

# DECISION POINTS IN THE MANAGEMENT OF ADULT COELIAC DISEASE IN PRIMARY CARE

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## INTRODUCTION

The clinical picture of coeliac disease has changed considerably with the increasing recognition that it may often present with ill-defined, extra-gastrointestinal symptoms. As a result it should no longer be considered a rare disease. The purpose of this document is to aid GPs in the recognition, diagnosis and management of adult coeliac disease.

## BASELINE FACTS

- The prevalence of coeliac disease in adults is at least 1 in 300, more than two-thirds of whom are undiagnosed (C)
- The primary treatment is with a strict gluten-free diet (B)
- Long-term risks include osteoporosis and a two-fold increase in gastrointestinal tumours, mainly due to increased incidence of small bowel adenocarcinoma and enteropathy associated T-cell lymphoma (C)

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## SYMPTOMS

### **Consider coeliac disease in patients presenting with:**

- Iron or folate deficiency anaemia
- Tired all the time ("TATT") or chronic fatigue
- Unexplained diarrhoea.

### **Particularly if the patient also has:**

- A family history of coeliac disease
- Insulin dependent diabetes mellitus
- Autoimmune thyroid disease
- Osteoporosis
- Infertility
- An undefined neurological disorder

# TESTING FOR COELIAC DISEASE

- **To make the diagnosis**  
*Endomysial antibody (EMA) test* is the initial screening test of choice. It will be negative, however, in the 2% of patients with coeliac disease who are IgA deficient. For this reason consider requesting an IgA level at the same time.
- **Patients with an uncertain diagnosis**  
Test by EMA after 6 weeks on a diet which includes four slices of bread daily. If the result is positive then intestinal biopsy should be offered.
- **To monitor adherence to diet**  
Serial measurements of EMA are a reliable marker for dietary adherence.
- **Population screening**  
An active case finding strategy is appropriate on present evidence (C). There is insufficient direct evidence of the health benefits of treating screen detected disease, or on the risks associated with having undetected coeliac disease, to support screening of the general population.

# BENEFITS OF LONG TERM COMPLIANCE

- Coeliac disease is strongly associated with osteoporosis. Compliance with a gluten-free diet, together with calcium and Vitamin D supplements, protects against further bone loss. It will also significantly increase bone mineral density, even in the early stages of treatment (C)
- Compliance with a gluten-free diet may result in conception when coeliac disease is the cause of infertility (C)
- Long-term dietary adherence protects against gastrointestinal malignance
- Non-compliance is associated with active enteropathy, symptomatic disease and long-term complications (C)

# FOLLOW-UP

- The principal purpose of regular follow-up is to support long-term dietary compliance. As such it is essential that a dietitian plays a key role in the management team
- Bone mineral density should be measured using dual energy X-ray absorptiometry (DEXA) at the time of diagnosis.

## **The test should then be repeated:**

- at the menopause for women
- at the age of 55 for men
- at any age should a fragility fracture occur

It is customary in hospital coeliac clinics to routinely measure haematological and biochemical indices.

There is a need for research evidence to support this as an effective clinical practice

Regular follow-up is an opportunity to provide patient centred care, reviewing the risks and benefits of treatment at different stages of life

# THE IMPORTANCE OF A DIETITIAN

An effective working relationship between the GP and a dietitian benefits patient care in the following ways:

- State registered dietitians can tailor dietary advice to individual requirements, and can assess the need for dietary supplements
- Product developments can be integrated into patient management
- The GP can be assured that appropriate volumes and types of products are being prescribed
- Dietitians are capable of taking the lead on the provision of follow-up care

The strength of these recommendations is based on the quality of supporting evidence and ranges from A (evidence from randomised controlled trials), B (evidence from other controlled or quasi-experimental studies), C (evidence from descriptive studies) to D (expert opinion and clinical experience).