OwieClear Type 2 Diabetes Page Accuracy Review

Page: https://owieclear.com/conditions/type-2-diabetes/
Reviewed: November 17, 2026

Overall assessment

This page is **directionally accurate but thin** for such a major condition. Insulin resistance, A1C ≥6.5% for diagnosis, asymptomatic onset, classic osmotic symptoms, metformin/GLP-1/SGLT2 framing, lifestyle, and organ checks are correct. It needs more depth on complications, targets, hypoglycemia, and modern cardiorenal-protective therapy to match stronger chronic-disease pages on the site.

What's currently listed

Common signs

• Often no symptoms at first · Very thirsty and peeing a lot · Tiredness

Less common

• Blurry vision · Slow-healing cuts · Tingling or numb feet · Dark, velvety skin in body folds (acanthosis nigricans)

Accuracy of the "Less common" section

Item	Verdict	Notes
Blurry vision	Acceptable	Common with hyperglycemia; can improve when glucose improves
Slow-healing cuts	Acceptable	Reflects vascular/immune effects
Neuropathy symptoms	Acceptable as less early	More a complication of longer-standing disease
Acanthosis nigricans	Good inclusion	Marker of insulin resistance; useful clinical clue

Strengths

• Most common form (~9 in 10) — correct
• A1C ≥6.5% diagnostic threshold stated
• Often asymptomatic at onset — accurate and important
• Polyuria/polydipsia and fatigue as lead symptoms — correct
• Metformin + GLP-1 / SGLT2 named, with heart/kidney benefit note — modern and appropriate
• Lifestyle (activity, diet, weight) and remission possibility mentioned
• Screening risk groups including prior gestational diabetes
• Yearly eye and kidney checks; daily foot care — right prevention habits
• Visit questions include A1C target and GLP-1/SGLT2 suitability — excellent

Major gaps / suggested improvements

1. Complications section missing

No dedicated complications list. Should include: heart disease and stroke, chronic kidney disease, retinopathy (vision loss), neuropathy, foot ulcers/amputation risk, and fatty liver. These drive why control and screening matter.

2. Diagnostic criteria incomplete

A1C ≥6.5% is listed. Also valid: fasting plasma glucose ≥126 mg/dL, 2-hour OGTT ≥200, or random glucose ≥200 with classic symptoms. Prediabetes range (A1C 5.7–6.4%) would help the prevention story.

3. Treatment depth

Metformin first-line for most remains standard; GLP-1 RAs and SGLT2is are appropriately elevated for cardiorenal benefit. Optional: hypoglycemia risk with insulin/sulfonylureas; don't stop meds when numbers improve without clinician advice.

4. Hypoglycemia

Not mentioned. People on insulin or certain pills need to recognize and treat low blood sugar — high-value safety content.

5. "Does it run in families?"

Page only says not contagious. Strong family history is a major risk factor — already listed under "who is more likely," but the genetics/heritability line could be explicit.

6. Race/ethnicity risk framing

Higher prevalence in listed groups is epidemiologically correct. Keep factual; pair with social and access factors when possible rather than implying purely biological causation.

7. Emergency / crisis

911 list is generic. Optional diabetes-specific: signs of severe hyperglycemia (very high sugars with vomiting, deep breathing, confusion) or severe hypoglycemia.

Suggested symptoms polish

Common

- Often none at diagnosis · Increased thirst and urination · Fatigue · Blurred vision

Other clues / complications

- Slow-healing sores · Numbness or tingling in feet · Acanthosis nigricans · Recurrent infections

Bottom line

Area	Rating
Insulin resistance concept	Accurate
A1C ≥6.5% diagnosis	Accurate (incomplete criteria set)
Asymptomatic onset	Accurate
Core osmotic symptoms	Accurate
Less common symptoms	Reasonable
Metformin / GLP-1 / SGLT2 framing	Modern & appropriate
Complications list	**Missing**
Hypoglycemia education	**Missing**
Lifestyle & screening	Good foundation

Overall: Correct core science and modern drug framing, but underbuilt for a flagship chronic disease. Highest-priority additions: (1) complications list (heart, kidney, eye, nerve, foot), (2) fuller diagnostic criteria + prediabetes, (3) hypoglycemia recognition for those on insulin/sulfonylureas, and (4) slightly richer treatment/monitoring narrative. No major factual errors in what is present.

Review based on page content as of November 17, 2026, cross-checked against standard type 2 diabetes clinical guidance (ADA-style diagnosis and cardiorenal risk reduction).