key points

SELECTED BY

Dr Matthew Lockyer
GP, Suffolk

The common presentation of coeliac disease has shifted from the historically classical symptoms of malabsorption in childhood to non-classical symptoms in adulthood such as irritable bowel syndrome-type symptoms, anaemia, chronic fatigue, change in bowel habit, abdominal pain and osteoporosis. Population screening studies have shown that the prevalence of coeliac disease is 1 in 100 and yet 75% of patients remain undiagnosed. A combination of coeliac serology and duodenal biopsy is required to diagnose coeliac disease in adults. Testing for IgA-tissue transglutaminase antibodies (IgA-TTG) should be carried out as a first-line screening test.

Advise patients to eat a gluten-containing diet (10 g of gluten a day, equivalent to four slices of bread) for six weeks before their investigations to ensure the serological and histological results are not affected. A confirmatory duodenal biopsy is mandatory to ensure that patients are correctly diagnosed with coeliac disease before being subjected to a lifelong gluten-free diet. Clinical response to a gluten-free diet does not confer a diagnosis of coeliac disease. This can be seen in patients with non-coeliac gluten sensitivity.

Paediatric patients no longer require biopsies to confirm the diagnosis of coeliac disease if they have TTG levels ten times over the upper limit of normal, positive EMA and the presence of the HLA DQ2 or HLA DQ8 genotype. All adult patients with positive coeliac serology should be referred to gastroenterology for a gastroscopy to confirm or exclude coeliac disease. Children with positive coeliac serology should be referred to paediatric gastroenterology for further investigations.

A lifelong strict gluten-free diet is the only effective treatment currently available. All patients should be referred to a specialist dietitian for thorough guidance and support. Patients should be encouraged to join coeliac disease advocacy groups, as evidence shows that this is strongly associated with strict dietary adherence. The goal of treatment is to relieve symptoms, achieve mucosal healing to prevent complications, and improve quality of life. Patients with persistent villous atrophy have an increased incidence of lymphoproliferative malignancies compared with those without.

Annual follow-up can begin when the disease is stable and patients are managing well on their diet. Small bowel absorption should be assessed by measuring full blood count, ferritin, folate and B12 levels. There is an increased risk of osteoporosis and fractures which improve with gluten exclusion. Calcium, vitamin D and alkaline phosphatase should be monitored and supplemented accordingly. Those with additional risk factors for osteoporosis or aged over 55 should have a baseline bone density scan one year after starting a gluten-free diet. Co-existing autoimmune diseases should be screened for.