Diagnosis of diabetes guidelines

TEST[1]	PREDIABETES	DIABETES	COMMENTS
Random glucose *plus* classic hyperglycemia symptoms or crisis		≥ 200 mg/dL ≥ 11.1 mmol/L	Random glucose: Any time of the day without regard to time since last meal Symptoms: Polyuria, polydipsia, unexplained weight loss
Fasting plasma glucose	Impaired fasting glucose ≥ 100 < 126 mg/dL ≥ 5.6 < 7.0 mmol/L	≥ 126 mg/dL ≥ 7.0 mmol/L	No caloric intake for at least 8 hours
2-hour plasma glucose (during an oral glucose tolerance test)	Impaired glucose tolerance ≥ 140 < 200 mg/dL ≥ 7.8 < 11.1 mmol/ L	≥ 200 mg/dL ≥ 11.1 mmol/L	Using glucose load of 75 g anhydrous glucose dissolved in water
HbA1C	Increased diabetes risk HbA1C 5.7-6.4%	≥ 6.5%	HbA1C should be measured in a NGSP-certified laboratory. The purpose of the NGSP is to standardize HbA1c test results to those of the Diabetes Control and Complications Trial (DCCT) and United Kingdom Prospective Diabetes Study (UKPDS) which established the direct relationships between HbA1c levels and outcome risks in patients with diabetes.

TABLE. 1. Criteria for the Diagnosis of Diabetes

FPG ≥126 mg/dL (7.0 mmol/L). Fasting is defined as no caloric intake for at least 8 h.*

OR

2-h plasma glucose ≥200 mg/dL (11.1 mmol/L) during an OGTT. The test should be performed as described by the World Health Organization, using a glucose load containing the equivalent of 75 g anhydrous glucose dissolved in water.*

OR

A1C ≥6.5% (48 mmol/mol). The test should be performed in a laboratory using a method that is NGSP certified and standardized to the Diabetes Control and Complications Trial assay.*

OR

In a patient with classic symptoms of hyperglycemia or hyperglycemic crisis, a random plasma glucose ≥200 mg/dL (11.1 mmol/L).

**In the absence of unequivocal hyperglycemia, results should be confirmed by repeat testing.*

Any one of the following is diagnostic:

1. Hb A_{1c} ≥6.5% (48 mmol/mol)[b]

OR

2. FPG ≥7.0 mmol/L (126 mg/dL)[c]

OR

3. 2-h Plasma glucose ≥11.1 mmol/L (200 mg/dL) during an OGTT[d]

OR

4. Symptoms of hyperglycemia and casual plasma glucose ≥11.1 mmol/L (200 mg/dL)[e]

[a] In the absence of unequivocal hyperglycemia, these criteria should be confirmed by repeat testing. From the ADA *(378)*.
[b] The test should be performed in a laboratory that is NGSP certified and standardized to the DCCT assay. Point-of-care assays should not be used for diagnosis.
[c] Fasting is defined as no caloric intake for at least 8 h.
[d] The OGTT should be performed as described by the WHO, with a glucose load containing the equivalent of 75 g of anhydrous glucose dissolved in water.
[e] "Casual" is defined as any time of day without regard to time since previous meal. The classic symptoms of hyperglycemia include polyuria, polydipsia, and unexplained weight loss.

Test	*IADPSG criteria (any one of the cut-off values below)*	*ADA criteria (at least two of the cut-off values below)*[a,b]
Fasting glucose (mg/dl [c])	≥92	≥95
1-h glucose (mg/dl [c])	≥180	≥180
2-h glucose (mg/dl [c])	≥153	≥155

Abbreviations: ADA, American Diabetes Association; IADPSG, International Association of Diabetes and Pregnancy Study Groups.
[a] The ADA has recently endorsed the IADPSG criteria.[b]
[b] 75-g OGTT was used in this study, so ADA criteria here referred to criteria for 75-g OGTT.

Figure 1. The recruitment procedures and results of the study. ADA, the American Diabetes Association; GDM, gestational diabetes mellitus; IADPSG, International Association of Diabetes and Pregnancy Study Groups.

Table 2 – American Diabetes Association diagnostic criteria for diabetes[18]

Test[a]	Threshold	Qualifier
Hemoglobin A_{1c} or	≥ 6.5%	Lab NGSP-certified, standardized DCCT assay
Fasting glucose or	≥ 126 mg/dL (7.0 mmol/L)	No caloric intake for at least 8 hours
2-hour glucose or	≥ 200 mg/dL (11.1 mmol/L)	After 75 g of anhydrous glucose
Random glucose	≥ 200 mg/dL (11.1 mmol/L)	Plus classic hyperglycemia symptoms or crisis

NGSP, National Glycohemoglobin Standardization Program; DCCT, Diabetes Control and Complications Trial.
[a] Results must be confirmed by repeated testing.

Guidelines in the diagnosis of diabetes mellitus in the philippines. Latest guidelines for diagnosis of diabetes. Acog guidelines for diagnosis of gestational diabetes. Who guidelines for diagnosis of gestational diabetes. Ada guidelines diagnosis of diabetes. Philippine practice guidelines for the diagnosis and management of diabetes. Nice guidelines for diagnosis of diabetes. What are the nice guidelines for healthcare professionals on the diagnosis of diabetes.

There are several ways to diagnose diabetes. Each way usually needs to be repeated on a second day to diagnose diabetes. Testing should be carried out in a health care setting (such as your doctor's office or a lab). If your doctor determines that your blood glucose (blood sugar) level is very high, or if you have classic symptoms of high blood glucose in addition to one positive test, your doctor may not require a second test to diagnose diabetes. A1C The A1C test measures your average blood glucose for the past two to three months. The advantages of being diagnosed this way are that you don't have to fast or drink anything. Diabetes is diagnosed at an A1C of greater than or equal to 6.5% Result A1C Normal less than 5.7% Prediabetes 5.7% to 6.4% Diabetes 6.5% or higher Fasting Plasma Glucose (FPG) This test checks your fasting blood glucose levels. Fasting means after not having anything to eat or drink (except water) for at least 8 hours before the test. This test is usually done first thing in the morning, before breakfast. Diabetes is diagnosed at fasting blood glucose of greater than or equal to 126 mg/dl Result Fasting Plasma Glucose (FPG) Normal less than 100 mg/dl Prediabetes 100 mg/dl to 125 mg/dl Diabetes 126 mg/dl or higher Oral Glucose Tolerance Test (OGTT) The OGTT is a two-hour test that checks your blood glucose levels before and two hours after you drink a special sweet drink. It tells the doctor how your body processes sugar. Diabetes is diagnosed at two-hour blood glucose of greater than or equal to 200 mg/dl Result Oral Glucose Tolerance Test (OGTT) Normal less than 140 mg/dl Prediabetes 140 to 199 mg/dl Diabetes 200 mg/dl or higher Random (also called Casual) Plasma Glucose Test This test is a blood check at any time of the day when you have severe diabetes symptoms. Diabetes is diagnosed at blood glucose of greater than or equal to 200 mg/dl What is Prediabetes? Before people develop type 2 diabetes, they almost always have prediabetes—blood glucose levels that are higher than normal but not yet high enough to be diagnosed as diabetes. Doctors sometimes refer to prediabetes as impaired glucose tolerance (IGT) or impaired fasting glucose (IFG), depending on what test was used when it was detected. This condition puts you at a higher risk for developing type 2 diabetes and cardiovascular disease. Symptoms There are no clear symptoms of prediabetes, so you may have it and not know it. Some people with prediabetes may have some of the symptoms of diabetes or even problems from diabetes already. You usually find out that you have prediabetes when being tested for diabetes. If you have prediabetes, you should be checked for type 2 diabetes every one to two years. Results indicating prediabetes are: An A1C of 5.7–6.4% Fasting blood glucose of 100–125 mg/dl An OGTT two-hour blood glucose of 140–199 mg/dl Preventing Type 2 Diabetes You will not develop type 2 diabetes automatically if you have prediabetes. For some people with prediabetes, early treatment can actually return blood glucose levels to the normal range. Research shows that you can lower your risk for type 2 diabetes by 58% by: Don't worry if you can't get to your ideal body weight. Losing even 10 to 15 pounds can make a huge difference. 1. Zimmet P, Alberti KGM, Shaw J. Nature. 2001;414:782–7. [PubMed] [Google Scholar]2. Dunstan DW, Zimmet PZ, Welborn TA, et al. The rising prevalence of diabetes mellitus and impaired glucose tolerance: the Australian diabetes, obesity and lifestyle study. Diabetes Care. 2002;25:829–834. [PubMed] [Google Scholar]3. McCance DR, Hanson RI, Charles M-A, et al. 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[Google Scholar]18. WHO Consultation: Definition, Diagnosis and Classification of Diabetes Mellitus and its Complications: Report of a WHO Consultation. Part I: Diagnosis and Classification of Diabetes Mellitus. WHO/NCD/NCS/99.2, World Health Organisation, Geneva, 1999.Page 2PMC full text:Clin Biochem Rev. 2003 Aug; 24(3): 77–80. ISSN 0159 – 8090 Position Statement from the Australian Diabetes Society*, New Zealand Society for the Study of Diabetes†, Royal College of Pathologists of Australasia‡ and Australasian Association of Clinical Biochemists§.Peter G Colman*, David W Thomas‡, Paul Z Zimmet*, Timothy A Welborn*, Peter Garcia-Webb§ and M Peter Moore†.First published in the Medical Journal of Australia (MJA 1999, 170: 375-378). Reprinted with permission.IntroductionRecently, there has been major growth in knowledge about the aetiology and pathogenesis of different types of diabetes and about the predictive value of different blood glucose levels for development of complications. In response, both the American Diabetes Association (ADA) and the World Health Organization (WHO) have re-examined, redefined and updated the classification of and criteria for diabetes, which have been unchanged since 1985. While the two working parties had cross-representation, they met separately, and differences have emerged between their recommendations.The ADA published its final recommendations in 19971, while the WHO group published its provisional conclusions for consultation and comment in June 19982.The WHO process called for comments on the proposal by the end of September 1998, with the intention of finalising definitive classification and criteria by the end of December 1998 and of publishing these soon thereafter. However, WHO publications need to go through an internal approval process and it may be up to 12 months before the final WHO document appears.A combined working party of the Australian Diabetes Society, New Zealand Society for the Study of Diabetes, Royal College of Pathologists of Australasia and Australasian Association of Clinical Biochemists was formed to formulate an Australasian position on the two sets of recommendations and, in particular, on the differences between them. This is an interim statement pending the final WHO report, which will include recommendations on diabetes classification as well as criteria for diagnosis. We see it as very important to inform Australasian health professionals treating patients with diabetes about these changes.Diagnosis of diabetes is not in doubt when there are classical symptoms of thirst and polyuria and a random venous plasma glucose level ≥ 11.1 mmol/L.The Australasian Working Party on Diagnostic Criteria for Diabetes Mellitus recommends:immediate adoption of the new criterion for diagnosis of diabetes as proposed by the ADA and the WHO – fasting venous plasma glucose level ≥ 7.0 mmol/Limmediate adoption of the new classification for diabetes mellitus proposed by the ADA and WHO, which comprises four aetiological types – type 1, type 2, other specific types, and gestational diabetes – with impaired glucose tolerance and impaired fasting glycaemia as stages in the natural history of disordered carbohydrate metabolismawareness that some cases of diabetes will be missed unless an oral glucose tolerance test (OGTT) is performed. If there is any suspicion or other risk factor suggesting glucose intolerance, the OGTT should continue to be used pending the final WHO recommendation.What are the new diagnostic criteria?The new WHO criteria for diagnosis of diabetes mellitus and hyperglycaemia are shown in Box 1. The major change from the previous WHO recommendation3 is the lowering of the diagnostic level of fasting plasma glucose to ≥7.0 mmol/L, from the former level of ≥7.8 mmol/L. For whole blood, the proposed new level is ≥6.1 mmol/L, from the former ≥6.7 mmol/L.This change is based primarily on cross-sectional studies demonstrating the presence of microvascular4 and macrovascular complications at these lower glucose concentrations. In addition, the 1985 WHO diagnostic criterion for diabetes based on fasting plasma glucose level (≥7.8 mmol/L) represents a greater degree of hyperglycaemia than the criterion based on plasma glucose level two hours after a 75g glucose load (≥11.1 mmol/L)6. A fasting plasma glucose level of ≥7 mmol/L accords more closely with this 2 h post-glucose level.Recommendation: The ADA and the WHO committee are unanimous in adopting the changed diagnostic level, and the Australasian Working Party on Diagnostic Criteria recommends that healthcare providers in Australia and New Zealand should adopt it immediately.Clinicians should note that the diagnostic criteria differ between clinical and epidemiological settings. In clinical practice, when symptoms are typical of diabetes, a single fasting plasma glucose level of ≥7.0 mmol/L or 2 h postglucose or casual postprandial plasma glucose level of ≥11.1 mmol/L suffices for diagnosis. If there are no symptoms, or symptoms are equivocal, at least one additional glucose measurement (preferably fasting) on a different day with a value in the diabetic range is necessary to confirm the diagnosis. Furthermore, severe hyperglycaemia detected under conditions of acute infective, traumatic, circulatory or other stress may be transitory and should not be regarded as diagnostic of diabetes. The situation should be reviewed when the primary condition has stabilised.In epidemiological settings, for study of high-prevalence populations or selective screening of high-risk individuals, a single measure – the glucose-level 2 h post glucose load – will suffice to describe prevalence of impaired glucose tolerance (IGT).Box 1: Values for diagnosis of diabetes mellitus and other categories of hyperglycaemia2 Glucose concentration (mmol/L (mg/dL)) Whole bloodPlasmaVenousCapillaryVenousCapillaryDiabetes mellitus fasting≥6.1 (≥110)≥5.1 (≥110)≥7.0 (≥126)≥7.0 (≥126)or 2 h post-glucose load≥10.0 (≥180)≥11.1 (≥200)≥11.1 (≥200)≥12.2 (≥220)or bothImpaired glucose tolerance (IGT)Fasting (if measured) and 2 h post-glucose load)

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