Post-Bariatric Hypoglycemia Diagnostic Checklist

AMYLYX

A resource to help you recognize post-bariatric hypoglycemia (PBH)

The journey to a PBH diagnosis can be long and challenging.[1,2] Recurring symptoms can go unrecognized for years, and this delay can have real consequences for patient safety and quality of life.[1-3]

This checklist draws on published guidance to highlight key considerations that may support recognition of PBH, and is intended to complement, not replace, your clinical judgment.

Suspecting PBH through history taking

The first clues may emerge from the patient's own account. Patterns that may raise suspicion of PBH include:[1,2]

- ☐ History of bariatric surgery
- ☐ Symptoms consistent with hypoglycemia (e.g., diaphoresis, tremors, confusion, fatigue)
- ☐ Symptoms occurring 1–3 hours postprandially
- ☐ Identifiable triggers (e.g., high-glycemic foods, alcohol, caffeine)

An episode tracker may help patients track timing, triggers, and symptoms between appointments.[2]
Download a copy at UncoverPBH.com/HCP/Resources

Strengthening the case by confirming hypoglycemia

Once suspicion has been raised, confirming hypoglycemia through Whipple's triad may help to bring the evidence together:[4]

- ☐ Symptoms consistent with hypoglycemia
- ☐ Documented glucose <54 mg/dL during symptoms (venous sample preferred; finger stick acceptable)
- ☐ Symptom resolution after glucose correction

Published guidelines do not recommend the use of an oral glucose tolerance test (OGTT) or mixed-meal tolerance test (MMTT) to confirm hypoglycemia in PBH.[3,4] Notably, OGTT carries a risk of hypoglycemic seizures in this population.[3]

A Note on Continuous Glucose Monitoring (CGM):[3]
While not adequate for diagnosis, CGM can support recognition of postprandial glucose patterns and dietary triggers. Real-time alerts may enable earlier intervention, particularly in individuals with hypoglycemia unawareness.

Separating the clues by differential diagnosis

Once hypoglycemia is established, evaluating alternative causes can be an important next step in clarifying the underlying condition.[1]

Other causes of hypoglycemia to consider can include:[1]

- Insulinoma/proinsulinoma
- Malnutrition
- Hormone deficiencies (e.g., adrenal)
- Autoimmune hypoglycemia
- Non-islet cell tumors
- Medication side effects

PBH vs. Dumping Syndrome

Separating PBH from dumping syndrome isn't always straightforward. The following features may help clarify the picture:

	PBH[1,2,5,6]	**Dumping Syndrome[2,4,7–9]**
Pathophysiology:	A multifactorial condition in which altered gut-derived signals, abnormal insulin dynamics, and impaired counter-regulatory responses may combine to promote an exaggerated postprandial insulin response, leading to hypoglycemia.	Rapid delivery of hyperosmolar gastric contents into the small intestine leads to fluid shifts and neurohormonal responses.
Onset After Surgery:	A key characteristic of PBH is its delayed onset. Hypoglycemic episodes may develop months or even years after surgery.	Dumping syndrome is an early postoperative complication that can develop weeks to months after surgery.
Symptom Timing:	~1–3 hours postprandially	~15–60 minutes postprandially
Hypoglycemia:	Yes	No
Symptoms:	**Autonomic:** Paresthesia, tremors, anxiety **Neuroglycopenic:** Confusion, seizures, behavioral changes	**Vasomotor:** Flushing, hypotension, tachycardia **Gastrointestinal:** Abdominal pain/discomfort, bloating, diarrhea
Overlapping Symptoms:	**Fatigue, weakness, palpitations, dizziness, syncope**	

This table represents characteristic patterns of presentation. Individual patient features may vary.

Earlier recognition of PBH may present an opportunity to anticipate and manage cumulative clinical and safety risks over time.[3]

All the clues are there. Find them at **UncoverPBH.com/HCP**

1. Sheehan A, Patti ME. Hypoglycemia after upper gastrointestinal surgery: Clinical approach to assessment, diagnosis, and treatment. *Diabetes Metab Syndr Obes*. 2020;13:4469–4482. **2.** Abdelgadir E, Rashid F, Awadi FA, et al. Post-bariatric hypoglycemia management: A Gulf Cooperation Council consensus statement. *J Endocr Soc*. 2025;10(2):bvaf225. **3.** Lawler HM, McGinnis T, Patti ME. Diagnosis and management of post-bariatric hypoglycemia. *J Am Board Fam Med*. 2025;38(2):383–394. **4.** Hazlehurst J, Khoo B, Lobato CB, et al. Society for Endocrinology guidelines for the diagnosis and management of post-bariatric hypoglycaemia. *Endocr Connect*. 2024;13(5):e230285. **5.** Hölzen L, Schultes B, Meyhöfer S, et al. Hypoglycemia unawareness-a review on pathophysiology and clinical implications. *Biomedicines*. 2024;12(2):391. **6.** Salehi M, Vella A, McLaughlin T, Patti ME. Hypoglycemia after gastric bypass surgery: Current concepts and controversies. *J Clin Endocrinol Metab*. 2018;103(8):2815–2826. **7.** Masclee GMC, Masclee AAM. Dumping syndrome: Pragmatic treatment options and experimental approaches for improving clinical outcomes. *Clin Exp Gastroenterol*. 2023;16:197–211. **8.** Cano R, Rodríguez D, Duran P, et al. Dumping syndrome after bariatric surgery: Advanced nutritional perspectives and integrated pharmacological management. *Nutrients*. 2025;17(19):3123. **9.** Rogowitz E, Patti ME, Lawler H. Time to dump late dumping syndrome terminology. *Obes Surg*. 2019;29(9):2985–2986.

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