The Neurology of Gluten Sensitivity: Science vs. Conviction

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The neurology of gluten sensitivity: science vs. conviction

Marios Hadjivassiliou and Richard Grünewald
Department of Neurology, The Royal Hallamshire Hospital, Sheffield, UK; E-mail: m.hadjivassiliou@sheffield.ac.uk

EDITORIAL COMMENT
Nottingham and Sheffield are less than 50 miles apart, but clearly patients are managed very differently in the two cities when it comes to searching for the neurological complications of coeliac disease or gluten sensitivity. Whilst the observational epidemiological arguments rage backwards and forwards, the proof that patients are benefited – or not – by a gluten free diet will only come from randomised trials. After all, observational epidemiology can get the wrong answer, for example with hormone replacement therapy and the risk of stroke. However, these trials will probably have to be done by neurologists who are much less certain of their position than those in Sheffield and Nottingham who have already made up their minds to treat or not to treat.

The proliferation of publications on the neurological manifestations of gluten sensitivity reflects a surge of interest in this fascinating group of immune-mediated diseases. Thorough knowledge of the literature on the subject is essential to avoid the bias in interpretation of such studies apparent in some recent editorials, in particular the article by Pengiran Tengah and Wills in the December 2003 issue of Practical Neurology.

In 1996 we published a paper entitled ‘Does cryptic gluten sensitivity play a part in neurological illness?’ (Hadjivassiliou et al. 1996). On the basis of a markedly increased prevalence of circulating antigliadin antibodies in a group of patients with otherwise idiopathic neurological dysfunction, we concluded the answer was ‘yes’. A follow-up paper demonstrated that the most common problem was ataxia and we introduced the term ‘gluten ataxia’ (Hadjivassiliou et al. 1998). This is no surprise. A review of all
Questions and answers about the neurology of gluten sensitivity

WHAT ARE THE MOST RELIABLE TESTS FOR GLUTEN SENSITIVE ENTEROPATHY?

The diagnostic criteria for coeliac disease (based on a histological enteropathy, villous atrophy) associated with abnormally high levels of anti-tissue transglutaminase antibodies) are almost always able to identify coeliac disease. However, the clinical challenge is not always identifying coeliac disease but rather identifying gluten enteropathy as a presenting form. We have seen a patient with cerebellar ataxia and a gluten-free diet. Both patients have coeliac disease, as do many patients with enteropathy as the "gold standard" for the diagnosis of dermatitis herpetiformis and coeliac disease, respectively. The diagnostic criteria include the following: (i) a histological enteropathy (villous atrophy) associated with a chronic inflammatory infiltrate (Fig. 1a) and low levels of IgA anti-gliadin antibodies (AMA), endomysial antibodies (EMA), and tissue transglutaminase antibodies (tTG). These are the most specific and sensitive tests (Fig. 1b). The combination of low levels of IgA antiguad antibodies and a gluten-free diet is essential to confirm the diagnosis. In addition, patients may sometimes present with a gluten-sensitive enteropathy and lead to symptomatic improvement. However, the clinical challenge is not always identifying coeliac disease but rather identifying gluten enteropathy as a presenting form.

WHAT ARE THE MOST PREDICTABLE TESTS FOR GLUTEN SENSITIVE ENTEROPATHY?

The diagnostic criteria for coeliac disease (based on a histological enteropathy, villous atrophy) associated with abnormally high levels of anti-tissue transglutaminase antibodies) are almost always able to identify coeliac disease. However, the clinical challenge is not always identifying coeliac disease but rather identifying gluten enteropathy as a presenting form. We have seen a patient with cerebellar ataxia and a gluten-free diet. Both patients have coeliac disease, as do many patients with enteropathy as the "gold standard" for the diagnosis of dermatitis herpetiformis and coeliac disease. In addition, patients may sometimes present with a gluten-sensitive enteropathy and lead to symptomatic improvement. However, the clinical challenge is not always identifying coeliac disease but rather identifying gluten enteropathy as a presenting form.

WHICH NEUROLOGICAL CONDITIONS ARE ASSOCIATED WITH COELIAC DISEASE?

Neuropathy is a well-recognized complication of coeliac disease, and it is not always helpful to the clinical status of the patients. Several studies have demonstrated that a gluten-free diet is effective for treating patients with neurological disease. The association of epilepsy with coeliac disease has been suggested by a number of authors (Goldstein et al. 1992) but denied by others. Holmes et al. suggested a prevalence of 3.6% in a group of 100 patients with established coeliac disease. Italian studies suggested a lifetime epilepsy prevalence of 3.6% (Holmes et al. 1992). Holmes et al. (1992) reported a gluten-free diet to be associated with a gluten-free diet. However, clinical trials have been few in number and of small scale. There have been few descriptions of patients who have been treated with gluten-free diets.
20 times higher than what it was thought to be 20 years ago because most cases are clinically silent. It is important to realize that amongst these 10% antigliadin antibody positive people lurks those with ‘silent’ gluten sensitive enteropathy. Furthermore, the high prevalence of the HLA haplotype associated with coeliac disease in those patients with circulating antigliadin antibodies but no enteropathy emphasizes that these antibodies represent more than coincidental antigenic cross-reactivity.

These observations have important implications for health care. It is ill-considered to suggest that antigliadin antibodies should not be used as a screening tool because they are found in ‘healthy’ individuals. Such an assertion would exclude a role for antineutrophil cytoplasmic antibodies in the diagnosis of vasculitis or of rheumatoid factor in the diagnosis of rheumatoid arthritis. It is also irresponsible to suggest that neurological patients should not be screened for coeliac disease unless additional factors are present such as unexplained anaemia or evidence of malabsorption. We have already demonstrated that gastrointestinal symptoms and occult malabsorption are rare in this patient group, even in the presence of an enteropathy (Hadjivassiliou et al. 1998). It is also well known that for every patient with coeliac disease presenting to the gastroenterologist there are eight without gastrointestinal symptoms (Fasano & Catassi 2001).

The evidence for the existence of gluten ataxia (sporadic ataxia with positive antigliadin antibodies) as a disease entity is now overwhelming. The syndrome is characterized by ataxia, antigliadin antibodies, the HLA haplotype associated with gluten sensitivity, Purkinje cell antibodies (Hadjivassiliou et al. 2002a); high chemokine IP-10 and often oligoclonal bands in the CSF (Hadjivassiliou et al. 2003c); inflammatory pathology of the cerebellum at postmortem (Hadjivassiliou et al. 1998), and the response to a gluten-free diet (Hadjivassiliou et al. 2003a).

The source of this dispute about the epidemiology of gluten ataxia comes mainly from two observations. Firstly, in some epidemiological studies, although the prevalence of antigliadin antibodies in sporadic ataxia was much higher than in healthy controls, the difference was not statistically significant. Such studies were under-powered to detect a significant difference. As an example, a recent study (Abele et al. 2003) demonstrated antigliadin antibodies in 8% of healthy controls and 19% in patients with sporadic idiopathic ataxia. A sample size of more than 300 would have been required to have 80% power to exclude the null hypothesis at P < 0.05. Yet the sample size in this study was 105. Only one of the studies published (Hadjivassiliou et al. 2003b; which confirms the association of gluten-sensitivity with ataxia) has adequate statistical power. All the other smaller studies showed a trend in favour of a higher prevalence of antigliadin antibodies amongst idiopathic sporadic ataxias (Abele et al. 2003; Pellecchia et al. 1999; Bürk et al. 2001; Bushara et al. 2001; Abele et al. 2002; Luostarinen et al. 2001). Secondly, two studies (Abele et al. 2003; Bushara et al. 2001) have shown the prevalence of antigliadin antibodies to be high in patients with familial ataxias. Whilst these studies also suffer from small sample sizes, they stimulate consideration of the interaction of gluten sensitivity with familial ataxias. Gluten sensitive enteropathy is familial in about 10% of patients with coeliac disease, not surprisingly given its strong association with HLA. It is likely therefore that gluten ataxia may have a similar familial predisposition. We have certainly encountered patients with familial gluten-related neurological dysfunction who respond to a gluten-free diet.

What about those cases with a genetically characterized ataxia? Could cerebellar degeneration provoke an immune response to gluten? We have demonstrated binding of antigliadin antibodies to Purkinje cells (Hadjivassiliou et al. 2002a). Could Purkinje cell degeneration provoke the production of antibodies to gliadin? Arguing against this is our failure to find Purkinje cell antibodies in the sera of patients with genetically characterized inherited ataxias (Hadjivassiliou et al. 2002a). Furthermore, cerebellar degeneration in the context of a genetically characterized inherited ataxia is not known to be associated with a pronounced inflammatory component, perhaps an important prerequisite in the production of such antibodies.

The conclusion of the article that ‘there is little evidence for the existence of true gluten sensitive neurological syndromes’ is dangerously misleading. Neurological manifestations of gluten sensitivity are a scientific fact, not a theological issue. Whilst the debate continues, we owe it to our patients to screen them effectively for gluten sensitivity with the simple widely available antigliadin antibody test so that we do not in the meantime deprive them of a harmless but potentially effective treatment in the form of a gluten-free diet.
REFERENCES

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