Diagnosis of Type 2 Diabetes
# Diagnostic Criteria for Prediabetes and Diabetes in Nonpregnant Adults

<table>
<thead>
<tr>
<th>Normal</th>
<th>High Risk for Diabetes</th>
<th>Diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>FPG &lt;100 mg/dL</td>
<td>IFG FPG ≥100-125 mg/dL</td>
<td>FPG ≥126 mg/dL</td>
</tr>
<tr>
<td>2-h PG &lt;140 mg/dL</td>
<td>IGT 2-h PG ≥140-199 mg/dL</td>
<td>2-h PG ≥200 mg/dL Random PG ≥200 mg/dL + symptoms*</td>
</tr>
<tr>
<td>A1C &lt;5.5%</td>
<td>5.5 to 6.4% For screening of prediabetes†</td>
<td>≥6.5% Secondary‡</td>
</tr>
</tbody>
</table>

*Polydipsia (frequent thirst), polyuria (frequent urination), polyphagia (extreme hunger), blurred vision, weakness, unexplained weight loss.

†A1C should be used only for screening prediabetes. The diagnosis of prediabetes, which may manifest as either IFG or IGT, should be confirmed with glucose testing.

‡Glucose criteria are preferred for the diagnosis of DM. In all cases, the diagnosis should be confirmed on a separate day by repeating the glucose or A1C testing. When A1C is used for diagnosis, follow-up glucose testing should be done when possible to help manage DM.

FPG, fasting plasma glucose; IFG, impaired fasting glucose; IGT, impaired glucose tolerance; PG, plasma glucose.

AACE Recommendations for A1C Testing

- A1C should be considered an additional optional diagnostic criterion, not the primary criterion for diagnosis of diabetes
- When feasible, AACE/ACE suggest using traditional glucose criteria for diagnosis of diabetes
- A1C is not recommended for diagnosing type 1 diabetes
- A1C is not recommended for diagnosing gestational diabetes
AACE Recommendations for A1C Testing

• A1C levels may be misleading in several ethnic populations (for example, African Americans)
• A1C may be misleading in some clinical settings
  – Hemoglobinopathies
  – Iron deficiency
  – Hemolytic anemias
  – Thalassemias
  – Spherocytosis
  – Severe hepatic or renal disease
• AACE/ACE endorse the use of only standardized, validated assays for A1C testing