Effect of blood sampling schedule and method of calculating the area under the curve on validity and precision of glycaemic index values

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To evaluate the suitability for glycaemic index (GI) calculations of using blood sampling schedules and methods of calculating area under the curve (AUC) different from those recommended, the GI values of five foods were determined by recommended methods (capillary blood glucose measured seven times over 2·0 h) in forty-seven normal subjects and different calculations performed on the same data set. The AUC was calculated in four ways: incremental AUC (iAUC; recommended method), iAUC above the minimum blood glucose value (AUCmin), net AUC (netAUC) and iAUC including area only before the glycaemic response curve cuts the baseline (AUCcut). In addition, iAUC was calculated using four different sets of less than seven blood samples. GI values were derived using each AUC calculation. The mean GI values of the foods varied significantly according to the method of calculating GI. The standard deviation of GI values calculated using iAUC (20·4), was lower than six of the seven other methods, and significantly less (P<0·05) than that using netAUC (24·0). To be a valid index of food glycaemic response independent of subject characteristics, GI values in subjects should not be related to their AUC after oral glucose. However, calculating GI using AUCmin or less than seven blood samples resulted in significant (P<0·05) relationships between GI and mean AUC. It is concluded that, in subjects without diabetes, the recommended blood sampling schedule and method of AUC calculation yields more valid and/or more precise GI values than the seven other methods tested here. The only method whose results agreed reasonably well with the recommended method (ie. within ±5 %) was AUCcut.

Glycaemic index: Blood glucose response: Methodology: Dietary carbohydrate

The glycaemic index (GI) is a classification of carbohydrate foods based on their acute blood glucose responses; it should not be used without also considering information about the chemical composition of foods (Jenkins et al. 1981). The GI has been recommended to help guide food choice (Food and Agriculture Organization, 1998), because low-GI foods have been shown to improve blood glucose control in people with diabetes (Brand-Miller et al. 2003), to increase insulin sensitivity (Frost et al. 1998) and β-cell function (Wolever & Mehling, 2002), and to reduce serum triacylglycerol (Jenkins et al. 1987). In addition, a low-GI diet has been associated with reduced risk for developing diabetes and CVD in some studies (Salmeron et al. 1997a,b; Liu et al. 2000), but not all (Meyer et al. 2000; Van Dam et al. 2000). Widespread use of the GI, as recommended, requires a standardized method for determining the GI of foods that is valid and precise.

The GI is defined as the incremental area under the blood glucose response curve (AUC) after consumption of a 50 g available-carbohydrate portion of a food expressed as a percentage of that after 50 g oral glucose.

For subjects without diabetes, the Food and Agriculture Organization (1998) recommends determining GI by collecting seven blood samples over 2 h and calculating incremental AUC (iAUC; Jenkins et al. 1981; Wolever & Jenkins, 1986). Shorter tests and less frequent blood sampling would reduce costs; other methods of calculating AUC have been used (Wolever, 1989; Ha et al. 1992), but the effect of these variables on the GI is not known. Thus, the purpose of the present paper was to compare the suitability for GI calculations of using different blood sampling schedules and other ways of calculating AUC than those recommended by the Food and Agriculture Organization (1998).

Methods

Data from a multicentre trial were used, the methods and results of which have been published by Wolever et al. (2003). The GI values of five foods were determined in subjects without diabetes in seven centres using the method recommended by the Food and Agriculture Organization (1998). Results from the five centres that measured
glucose in whole blood or plasma obtained from capillary blood samples were used in this analysis. Results from the two centres that measured glucose in venous plasma were not used because of higher variability of glycaemic responses and GI values (Wolever et al. 2003). In brief, subjects without diabetes (twenty-three male, twenty-four female; age 28.9 (SEM 1.2) (range 19–50) years, BMI 23.3 (SEM 0.5) (range 16.8–35.0) kg/m²) were studied on eight occasions in the morning after a 10–14 h overnight fast. On each occasion, after a fasting blood sample was obtained, subjects consumed a test meal containing 50 g available carbohydrate (defined as total carbohydrate minus dietary fibre), with further blood samples being taken 15, 30, 45, 60, 90 and 120 min after starting to eat. On three occasions (first, middle and last trials), subjects consumed 50 g anhydrous glucose. On the other occasions subjects consumed instant potato, white bread, polished rice, white spaghetti or pearled barley in randomized order. The AUC was calculated for each trial and the AUC after consuming each food was expressed as a percentage of the average AUC after oral glucose taken by the same subject. The average of these values for each food was the GI of the food.

For this analysis, eight different calculations were performed on the same data set and the results compared. Table 1 shows the results of AUC calculations using the different methods on real sets of blood glucose profiles from one subject. The recommended calculation used all seven blood samples with iAUC being calculated. The iAUC includes all area below the curve and above the fasting concentration, with any area beneath fasting being ignored (Wolever & Jenkins, 1986). The iAUC was also calculated on four different combinations of four, five or six blood samples representing a shorter test period, less frequent blood sampling or both. Net incremental AUC (netAUC) (Gannon et al. 1989) includes all incremental area below the curve, including the area below the fasting concentration. Since it is calculated by applying the trapezoid rule to both positive and negative blood glucose increments, the effect is to subtract the area below the fasting level from that above. AUCcut (Hu et al. 1992) is calculated in the same way as iAUC, but only includes the area before the blood glucose concentration drops below (cuts) the baseline (fasting concentration); the area after the glucose concentration cuts the baseline is not included. The iAUC above the lowest blood glucose concentration attained (AUCmin) (Vorster et al. 1990) is calculated by subtracting the lowest blood glucose concentration attained during the test period from each of the other blood glucose concentrations, and calculating the AUC by applying the trapezoid rule to the resulting increments.

There is no easy way to measure the validity of different methods of calculating the GI. The approach taken here was to determine the correlation between the mean GI (average GI of the five foods) and the mean AUC after oral glucose (average of three trials) for the forty-seven subjects. The rationale for this approach is that the GI is intended to indicate the blood-glucose-raising potential of foods independent of the glycaemic response of the subject. Thus, for valid methods of calculating GI, there should be no correlation between the GI values obtained and the AUC after oral glucose. The presence of a significant correlation between GI and AUC would indicate that the method was not valid, because the GI values obtained depended on the glucose tolerance status of the subject.

The standard deviation of the mean GI values is a measure of precision, which is the degree of variation of values about their mean value. Since the standard deviation

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**Table 1. Sample calculations (using the same data from one subject for each method)**

<table>
<thead>
<tr>
<th>Method</th>
<th>Glucose</th>
<th>Food</th>
<th>AUC1</th>
<th>AUC2</th>
<th>AUC3</th>
<th>AUC4</th>
<th>netAUC</th>
<th>AUCcut</th>
<th>AUCmin</th>
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</thead>
<tbody>
<tr>
<td>Time (min)…</td>
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<td>15</td>
<td>30</td>
<td>45</td>
<td>60</td>
<td>90</td>
<td>120</td>
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<td>GI</td>
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<tr>
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<td>6·11</td>
<td>6·06</td>
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<td>3·17</td>
<td>3·61</td>
<td>4·00</td>
<td>85·8</td>
<td>41</td>
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</tr>
<tr>
<td>3·94</td>
<td>5·00</td>
<td>5·11</td>
<td>3·44</td>
<td>3·50</td>
<td>3·83</td>
<td>4·33</td>
<td>35·4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3·94</td>
<td>5·11</td>
<td>3·44</td>
<td>3·50</td>
<td>3·83</td>
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<td>6·06</td>
<td>4·44</td>
<td>3·17</td>
<td>3·61</td>
<td>–</td>
<td>81·7</td>
<td></td>
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<tr>
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<td>3·50</td>
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<td>3·17</td>
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<td>4·00</td>
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<td>3·94</td>
<td>5·00</td>
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<td>4·33</td>
<td>78·6</td>
<td>58</td>
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</tbody>
</table>

AUC, area under the curve; GI, glycaemic index; iAUC, incremental area under the curve; AUC1, incremental area under the curve using 0, 15, 30, 45, 60 min glucose values; AUC2, incremental area under the curve using 0, 15, 30, 45 and 60 min glucose values; AUC3, incremental area under the curve using 0, 30, 60 and 120 min glucose values; AUC4, incremental area under the curve using 0, 30, 60, 90 and 120 min glucose values; netAUC, incremental area under the curve; AUCcut, incremental area under the curve up to first cut of baseline; AUCmin, incremental area under the curve above minimum glucose.

* For details of procedures and calculations, see pp. 296–297.
† Recommended method (Food and Agriculture Organization, 1998).
of the GI is largely determined by within-subject variation (Wolever, 1992), the CV (CV = 100 × sd/mean value) of the AUC after the repeated trials of oral glucose was calculated.

The mean GI values for each of the five foods from each of the five centres calculated using each of the different methods were compared with those calculated using the recommended method using the Bland & Altman (1986) procedure. They defined the ‘limits of agreement’ as being the mean value ±1.96 × sd of the differences between the results from two methods, representing, therefore, the range within which 95 % of the differences between the methods would be expected to fall. In the present study, the analysis involved comparison of twenty-five values (five foods and five centres) for each method vs. the recommended method. Using the recommended method, foods were classified as high (>69), medium (56–69) or low (<56) GI (Brand-Miller et al. 2002), and the number of misclassifications for each alternate method was calculated.

Unless otherwise indicated, results are expressed as mean values with their standard errors. The mean values, standard deviations and CV of the AUC values after the repeated trials of oral glucose taken by each subject were subjected to repeated-measures ANOVA examining for differences between subjects and methods of calculating AUC. Mean values and standard deviations of the GI values were subjected to ANOVA for the main effects of food, method of calculating AUC (method), subject, and the food × method interaction. If significant effects were found by ANOVA, the significance of differences between individual mean values was determined using the Newman–Keuls method to adjust for multiple comparisons (Snedecor & Cochran, 1980). Pearson’s correlation coefficients between AUC and GI were calculated by the method of least squares (Lotus 123, 1997 edition; Lotus Development Corp., Cambridge, MA, USA). Effects were considered to be statistically significant if two-tailed P<0.05.

Results

The mean blood glucose responses after oral glucose and the five foods are shown in Fig. 1. The different methods of calculating iAUC yielded significantly different mean values. After oral glucose (Table 2), AUCmin was significantly greater (P<0.05) than iAUC and AUCcut, which in turn were significantly greater (P<0.05) than AUC1 and AUC4, which in turn were significantly greater (P<0.05) than AUC2. Mean values for netAUC and AUC3 were intermediate between iAUC and AUC1. Statistical analysis of the GI values after the five foods revealed significant main effects of food (F4,28 240·9, P<0.001) and method of AUC calculation (F7,179 26·5, P<0.001), and a significant food × method interaction (F28,1794 1·87, P=0.003). The significant food × method interaction indicates that the difference in AUC between foods differed significantly depending on the method of calculating AUC. The greatest AUC after the five foods was obtained with AUCmin and the smallest with AUC2, with the others being intermediate (Table 3).

The degree of within-subject variation, assessed by standard deviations and CV of the repeated glucose trials, varied significantly by method of AUC calculation (Table 2). The largest CV was obtained with netAUC (28·0 %) and the smallest with AUC2 (20·7 %) and AUCmin (20·5 %), with the CV of iAUC, the recommended AUC calculation method, being intermediate (23·4 %).

Statistical analysis of the GI values calculated using the different AUC methods revealed significant main effects of food (F4,28 649·9, P<0.001) and method of AUC calculation (F7,179 8·6, P<0.001), but the food × method interaction was not significant (F28,1794 0·86, P=0·68). When individual mean values were compared, mean GI calculated using AUCmin, 57·2, was significantly less than that calculated using the other methods (61·4–66·4), which in turn, did not differ significantly from each other (Table 3). The method of calculating AUC significantly

![Fig. 1. Blood glucose concentrations of forty-seven subjects after consuming 50g available carbohydrate from glucose (●), instant potato (□), white bread (▲), polished rice (▲), white spaghetti (▲) and pearled barley (■). Values are means. For details of subjects and procedures, see pp. 296–297.](https://www.cambridge.org/core/core/terms)

Table 2. Areas under the curves calculated by different methods after repeated trials of oral glucose in forty-seven subjects* (Mean values, standard deviations and coefficients of variation)

<table>
<thead>
<tr>
<th>Method</th>
<th>Mean (mmol × min/l)</th>
<th>SD (mmol × min/l)</th>
<th>CV (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>IAUC†</td>
<td>196±11</td>
<td>45·2±4</td>
<td>23·4±2</td>
</tr>
<tr>
<td>AUC1</td>
<td>179±9</td>
<td>39·4±3</td>
<td>22·4±2</td>
</tr>
<tr>
<td>AUC2</td>
<td>138±6</td>
<td>26·8±2</td>
<td>20·7±2</td>
</tr>
<tr>
<td>AUC3</td>
<td>187±11</td>
<td>47·4±4</td>
<td>26·1±2</td>
</tr>
<tr>
<td>AUC4</td>
<td>177±9</td>
<td>41·9±3</td>
<td>25·3±2</td>
</tr>
<tr>
<td>netAUC</td>
<td>184±11</td>
<td>49·6±4</td>
<td>25·9±2</td>
</tr>
<tr>
<td>AUCcut</td>
<td>195±11</td>
<td>46·4±4</td>
<td>24·3±2</td>
</tr>
<tr>
<td>AUCmin</td>
<td>258±12</td>
<td>52·1±5</td>
<td>20·5±2</td>
</tr>
<tr>
<td>P†</td>
<td>&lt;0·001</td>
<td>&lt;0·001</td>
<td>&lt;0·001</td>
</tr>
</tbody>
</table>

IAUC, incremental area under the curve; AUC1, IAUC using 0, 15, 30, 45, 60 and 90 min glucose values; AUC2, IAUC using 0, 15, 30, 45 and 60 min glucose values; AUC3, IAUC using 0, 30, 60, 90 and 120 min glucose values; AUC4, IAUC using 0, 30, 45 and 90 min glucose values; netAUC, net incremental area under the curve; AUCmin, incremental AUC above minimum glucose.

abcMean values with unlike superscript letters were significantly different (P<0.05).

†Recommended method (Food and Agriculture Organization, 1998).
‡Significance of main effect of method of calculation from ANOVA.

For details of procedures and calculations, see pp. 296–297.
affected not only the mean GI values, but also the standard deviation of the GI values ($F_{7,28}=3.13, P=0.014$; Table 3). The mean standard deviation obtained using AUC1, 20.3, was significantly less ($P<0.05$) than that using netAUC (24.0). The recommended method of calculating AUC, iAUC, had the second lowest mean standard deviation (20.4). Although by the primary statistical analysis mean standard deviation of GI values obtained using AUCcut (21.2), did not differ significantly from that using iAUC, the standard deviation of the GI value for each of the five foods was greater with AUCcut than iAUC, a difference which, though small, was significant by paired $t$ test (0.82 (sd 0.17), $P<0.01$).

The correlation between AUC and GI was statistically significant for AUC2 ($r=0.306, P<0.001$), AUC3 ($r=0.308, P=0.035$) and AUCmin ($r=-0.430, P=0.003$), with those for AUC and AUC3, $-0.23$ and $-0.21$ respectively approaching significance ($P=0.12$ and $P=0.16$ respectively). The correlations between AUC and GI were not statistically significant for iAUC ($r=-0.139, P=0.35$), netAUC ($r=0.140, P=0.35$) and AUCcut ($r=-0.112, P=0.45$).

The limits of agreement between each method and the recommended method expressed in absolute terms (with % mean GI value calculated using the recommended method in parentheses) were as follows: AUC1 7.0% (11.2), AUC2 13.5% (21.4), AUC3 6.6% (10.5), AUC4 7.6% (12.1), netAUC 8.9% (14.2), AUCmin 13.0% (20.7), AUCcut 3.3% (5.1). The limits of agreement for the different methods were directly correlated ($r=0.966, P<0.001$) with the number of foods misclassified using the different methods ($n$): AUC1 2 (8%), AUC4 16 (16%), AUC2 2 (8%), AUC2 2 (8%), netAUC 3 (12%), AUCmin 7 (28%), AUCcut 2 (8%).

**Discussion**

The present results suggest that the method recommended by the Food and Agriculture Organization (1998), based on taking seven blood samples over 2.0 h and calculating iAUC, is the best method for calculating GI of those foods tested here. Other methods resulted in GI values that either were correlated with the glucose tolerance status of the different subjects or were more variable than the recommended method. Most of the methods yielded GI values that did not agree well with the recommended method, with limits of agreement ranging from $±10.5$ to $±21.4$. Only one of the alternative methods, AUCcut, yielded mean GI values 95% of which were within $±5$% of the recommended method.

There is no universally ‘right’ or ‘wrong’ way to measure blood glucose responses. Different methods are required for different purposes. For example, to determine whether a new treatment for diabetes reduces blood glucose concentrations, total AUC may be preferred over iAUC, since the former is a measure of the average blood glucose concentration over time, whereas the latter is a measure of change over time. Calculating netAUC may be more appropriate for measuring postprandial responses of variables such as NEFA, whose concentrations normally fall after eating. This is because netAUC can have a negative value, whereas the minimum value of iAUC is 0.

The GI is intended to be an index of the relative blood-glucose-raising potential of the available carbohydrate in different foods. For this concept to be valid and useful, the GI value of the same food must be the same in different subjects. Glycaemic responses vary from day-to-day within subjects, and also vary between subjects. To distinguish
between these sources of variation, repeated trials of both
the reference and test food must be performed. When
blood glucose response trials of two test foods and one
reference food were repeated four times in each of
twelve heterogeneous subjects with diabetes, there was
no significant difference in GI between subjects, despite
4-fold variation in mean iAUC values between subjects
(Wolever et al. 1990). This is consistent with the present
results showing no significant correlation between iAUC
and GI. The GI is a ratio of two independently variable
values, and the statistical problems associated with the
use of ratios have been described by Allison et al.
(1995). The presence of a significant correlation between
a ratio and its denominator indicates that the ratio does
not adequately control for the denominator (Allison et al.
1995). Thus, methods of AUC calculation resulting in a
significant correlation between GI and AUC cannot be con-
sidered valid for determining the GI of foods.

Ha et al. (1992) studied the glycaemic responses elicited
by three different fruits taken by a group of fifteen subjects
with impaired glucose tolerance or diabetes and compared
the results after calculating the AUC in six different ways.
They concluded that iAUC and AUCcut were more appro-
priate than netAUC, because netAUC resulted in larger
standard deviations, and also that less frequent blood
sampling increased the standard deviation of glycaemic
responses. The results of Ha et al. (1992) cannot be com-
pared exactly with the present results because the standard
deviations calculated by Ha et al. (1992) included both
within- and between-subject variation, and no results for
GI were presented. Nevertheless, the present results also
show that calculating netAUC, and reducing the frequency
of blood sampling, tended to result not only in higher
within-subject variation of glycaemic responses than
other methods, but also higher standard deviations of the
GI values.

AUC methods iAUC, AUC1 and AUC2 represent the
same frequency of blood sampling, but a shorter test
period; 2:0 h for iAUC, 1:5 h for AUC1 and 1:0 h for
AUC2. It is of interest that as the time over which blood
glucose was measured decreased, within-subject variation
tended to decrease from 23·4 % for 2·0 h to 20·7 % for
1·0 h (Table 2). This suggests that, in normal subjects,
blood glucose concentrations during the second postpran-
dial hour are more variable within-subjects from day-to-
day than those during the first hour. Although reducing
within-subject variation is desirable for the most precise
GI results, reducing the time over which blood samples
were taken was also associated with a progressively
higher correlation between GI and AUC, a factor that
tends to make the GI values invalid.

It is not possible to say from the present results what
would happen to GI values if the test was carried out for
more than 2·0 h. Using tests conducted over 5 h in
showed that the AUC value and the relative glucose area
of foods could be markedly affected by the time over
which the test was done. As the time of blood sampling
increased from 1 to 5 h, AUC values after oral glucose
dehydrated by >50 %, relative glucose area values for
legumes increased by approximately 100 %, relative

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