

Changing Clinical Manifestations of Celiac Disease in Children

To the Editor: I read with great interest and appreciate the report by Khatib et al (1). They reported that the average age at diagnosis of celiac disease (CD) was much higher than previously reported (10.7 years), and that a nonclassical presentation predominated in this group of patients. These findings, however, are not limited to the region where this study was performed. We also have reported an older age of presentation (9.3 years after 2008) at diagnosis, and most had an atypical or silent presentation (2). Other investigators have also shown increased prevalence of nonclassical manifestations and older age at diagnosis (3,4).

Khatib et al also reported that 22% of the patients had type I diabetes compared with 3.2% to 11.0% in previous reports of children with CD. Such a high prevalence is a new observation that needs to be corroborated. This finding is probably attributable to greater recognition of atypical presentations and screening of asymptomatic groups who are at increased risk, and to improved diagnostic specificity and sensitivity of serological tests. This finding, however, may also be ascribed to an overall increase in the prevalence.

Refractory iron deficiency anemia is an important atypical feature of CD and has been reported as the sole manifestation in 7.9% to 19% of children (2,4–6). It primarily results from impaired iron absorption (7,8). Occult gastrointestinal blood loss has also been noted in 26.7% of children with CD, and the children appeared to respond to gluten-free diet (9). Although Khatib et al did not document refractory anemia, testing for anemia may have a role in screening for CD and deserves further attention.

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The Presenting Pattern of Pediatric Celiac Disease

To the Editor: In our retrospective chart review study we describe different presenting features and age at diagnosis of celiac disease than the original articles. This seems to be in agreement with findings of studies done in different geographically located areas (1–4).

Diabetes mellitus type 1 has strong correlation with celiac disease and share common human leukocyte antigen typing mainly DQ2 (5). In our study we have noticed higher prevalence of celiac disease among patients recently diagnosed with DM1. This is likely because of the awareness of the close association between the 2 diseases, greater recognition of atypical presentations, screening of asymptomatic groups at increased risk, improved diagnostic specificity and sensitivity of serological testing, and possibly secondary to increase in the incidence of the disease overall. (5,6).

Chronic inflammation of the intestinal epithelium impairs iron absorption and can lead to persistent blood loss, resulting in refractory iron deficiency anemia that has been reported in patients with celiac disease. Our approach in diagnosing celiac disease is to obtain screening serology and confirm it by obtaining tissue biopsies. In our study, we did not focus on refractory anemia, stool occult blood, and its response to gluten-free diet. This is an interesting area for further research.

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Carcinoid Tumor Complicating Crohn Disease in a Female Adolescent

To the Editor: We would like to alert the readers to carcinoid tumors in children, a rare incidental finding typically following appendectomy (1). Among children with inflammatory bowel disease (IBD), carcinoids are even rarer (2,3). A 16-year-old girl with Crohn disease of the terminal ileum and intestinal obstruction required resection of the ileum and cecum. A 0.5-cm carcinoid tumor was found at the tip of the appendix with micro-metastasis within the mesoappendix. As follow-up for carcinoids varies among pediatric institutions, we suggest applying the North