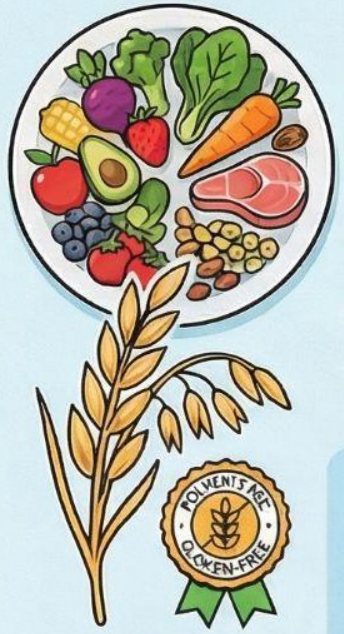
ESsCD 2025 Updated Guidelines on Management of Coeliac Disease in Adults

FOUNDATION OF CARE



The Central Role of the Dietitian

A specialized dietitian is essential for providing initial education, performing nutritional assessments, and addressing micronutrient deficiencies.

Inclusion of Certified Gluten-Free Oats

Only certified gluten-free oats are safe and can be recommended as part of a well-balanced diet from the point of diagnosis.

Lifelong Strict Gluten-Free Diet (GFD)

Maintain a safe gluten threshold of ≥ 10 mg/day (equivalent to 20 ppm in food) to ensure mucosal healing and prevent complications.

ueg journal

Al-Toma A, et al. United European Gastroenterology J 2026

MONITORING & PREVENTION

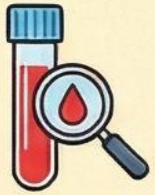
Tailored vs. Standardized Follow-up

Model Adapted to Specific Patient Risk Profiles

Standardized Model with Fixed Intervals for Assessment

Pneumococcal Vaccination

Recommended for at-risk patients, including those with functional asplenia, RCD-II, age over 65, or other autoimmune disorders



Limitations of IgA anti-TG2 Serology

Negative result does not confirm the absence of gluten or the healing of villous atrophy.

Bone Health & DXA Scanning

Adults with other risk factors should receive a DXA scan after one year on a GFD.

Family Screening Protocols

Children: HLA-DQ2/8 Genotyping

Adults: Initial anti-TG2 Serology

Transitioning Care: The Coeliac Passport

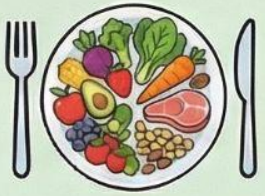
Use a standard "Coeliac Passport" (diagnosis, serology, growth, comorbidities, adherence)

MANAGING PERSISTENT SYMPTOMS

Rule Out Alternative Causes

Before adjusting treatment, first exclude other potential causes of symptoms such as inadvertent gluten exposure.

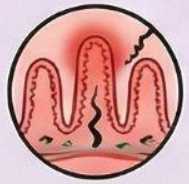
Mucosal Healing Confirmed & Other Causes Excluded



Strategic Use of Low-FODMAP Diet

A low-FODMAP diet should only be implemented after mucosal healing is confirmed and other causes for symptoms are excluded.

COMPLEX DISEASE COURSES

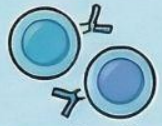


Defining Refractory Coeliac Disease (RCD)

Diagnosed when symptoms and villous atrophy persist after 12+ months on a strict GFD, with other causes excluded.

Differentiating RCD Subtypes

Type I



Normal T-cells, Better Prognosis

Type II

Aberrant T-cells (≥20%), Higher Pre-lymphoma Risk, Worse Prognosis

Advanced Therapeutic Options

JAK inhibitors

Cladribine

Fludarabine

Autologous Haematopoietic Stem-Cell Transplantation (HSCT)

Mandatory Tertiary Referral

All patients suspected of having RCD must be referred