner’s Hospital, Gwent Healthcare NHS Trust, Caerphilly

Correspondence to: Dr LDKE Premawardhana, Department of Medicine, Caerphilly Miner’s Hospital, St Martin’s Road, Caerphilly CF83 2WW, UK; ldke.premawardhana@gwent.wales.nhs.uk Submitted 20 March 2002 Accepted 6 August 2002

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**Neurology**

**A bed bound patient**

**G G Hanna, G V McDonnell**

Correspondence to: Dr Gavin V McDonnell, Department of Neurology, Ward 4E, Royal Victoria Hospital, Belfast, Co Antrim, Northern Ireland BT12 6BA, UK; hanna@doctors.org.uk Submitted 12 July 2002 Accepted 27 August 2002
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G G Hanna and G V McDonnell

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