We read with interest the article entitled “Celiac disease variations of presentations in adults” by Makharia et al in a recent issue of the Journal.¹ This article reiterates that celiac disease is an important cause of malabsorption in India. Furthermore, it highlights an important fact that celiac disease can have varied manifestations, and therefore present to a specialist other than the gastroenterologist. However, several issues need attention.

The study focussed on varied presentations in adults i.e., age >18 years. The mean (SD) age of patients was 28.7 (11.2) years. However, the mean age of the “adults” – who presented with short stature was 15 years. Thus, it appears that some children were also included in the study. If this is indeed correct, then it is reasonable to accept a gain in height of 8 mm/year during the follow up period. The authors have not provided the definitive criteria for defining short stature in adults. This I feel is important as this study was designed for studying this aspect in the adult population.

The authors concluded that almost half of their adult patients presented with atypical manifestations. However, 71% patients had associated diarrhea, indicating that at best only 29% of patients presented without diarrhea.

In patients with liver cirrhosis, the diagnosis of co-existing celiac disease is fraught with problems. Anti-TTG antibody is known to have a higher false positivity rate in several diverse conditions including cirrhosis.² Conversely portal hypertension is known to be associated with abnormalities in jejunal morphology – the so called, portal hypertensive enteropathy.³ Three patients in this study had liver cirrhosis and diagnosis of the celiac disease in them may not be unequivocal as TTG was the only serologic marker determined. Celiac disease is known to co-exist with auto-immune hepatitis and primary biliary cirrhosis. However, no data are provided on the etiology of the co-existing liver disease in these patients.

The authors also describe one patient with normal duodenal biopsy and positive serology. This patient should technically be classified as potential celiac disease, rather than as manifest celiac disease.

The most important component in the diagnosis of celiac disease is the response to dietary gluten exclusion; authors have not provided adequate follow up data except for a passing reference in the discussion. Such data would have added to the value of the paper.

For the above mentioned reasons the number of the adult celiacs seen by the authors during the study period seems overinflated. These discrepancies notwithstanding, the paper adds to the available evidence that celiac disease is an important and easily treatable cause of malabsorption syndrome in northern India.

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References