

PATHOLOGY FOCUS

Medical Newsletter

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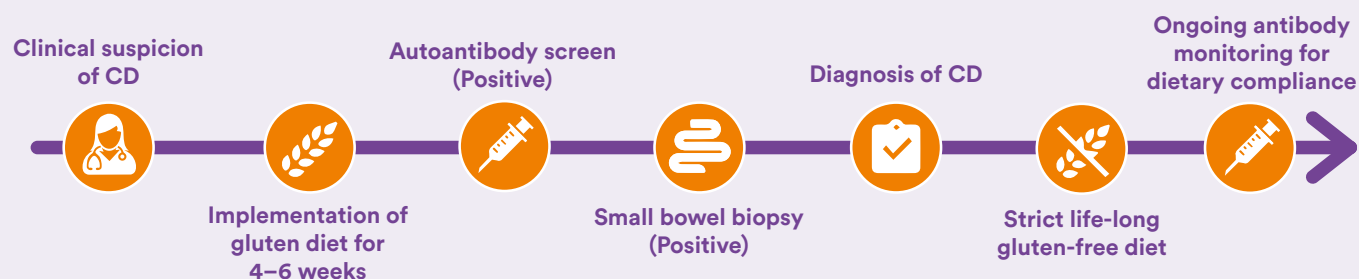
Coeliac Disease: The pathway to an accurate diagnosis

By Emeritus Prof. Ban-Hock Toh

If left untreated, coeliac disease can lead to major health complications for patients and severely affect their quality of life. To achieve an accurate diagnosis, a series of steps need to be carefully followed, to avoid patients being misdiagnosed and unnecessarily implementing restrictive life-long changes to their diet.

Coeliac disease (CD) is a chronic inflammatory CD4 T cell-mediated disease of the proximal small bowel induced by gluten present in wheat, barley and rye. It leads to atrophy of the proximal small intestinal villi resulting in nutrient malabsorption and is associated with diagnostic autoantibodies directed to endomysium tissue transglutaminase. In developed countries the incidence is increasing, but currently it affects approximately 1% of the Caucasian population. There is a strong genetic predisposing component with 10–15% of first-degree relatives of probands affected and 70% concordance between monozygotic twins. HLA-DQ2 and HLA-DQ8 genotypes are present in 99.6% of patients with CD, and the HLA type is requisite, but not sufficient for the development of disease. Clinical disease is initiated by consumption of gluten-containing wheat, barley and rye. Onset can occur in either childhood or adulthood, with a female to male ratio of 2:1. Once an accurate diagnosis has been reached, CD can be effectively managed through the implementation of a strict life-long gluten-free diet.

Coeliac Disease - Clinical Diagnosis Paradigm



Clinical indications for autoantibody tests

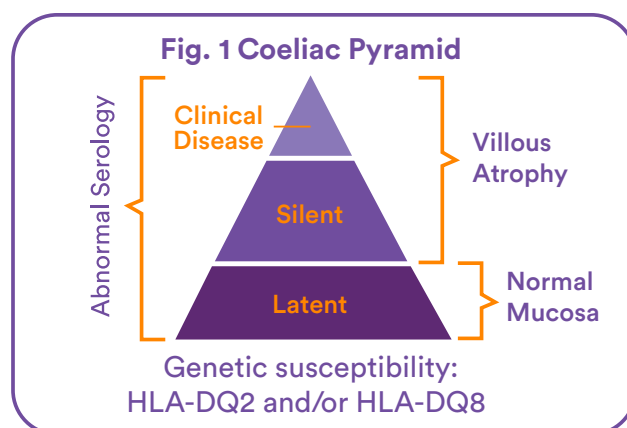
Along with a genetic predisposition (family history) of CD and gastrointestinal indicators such as chronic/recurrent diarrhoea, IBS, fatigue, weight loss, bloating and gas, abdominal pain, nausea and vomiting, and constipation, patients at high risk of CD may present with the following health issues:

- Iron deficiency/anaemia
- Folate, vitamin E or K deficiency
- Osteoporosis
- Failure to thrive
- Pubertal delay
- Hypocalcaemia, vitamin D deficiency, secondary hyperparathyroidism

Patients may also present with diseases found to be associated with CD, including:

- Autoimmune liver disease, elevated transaminases
- Autoimmune endocrinopathy: type 1 diabetes, Hashimoto's thyroiditis, Addison's disease
- Sjogren's syndrome
- Inflammatory bowel disease
- Neurological disorders: peripheral neuropathy, epilepsy ataxia
- Arthritis of unknown aetiology
- Infertility
- Down and Turner syndromes

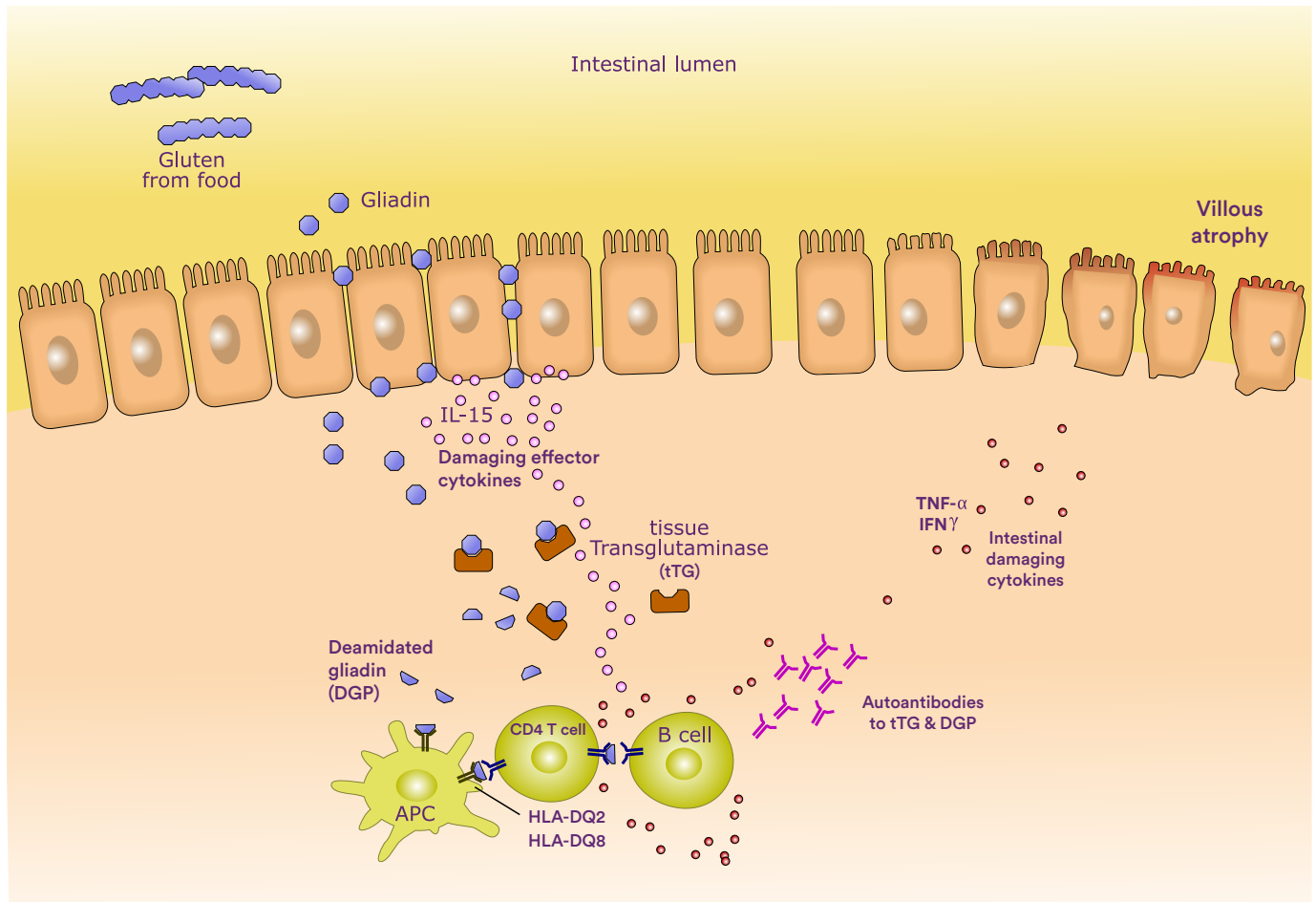
The onset of clinical symptoms can be represented by the tip of the 'Coeliac Pyramid' (see Fig. 1). Coeliac disease may present with classic malabsorption symptoms (as already listed), or more typically remains silent, latent, or becomes apparent through a wide range of non-classical symptoms arising from pathology in multiple organs (as previously listed). Therefore, a diagnosis of symptoms is likely to be missed unless CD is considered. If undiagnosed, CD can lead to nutrient deficiency and gastro-intestinal malignancy including enteropathy-associated T cell lymphoma (EATL) or intestinal malignancies such as adenocarcinoma of the small intestine, pharynx and oesophagus.



Autoantibody screen testing

HLA-DQ2 or HLA-DQ8 genotypes are present in >99% of people with CD, but are also present in up to 40% of Americans, Europeans and South East Asians, and similar proportions of Australians. The enzyme tTG deamidates dietary gluten in wheat, barley and rye. Deamidated gluten peptides form molecular complexes with DQ2 or DQ8 molecules that activate CD4 T cells to release damaging effector cytokines. Helper CD4 T cells then activate B cells to produce autoantibodies to tissue transglutaminase (tTG) and to deamidated gliadin peptide (DGP), diagnostic serological markers of CD.

Autoimmune response to gluten (gliadin) in a patient with coeliac disease.



Ordering an IgA antibody to tTG test is the first step in an accurate diagnosis for patients at high risk of CD, as this is a very sensitive and specific blood test for CD.

Ordering an IgG antibody to tTG or deamidated gliadin test for patients who test negative to IgA. This is a newer test, which is recommended in Australia alongside anti-tTG IgA. IgG antibody to deamidated gliadin may also identify patients who test negative to tTG antibody.

The patient is required to maintain a gluten-containing diet for 4–6 weeks before their blood test, as reducing or eliminating gluten from their diet can affect the results.

Genetic tests for HLA-DQ2 or HLA-DQ8 genotypes should be ordered for high-risk patients when:

- they refuse a gluten diet
- their tTG antibody test was negative
- their tTG antibody test was positive, but a biopsy of the small bowel shows healthy villi

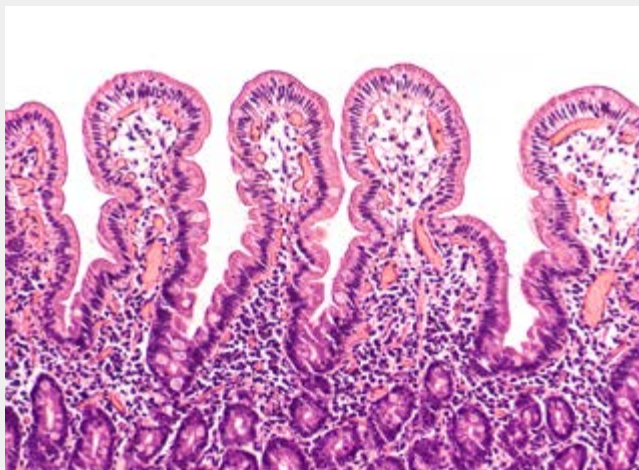
A negative result for the HLA-DQ2 or HLA-DQ8 genotypes virtually excludes CD. *Note: 40% of Caucasians will test positive for HLA-DQ2 or HLA-DQ8 genotypes, but only 3% of these are at risk of CD.*

Other tests, such as a full blood exam, may be ordered to evaluate malnutrition, malabsorption and organ involvement.

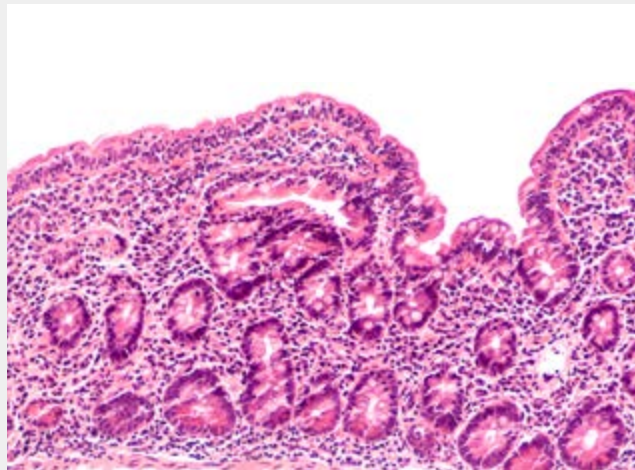
Small bowel biopsy

If the patient tests positive for serological and genetic markers, a small bowel biopsy via endoscopy is recommended to confirm CD before lifelong treatment is implemented.

In patients with CD, activation of CD4 T cells leads to production of inflammatory cytokines which causes villous atrophy, inflammation and flattening of the lining of the small intestine, reducing the surface area of the bowel available for nutrient absorption. There is an infiltration of intraepithelial lymphocytes of natural killer and CD8 phenotypes.



Healthy intestinal villi



Flattened and inflamed intestinal villi in a patient with coeliac disease

Diagnosis and treatment

Once CD has been formally diagnosed, via a combination of autoantibody blood tests, genetic blood tests and small bowel biopsy, treatment can commence. Although there is no cure for CD, the most effective treatment is a strict life-long gluten-free diet. Removing gluten from the diet allows the small bowel lining time to heal. If this diet is strictly adhered to, the patient's autoantibody levels should return to normal within 6–9 months and their symptoms and villous atrophy should resolve. Relapse will occur if gluten is reintroduced into the patient's diet.

While most of the intestinal damage caused by CD is reversible, some effects of prolonged malabsorption, such as short stature and weakened bones, may be permanent. It is therefore vital to detect and treat the disease as soon as possible.

Follow-up testing

For monitoring of dietary compliance, request a tTG antibody test.

References

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Early detection has been called the ‘Holy Grail’ of cancer management, and thanks to a new widely accessible monitoring test, more clinicians are now able to detect cancer biomarkers in blood earlier than they could using conventional methods.



Dr Prasad Cooray is a specialist oncologist with consulting rooms at several locations in Melbourne’s Eastern suburbs. Dr Cooray specialises in the treatment of oesophageal, gastric, colon, rectal, pancreatic, liver and biliary system cancers and is actively involved in cancer clinical trials, as a Principal and co-investigator at Eastern Health, Box Hill Campus. In addition, Dr Cooray is a participant in weekly multidisciplinary clinician meetings, where treatment decisions are made on the management of patients with complex gastrointestinal, pancreatic and hepato-biliary cancers.

In this article, he draws on his experience and elaborates on why he believes the Aspect Liquid Biopsy test will soon become a cornerstone in modern patient care.

Almost by default, as a medical oncologist, you are entrusted with the responsibility of completely coordinating your patient’s journey of care. You oversee timing, you guide clinical approach, and you are responsible for all systematic treatments more generally, whether they are adjuvant or more advanced – for example, chemotherapy and biological treatments.

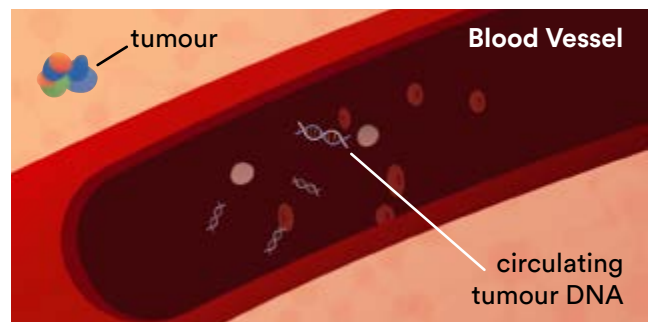
Recently, the Aspect Liquid Biopsy test became available, and now its benefits are accessible to oncologists throughout the community.

Particularly in the oncology field, we know that liquid biopsy tests have been around for quite a while – in fact, a number of Melbourne researchers have been at the forefront of their development. I specifically point to Dr Jeanne Tie, who led some pioneering studies three or four years ago demonstrating the tests could be a very useful indicator of early relapses in cancer patients.

However, despite the encouraging nature of these results, only recently have oncologists been given the opportunity to integrate this clinical tool in the care they offer patients.

It was one of those things that sounded good theoretically, and researchers were in the midst of realising its efficacy, but clinicians just didn’t have access to it.

The awareness of the liquid biopsy test is growing within the industry, and more oncologists are not only learning about it but also relying on it in their day-to-day practice. We are very fortunate that the Aspect Liquid Biopsy test is now available to provide a non-invasive accurate and sensitive detection of the circulating tumour DNA (ctDNA) in patients’ blood.



Clinical utility of Aspect Liquid Biopsy

How I use Liquid Biopsy with patients obviously changes on a case-by-case basis, but I have personally found that it lends itself to certain cancer types. For example, the test is a useful tool for patients with pancreatic cancer, as 90-95% of this patient population have the KRAS mutation.

Recently, I was part of a clinical trial where we looked at patients having liquid biopsies before their pancreatic cancer operations and then post-procedure, during their follow-up phase. It showed that people who still had circulating tumour DNA post-operation were at much

higher risk of cancer relapse down the track. The liquid biopsy test results helped us to select a subgroup of patients who would then undertake chemotherapy.

That’s one scenario that I think highlights the benefits of Liquid Biopsy. Ideally, you would want to conduct a preoperative biopsy and then a postoperative one, so a baseline is established. However, we sometimes don’t get the benefit of doing a preop test because the patient may have already had the procedure by the time they come and see us clinically. However, I will always test them post-procedure. It helps me stratify their risk. And down the track, once all treatments are concluded, it acts as an extremely useful surveillance monitoring device as well.

Besides those with pancreatic cancer, I have also found Liquid Biopsy tests extremely useful for lung cancer and colorectal cancer patients, respectively.

The former, because the test picks up any resistant mutations emerging; and the latter (especially in stage 2 or 3), because this is usually the time that, as a clinician, you are deciding whether the patient needs adjuvant therapy or not.

In colorectal cancer, one of the limitations is having no KRAS mutation, meaning that the probability is not as high as in pancreatic cancer, for example. In those mutation negative cases, it's a wild type – meaning we have to rely on the circulating tumour DNA level and see how the levels correlate up or down with regards to treatment, rather than actually following a mutation.

Liquid Biopsy gives us another tool in our armament, which fuels our clinical decision-making. Additionally, for those cancer sufferers undergoing aggressive treatment with the aim of cure, these tests are a useful device to gauge how the cancer is responding to treatments, and to detect minimal residual disease and potential relapses.

“Without a doubt, I think Liquid Biopsy will become a standard part of oncology treatment in the future.”

A patient-specific approach

When I have a patient whom I think could benefit from a Liquid Biopsy, I inform them of the tool, its efficacy and the associated costs. I also pick the time and point where we should do it and lay out a plan for them. For example, in pancreatic patients, I suggest they undertake the test postoperatively so we get a baseline result that I can then use for monitoring down the track. We know that DNA is cleared from the blood fairly quickly, so fortunately, we can pursue this as little as a week following procedure.

Most patients, following our discussion, see the utility of the test and are happy to self-fund. Generally, people see it as another test that is on their calendar, like a scan. Most are relieved it's just a simple blood test.

However, I contend that the utility of Aspect Liquid Biopsy becomes clearly evident when one undertakes a series of tests. There is just so much utility in continuing the testing and knowing what comes up in scans.

For example, let's say you treated someone with curative intent and you reached a very low level of circulating DNA. Further, it was an aggressive cancer to begin with, and the patient has a high risk of relapse. In this case, you may want to do a Liquid Biopsy every six weeks, or at least every two months. Of course, one must be mindful of the fact that each case is variable and multiple factors come into play.

The future of Liquid Biopsy

Without a doubt, I think Liquid Biopsy will become a standard part of oncology treatment in the future. I'm expecting the costs will go down in time as well, so I would expect it to become quite an important tool for oncologists in every stage. I think the real future lies in it being a screening test in the population – there is just a huge opportunity there, our “secret weapon” in the early detection of cancers.

Aspect Liquid Biopsy is only available at Australian Clinical Labs.

Expert pathologist



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Associate Professor Mirette Saad is a Consultant Chemical Pathologist and the National Clinical Director of Molecular Genetic Pathology at Australian Clinical Labs. Upon receiving the National Health and Medical Research (NHMRC) Scholarship in 2006, Associate Professor Saad commenced her PhD studies at Melbourne University and Peter MacCallum Cancer Institute in Cancer Genetics. Associate Professor Saad undertook her specialty training at Healthscope Pathology (now Australian Clinical Labs) and Monash Health and obtained the Chemical Pathology Fellowship (FRCPA) and the Membership (MAACB) by examination from the Royal College of Pathologists of Australasia (RCPA) and the Australasian Association of Clinical Biochemists (AACB), respectively.

Clinical Labs Educational Modules



View our educational videos presented by National Clinical Director of Molecular Genetic Pathology, Associate Professor Mirette Saad, on Aspect Liquid Biopsy.

There are two videos, each about 18 minutes in length. View at link below

clinicallylabs.com.au/doctor/gp-services/educational-modules/

Or, scan this QR code to go directly to the first video.

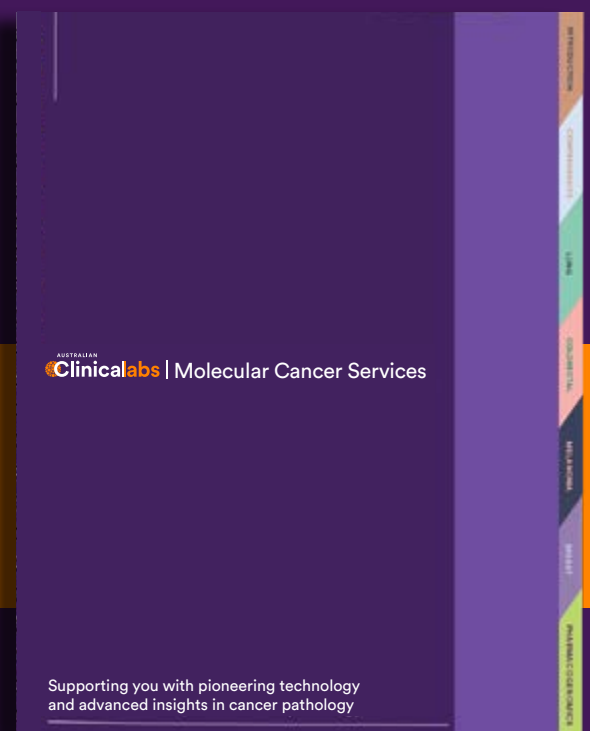


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Visit our new Antenatal website antenatal.clinicallabs.com.au/doctor today to gain detailed information, brochures and educational resources, pricing and request forms for Clinical Labs Antenatal pathology tests, including Harmony NIPT.

You can also direct your patients to the new patient site antenatal.clinicallabs.com.au/patient for comprehensive information on Antenatal testing at Clinical Labs.

The screenshot displays the Clinical Labs Antenatal website. The main header features the Clinical Labs logo and navigation links: Home, Carrier Screening, Paternity, Early Pregnancy, Harmony NIPT, Follow-Up Tests, and Postnatal. The primary content area is titled "harmony® PRENATAL TEST" with the tagline "Actionable results you can trust" and an image of a pregnant woman. Below this, text describes the Harmony prenatal test as a DNA-based blood screening test for Down syndrome, noting its accuracy and ease of use. A secondary section titled "Our most frequently ordered tests" lists three options: Gene Access, Harmony NIPT, and Combined First Trimester Screening, each with a "Learn More" button. A sidebar on the right highlights the "Antenatal" section with the text "Give your patients peace of mind every step of the way".

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Please tick one of the below:

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Thank you

Our new South Australian state-of-the-art lab proves an excellent resource for local referrers

Earlier this year, we opened one of the most technologically advanced pathology laboratories in South Australia. The 2,500 sqm purpose-built facility boasts market-leading technology equipment including an Aptio track system with Siemens Atellica instrumentation, as well as Sysmex Haematology and Coagulation analysers. On-board refrigeration is integrated into the track system, allowing additional tests to be added easily, as the system immediately retrieves and runs the samples.

A purpose-built histology and cytology area has been created to allow for greater efficiencies, with improved dictation and cutup facilities. Our pathologists' offices are adjacent to the histopathology area, allowing easy connection with the lab and improved workflow.

In addition to providing biochemistry, haematology and molecular biology services, we have relocated our microbiology, immunology and serology services from Wayville to the Adelaide Airport lab. We are now also able to provide a 24-hour turnaround on toxicology samples, thanks to our new, highly secure toxicology laboratory. Our PC2 TB lab continues to be entrusted to run the TB testing for the whole of the Clinical Labs business, and all fungi analysis for the company is also conducted at the Adelaide Airport lab.

Being located in the Adelaide Airport precinct guarantees swift access and connection to other Clinical Labs laboratories, or specialist labs when required. The Adelaide Airport site holds a large warehouse enabling us to quickly dispatch consumables orders to our valued client base.

To find out more about the pathology services offered by our new Adelaide Airport laboratory, call 1300 134 111.



To receive our bi-monthly clinical newsletter, updates, educational resources and more, go to clinicallabs.com.au/subscribe and follow the instructions.

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