

## Hypoglycaemia in nondiabetic patients

### Dear Editor

I read with concern the article by Ching Luen Ng (*AFP* June 2010). This article details a number of rare causes of hypoglycaemia but fails to discuss the common differential diagnoses. I refer in particular to the conditions 'idiopathic postprandial hypoglycaemia' and 'idiopathic postprandial syndrome'.

A more common cause for autonomic symptoms and reduced awareness after a meal is the common condition of postprandial hypotension – a condition occurring in approximately 40% of institutionalised elderly and easily detected with blood pressure assessment 30–60 minutes postmeal or with 24 hour blood pressure monitoring.

General practitioners should be aware that postprandial hypotension is a much more likely cause of these symptoms occurring in the postprandial period.

Susan Corcoran  
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## Reply

### Dear Editor

I totally agree with Dr Corcoran that postprandial hypotension is an important differential diagnosis of hypoglycaemia, and is a common cause of postprandial syncope and falls in elderly patients. Clinicians should not overlook this important condition. Since hypoglycaemia can present with a wide range of autonomic symptoms (eg. palpitation, tremor, sweating) and neuroglycopenic symptoms (eg. weakness, confusion, seizure, focal neurological deficits, coma), the differential diagnosis should also include generalised anxiety disorder, cardiac arrhythmia, pheochromocytoma, alcohol and substance abuse, psychosis, psychosomatic disorder, epilepsy, transient ischaemic attack, and space occupying lesion in brain. The complete list of differential diagnoses of hypoglycaemia is indeed very long.

Due to word limitation, my article only concentrated on discussing the various causes of true hypoglycaemic disorders. This article did not intend to include a thorough discussion on the various mimics (or differential diagnoses) of hypoglycaemia. If there is a future article on differential diagnosis of hypoglycaemia, all the medical conditions mentioned above (including postprandial hypotension) should definitely be mentioned and discussed.

Ching Luen Ng  
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## Measles in the unvaccinated

### Dear Editor

Measles is a relatively uncommon diagnosis in Australia, but carries significant complications for both the individual infected and the community. The following case highlights the risks to unvaccinated individuals.

A man, 22 years of age, from Nimbin in New South Wales, presented to the hospital emergency department. He had a 7 day history of diarrhoea and fever, a 2 day history of vomiting, a 'crushing' central headache and a 1 day history of a descending, blanching, maculopapular, nonpruritic rash that, on presentation, had started on his face and had progressed down to his pelvis. He also reported a dry cough, abdominal pain and shortness of breath at rest. He had returned from a trip to New Zealand 2 days earlier where he had spent time on a farm and had been in contact with some children from India who had come down with flu-like symptoms. He had no history of childhood immunisations.

On admission to the emergency department, the patient had a fever of 37.8°C, a heart rate of 88 bpm, blood pressure of 120/66 mmHg, and a respiratory rate of 14 breaths/min. The patient was lethargic and dehydrated. Intravenous (IV) access was obtained and IV fluids were started. He was started on 300 mg gentamycin, and 2 g ceftriaxone qid to cover for sepsis, as well as 1 g paracetamol qid for pain. Blood and faecal samples were obtained for culture, and viral

serology. Chest X-ray was clear, and Koplik spots were visualised on the patient's buccal mucosa. Serology returned positive immunoglobulin M (IgM) antibodies to the measles virus, and a diagnosis of acute measles infection was made. At this time, antibiotics were ceased and the public health department was notified.

Measles is an important cause of serious medical complications and death. With increased total vaccination levels, unvaccinated individuals may progress to adulthood before being exposed to the measles virus. Patients over the age of 20 years have higher rates of complication, with those over 30 years having the highest rates of hospitalisation and death.<sup>1</sup>

The Northern Rivers area has some of the lowest rates of vaccination in Australia.<sup>2</sup> This places unvaccinated and some (~5%) vaccinated individuals<sup>3</sup> in this area at much higher risk of measles infection and complications.<sup>4</sup>

Andrew J Low, Vinay Pothumutu, Michael Glover  
New South Wales

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