

Viscoelastic and Viscoplastic Glucose Theory (VGT #142): An Updated Study of Paper No. 732 that Includes Meals Number Count Influence using Space-Domain VGT Analysis to Estimate Predicted Combined PPG Values Resulting from 3 SD-VGT Energy Ratios of PPG Waveforms, i.e. Himalaya, Grand Canyon, and Twin Peaks, over 7+ Years from 5/1/2015 to 8/29/2022 Based on Math-Physical Medicine Method (No. 734)

Gerald C Hsu

EclaireMD Foundation, USA

***Corresponding author**

Gerald C. Hsu, EclaireMD Foundation, USA

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Introduction

Due to the author's original software lacking the meal number counting ability for 3 specific postprandial plasma glucose (PPG) waveforms in Paper No. 732, he had to utilize the normalization factor of (1/120 mg/dL) for 3 distinctive types of PPG waveforms, Himalaya, Grand Canyon, and Twin Peaks, without considering the influences from data item or data amount.

Because of this research effort, he has enhanced his developed software to include the meal counting ability, so that he can calculate the summation numbers of meals associated with the fasting plasma glucose (FPG), PPG and the 3 specific types of PPG. After implementing this data-mining capability, **he discovered that the 3 special types of PPG waveforms only occupy 50% of his total meals PPG over the period from 5/8/2018 to 8/29/2022.** Therefore, the first correction in this study is that **he now uses "the combined 3 PPG types" instead of the original term of "the total PPG" in Paper No. 732. The "total PPG" actually contains about half of the meals that do not match with any type of the 3 special PPG waveforms.** The second improvement is that **Paper No.734 now includes both "with meal numbers" influence and "without meal numbers" influence.** Initially, he used 3 special PPG values divided by 120 mg/dL only, i.e. (1/120 mg/dL). But, now he has multiplied each type's individual meals count percentages of total meals **(13% for Himalaya, 51% for Grand Canyon, and 36% for Twin Peaks) with the original (1/120 mg/dL) as the new normalization factor.** Specifically, the 3 different normalized viscosities are defined as:

**Normalized Himalaya =
(Himalaya PPG/120) * 13%**

**Normalized Grand Canyon =
(Grand Canyon PPG/120) * 51%**

**Normalized Twin Peaks =
(Twin Peaks PPG/120) * 36%**

After making these improvements, the follow-on calculation steps are identical to other standard VGT analyses.

The changes in normalization will affect the stress, the height of trapezoidal stress-strain area, and then the hysteresis loop areas. As a result, the area ratios (i.e. energy ratios) can be inserted into the final predicted PPG equations.

The author, who does not often rely on statistical resources, usually applies his developed math-physical medicine (MPM) methodology and tools to conduct his biomedical research work. When statistics is used, we can easily "tweak and extract the results that we want" to a certain degree; however, we cannot change the output results that are derived or proven through the basic laws of physics (engineering is an extension of physics). In fact, many observed and known phenomena under the sun, including the biomedical field, indeed follow the basic laws of physics. We can only try to understand the phenomena and/or to interpret the results using physics principles or engineering techniques, but we can not tweak or twist them to fit into what we would like to see.

His biomedical research work does not utilize surveyed or collected data from any health institution or collected data from other patients. Instead, he mostly uses the 3 million collected and processed data from his own health conditions and lifestyle details for his medical research work during the past 13 years.

He has conducted various biomedical research work using engineering viscoelastic or viscoplastic glucose theory (VGT) since 1/8/2022 beginning with Paper No. 578 upon the advice of his MIT advisor, Professor Norman Jones, in December 2021. During this past 8-month period, he has written 141 papers on different biomedical subjects using this approach where he has learned in depth the subtlety and things to watch out for by applying this specific VGT research tool in his various biomedical research work. To date, he has learned the sensitivities and importance of “normalization factors” utilization; and further realized that the SD-VGT energy ratios for input causes can also be served as a sort of “weighting factor” of inputs for the predicted output value of a symptom and its behavior. Of course, whether a particular prediction method is useful or not depends on both prediction accuracy and correlation between measured data and predicted data. Not only has he been analyzing the associated energy of causes, but he is now able to connect the multiple medical input cause energies with the predicted symptom of certain specific medical output.

The symptom used in this study is his combined PPG from 2,360 meals during the period from 5/1/2015 to 8/29/2022. There are 3 input causes of PPG waveforms, 312 Himalaya PPG (13%), 1206 Grand Canyon PPG (51%), and 842 Twin Peaks PPG (36%). All of the PPG values are represented via 4 different waveforms with 15-minute intervals of a sensor glucose device.

Here is a detailed explanation of the 3 different special waveform shapes as shown in Figure 1:

First, the Himalaya PPG waveform is the PPG curve climbing up from 0-minute to 60-minutes, then staying at that high elevation throughout the next 2 hours until reaching to 180-minutes. This Himalaya waveform has mainly resulted from the lack of post-meal exercise. Its peak elevation depends on the consumed amount of carbohydrates and sugar. For his case, since he has reduced his carbs/sugar amount because he realized his post-meal exercise would be limited, therefore his Himalaya PPG curve's peak is lower.

Second, the Grand Canyon PPG waveform is the PPG curve climbing up from 0-minute to 60-minutes, then quickly dropping down to the “bottom” of the curve and then maintaining at this low elevation until 180-minutes. This “most healthy” waveform is usually caused by having sufficient and persistent post-meal exercise during the last 2 hours.

Third, the Twin Peaks PPG waveform is the PPG curve having two peak elevations with the first higher peak around 60-minutes and the second lower peak near 180-minutes. This waveform mainly resulted from having some but insufficient amount of post-meal exercise between 60-minutes and 120 minutes. Therefore, the left-over or unburned energy is rolled into the third hour to create the second peak with a lower elevation around 180-minutes. This situation happened usually when he was physically tried to complete his target of 4,000 steps after his meals.

Actually, the PPG curve behaves like a typical “wave”; therefore, the wave theory of physics can be easily applied on

this domain of problems. Other than the above-mentioned 3 specific and distinctive waveforms, there are many varieties of other waveforms. However, these 3 waveforms have occupied ~50% of total PPG waveforms, therefore, it warrants a special study of their characters and impacts on health.

In the following Methods section, he provides a brief description of this SD-VGT tool using English words instead of theories of physics and engineering with complex mathematical equations.

Furthermore, his developed equation **for the predicted PPG in this paper No.734** is listed as follows:

Predicted PPG based on SD hysteresis loop areas (with meal#) = (Himalaya PPG component value* SD Himalaya PPG energy ratio of 12% + Grand Canyon PPG component value* SD Grand Canyon PPG energy ratio of 50% + Twin Peaks PPG component value* SD Twin Peaks PPG energy ratio of 38%)

However, his developed equation for the predicted PPG (in previous paper No.732) is listed as follows:

Predicted PPG based on SD hysteresis loop areas (without meal#) = (Himalaya PPG component value* SD Himalaya PPG energy ratio of 31% + Grand Canyon PPG component value* SD Grand Canyon PPG energy ratio of 33% + Twin Peaks PPG component value* SD Twin Peaks PPG energy ratio of 36%)

Finally, he calculates the prediction accuracy and correlation between measured PPG versus predicted PPG.

Prediction Accuracy

= (predicted PPG - measured PPG) / measured PPG

All of the above-mentioned features can be included in a developed medical software program. As a result, other patients can easily conduct similar health analyses based on their own data of lifestyle details and medical conditions.

From Paper No.732:

“It should be mentioned here that when the number of meals is included in the normalization process, it usually can further improve the prediction accuracy of a symptom (e.g. the total PPG in this article). For this paper No.732, the author needs to enhance his software program to include the meal number count of each type of PPG waveform. Therefore, in his future article, he will be able to see this kind of result improvement. For this particular paper, the prediction accuracy of the total PPG is somewhat lower than his desired answer since only the energy ratios (without meals % influences) are included in his calculations.”

Methods

The Author's Case of Diabetes and Complications

The author has been a severe T2D patient since 1996. He weighed 220 lb. (100 kg, BMI 32.5) at that time with a one-time glucose reading of 380 mg/dL. By 2010, he still weighed 198 lb. (BMI 29.2) with average daily glucose of 250 mg/dL

(HbA1C of 10%). During that year, his triglycerides reached 1161b (hyperlipidemia) and albumin-creatinine ratio (ACR) at 116 (kidney issues). He also suffered from five cardiac episodes within a decade from 1993 through 2003 caused by work stress and diabetes. In 2010, three independent physicians warned him about his urgent need for kidney dialysis treatment and the risk of his life-threatening health situation such as dying from his severe diabetic complications. Other than the cerebrovascular disease (stroke), he has suffered most of the known diabetic complications, including both macro-vascular & micro-vascular complications, nerve damage as in retinopathy and foot ulcer, as well as a hormonal disturbance, e.g. hypothyroidism.

In 2010, he decided to launch his self-study on endocrinology, diabetes, and food nutrition to save his own life. After developing the metabolism model in 2024, during 2015 and 2016, he developed four prediction models related to diabetes conditions: weight, PPG, fasting plasma glucose (FPG), and A1C. As a result, from using his developed mathematical metabolism index (MI) model in 2014 and those 4 prediction tools, by end of 2016, his weight was reduced from 220 lbs. (100 kg, BMI 32.5) to 176 lbs. (89 kg, BMI 26.0), waistline from 44 inches (112 cm) to 33 inches (84 cm), average finger glucose reading from 250 mg/dL to 120 mg/dL, and lab-tested A1C from 10% to ~6.5%. ***One of his major accomplishments is that he no longer takes any diabetes medications as of 12/8/2015.***

Around that time (2014-2017), he started to focus on preventive medicine instead of blindly trusting and depending on medical treatments only. He also gambled on his belief that most human organs have the inherent ability to self-repair themselves through lifestyle improvements by taking good care of them - even though it can only accomplish a certain degree of repairing or healing dependent on different organ cells and their status of damage.

In 2017, he has achieved excellent results on all fronts, especially glucose control. However, during the pre-COVID period of 2018 and 2019, he traveled to approximately 50+ international cities to attend 65+ medical conferences and made ~120 oral presentations. This hectic schedule inflicted damage to his diabetes control, through dining out frequently, post-meal exercise disruption, jet lag, and along with the overall metabolic impact due to his irregular life patterns through a busy travel schedule; therefore, his glucose control and overall metabolism state were somewhat affected during this two-year heavy traveling period.

Since 1/19/2020, living in a COVID-19 quarantined lifestyle, not only has he written and published ~500 medical papers in 100+ journals, but he has also reached his best health conditions in the past 26 years. By the beginning of 2022, his weight was further reduced to ***168 lbs. (BMI 24.8) along with a 5.8% A1C value (beginning level of pre-diabetes)***, without having any medication interventions or insulin injections. During the period from 1/1/2022 to 8/20/2022, his average FPG is 93 mg/dL, PPG is 113 mg/dL, and daily glucose is 106 mg/dL. These good results are due to his non-traveling, low-stress, and regular daily life routines. Of course, the accumulated knowledge of chronic

diseases, various complications, practical lifestyle management experiences, and development of many high-tech tools along with his medical research academic findings have contributed to his excellent health status since 1/19/2020, the beginning date of his self-quarantined life.

On 5/5/2018, he applied a continuous glucose monitoring (CGM) sensor device on his upper arm and checks his glucose measurements every 5 minutes for a total of ~288 times each day. He has maintained the same measurement pattern to the present day. In his research work, he uses his CGM sensor glucose at a time interval of 15 minutes (96 data per day). Incidentally, ***the average sensor glucoses between 5-minute intervals and 15-minute intervals has only a 0.6% difference (average glucose of 111.86 mg/dL for 5 minutes and average glucose of 111.18 mg/dL for 15 minutes with a correlation of 94% between these two sensor glucose curves)*** during the period from 2/19/20 to 7/22/22.

Therefore, over the past 13 years, he could study and analyze his collected 3+ million data regarding his health status, medical conditions, and lifestyle details. He applies his knowledge, models, and tools from mathematics, physics, engineering, and computer science to conduct his medical research work. ***His research work has a goal of achieving both "high precision" and "quantitative proof" in the medical findings for the ultimate objectives of "preventive medicine".***

The following timetable provides a rough sketch of the emphasis in his medical research during each stage:

- 2000-2013: Self-study diabetes and food nutrition, developing a data collection and analysis software.
- 2014: Develop a mathematical model of metabolism, using engineering modeling and advanced mathematics.
- 2015: Weight & FPG prediction models, using neuroscience.
- 2016: PPG & HbA1C prediction models, using optical physics, artificial intelligence (AI), and neuroscience.
- 2017: Complications due to macro-vascular research, such as cardiovascular disease (CVD), coronary heart diseases (CHD), and stroke, using pattern analysis and segmentation analysis.
- 2018: Complications due to micro-vascular research such as kidney (CKD), bladder, foot, and eye issues (DR).
- 2019: CGM big data analysis, using wave theory, energy theory, frequency domain analysis, quantum mechanics, and AI.
- 2020: Cancer, dementia, longevity, geriatrics, DR, hypothyroidism, diabetic foot, diabetic fungal infection, and linkage between metabolism and immunity, learning about certain infectious diseases, such as COVID-19.
- 2021: Applications of linear elastic glucose theory (LEGT) and perturbation theory from quantum mechanics on medical research subjects, such as chronic diseases and their complications, cancer, and dementia.
- 2022: Applications of viscoelastic/viscoplastic glucose theory (LEGT) on 128 biomedical research cases and 5 economics research cases.

Again, to date, he has spent ~40,000 hours self-studying and researching medicine and he has read 3,000+ published medical

papers online. He has collected and calculated more than three million pieces of data regarding his own medical conditions and lifestyle details. In addition, he has written and published 700+ medical research papers in 100+ various medicine, physics, mathematics, and engineering journals. Moreover, he has also given 120+ presentations at 70+ international medical conferences. He has continuously dedicated his time (11-12 hours per day and work each day of a year, without rest during the past 13 years) and efforts to his medical research work and shared his findings and learnings with other patients worldwide. In addition, he has also spent the past 12 years developing and maintaining a medicine and health software APP on his iPhone which functions as his private numerical laboratory to process the various experimental datasets of his medical conditions and lifestyle details.

Brief Introduction of Math-Physical Medicine (MPM) Research

The author has collected 3+ million data regarding his health condition and lifestyle details over the past 13 years. He spent the entire year of 2014 developing a metabolism index (MI) model using a topology concept, nonlinear algebra, algebraic geometry, and finite element method. This MI model contains various measured biomarkers and recorded lifestyle details along with their induced new biomedical variables for an additional ~1.5 million data. Detailed data of his body weight, glucose, blood pressure, heart rate, blood lipids, body temperature, and blood oxygen level, along with important lifestyle details, including diet, exercise, sleep, stress, water intake, and daily life routines are included in the MI database. In addition, these lifestyle details also include some lifetime bad habits and certain environmental exposures. Fortunately, the author has none of these lifetime bad habits and an extremely low degree of exposure to environmental factors. The developed MI model has a total of 10 categories covering approximately 500 detailed elements that constitute his defined “metabolism index model” which are the building blocks or root causes for diabetes and other chronic disease-induced complications, including but not limited to CVD, CHD, stroke, CKD, DR, neuropathy, foot ulcer, hypothyroidism, dementia, and various cancers. The end result of the MI development work is a combined MI value within any selected period with 73.5% as its dividing line between a healthy and unhealthy state. The MI serves as the foundation for many of his follow-up medical research work.

During the period from 2015 to 2017, he focused his research on type 2 diabetes (T2D), especially glucose, including FPG, PPG, estimated average glucose (eAG), and hemoglobin A1C (HbA1C). During the following period from 2018 to 2022, he concentrated on researching medical complications resulting from diabetes, chronic diseases, and metabolic disorders which include heart problems, stroke, kidney problems, retinopathy, neuropathy, foot ulcer, diabetic skin fungal infection, hypothyroidism, diabetic constipation, dementia, and various cancers. He also developed a few mathematical risk models to calculate the probability percentages of developing various diabetic complications based on this MI model. From his previous medical research work with 700+ published papers, he has identified and learned that the associated energy of

hyperglycemic conditions is the primary source of causing many diabetic complications which lead to death. Therefore, a thorough knowledge of these energies is important for achieving a better understanding of the dangerous complications.

TD, SD, and FD Analysis Tools

This section has brief descriptions of TD correlation analysis with other observational results, SD VGT analysis with hysteresis loop area's energy results, and FD analysis with frequency curve area's energy results.

First of all, by using a TD analysis tool, we can examine the curves' moving trend and pattern visually along with their correlation numerically. We can also study the extremely high or low data values in the dataset. The visual observation or calculation-derived interpretations are a part of statistical analysis results which can indeed provide some useful hints or even derive some accurate conclusions. However, we must be aware of the limitations of the selected data size and time window and also be cautious of the appropriate statistics tool we choose.

The author would like to describe the essence of his developed “hybridmodel” that combines both the SD viscoelastic/plastic VGT analysis method and FD fast Fourier transform (FFT) analysis method together with a comparison against the traditional time-domain statistical correlation analysis.

It is described in 10 steps in the English language instead of using mathematical equations to explain it. In this article, he has applied both the SD-VGT operations (steps 1-7) and the FD-FFT operations (steps 8-10). As a result, it is aimed at readers who do not have an extensive background in the academic subjects of engineering, physics & mathematics.

The first step is to collect the output data or symptom (strain or ϵ) on a time scale. The second step is to calculate **the output change rate with time ($d\epsilon/dt$)**, i.e. the change rate of strain or symptom over each period. The third step is to gather the input data or cause (**viscosity or η**) on a time scale. The fourth step is to calculate the time-dependent input or cause (**time-dependent stress or σ**) by multiplying $d\epsilon/dt$ and η together. The “time-dependent input or cause equation” of **“stress $\sigma = \text{strain change rate of } d\epsilon/dt * \text{viscosity } \eta$ ”** is the essential part of this “time dependency”. The fifth step is to plot the input-output (i.e. stress-strain or cause-symptom) curve in a two-dimensional space-domain or SD (x-axis versus y-axis) with strain (output or symptom) on the x-axis and stresses (time-dependent inputs, causes, or stresses) on the y-axis.

The sixth step is to calculate the total enclosed area within these stress-strain curves or input-output curves (i.e. the hysteresis loops), which is also an indicator of associated energies (either created energy or dissipated energy) of this input and output dataset. These energy values can also be considered as the degrees of influence on output by inputs. The seventh step is the assembly of the area values of the selected periods to compare the “historical progression and contribution of medical condition” over certain time periods.

For the frequency domain, the eighth step is to define a “hybrid input variable” by using “*strain*stress*” which yields another accurate estimation of the energy ratio similar to the SD-VGT energy ratio associated with the hysteresis loop. The ninth step is to present these hybrid models’ results of (*strain*stress*) in TD then perform the FFT operation to convert them into FD. The enclosed area of the frequency curve (where the x-axis is the frequency and the y-axis is the amplitude of energy) can be used to estimate the total FD-FFT energy. The tenth step is to compare these FD energy results against the SD-VGT energy results, or even TD energy results.

After providing the above 10-step description, the author would still like to use the following set of VGT stress-strain mathematical equations in a two-dimensional SD to address the selected medical variables:

Strain

= ϵ (*time-dependency characteristics of individual strain value at the present time duration*)

Stress

= σ (*based on the change rate of strain multiplying with a chosen viscosity factor η*)

$$= \eta * (d\epsilon/dt)$$

$$= \eta * (d\text{-strain}/d\text{-time})$$

$$= (\text{viscosity factor } \eta \text{ using individual viscosity factor at present time duration}) * (\text{strain at present quarter} - \text{strain at previous time duration})$$

Some of these inputs (causes or viscosity factors) are further normalized by dividing them or being divided by a normalization factor using certain established health standards or medical pieces of knowledge. Some examples of normalization factors are 6.0 for HbA1C, 120 mg/dL for glucose, 25 for body mass index (BMI), 4,000 steps after each meal, 10,000 or 12,000 steps for daily walking exercise depending on time-period selection, 13 grams to 20 grams of carbs/sugar intake amount per meal depends on time-period selection. If using the originally collected data, i.e. the non-normalized data, it would distort the numerical comparison of the hysteresis loop areas. Using this “normalization process”, we can remove the dependency of the individual unit or certain unique characteristics associated with each viscosity factor. This process allows us to convert the originally collected variables into a set of “*dimensionless variables*” for easier numerical comparison and result interpretation.

Results

Figure 1 shows the Himalaya shape, Grand Canyon shape, and Twin Peaks shape (from Google photos). The red outlines indicate the meaning of each waveform.

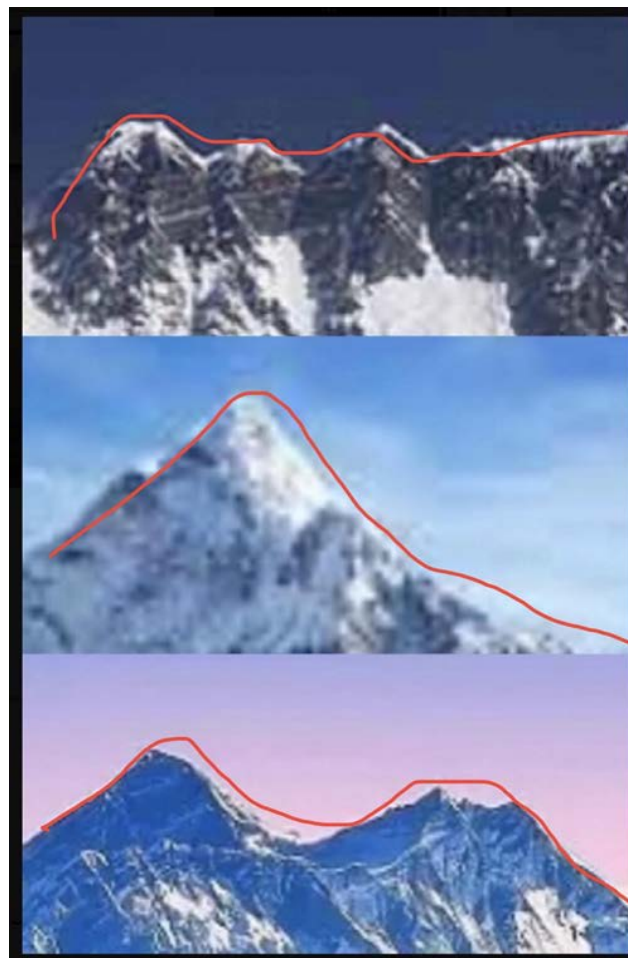


Figure 1: Himalaya shape, Grand Canyon shape, Twin Peaks shape (from Google photos)

Figure 2 depicts both TD analysis of the combined PPG with its 3 PPG sub-waveforms, and two data tables.

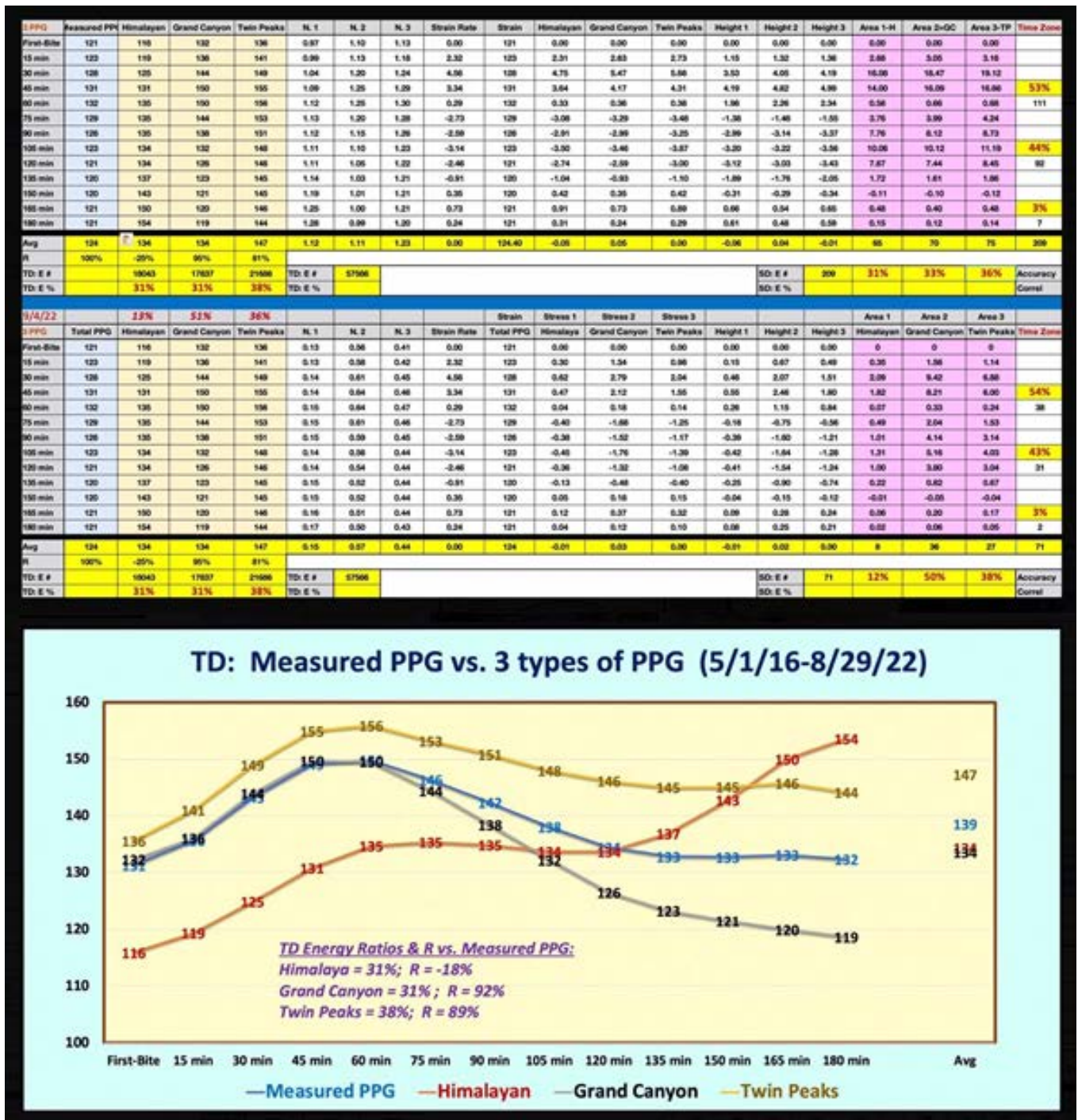


Figure 2: 2 data tables and TD chart with 4 waveforms

Figure 3 displays the SD-VGT analysis results of without meals number case and with meals number case.

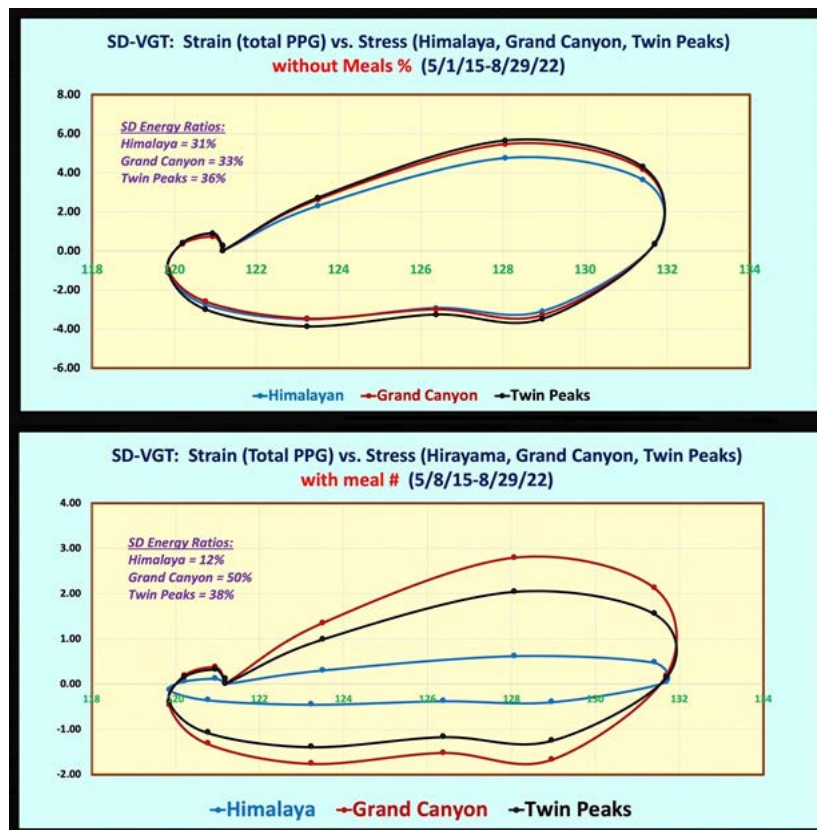


Figure 3: 2 SD-VGT viscoelastic stress-strain diagrams

Figure 4 illustrates the comparison of his combined 3-types of PPG versus two predicted PPG values (both with meals number influence and without meals number influences).

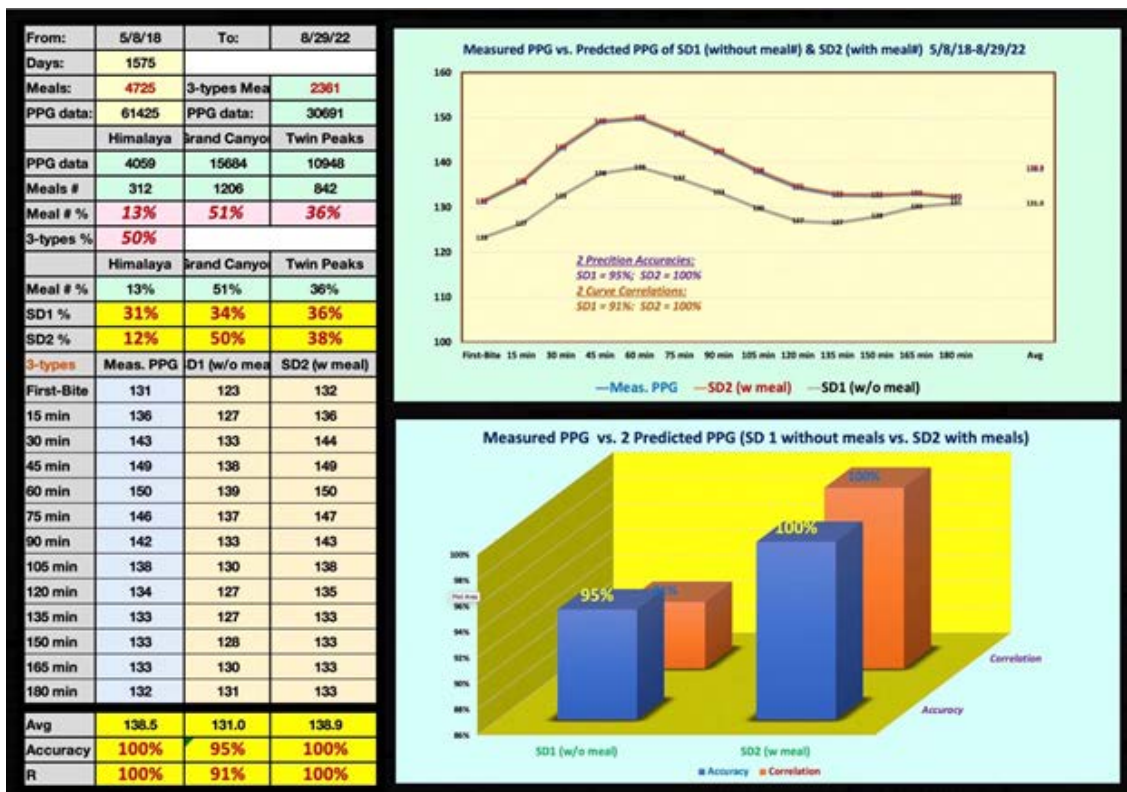


Figure 4: Comparison of combined 3-types PPG versus 2 predicted PPG and the supporting data table

Conclusion

In summary, there are 5 findings from this study on *the output symptom of the combined PPG waveform versus 3 individual and distinctive input waveforms of Himalaya PPG, Grand Canyon PPG, and Twin Peaks PPG.*

(1) From the TD diagram, *the average PPG values are: Combined PPG = 124 mg/dL, Himalaya PPG = 134 mg/dL with lower peak, Grand Canyon PPG = 134 mg/dL with higher peak, Twin Peaks PPG = 147 mg/dL.* The correlations between the total PPG versus Himalaya PPG = -25% (it has a lower meal number but with a different waveform shape), Grand Canyon PPG = 95% (it has the highest meal numbers, so it has a very similar waveform shape as the combined PPG), and Twin Peaks PPG = 81%. In conclusion, both the Grand Canyon PPG and Twin Peaks PPG are close to the combined PPG, while the Himalaya PPG is classified as unhealthy conditions due to lacking post-meal exercise, such as in-flight meals. However, the author has tried to minimize its impact on his PPG by avoiding airline meals or by consuming less amount of carbohydrates and sugar (reducing the total food quantity is an effective approach).

(2) From the TD squared amplitude method, the energy ratios are: Himalaya PPG = 31%, Grand Canyon PPG = 31%, and Twin Peaks PPG = 38%. Here, Twin Peaks have the highest energy ratio which is resulted in their higher average PPG. This demonstrates that insufficient post-meal exercise is also unfavorable for PPG.

(3) From the SD-VGT analysis results *without meals number influence*, the energy ratios are: Himalaya PPG = 31%, Grand Canyon PPG = 33%, and Twin Peaks PPG = 36%. These SD energy ratios are highly similar to TD energy ratios. However, from the SD-VGT analysis results *with the meals number influence*, the energy ratios are: Himalaya PPG = 12%, Grand Canyon PPG = 50%, and Twin Peaks PPG = 38%. These SD energy ratios are extremely different from the TD energy ratios.

(4) From the SD-VGT time-zone energy analysis results *without meals number influence are: 0-60 minutes = 53%, 75-120 minutes = 44%, and 135-180 minutes = 3%.* However, from the SD-

VGT time-zone energy analysis results *with meals number influence are: 0-60 minutes = 54%, 75-120 minutes = 43%, and 135-180 minutes = 3%.* It is evident that for both without and with meals number influences, the combined three PPG energies generated from food during the first hour are 53%-54%; the 3 PPG energies dissipated via exercise during the second hour is 43%-44%, and the left-over energy during the third hour is only 3%. By the way, for both without and with meals number cases, these two stress-strain diagrams with three PPG waveforms have demonstrated a similar "viscoelastic" behavior.

(5) For the predicted PPG using his *combined 3-types PPG of 138.5 mg/dL* and 2 different sets of SD hysteresis loop area percentages in the three normalization factors: (1) for the case of *excluding* meal number influence, the predicted PPG is **131.0 mg/dL** which provides a **lower prediction accuracy of 95% and a lower correlation of 91%**; while (2) for the case of *including* meal number influence, the predicted PPG is **138.9 mg/dL** which provides an **extremely high prediction accuracy of 100% and high correlation of 100%**. These results have proven that the author's enhanced software capability with the meals number count ability has indeed improved the prediction accuracy and curve correlations of his predicted PPG versus the combined 3-types of PPG.

This article has demonstrated the importance of including meal quantity in his normalization process. The research methodology behind this particular study has offered a subtle and deeper understanding of the complicated biophysical behaviors of PPG. In addition, it has further proven the usefulness of math-physical medicine research methodology in biomedical research.

References

For editing purposes, the majority of the references in this paper, which are self-references, have been removed for this article. Only references from other authors' published sources remain. The bibliography of the author's original self-references can be viewed at www.eclairermd.com.

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