Table 1. Rules of thumb for interpreting C-peptide results (adapted from Exeter Clinical Laboratory International, 2026).

Threshold			
Fasting blood C-peptide (pmol/L)	**Stimulated blood C-peptide (pmol/L)**	**UCPCR (nmol/mmol)**	**Interpretation**
<80	<200	<0.2	**Severe insulin deficiency** • Expected in longstanding type 1 diabetes (>3–5 years, depending on age of onset) • Associated with an absolute requirement for insulin, high glycaemic variability and high hypoglycaemia risk • Manage as type 1 diabetes • MODY unlikely • Patients with neonatal monogenic diabetes (onset in the first 6 months of life) may have C-peptide in this range but may not require insulin if treated with sulfonylureas
≥80 to <250	≥200 to <600	≥0.2 to <0.6	**Intermediate insulin secretion** • MODY should be considered where a person with young-onset "type 1" diabetes has C-peptide in this range >3 years from diagnosis • <3% of adolescent-onset and <6% of adult-onset type 1 diabetes will have persisting C-peptide in this range after 5 years from diagnosis • Most people with type 2 diabetes will have a C-peptide above this range
≥250	≥600	≥0.6	**Substantial endogenous insulin secretion** • Associated with type 2 diabetes and MODY and no absolute requirement for insulin • May occur in type 1 diabetes in the honeymoon period, particularly if the person is obese • If >3–5 years from diagnosis, type 1 diabetes is unlikely – consider alternative diagnoses

MODY=maturity-onset diabetes of the young; UCPCR=C-peptide-to-creatinine ratio.