PRÉSENTATION CAS CLINIQUE

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DR. CHRISTOS MARAGKOUDAKIS

Hôpitaux Universitaires Genève

SERVICE SMPR

CAS CLINIQUE

Patient de 39 ans

Originaire d'Inde, fleuriste, non fumeur, OH à risque

MC : *Epigastralgies* Chroniques post prandial > 4 ans & *Pyrosis* associé avec aliments gras & piquants

AP

- Asthme allergique
- Alcoolisme chronique depuis 2016

TRAITEMENT

- Symbicort en R & Cetirizine en R
- Nexium en R

DÉMARCHES DIAGNOSTIQUES 2017/2018

Hb 150 mg/dl

Ferritine 50 mg/dl, Acide folique 1.4 mg/dl, Vit B12 sp

Test hépatiques aligné

Breath test ***neg***

U/S abdo: ***Stéatose*** hépatique

Gastroscopie : Suspicion de gastrite & d'***atrophie*** duodénale

DÉMARCHES DIAGNOSTIQUES 2018/2019

- Hb 121 mg/dl, MCV 72.4, MCH 24.2
- Ferritine 7 mg/dl, Acide folique 2.1 mg/dl, Vit B12 sp
- Test hépatiques légèrement perturbés
- U/S abdo: ***Stéatose*** hépatique
- Anti-translgutaminases à 128 UI/ml
- Gastroscopie : Atrophie duodénale avec muqueuse en pavé ***«scalopine»***

DIAGNOSTIC

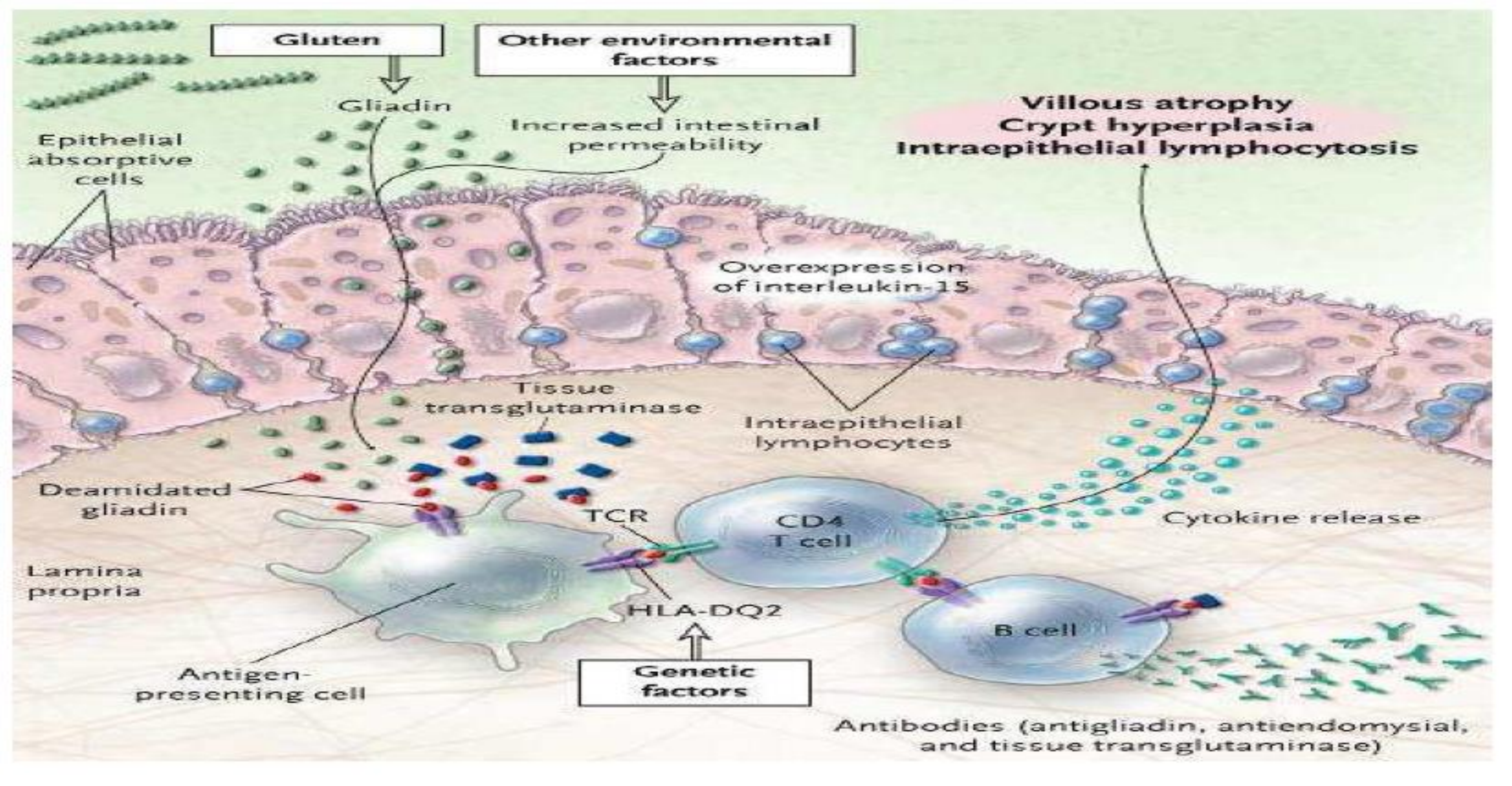
MALADIE COELIAQUE

Epidémiologie 1/100 à 1/300

Age de 10 à 40 ans

Symptomatologie: Douleurs abdominales, météorisme, diarrhées (stéatorrhées),perte du poids OU *asymptomatique*

PATHOPHYSIOLOGIE



MANIFESTATIONS EXTRADIGESTIVES

Tableau I. Manifestations extradigestives non malignes

Dermatologiques	
• Disparition des plis cutanés, pétéchies, ecchymoses • Œdèmes périphériques	• Dermatite herpétiforme, hyperkératose folliculaire, dermatite atopique
Endocrinologiques et nutritionnels	
• Aménorrhée, infertilité, impuissance • Hyperparathyroïdisme secondaire	• Déficit en vitamines A, du groupe B, D, E, K • Déficit en calcium, protéine, magnésium, albumine, fer
Hématologiques	
• Anémie • Dyscrasie, hémorragie, hématurie	• Hyposplénisme avec thrombocytose, corps de Howell-Jolly
Hépatiques	
• Perturbation des transaminases	• Fibrose hépatique, cirrhose
Musculaires	
• Atrophie, tétanie, faiblesse	
Neuropsychiatriques	
• Neuromyopathie périphérique, ataxie, maladie démyélinisante centrale, épilepsie	• Trouble de la thymie, dépression, céphalées • Trouble visuel
Pulmonaire	
• Hémosidérose pulmonaire idiopathique	
Pédiatrique	
• Trouble de la croissance staturo-pondérale	
Rénale	
• Glomérulopathie à IgA	
Rhumatologiques	
• Ostéoarthropathie, ostéopénie, ostéoporose, ostéomalacie	
Autres	
• Etat fébrile • Hypocratisme digital	• Aphtes buccaux, glossite, chéilite • Défaut émail dentaire

MALADIES ASSOCIÉES

Tableau 2. Maladies associées à la cœliaquie

Inflammatoires	
• Œsophagite à éosinophiles	• Colite microscopique
• Maladies inflammatoires chroniques intestinales	• Sarcoïdose
Auto-immunes	
• Diabète de type I	• Cholangite sclérosante primaire
• Dermatite herpétiforme	• Arthrite rhumatoïde
• Thyroïdite auto-immune	• Syndrome de Sjögren
• Hépatite auto-immune, cirrhose biliaire primitive	• Pancréatite auto-immune
Génétiques	
• Syndrome de Down (trisomie 21)	• Déficit en immunoglobuline A
• Syndrome de Turner (monosomie X)	

QUAND TESTER ?

WHEN TO TEST FOR CD

(1) Patients with symptoms, signs, or laboratory evidence suggestive of malabsorption, such as chronic diarrhea with weight loss, steatorrhea, postprandial abdominal pain, and bloating, should be tested for CD. (Strong

(2) Patients with symptoms, signs, or laboratory evidence for which CD is a treatable cause should be considered for testing for CD. (Strong recommendation, moderate

(3) Patients with a first-degree family member who has a confirmed diagnosis of CD should be tested if they show possible signs or symptoms or laboratory evidence of CD. (Strong recommendation, high level of evidence)

degree family member who has a confirmed diagnosis of CD. (Conditional recommendation, high level of evidence)

(5) CD should be sought among the explanations for elevated serum aminotransferase levels when no other etiology is

(6) Patients with Type I diabetes mellitus (DM) should be tested for CD if there are any digestive symptoms, or signs, or laboratory evidence suggestive of CD. (Strong recommendation, high level of evidence)

MALADIE COELIAQUE

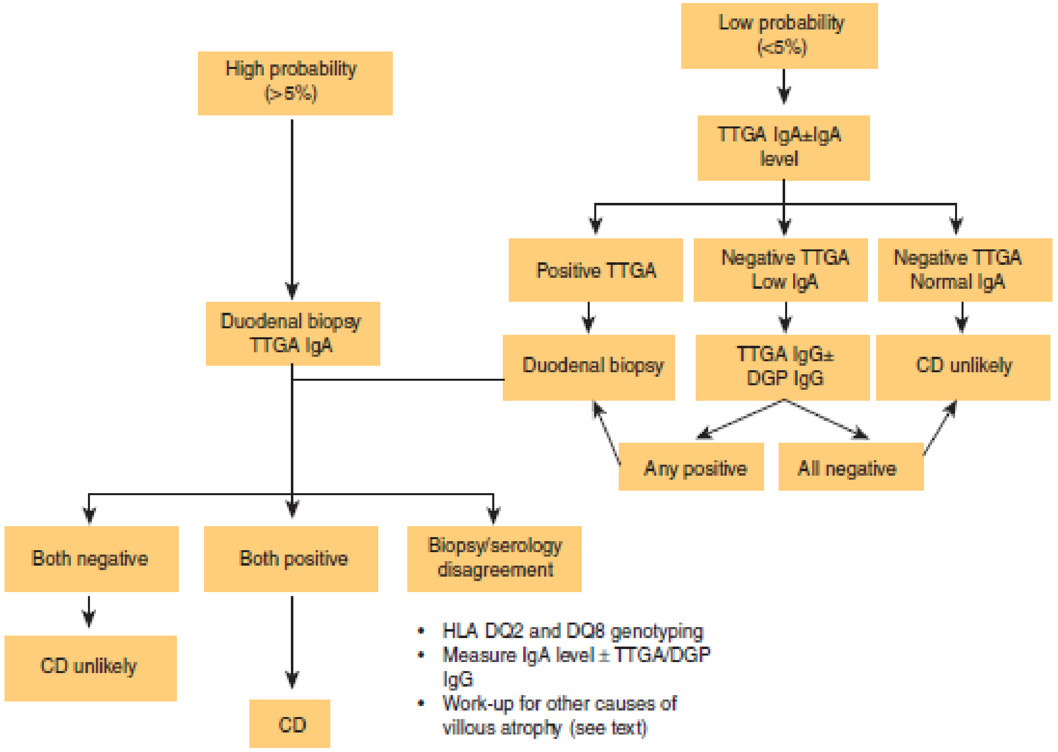


Figure 1. Celiac disease (CD) diagnostic testing algorithm. DGP, deamidated gliadin peptide; HLA, human leukocyte antigen; Ig, immunoglobulin; TTGA, tissue transglutaminase antibody.

TESTS SÉRIQUES (I)

Tests sériques pour le diagnostic de la maladie coeliaque			
Test	Sensibilité % (Intervalle)	Spécificité % (Intervalle)	Commentaires
Anticorps anti-tTG IgA	>95.0 (73.9–100)	>95.0 (77.8–100)	Recommandé comme test de dépistage de premier niveau
Anticorps anti-tTG IgG	Variable (12.6–99.3)	Variable (86.3–100)	Chez les patients présentant une déficience en IgA
Anticorps anti-dGP IgG	>90.0 (80.1–98.6)	>90.0 (86.0–96.9)	Chez les patients présentant une déficience en IgA Chez les jeunes enfants
Anticorps antiendomysium IgA	>90.0 (82.6–100)	98.2 (94.7–100)	Pour les patients présentant un diagnostic incertain
HLA-DQ2 or HLA-DQ8	91.0 (82.6–97.0)	54.0 (12.0–68.0)	Valeur prédictive négative élevée

tTG: Transglutaminase tissulaire
dGP: Peptide de la Gliadine désaminée

TESTS SERIQUES (II)

(1) IgA-TG2 antibody is the preferred single test for detection of CD at any age. (*Strong recommendation, high level of evidence*)

(2) Total IgA level needs to be measured concurrently with serology testing to determine whether IgA levels are sufficient. (*Strong recommendation,*

based testing (IgG-DGPs or IgG-TG2) should be performed at diagnosis and follow-up. (*Strong recommendation, moderate level of evidence*)

(4) All diagnostic serologic testing should be done while patients on a gluten-containing diet. (*Strong recommendation, high level of*

(6) Antibodies directed against native gliadin (AGA) are not recommended for the primary detection of CD. (*Strong recommendation, high*

CONFIRMATION DU DIAGNOSTIC

CONFIRMATORY TESTING IN CD

Recommendations

(1) The confirmation of a diagnosis of CD should be based on a combination of findings from the medical history, physical examination, serology, and upper endoscopy with histological analysis of multiple biopsies of the duodenum. (Strong recommendation, high level of evidence)

(2) Upper endoscopy with small-bowel biopsy is a critical component of the diagnostic evaluation for persons with suspected CD and is recommended to confirm the diagnosis. (Strong recommendation, high level of evidence)

(3) Multiple biopsies of the duodenum (one or two biopsies of the bulb and at least four biopsies of the distal duodenum) are recommended to confirm the diagnosis of CD. (Strong recommendation, high level of evidence)

(4) Lymphocytic infiltration of the intestinal epithelium in the absence of villous atrophy is not specific for CD and other causes should also be considered. (Strong recommendation, high level of evidence)

AUTRES CAUSES D'ATROPHIES DUODÉNALE

Table 3. Other causes of villous atrophy in duodenum
Tropical sprue
Small-bowel bacterial overgrowth
Autoimmune enteropathy
Hypogammaglobulinemic sprue
Drug-associated enteropathy (e.g., olmesartan)
Whipple disease
Collagenous sprue
Crohn's disease
Eosinophilic enteritis
Intestinal lymphoma
Intestinal tuberculosis
Infectious enteritis (e.g., giardiasis)
Graft versus host disease
Malnutrition
Acquired immune deficiency syndrome enteropathy

ALIMENTS CONTENANT GLUTEN

Tableau 4. Aliments contenant du gluten et principes de base du régime
Recommandations de l'Association romande de la cœliaquie; www.coeliakie.ch.

- Exclure les aliments contenant du froment, du seigle et de l'orge
- Ces céréales seront remplacées par d'autres sans gluten: l'avoine, le riz, le maïs, le millet, le sarrasin, ainsi que par des farines à base de pommes de terre, de soja, lentilles, pois, tapioca, châtaignes

Supprimer

Tableau 5. Principales sources cachées de gluten

- Bouillons, soupes
- Bonbons, sucreries
- Sauces, marinades, sauce soja
- Salades préparées
- Thé aux herbes
- Viandes, fruits de mer préparés
- Baumes pour les lèvres
- Médicaments
- Jouets, pâte à modeler
- Dentifrices

certaines boissons chocolatées
- Boissons maltées, bières, sodas
- Médicaments avec gluten, colorants, émulsifiants, additifs

En règle générale, il est conseillé de donner autant que possible une alimentation naturelle, préparée à la maison avec des denrées connues, sans gluten
- Lire chaque composition des aliments, médicaments, produits consommables
- Limiter les produits laitiers au début du régime sans gluten et définitivement s'il existe une intolérance au lactose

MONITORING (I)

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

(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

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,

(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

(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)

MONITORING (II)

Table 4. Suggested follow-up scheme for adult CD patients.

At diagnosis (physician and dietitian)	Physical examination including BMI Education on CD Dietary counselling by a skilled dietician Recommend family screening (DQ2/D8 and coeliac serology) Recommend membership of coeliac national society or support group Coeliac serology (if not previously obtained) Routine tests (complete blood count, iron status, folate, vitamin B12, thyroid function tests, liver enzymes, calcium, phosphate, vitamin D)/bone densitometry at diagnosis but not later than 30-35 years of age
At 2nd visit 3-4 months (physician and dietitian)	Assess symptoms and coping skills Dietary review Coeliac serology (IgA-TG2)
At 6 months (physician) (by telephone)	Assess symptoms Dietary review Coeliac serology Repeat routine tests (*if previously abnormal*)
At 12 months (physician and dietitian)	Assess symptoms Physical examination (on indication) Dietary review Coeliac serology Repeat routine tests Small-bowel biopsy (*not routinely recommended, see text*)

TAKE HOME MESSAGE

1st STEP   THINK ABOUT IT

2nd STEP   THINK ABOUT IT

3rd STEP   THINK ABOUT IT

Dosage de TTGA IgA+IgA

Biopsies *distal duodenum*

Follow UP every year + *Dietitian*

RÉFÉRENCES

- ACG Clinical Guidelines: Diagnosis and Management of Celiac Disease*Am J Gastroenterol* 2013; 108:656–676; doi: 10.1038/ajg.2013.79; published online 16 April 2013
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