Wrong question

In response to Dr Rashid et al's Clinical Review, "Home blood testing for celiac disease,"[1] published in the February 2009 issue, I would like to point out that a major problem with all the studies on celiac disease is that the wrong question keeps getting asked. The real question is, "Does the rapid test provide any true benefit to the patient?" The real *test* question, therefore, should be, "Does a gluten-free diet work?" Although gastrointestinal specialists will gasp in shock and disbelief, this does not require a blood test or a biopsy. What difference does it make to the patient whether or not diagnosis is confirmed if they won't be able to follow a diet regimen either way? It would be nice not to have a "disease" diagnosis that will cost the system a ton of money when the treatment is a test in and of itself and actually affects patient outcomes. Save the confirmatory test (and the endoscopy) for when the diagnosis is still unclear despite an adequate trial of dietary intervention. That will free up the endoscopy suite for patients that actually need something scoped and will leave some money in the budget for interventions that will actually help patients. Insurance companies will love this test as another excuse to jack up rates for no good reason.

—Yogi Sehgal MD
Sioux Lookout, Ont

Reference
1. Rashid M, Butzner JD, Warren R, Molloy M, Case S, Zarkadas M, et al. Home blood testing for celiac disease. Recommendations for management. *Can Fam Physician* 2009;55:151-3.

Response

Treating the symptoms of a patient without an attempt to make a diagnosis is bad medicine. For instance, one should not treat a 12-year-old boy with iron deficiency anemia with oral iron supplements. The cause of anemia must be established first. Although the ultimate goal of any therapy is to alleviate patients' symptoms, this must be done in the context of a clinical diagnosis. Celiac disease is a good example of such a practice.

The fact that abdominal pain or bloating improves with a gluten-free diet is no proof that the patient is suffering from celiac disease. Dietary therapies can have a substantial placebo effect in many gastrointestinal disorders. It must be remembered that celiac disease is a permanent sensitivity to gluten and the diet must be strictly gluten-free—forever—with no exceptions. Gluten sensitivity is not analogous to lactose intolerance, which is a noninflammatory, dose-related problem. Celiac disease is an all-or-nothing phenomenon: an individual either has it or does not. Even small amounts of gluten can cause intestinal mucosal injury. If this goes unchecked, the patient is at risk of developing serious complications like osteoporosis and cancer.

It is common for the physician (or individuals themselves) to put the patient on a trial gluten-free diet based on symptoms alone. The symptoms might improve; however, the patient soon realizes that a strict gluten-free diet is not easy to follow. The diet is costly, complex, and socially restrictive. Now the patient wants to know if celiac disease is truly present so that he or she can liberalize the diet, and a referral is made. Those of us who work in the field know how difficult this situation is for the patients, their families, and gastroenterologists.

The focus should be on improving awareness of celiac disease and advocating wider availability of serologic screening and timely access to endoscopy, rather than empirical therapy of this lifelong disorder.

—Mohsin Rashid MBBS MEd FRCPC
Halifax, NS

Data needed

Rashid et al[1] recommend a laboratory test for tissue transglutaminase (tTG) following positive tTG home-test results. Yet they fail to provide any data or rationale to support such unnecessary delays and duplication of costs, which needlessly increase the burden on our health care system. The specificity of the tTG rapid home test is reported to be very close to 100%.[2,3] Although Rashid and colleagues quite rightly decry the unfortunate practice of beginning a gluten-free diet before endoscopic biopsy, the unnecessary delays they recommend might well increase the frequency of patients beginning gluten-free diets prematurely.

As reported, false-negative test results will, predictably, increase in the absence of total immunoglobulin A measurement, owing to the increased incidence of immunoglobulin A deficiency among individuals with celiac disease. This limitation has long been recognized in association with all serology testing for antibodies suggestive of celiac disease. Home tests are, of course, similarly and equally compromised. However, Rashid et al do not provide any data suggesting that the specificity of the home test is compromised. The very study they cite to impugn the home test's sensitivity reported 100% specificity of this test in the group investigated.[2]

Admittedly, a reduction in sensitivity is reported for rapid tTG antibody testing when nurses who have not been trained in the administration of this test conduct population screening for celiac disease.[2] Rashid and colleagues point to the conclusions drawn by Korponay-Szabó et al, who mention that "extra training is needed