CONDITIONS CAUSING MALABSORPTION Coeliac disease

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Coeliac disease is the most common cause of malabsorption in the UK with a reported prevalence of 1:1800, although this may be an underestimate. It is characterised by a hyper- trophic small bowel mucosa with atrophic villi and deep crypts. Loss of surface area and brush border enzymes results in malabsorption. Coeliac disease is caused by an abnormal immune response to gluten, a cereal protein, although the exact mechanism remains unclear. There is a genetic component, as the disease is more common in first-degree relatives and has an associa - hildren, coeliac disease presents with tion with HLA-B8. In c steatorrhoea and growth retardation. In adults, it may result in diarrhoea and weight loss but many patients simply present tients develop a charac - with iron deficiency anaemia. Some pa teristic skin rash (dermatitis herpetiformis). The diagnosis is usually made after an endoscopic duo - denal biopsy allows pathological examination of the mucosa. A /uni00A0 blood test for immunoglobulin A anti-tissue transglutaminase (IgA tTGA) is relatively sensitive and specific for diagnosing - coeliac disease, making it the preferred test for detection. Mea surement of IgA antiendomysial antibodies (anti-EMA) should be used as a confirmatory test. A duodenal biopsy is usually - indicated to confirm the diagnosis. The biopsy usually shows flattening of the mucosa, marked inflammatory changes and characteristic findings of intraepithelial lymphocytes. All tests should be performed while the patient is on a gluten- containing diet as false-negative tests may occur if on a gluten- free diet. Patients with coeliac disease may develop an acute inflam matory condition of the small intestine (ulcerative jejunoileitis) and have an increased risk of small bowel lymphoma and ade nocarcinoma. T he main treatment for coeliac disease is the withdrawal of gluten from the diet by avoiding wheat, rye and barley . Sur gery does not usually play a role in the management of disease and is primarily reserved for resection of malignancy .

(d) (e) Figure 74.9 Common types of blind loop: (a) self- /f_i lling: de /f_i ciency occurs; in Pólya gastrectomy; (d) jejunal diverticula; (e) intestinal stricture causing stasis;

Revision #1
Created 2025-12-31 15:27:20 UTC by Omar Ayman
Updated 2025-12-31 15:27:20 UTC by Omar Ayman