

Mucosal healing in corso di dieta senza glutine: quando preoccuparsi

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Mucosal healing in corso di dieta senza glutine: quando preoccuparsi

.....Ma va documentato il «mucosal healing» ?

Quando è opportuno ripetere una biopsia duodenale ?

Quando preoccuparsi ?



ACG Clinical Guidelines: Diagnosis and Management of Celiac Disease

Alberto Rubio-Tapia, MD¹, Ivor D. Hill, MD², Ciarán P. Kelly, MD³, Audrey H. Calderwood, MD⁴ and Joseph A. Murray, MD¹

MONITORING OF CD

Recommendations

- (1) People with CD should be monitored regularly for residual or new symptoms, adherence to GFD, and assessment for complications. In children, special attention to assure normal growth and development is recommended. (Strong recommendation, moderate level of evidence)
- (2) Periodic medical follow-up should be performed by a health-care practitioner with knowledge of CD. Consultation with a dietitian should be offered if gluten contamination is suspected. (Strong recommendation, moderate level of evidence)
- (3) Monitoring of adherence to GFD should be based on a combination of history and serology (IgA TTG or IgA (or IgG) DGP antibodies). (Strong recommendation, moderate level of evidence)
- (4) Upper endoscopy with intestinal biopsies is recommended for monitoring in cases with lack of clinical response or relapse of symptoms despite a GFD. (Strong recommendation, moderate level of evidence)
- (5) Monitoring of people with CD should include verification of normalization of laboratory abnormalities detected during initial laboratory investigation. (Strong recommendation, moderate level of evidence)

There are several methods to assess adherence to GFD: visits with the doctor and/or dietitian, serology, biopsy of intestine, and structured surveys. The gold standard for monitoring adherence to GFD is consultation with a skilled dietitian.

Serology is not accurate to detect lesser degrees of gluten contamination. Seroconversion after GFD does not necessarily imply healing of the intestine.

Intestinal biopsies are the only way to document healing of the intestine.

In adults, the intestine will often fail to heal despite negative serology and absence of symptoms



Diagnosis and management of adult coeliac disease: guidelines from the British Society of Gastroenterology

Jonas F Ludvigsson,^{1,2} Julio C Bai,³ Federico Biagi,⁴ Timothy R Card,⁵ Carolina Ciacci,⁶ Paul J Ciclitira,⁷ Peter H R Green,⁸ Marios Hadjivassiliou,⁹ Anne Holdoway,¹⁰ David A van Heel,¹¹ Katri Kaukinen,^{12,13,14} Daniel A Leffler,¹⁵ Jonathan N Leonard,¹⁶ Knut E A Lundin,¹⁷ Norma McGough,¹⁸ Mike Davidson,¹⁹ Joseph A Murray,²⁰ Gillian L Swift,²¹ Marjorie M Walker,²² Fabiana Zingone,²³ David S Sanders,²⁴ Authors of the BSG Coeliac Disease Guidelines Development Group

Recommendations

- ▶ Follow-up biopsies may be considered in patients with CD, and are potentially helpful in identifying patients at increased risk of lymphoma. (Grade B)
- ▶ Follow-up biopsies are not mandatory if the patient with CD is asymptomatic on a GFD, and has no other features that suggest an increased risk of complications. (Grade C)
- ▶ Follow-up biopsies should be undertaken in patients with CD whose condition does not respond to a GFD. (Grade C)

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Some experts favour repeat intestinal biopsy after 1 year of dietary therapy.

Others, however, do not believe a repeat biopsy is essential for coeliac management in typical cases.

It is universally acknowledged that there is little evidence to address whether clinical outcomes are significantly altered as a result of re-biopsy and that the cost–benefit analysis of such an approach has yet to be fully established.

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In follow-up of CD, the key endpoints are normalisation of the health of patients judged by an absence of symptoms, and mucosal healing. ?

A lack of symptoms or negative serological markers are not reliable or responsive surrogates of mucosal response to diet.

The proportion of patients who do not achieve full histological recovery on diet varies, with most reports suggesting mucosal healing in 57–76%

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Table 3 Histological recovery of duodenal mucosa in CD

Study	Country	Number of patients	Female patients (%)	Median (M)/average (A) follow-up, years	Positive correlation between dietary adherence and mucosal improvement	Symptoms assessed	Main reason for mucosal damage	Histological recovery of duodenal mucosa		
								Normal	Improved	No change/worse
Hutchinson <i>et al</i> ¹⁵⁶	UK	284	71	1.9 (M)	p=0.014	No	9% poor adherence	35%	40%	20.10%
Rubio Tapia <i>et al</i> ¹⁵⁰	USA	241	73	—*	p<0.01	Yes	Poor adherence/severe CD at diagnosis	66% (5 years)		19% (2–5 years)
Lanzini <i>et al</i> ¹⁵⁹	Italy	465	77†	1.3 (A)	p=0.029	Yes	25% poor adherence	8%	65%	27%
Ciacci <i>et al</i> ¹⁵⁸	Italy	390	77	6.9 (A)	p<0.001	Yes	Poor adherence	43.60%	32.60%	
Wahab <i>et al</i> ¹⁶⁰	The Netherlands	158	72	1–2‡	No data	NRCD=symptoms		65%		17.1% (5 years)
Kaukinen (specific study of NRCD) ¹⁵¹	Finland	591 13 with NRCD	69% of those with NRCD	0.7 (M)§	p=0.02††	Became symptomatic if NRCD	46% poor adherence			1.90%
Tuire <i>et al</i> ⁷²	Finland	177	73	7–10¶	No correlation**	Patients asymptomatic Clinical relevance of persistent IELs with normal villi			85%	
Lebwohl <i>et al</i> ¹⁵⁵	Sweden	7648	63	1.3 (M)	No data	no	No data	57%	43%	

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ORIGINAL ARTICLE

Long-term mucosal recovery and healing in celiac disease is the rule – not the exception

Petter Hære^a , Ole Høie^a, Tom Schulz^a, Irina Schönhardt^b, Melinda Raki^c and Knut E. A. Lundin^d

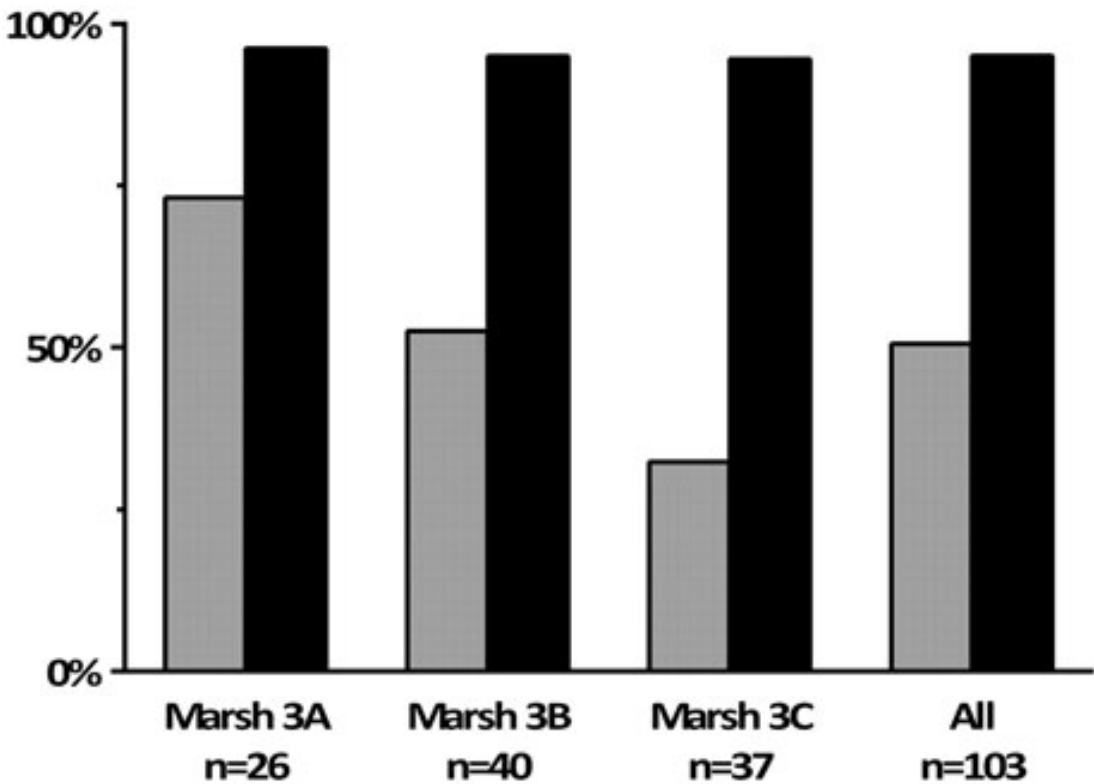


Table 3. Characteristics of the seven patients who were found to have persistent villous atrophy.

Age	Gender	Age at diagnosis	Duration of GFD (years)	GSRS-IBS score	Clinicians assessment of adherence
55	Female	53	3	22	Moderate adherence
65	Male	64	2	34	Poor adherence, eats gluten voluntarily.
35	Male	27	8	15	Poor adherence, eats gluten voluntarily
66	Female	57	10	43	Poor adherence, eats gluten voluntarily
53	Male	43	11	20	Poor adherence, eats gluten voluntarily
64	Female	45	19	18	Good adherence
37	Female	17	21	24	Poor adherence, eats gluten voluntarily

Figure 3. Prevalence of mucosal recovery for the 103 patients who underwent both a routine follow-up biopsy and a study biopsy. The patients are grouped according to the severity of the villous atrophy (VA) at diagnosis. Gray bars show the prevalence of mucosal recovery at the routine follow-up biopsy 12.6 months (median, range 5.2–28.8) after diagnosis. Black bars show the prevalence of mucosal recovery at the time of the study biopsy 7.2 years (median, range 2.3–22.3) after diagnosis.

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Table 4. Prior studies which have reported histological follow-up in adult patients with celiac disease. The studies are sorted by the reported proportion of villous atrophy (VA).

Author	Year	Country	n	Duration of gluten-free diet	Marsh			
					0	1	2	3
Lee et al. [18] ^a	2003	USA	39	8.5 years (mean), range 1–45	21%			79%
Bardella et al. [20] ^b	2007	Italy	114	2 years (median), range 1–23	18%	20%		62%
Hutchinson et al. [22] ^c	2010	UK	284	1.6 years (median), IQR 0.9–3.7	39%	17%		44%
Martini et al. [17] ^d	2002	Italy	101	1 year	12%	51%		38%
Ciacchi et al. [15]	2002	Italy	390	6.9 years (mean), range 2–22	44%	10%	23%	24%
Lanzini et al. [21]	2009	Italy	465	1.3 years (mean), range 1.1–18.5	8%	9%	62%	21%
Newnham et al. [24] ^b	2016	Australia	45	5 years	50%	35%		15%
Tursi et al. [19]	2006	Italy	42	2 years	60%	17%	12%	12%
Wahab et al. [16]	2002	The Netherlands	158	>5 years	39%	24%	27%	10%
Tuire et al. [23] ^b	2012	Finland	177	11 years (mean), range 2–41	42%	54%		4%

Table 1 | Clinical, serological and histological characteristics at diagnosis in 760 coeliac disease patients without (No repeat biopsy) or with (Repeat biopsy) a follow-up biopsy done

	No repeat biopsy n = 244		Repeat biopsy n = 516		P-value
	n	%	n	%	
Females	181	74	413	80	0.093
Clinical presentation*					
Malabsorption	80	33	235	46	0.001
Gastrointestinal symptoms	204	84	425	82	0.664
Extra-intestinal symptoms [†]	97	40	201	39	0.864
Screen-detected	39	16	49	10	0.010
Duration of symptoms before diagnosis					0.571
>5 year	96	42	209	43	
<5 year	119	50	245	50	
Severity of symptoms at diagnosis					0.052
Severe	40	16	122	24	
Moderate	100	41	216	42	
Mild	91	37	158	31	
No symptoms	13	5	18	4	
Symptoms during childhood	72	28	181	35	0.223
Coeliac disease in family	146	63	329	64	0.790
Endomysial antibody titres at diagnosis					0.461
High 1: >200	36	39	77	35	
Low 1:5–1:200	47	51	107	49	
Negative	10	11	35	16	
Severity of villous atrophy at diagnosis					<0.001
Total	42	24	124	26	
Subtotal	58	34	196	42	
Partial	73	42	149	32	
Site of diagnosis					<0.001
Primary care	41	17	79	15	
Private care	57	23	58	11	
Secondary care	108	44	250	49	
Tertiary care	38	17	125	24	



Table 5 | Long-term follow-up characteristics in 476 coeliac disease patients with (Recovery) or without (Atrophy) histological response at follow-up biopsy

	Atrophy <i>n</i> = 200		Recovery <i>n</i> = 276		<i>P</i> -value
	<i>n</i>	%	<i>n</i>	%	
Received dietary advice	154	77	215	78	0.683
Capable of managing GFD	184	92	264	95	0.820
Strictness of GFD					0.060
Strict	195	97	275	100	
Occasional lapses	5	3	1	0	
Normal gluten use					
Use of oats	162	81	231	82	0.947
Regular follow-up	131	66	198	71	0.426
TG2-ab positivity	45	23	79	28	0.497
Any malignancy	9	5	14	5	0.762
Fractures	53	27	80	28	0.859

GFD, gluten-free diet; TG2-ab, transglutaminase-2 antibodies.

Performing routine follow-up biopsy 1 year after diagnosis does not affect long-term outcomes in coeliac disease

H. Pekki*, K. Kurppa[†] , M. Mäki[†], H. Huhtala[‡], K. Laurila[†], T. Ilus[§] & K. Kaukinen^{*,¶}

Conclusions

Severe disease at diagnosis predicted the record of a repeat biopsy and incomplete mucosal recovery. Neither lacking biopsy nor incomplete recovery in a relative short time span of 1 year was associated with poorer long-term outcome, although survival bias cannot be excluded.

Aliment Pharmacol Ther 2017; 45: 1459-1468

A second duodenal biopsy is necessary in the follow-up of adult coeliac patients

Federico Biagi, Claudia Vattiato, Simona Agazzi, Davide Balduzzi, Annalisa Schieppatti, Paolo Gobbi & Gino Roberto Corazza

Results. Data from 317 adult patients were collected. Duodenal biopsy showed a lack of satisfactory histological response in 25/317 patients; endomysial antibodies were still positive in 76, and diet adherence and clinical response were unsatisfactory in 58 and 97, respectively. Correlations of serological data, clinical response, and diet adherence with histological findings were evaluated. Although the *P* values showed statistically significant differences, sensitivity and specificity were disappointing: 64% and 80% for serological response, 48% and 71% for clinical response, 56% and 85% for diet adherence.

Conclusions. After 12–18 months on a gluten-free diet, 8% of the patients do not present a satisfactory histological response; only some of them could have been identified with a serological and/or clinical re-evaluation. Therefore, a duodenal biopsy seems to be the only tool that could identify patients with unsatisfactory histological response.

As far as the 25 patients with unsatisfactory histological response are concerned, a third duodenal biopsy and further investigations, including demonstration of TCR- γ chain monoclonal rearrangements of intraepithelial T lymphocytes, allowed the diagnosis of refractory CD type 2 in one patient; four patients were deliberately consuming gluten, three are currently under investigations, and in the remaining patients a dietary re-evaluation suggested possible inadvertent gluten intake. However, in 10 patients the possibility of inadvertent gluten intake was so small that 'slow responder CD' was also possible.

Key messages

- The need for a regular follow-up of coeliac patients is unquestionable. However, a consensus on timing and methods to follow up coeliac patients is at present still lacking.
- Histological response was unsatisfactory in 8% of the coeliac patients on a gluten-free diet.
- Clinical and serological response could not have been used to predict unsatisfactory histological response. A duodenal biopsy is necessary in the follow-up of adult coeliac patients.

Mucosal Healing and Mortality in Celiac Disease

Benjamin Lebwohl, MD, MS^{1,2}, Fredrik Granath, PhD², Anders Ekbom, MD, PhD², Scott M. Montgomery, PhD^{2,3}, Joseph A. Murray, MD⁴, Alberto Rubio-Tapia, MD⁴, Peter HR Green, MD¹, and Jonas F. Ludvigsson, MD, PhD^{2,5,*}

METHODS—Through biopsy reports from all pathology departments (n=28) in Sweden we identified 7,648 individuals with CD (defined as VA) who had undergone a follow-up biopsy within 5 years following diagnosis. We then used Cox regression to examine overall mortality according mucosal recovery in the follow-up biopsy (persistence of VA vs. recovery).

RESULTS—The mean age of CD diagnosis was 28.4, 63% were female, and the median follow-up after diagnosis was 11.5 years. Of the 7,648 patients, persistent VA was present in 3,317 (43%). There were 606 (8%) deaths. Patients with persistent VA were not at increased risk of death compared to those with mucosal healing (Hazard Ratio 1.01; 95% Confidence Interval 0.86-1.19). Mortality was not increased in children with persistent VA (HR 1.09 95% CI 0.37-3.16) or adults (HR 1.00 95% CI 0.85-1.18), including adults older than age 50 years (HR 0.96 95% CI 0.80-1.14).

CONCLUSION—Persistent VA was not associated with increased mortality in CD in this population followed for a median of 11.5 years. While a follow-up biopsy will determine if there is improvement in histology and allow detection of refractory disease in symptomatic patients, our study suggests that early routine follow up biopsies performed within 5 years does not predict long-term mortality risk.

Mucosal Healing and Risk for Lymphoproliferative Malignancy in Celiac Disease

A Population-Based Cohort Study

Benjamin Lebwohl, MD, MS; Fredrik Granath, PhD; Anders Ekblom, MD, PhD; Karin E. Smedby, MD, PhD; Joseph A. Murray, MD; Alfred I. Neugut, MD, PhD; Peter H.R. Green, MD; and Jonas F. Ludvigsson, MD, PhD

Results: Among 7625 patients with CD and follow-up biopsy, 3308 (43%) had persistent villous atrophy. The overall risk for LPM was higher than that in the general population (standardized incidence ratio [SIR], 2.81) and was greater among patients with persistent villous atrophy (SIR, 3.78) than among those with mucosal healing (SIR, 1.50).

Persistent villous atrophy compared with mucosal healing was associated with an increased risk for LPM (hazard ratio [HR], 2.26 [CI, 1.18 to 4.34]).

The risk for T-cell lymphoma was increased (HR, 3.51) but not for B-cell lymphoma (HR, 0.97).

Limitation: No data on dietary adherence.

Conclusion: Increased risk for LPM in CD is associated with the follow-up biopsy results, with a higher risk among patients with persistent villous atrophy.

Follow-up biopsy may effectively stratify patients with CD by risk for subsequent LPM.

Anxiety after coeliac disease diagnosis predicts mucosal healing: a population-based study

Jonas F. Ludvigsson^{1,2,3,4} | Benjamin Lebwohl⁴ | Qi Chen¹ | Gabriella Bröms^{5,6}
Randi L. Wolf⁸ | Peter H. R. Green⁴ | Louise Emilsson^{7,9,10}

TABLE 1 Characteristics of patient cohort with coeliac disease and follow-up biopsies

Characteristic	Full cohort			Cohort restricted to the years 2005-2009		
	Mucosal healing, n (%)	Persistent villous atrophy, n (%)	P-value (χ^2)	Mucosal healing, n (%)	Persistent villous atrophy, n (%)	P-value (χ^2)
Total number	4331	3317		418	155	

Results: During follow-up, 123 (2.8/1000 person-years) individuals with mucosal healing had developed anxiety, compared to 94 (2.1/1000 person-years) with persistent villous atrophy. Mucosal healing was hence associated with a higher risk of future anxiety (HR = 1.49; 95% CI = 1.12-1.96). Similarly, 167 (3.8/1000 person-years) individuals with mucosal healing developed depression, compared to 148 (3.3/1000 person-years) with persistent villous atrophy, corresponding to a HR of 1.25 (95% CI = 0.99-1.59). Mucosal healing was more common in individuals with prior diagnoses of anxiety or depression before follow-up biopsy. Anxiety diagnosed between diagnostic and follow-up biopsy for coeliac disease was associated with an almost nine-fold increased chance of mucosal healing (odds ratio = 8.94; 95%CI = 2.03-39.27).

Conclusion: Anxiety and depression are more common in coeliac disease patients with mucosal healing, both before and after follow-up biopsy, an association potentially mediated through more vigilant compliance with a gluten-free diet. This finding raises concern that achieving the goal of mucosal healing may come at a cost of an increased risk of mood disorders.

TABLE 2 Association of mucosal healing with “subsequent” outcomes of anxiety, depression, antidepressants, psychostimulants, anxiolytics and hypnotics/sedatives

Outcome (group)	Number of events	Adjusted ^a HR (95% CI)	P value
Diagnosis of anxiety			
Persistent villous atrophy	94	1.0	<0.01
Mucosal healing	123	1.49 (1.12-1.96)	
Stratified analyses of anxiety			
Diagnosis of anxiety in children			
Persistent villous atrophy	40	1.0	0.02
Mucosal healing	49	1.75 (1.11-2.78)	
Diagnosis of anxiety in adults			
Persistent villous atrophy	54	1.0	0.04
Mucosal healing	74	1.47 (1.02-2.12)	

TAKE HOME MESSAGES – FIRST STEP

LA BIOPSIA INTESTINALE E' IL SOLO METODO PER ACCERTARE IL «MUCOSAL HEALING»

IL MUCOSAL HEALING NON E' »LA REGOLA»

ESISTE UN'AMPIA VARIABILITA' DI DATI SULLA FREQUENZA DEL MUCOSAL HEALING, DOPO L'AVVIO DELLA GFD E VI SONO DATI CHE MOSTRANO UNA PERSISTENTE ATROFIA NEL 40% DEI PAZIENTI AD UN ANNO

LE CAUSE DEL MANCATO «MUCOSAL HEALING» POSSONO ESSERE VARIE, MA LA SCARSA ADERENZA ALLA GFD E' LA PIU' COMUNE

IL MANCATO «MUCOSAL HEALING» AD 1 ANNO NON SEMBREREBBE ASSOCIATO AD UNA PEGGIORE PROGNOSI

IL REGOLARE COUNSEILING DIETETISTICO POTREBBE SOSTITUIRE LA RIVALUTAZIONE ISTOLOGICA (ruolo «educativo»)

TEST URINARI E FECALI POTREBBERO SOSTITUIRE L'ISTOLOGIA NEL VALUTARE L'ADERENZA ALLA GFD

...ALTRE CONSIDERAZIONI SULL'ISTOLOGIA.....

How Patchy Is Patchy Villous Atrophy?: Distribution Pattern of Histological Lesions in the Duodenum of Children With Celiac Disease

Alberto Ravelli, MD¹, Vincenzo Villanacci, MD², Chiara Monfredini, MD¹, Silvia Martinazzi, MS¹, Veronica Grassi, MD¹ and Stefania Manenti, MD²

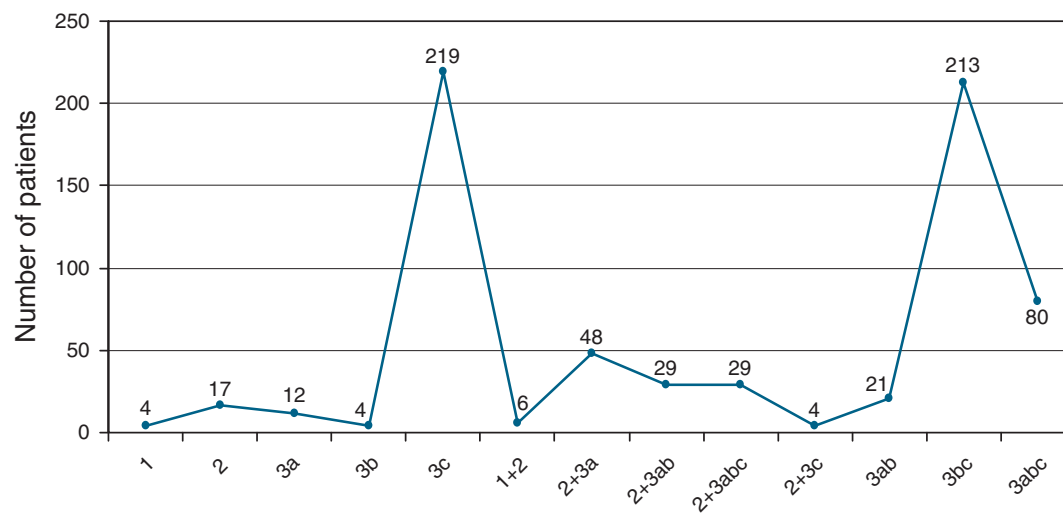


Figure 1. Type and frequency of histological lesions in 686 patients with celiac disease. Along the x axis the type of lesion is shown, according to Oberhuber's classification. The coexistence of two different types of lesions is marked with a "+" and the coexistence of different degrees of villous atrophy is indicated as 3ab, 3abc, and 3bc.

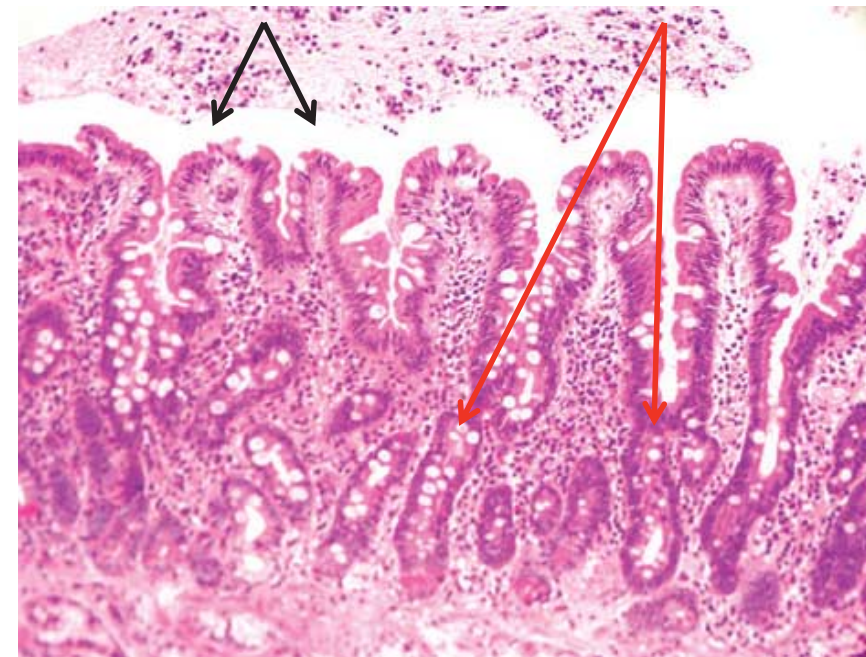


Figure 2. Duodenal biopsy showing coexistence of lesions types 2 and 3A. Crypt hyperplasia (lesion type 2) on the right is indicated by red arrows, whereas mild villous atrophy (lesion type 3A) on the left is indicated by black arrows (hematoxylin/eosin (H&E), $\times 20$).

...ALTRE CONSIDERAZIONI SULL'ISTOLOGIA.....

What is the best histopathological classification for celiac disease? Does it matter? A letter of comment to the review of Amado Salvador Pena; a new proposal

Vincenzo Villanacci

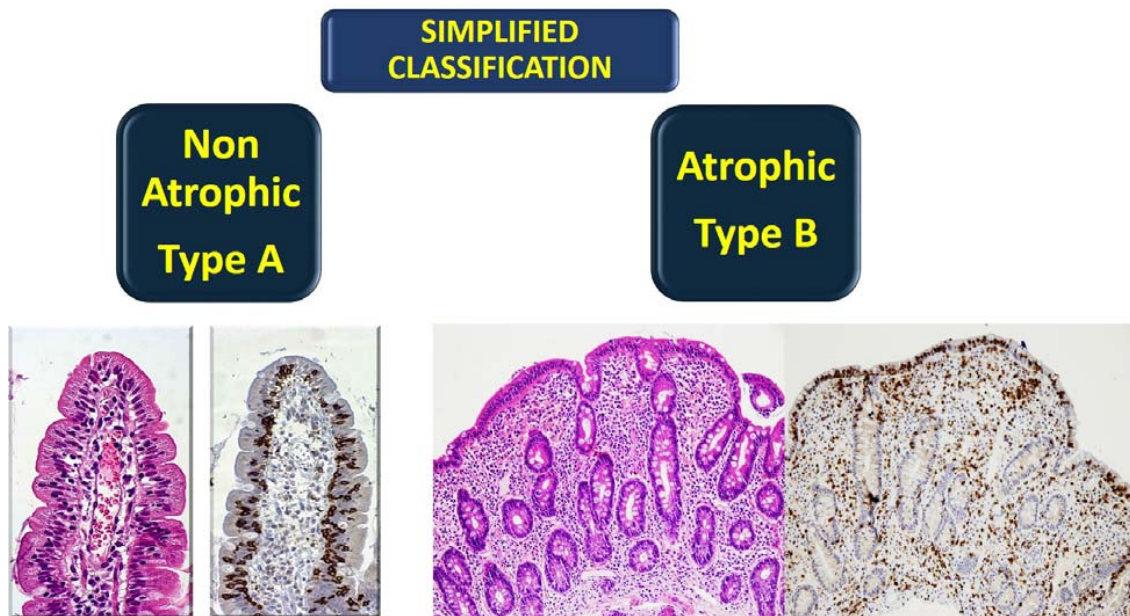


Figure 2. A simplified histological scheme for the diagnosis of CD

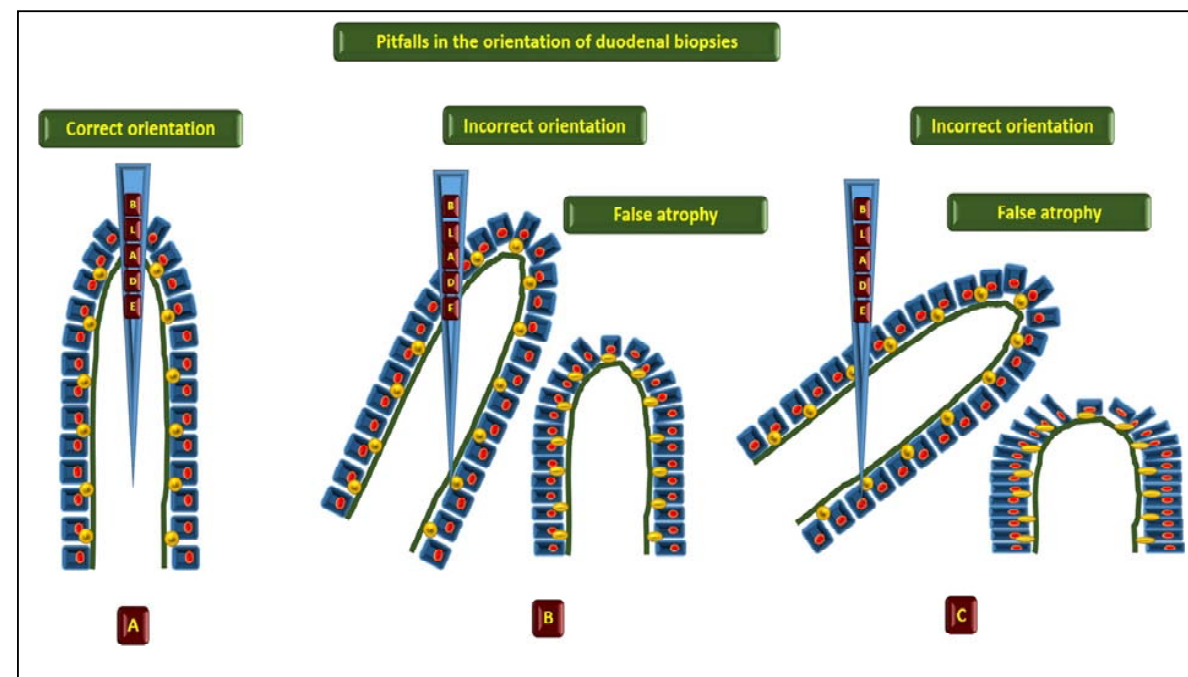


Figure 1. The orientation of the biopsies to avoid incorrect evaluation of the architecture of villi

.....e allora, quando «cercare» il mucosal healing ?

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Dig Liver Dis. 2018 Jun;50(6):549-552. doi: 10.1016/j.dld.2017.12.001. Epub 2017 Dec 8.

Risk of complications in coeliac patients depends on age at diagnosis and type of clinical presentation.

Biagi F¹, Schiepatti A², Maiorano G², Fraternale G², Agazzi S², Zingone F³, Ciacci C³, Volta U⁴, Caio G⁴, Tortora R⁵, Klersy C⁶, Corazza GR².

RESULTS: Between 01/1999 and 06/2015, 2225 adult coeliac patients were directly diagnosed in our centres. 17 of them developed a complication and 29 died. In patients older than 60 years at diagnosis of **coeliac disease**, the risk of complication is 18 times higher than in patients diagnosed at 18-40 years and 9 times higher than in patients diagnosed at 40-60 years.

Classical presentation increases the risk of complications by 7 times compared to non-classical presentation; in asymptomatic patients the risk of complication is virtually absent.

CONCLUSIONS: The risk of developing complications in coeliac patients is linked to age at diagnosis of **coeliac disease** and type of clinical presentation. Follow-up methods of coeliac patients should be tailored according to these parameters.

.....e allora, quando «cercare» il mucosal healing ?

.....nei non responsivi alla GFD, ovviamente,
La «NRCD»

ACG Clinical Guidelines: Diagnosis and Management of Celiac Disease

Alberto Rubio-Tapia, MD¹, Ivor D. Hill, MD², Ciarán P. Kelly, MD³, Audrey H. Calderwood, MD⁴ and Joseph A. Murray, MD¹

NRCD may be defined as persistent symptoms, signs or laboratory abnormalities typical of CD despite 6–12 months of dietary gluten avoidance

NRCD is common, affecting from 7 to 30% of patients treated with a GFD for CD

There are many distinct etiologies, including inadvertent gluten ingestion (the most common cause), other food intolerances, small-intestinal bacterial overgrowth, microscopic colitis, pancreatic insufficiency, irritable bowel syndrome and refractory CD

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Celiac serologies are helpful if positive, as this points to probable gluten exposure as the cause for NRCd. However, normal serologies do not exclude intermittent or low-level gluten ingestion sufficient to cause persistent CD activity.

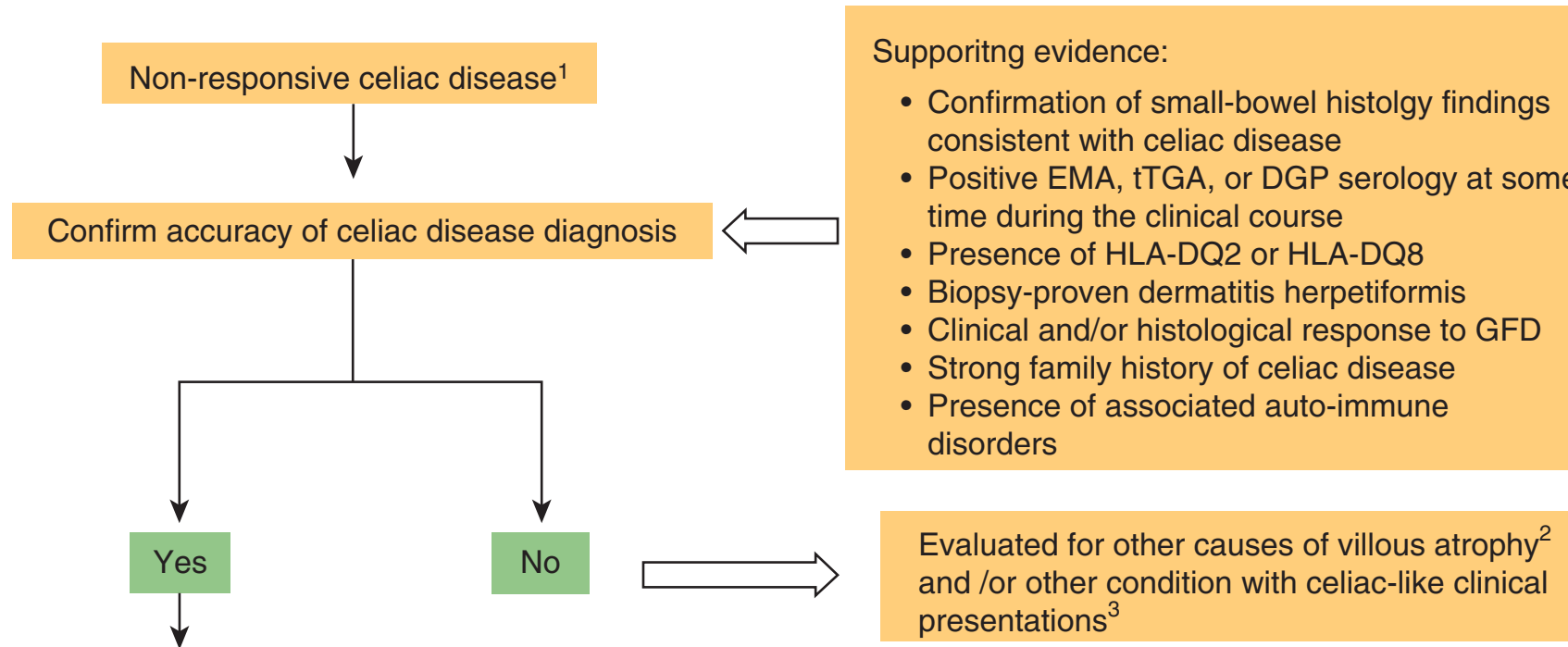
Once dietary causes of NRCd have been excluded, small-intestinal biopsy should be repeated and the findings compared to the diagnostic biopsy.

??

Ongoing inflammatory enteropathy with villous atrophy is consistent with refractory CD, gluten exposure, or possibly small-intestinal bacterial overgrowth and other causes of villous atrophy

ACG Clinical Guidelines: Diagnosis and Management of Celiac Disease

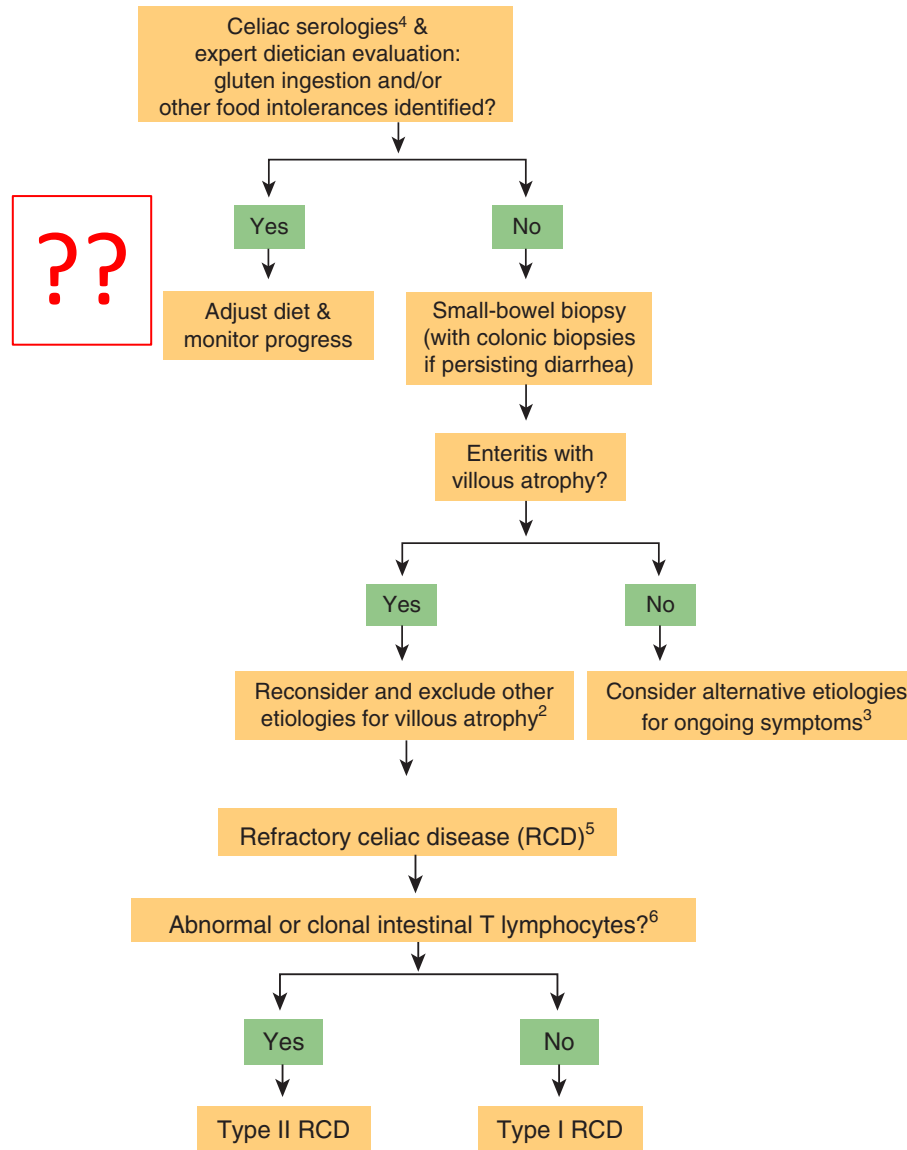
Alberto Rubio-Tapia, MD¹, Ivor D. Hill, MD², Ciarán P. Kelly, MD³, Audrey H. Calderwood, MD⁴ and Joseph A. Murray, MD¹



ACG Clinical Guidelines: Diagnosis and Management of Celiac Disease

Alberto Rubio-Tapia, MD¹, Ivor D. Hill, MD², Ciarán P. Kelly, MD³, Audrey H. Calderwood, MD⁴ and Joseph A. Murray, MD¹

Celiac serologies are helpful if positive, as this points to probable gluten exposure as the cause for NRCD. However, normal serologies do not exclude intermittent or low-level gluten ingestion sufficient to cause persistent CD activity.



The Oslo definitions for coeliac disease and related terms

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Non-responsive Celiac Disease

Generally, most patients are negative for EMA and TTG at the time of RCD diagnosis, but the presence of persisting elevated titres of circulating EMA and/or TTG does not necessarily rule out RCD, though this should lead to questions about dietary adherence.

In all cases, a careful dietary interview should be performed to exclude gluten exposure before diagnosing RCD.

La sierologia non ci aiuta, dobbiamo vedere l'istologia !

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Diagnosis and management of adult coeliac disease: guidelines from the British Society of Gastroenterology

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Recommendations

- ▶ Patients with persistent symptoms despite a GFD should have a follow-up biopsy. (Grade B)
- ▶ In symptomatic patients with ongoing enteropathy and RCD, coeliac-related malignancies and disorders that mimic CD must be excluded. (Grade C)
- ▶ Small bowel imaging should be performed in any patient with abdominal pain, fever, obstruction, anaemia, gastrointestinal bleeding or unexplained weight loss. (Grade D)
- ▶ Patients with RCD should be referred to a tertiary centre to optimise their management. (Grade D)

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TAKE HOME MESSAGES – END STEP

LA RIVALUTAZIONE ISTOLOGICA PUO' ESSERE OPPORTUNA NEI PAZIENTI CON DIAGNOSI DI CELIACHIA POSTA AD UNA ETA' > 60 ANNI E PRESENTAZIONE CLINICA «TIPICA»

IL TIMING DI QUESTA VALUTAZIONE NON E' COMUNQUE DEFINITO E LA SUA UTILITA' DOVREBBE ESSERE ULTERIORMENTE DIMOSTRATA

LA RIVALUTAZIONE ISTOLOGICA E' MANDATORIA IN PAZIENTI CON SINTOMI PERSISTENTI A 6-12 MESI

IL TIMING DI QUESTA RIVALUTAZIONE DEVE ESSERE PERSONALIZZATO E PUO'/DEVE ESSERE ANTICIPATO SULLA BASE DEI DATI CLINICI

LA PERSISTENZA DI ATROFIA DEVE FARE CONSIDERARE SIA ASPETTI DI ADERENZA ALLA DIETA, CHE CAUSE DI ATROFIA DIVERSE DALLA CELIACHIA

ASPETTI ISTOLOGICI/CLINICI CHE RICHIAMINO AD UNA RCD DEVONO CONDURRE IL PAZIENTE A CENTRI DI RIFERIMENTO DI III LIVELLO

7° CONGRESSO NAZIONALE AIC
9 Novembre 2018 - Roma



*Grazie per
l'attenzione*

