# Letters

## Autism in general practice

We congratulate you on highlighting neurodiversity and particularly for centring the autistic professional voice in the March 2021 issue of *Australian Journal of General Practice*. Autistic people form a vulnerable minority group among primary care patients. They are often unrecognised and suffer disproportionately high morbidity and mortality,[1] which may be preventable with timely intervention and reduction of access barriers. The majority of autistic adults experience co-occurring mental ill health, and suicide rates are markedly increased when compared with the non-autistic population.[2]

A survey of UK general practitioners (GPs) showed a lack of confidence in supporting autistic patients and expressed the need for better resources and specialist support;[3] therefore, the support tools demonstrated in the articles are a welcome addition for primary care clinicians. In particular, the emphasis on the part played by the attitude of the GP and the language used was powerful, given that stigma-related stress contributes to mental ill health in autistic people.[4]

As GPs are commonly the first professionals consulted regarding child developmental concerns or adult diagnosis, there is a unique opportunity to influence family dynamics or individual self-perception, with consequent effects on mental health. All too frequently, an autism diagnosis is framed negatively, with language and demeanour more typical of 'breaking bad news'. We would urge practitioners to resist this tragedy narrative as we accelerate the move towards a strengths-based approach to autism. That is not to deny the serious disability that may be associated with autism or the heterogeneity in presentation, but the way in which autism is framed will have a profound effect on outcome.

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## Diagnosing reactive hypoglycaemia following bariatric surgery

I thank Bhattarai and Au for their interesting case of postprandial hypoglycaemia (*AJGP* March 2021).[1] I would, however, advise against using an oral glucose tolerance test for the diagnosis of reactive hypoglycaemia, particularly following bariatric surgery. Approximately 10% of healthy individuals will develop venous glucose <2.6 mmol/L following glucose challenge.[2] Reactive hypoglycaemia has been reported in up to 68% of non-pregnant individuals and 83% of pregnant women following glucose challenge in the setting of previous bariatric surgery.[3] Symptomatic hypoglycaemia following bariatric surgery in individuals consuming a normal diet is uncommon, having been reported in only 0.1–1.2%.[4] Glucose challenge in individuals with previous bariatric surgery is associated with adverse symptoms in 65%, including nausea (38%), diarrhoea (24%), dizziness (23%), tachycardia (14%), tremor (13%) and profuse diaphoresis (13%).[5]

The presence of reactive hypoglycaemia can alternatively be sought after mixed meal testing, or by measuring interstitial fluid glucose over a period of 1–2 weeks using flash or continuous glucose monitoring. Nesidioblastosis and noninsulinoma pancreatogenous hypoglycaemia syndrome are additional diagnostic considerations in individuals with hypoglycaemia following bariatric surgery. As well as acarbose and octreotide, nifedipine, diazoxide and glucagon-like peptide-1 agonists may be useful in the management of reactive hypoglycaemia in individuals who do not respond to lifestyle/dietary manoeuvres.

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## Reply

I agree with the responder that significant hypoglycaemia can be associated with the oral glucose tolerance test (OGTT) in patients with dumping syndrome; hence, it is advised to conduct the test under clinical supervision.[1] There is a high incidence of adverse events reported while these patients undergo the OGTT.[2] However, available literature does not report serious adverse events during the OGTT.[3] A recent international Delphi consensus on diagnosis and management of dumping syndrome considers the OGTT as the preferred diagnostic test for dumping syndrome, and the mixed meal test is not considered a standard for diagnosis.[3] This consensus also recommends acarbose or somatostatin analogues, which have enough evidence, to use as the first-line agents after failed conservative management. Diazoxide, which inhibits insulin secretion by opening ATP-sensitive K-channels in pancreatic β-cells, has no established value for treatment of dumping syndrome.[3]

There is only a limited number of studies that use the mixed meal test for diagnosing dumping syndrome. The mixed meal test is claimed to have low risk of hypoglycaemia but it might actually underestimate the true incidence of late dumping syndrome as it contains high glycaemic index carbohydrates.[4] There are a few case reports of continuous glucose monitoring used to diagnose and monitor treatment in patients with dumping syndrome.[3] However, there are no standard head-to-head comparison trials between these tests to determine their sensitivity to diagnose dumping syndrome.

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