H Pylori and Celiac Disease

H Pylori – Pearls

- **Key screening tests**
  - **Stool antigen**
  - **Urease breath test**
  - **False negative rate with PPI – need to withdraw PPI for roughly 2 weeks prior.**
  - H pylori serology should not be routinely ordered

- **Who should be tested/indications for therapy**
  - Active or Past Peptic ulcer disease
  - Malignancy: low grade MALT lymphoma, endoscopic resected gastric cancer
  - Dyspepsia
  - Gastric biopsies showing H pylori
  - Chronic ASA/NSAIDS
  - Iron deficiency anemia
  - ITP

- **Who <u>not</u> to screen**
    - GERD: BUT if positive, should offer treatment, may worsen GERD

- **Unclear**
  - Famiy history of gastric cancer

Lines of therapy

- **First line**
  - Clarithromycin 500 mg PO BID + Amoxil 1000 mg PO BID + Metronidazole 500 mg PO BID + PPI BID x 14 days
  - Hpac: we are unsure local clarithromycin resistance rates
- **Second Line:**
  - Bismuth subsalicylate 262 mg 2 tabs QID + Tetracycline 500 mg PO QID + Metronidzole 500 mg PO QID + PPI BID x 14 days
- **Third Line:**
  - Levofloxacin 500 mg PO once daily + Amoxil 1g PO BID + PPI BID x 14 days
- More complex regimens (ie. Hybrid/Sequential) and 4th line also used in Canadian and American guidelines

Confirmation of Eradication

- Should be offered to ensure successful therapy
  - Stool antigen or breath test roughly 4 week post therapy and 2 weeks off PPI

Celiac Disease

- **When to suspect**
  - IBS symptoms
  - Iron deficiency
  - Dermatitis herpetiformis
  - Premature osteoporosis
  - Unusual neuropsychiatric disorders
  - Hyposplenism (Howell Jowell bodies seen on blood film)

Celiac disease

- **Testing**
  - Must be done on Gluten **containing** diet
  - Anti – TTG (IgA): best screening test, do not require IgA testing as lab screens for IgA deficiency
    - Sensitivity/Specificity > 95%
  - Deaminated gliadin peptides (IgA, IgG): mainly used if IgA deficiency, young children – needs lab approval to order
- **Endoscopy**
  - TTG positive
  - TTG negative + family history (first degree preferred)
- **HLA testing**
  - DQ2/DQ8: negative predictive value of 99%
  - When to consider
    - Discordance between serology/biopsy
    - Unkeen to go on gluten containing diet/gastroscopy

Celiac disease

- **Treatment**
  1. Gluten free diet: lifelong, refer to dietician
     1. Monitor TTG every 6 months until normalized then annually. Check B12/Fe/Vitamin D
  2. Tax benefits: victoriaceliac.org
  3. Bone health: Vitamin D, consider baseline bone density
  4. Hyposplenism: pneumovax considered
  5. 1st degree family member screening: TTG or EGD if negative/symptoms
  6. Malignancy screen: not indicated if TTG negative on a gluten free diet, no clear guidelines
  7. Follow up endoscopy: not routinely done

Refractory Sprue

- Cause for persistent TTG in spite of gluten free diet
  - Often takes 1-2 years for TTG to normalize, especially if high titer at diagnosis.
  - Best to have dietician follow patients who are having slow response

- Need to first rule out hidden gluten as cause (most common issue)
  - Eg. Cosmetics, household appliances like toasters

- If concerned/not clear refer back to GI for repeat EGD
  - Type 1: normal intraepithelial lymphocytes
  - Type 2: abnormal T cells – at risk of lymphoma