Gluten enteropathy. The role of ART and multiresonance therapy

O.I. Eliseeva
(LLC "Eliseeva Methodological Center", Moscow, Russia)

Gluten enteropathy (GEP) is an immune-dependent inflammation of the small intestine lining in people with genetic sensitivity to gluten, a protein found in cereals.

Doctors of our Center used the ART method to often test allergies to wheat, rye, barley. But we did not treat this as a pathology of the EFG. Therefore, all of our treatments and restrictions on the intake of cereals resulted in only to temporary improvements. The evania of the gastrointestinal tract reappeared and decreased disease is the disability of patients.

The introduction of clinical practice of immunological methods of diagnostics has changed the traditional understanding celiac disease (GEP) as a rare disease. Epidemiological screening studies based on the determination of antibodies to gliadin have shown that the disease occurs in dozens of people, and in risk groups - hundreds of times more often than previously thought. This prevalence is explained by the identification of the proportion of latent, low-symptom forms. In this case, obvious signs of the disease (diarrhea, steatorrhea, exhaustion, anemia, hypoproteinemia, etc.) may be absent for a long time. As a result, patients are deprived of the opportunity to receive etiotropic therapy for many years, and often throughout their lives.

Partial, and in a number of patients, atrophy of the villi of the mucous membrane of the small intestine, which develops in GEP, deep dystrophic changes in enterocytes lead to impaired intestinal digestion and absorption. The disease always begins in childhood, but sometimescan be subclinical for a long time and appear for the first time in adults or even the elderly. GEP is a common disease of children and adults; it occurs in women approximately 3-4 times more often than in men.

The clinical picture of the disease in adults is often erased and for a long time can be limited to vague abdominal pain, bloating, episodic diarrhea and increased fatigue. The factors provoking an exacerbation of the disease or the manifestation of the first clinical symptoms of EBS are most often pregnancy and childbirth, neuropsychiatric injuries, less often concomitant diseases, acute intestinal infections. In typical cases, the clinical picture is characterized by diarrhea with polyfecal and steatorrhea, the development of severe malabsorption syndrome. In the future, persistent constipation may develop with the development of severe hemorrhoids.

A common symptom is bloating, which increases in the evening. There may be dull pains of a diffuse nature in all parts of the abdomen associated with bloating. Clinically, the syndrome of impaired absorption is characterized by a violation of the general condition - weakness, decreased performance up to its persistent loss, progressive weight loss. Weight loss can range from 5 kg to 30 kg.

If the disease began in childhood, patients lag behind in growth and physical development.

There are the following clinical forms or variants of gluten

enteropathy:

1. The typical form is characterized by the development of the disease in early childhood age, diarrhea with polyfecal and steatorrhea, anemia, metabolic disorders inherent in severe malabsorption syndrome.

2. In the latent form, the disease is subclinical for a long time and first appears in adulthood or even in old age. With a careful study of the anamnesis, it can be revealed that in childhood, patients lagged behind in physical development, often they had decreased hemoglobin or mild signs of hypovitaminosis (cracks in the corners of the mouth, glossitis, etc.) were observed.

From the moment the first signs of the disease appear, the clinical picture may be similar to the typical or low-symptom form:

one. Torpid (refractory) shape characterized by a severe course, the lack of effect from conventional treatment, and therefore it becomes necessary to use glucocorticoid hormones.

2. When atypical form clinical syndromes observed with EDS, are relatively rare, and in the clinical picture of the disease, extraintestinal symptoms prevail, due to impaired absorption (anemia, hemorrhages, osteoporosis) or immune disorders (allergies, autoimmune thyroiditis, type 1 diabetes mellitus, Sjogren's syndrome, etc.).

3. The asymptomatic form is characterized by the absence of clinical symptoms of the disease. It is diagnosed during broad epidemiological surveys of risk groups and can be of two options:

- latent celiac disease: there are no symptoms of malabsorption, but the mucous membrane shell thin intestines with characteristic signs hyperregenerative atrophy and / or increased quantity interepithelial lymphocytes (MEL);
- potential (probable) celiac disease.

The second form of pre-disease is characteristic of those who have a mucous membrane the small intestine is normal, there are no symptoms of impaired absorption, but the risk of HEP disease is very high.

Lymphoma and small bowel cancer are 40–100 times more likely to develop in patients with HEP. Cancers of the esophagus, pharynx, stomach and rectum are also more often diagnosed. IN GENERAL MALIGNANCES BECOME THE CAUSE OF DEATH IN Roughly HALF PATIENTS WITH NONTREATED CELLIACIA. An unmotivated deterioration in the condition of patients and a number of laboratory parameters with strict adherence to a gluten-free diet is the basis for the assumption of a complication of the disease by a malignant neoplasm. The possibility of lymphoma development must be foreseen in each case of torpid course of celiac disease, that is, in the absence of the effect of long-term treatment, despite strict adherence to the diet.

Currently, a number of diseases are distinguished, genetically and autoimmune associated with celiac disease.

Diseases genetically associated with celiac disease: herpetiformis Dühring's dermatitis, recurrent aphthous stomatitis and hypogammaglobulinemia, Down syndrome, autism, schizophrenia.

Autoimmune diseases associated with celiac disease:

insulin-dependent diabetes mellitus, autoimmune thyroiditis, primary biliary cirrhosis, autoimmune hepatitis, Sjogren's syndrome, rheumatoid arthritis, vasculitis, systemic lupus erythematosus, recurrent pericarditis, fibrous alveolitis, polymyositis, dementia, etc.

For all of these diseases, clinical symptoms, characteristic of the GEP, may be absent, however, increased values of serological tests and morphological changes in the mucous membrane of the small intestine, characteristic of celiac disease, are revealed. The appointment of a gluten-free diet in some cases allows to reduce the clinical manifestations of the disease, and also reduces the risk of complications in the form of the development of malignant neoplasms.

Since GEP can take a long time under the guise of various autoimmune diseases, celiac disease should be considered an interdisciplinary problem, i.e. applicable to all medical specialties.

To survey the population in order to identify those who have risk factors in in relation to GEP, as a screening diagnosis, immunological methods. use The definition of antibodies to especially ego a-fraction in gliadin and immunoglobulins (Ig) of class A is used through enzyme immunoassay and determination of antibodies to tissue components of the lamina propria of the small intestine mucosa, in particular to endomysium and tissue transglutaminase. All patients who show increased concentrations of antigliadin antibodies Ig of class A and / or titers of endomysial antibodies and tissue transglutaminase are shown morphological examination of the mucous membrane of the small intestine (jejuno-or duodenobiopsy) for definitive diagnosis.

For young children, the presence of antibodies to Ig A gliadin, Ig A endomysia, and tissue transglutaminase is sufficient for diagnosing and prescribing a gluten-free diet.

The appointment of a gluten-free (grain-free) diet is of diagnostic value. Its positive effect is often shown already within the first month. However, in some patients, a distinct therapeutic effect occurs after 6 months or later.

It should be noted that there is no direct relationship between the consumption of bread and cereals and the nature of the stool with EEP, therefore, patients never associate the development of the disease with bread intolerance. The damaging effect of gluten can be detected only by the degree of atrophy of the mucous membrane of the small intestine and its decrease with careful adherence to the diet.

The main treatment for GEP is strict life-long adherence to a gluten-free (grain-free) diet. However, the treatment of various forms of celiac disease has its own characteristics. With an erased, oligosymptomatic course of the disease, along with a gluten-free diet, multivitamins, periodic courses of taking enzyme and choleretic drugs are prescribed.

With a gluten-free diet, wheat, rye, and barley are completely excluded from the diet. Allowed to use up to 60 g of oats per day. Long-term follow-up of patients with HEP shows that those who strictly adhere to the gluten-free diet have more stable clinical remission than those who violate it.

In the group of patients who do not strictly adhere to a gluten-free diet, that is, who occasionally consume a few bread products, there is a pronounced tendency to exacerbate diarrhea with polyfecal matter, weakness, symptoms of hypopolivitaminosis, and calcium deficiency persist for a long time.

With long-term adherence to a gluten-free diet, the concentration of antigliadin and antiendomysial antibodies in IgA is significantly reduced, up to threshold values. In patients who have ceased to follow a diet, the content of antigliadin and antiendomisial antibodies increases sharply even before the onset of clinical symptoms of a relapse of the disease.

With strict adherence to the gluten-free diet, the normal structure of the mucous membrane is restored in some patients with HEP after 6-12 months shell thin intestines. Have the rest villi remain atrophied, but epithelial height cases. iya clearly increases in all Thus, the main reab method litational therapy patients suffering from HEP, is strict adherence to a gluten-free diet throughout life.

In our testing practice for 2006, the gap was established in only six cases, but if we had checked patients more carefully, their number would have been greater.

Clinical example

I. A.K.P., 50 years old. Anamnesis. Diseases of the gastrointestinal tract manifested themselves throughout life. There has been a significant deterioration in the past 10 years. The patient was examined in clinics and even abroad. Three years ago in England he was operated on hemorrhoids in serious condition, part of the sphincter was operated on. Present complaints: diarrhea alternating with constipation, indigestion, clayey stools, sometimes frothy, abdominal pain, bloating, weakness. On ART: depletion of immunity, anemia, osteoporosis, enterocolitis, autoimmune thyroiditis. Intestinal infection is not tested. In the allergy section, rye, wheat, barley, and rice are tested.

Gliadin antibody testing is recommended. Laboratory test result: antibody titer to gliadin 60 IU / ml (high).

Treatment is recommended:

1. Exclude cereals and rice.
2. Take decoctions of oats, flax seeds.
3. BRT along the meridians: lungs, bladder, allergies.
4. EPT - E-programs: 1; 124; 192; eleven.
5. Complex preparation: organopreparation (ileum D6, small intestine mucosa D6, jejunum D6) + homeopathy (Colocynthis D6, ColehicumD6)
6. Homeopathic medicine - Nux vomica comp.

After 2 weeks, the patient's well-being improved significantly, but the immune system remained in a state of exhaustion. Added to the above treatment: TF (Transfer factor classic), 4 caps. alternate a day with Advensd TF, 3 capsules a day for 20 days. Then, every 20 days, reduce 1 capsule (both drugs).

After 1 month, the patient's well-being improved significantly. Analysis

for antibodies to gliadin 40 IU / ml (weakly positive).

After 4 months: the patient feels well. Analysis for antibodies to gliadin 30 IU / ml (figure of the risk zone).

The patient continues to take complex homeopathy and has eliminated cereals and rice from the diet. The state of health is good, there are no complaints.

II. The patient's eldest daughter, 40 years old. Allergy complaints, allergic dermatitis, abdominal pain, stool - frequent diarrhea. Allergy to cereal and rice. Analysis on the antibodies To gliadin 40 IU / ml (weakly positive).

This was done the same treatment as the mother. The state of health is good. Term observation - 4 months. Analysis for antibodies to gliadin 30 IU / ml (risk zone).

III. Youngest daughter, 34 years old. Complaints of recurrent abdominal pain, sometimes diarrhea. History of late onset of menstruation, anemia, growth retardation. Allergies to cereals and rice were also tested on ART. Analysis for antibodies to gliadin 30 IU / ml (risk zone). Recommended: to exclude cereals and rice from the diet, the drug Nux vomica comp. in potency 500: 3 globules 2 times a week.

Conclusions and recommendations:

1. Patients with chronic diarrhea, exhaustion, abdominal pain, systemic osteoporosis complicated by bone pain and fractures, iron deficiency anemia of unknown etiology, primary infertility, autoimmune thyroiditis, allergies of unknown etiology
it is recommended to carry out a (ART) test for intolerance to cereal products.

2. When tested positive for cereal allergy
refer the patient to a laboratory blood test for antibodies to gliadin. 30 IU / ml and above is an indication of a gap.

3. In case of GEP confirmation, the patient should be advised
lifelong exclusion from the diet of foods containing gluten, BRT, EPT and complex homeopathic medicines, observation by a gastroenterologist.

4. At exhaustion immunity recommended application transfer factors: TF (classic) and TF Advensd.

Literature

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