Is celiac disease common in patients with vitiligo?

Çölyak hastalığı vitiligolu hastalarda sık mıdır?

To the Editor,

Vitiligo is an acquired depigmentation disorder affecting between 0.5-2% of the general population (1). The relationship between celiac disease (CD) and vitiligo is controversial. Although some authors have described some cases of vitiligo in patients with CD (2-4), one serological screening study for CD in patients with vitiligo did not show any correlation (4). Because we found noticeable vitiligo prevalence (9.1%) in children with CD in our recent study (5), we decided to perform serological screening for CD in our vitiligo series.

Sixty-one patients (21 children) with vitiligo and 60 healthy volunteers were included. The mean age was 27.9±17.2 years (2-70 years). Sera provided from patients and controls were tested for immunoglobulin (Ig)G and IgA antigliadin antibodies and antiendomysial antibody IgA by ELISA technique. Upper gastrointestinal endoscopy for duodenal biopsy was performed in seropositive patients, who gave informed consent. The study was approved by Firat University Medical Faculty Hospital's Ethics Committee.

Of patients, only 1 had segmental vitiligo and 60 had nonsegmental vitiligo type. Mean duration of vitiligo was 2.8±3.7 years (3 months-40 years). Eleven patients with vitiligo (18.0%) and 1 control (1.7%) were seropositive for CD (p: 0.004). Of those seropositive patients, 5 (45.5%) were younger than 18 years. Three (27.3%) had gastrointestinal symptoms; 2 of the children had short stature.

The seropositivity rates among children and adults were 23.8% and 15%, respectively (p>0.05). Of 5 seropositive patients who underwent upper gastrointestinal endoscopy, 2 had diagnostic intestinal findings for CD; biopsy-proven CD prevalence was 3.2%. Some demographic and clinical features of the seronegative and seropositive patients are shown in Table 1.

The high seropositivity rate we found, especially in children, was consistent with the results of our previous study (5). An interesting finding was that the mean duration of vitiligo was significantly shorter in our seropositive patients compared to others. Speculatively, this was due to the transient positivity of those serological markers in vitiligo rather than the permanent positivity associated with CD. On the other hand, all our seropositive patients who had normal intestinal mucosa can be considered as potential CD, who might develop characteristic histology at any time in their lives.

Volta et al. (4) found no seropositive cases among their 198 patients with vitiligo. In another study performed in patients with type 1 diabetes mellitus, vitiligo was more frequent in those with CD (30% vs. 3%) (6).

Even though the association may be coincidental, the presence of vitiligo should remind dermatologists of the possibility of CD. There is no doubt that many patients with CD primarily contact specialists other than gastroenterologists; the majority of cases thus remain undetected (7). A greater awareness of the many presentations of CD, such as vitiligo, will aid in its identification.

Table 1. Some demographic and clinical features of the patients with vitiligo

	Seropositive patients	Seronegative patients	P value
Mean age (yrs)	23.9±13.83	28.7±17.8	>0.05
Female/male ratio	6/5	23/27	>0.05
Mean duration of the disease (yrs)	2.8±3.7	7.6±9.6	0.05
Family history rate	-	11/50	-
Gastrointestinal symptom rate	3/11	16/34	>0.05

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Behçet's disease associated with diarrhea and secondary amyloidosis

İshal ve sekonder amiloidoz ile ilişkili Behçet Hastalığı

To the Editor,

The symptoms associated with gastrointestinal manifestations of Behçet's disease (BD) are abdominal pain, nausea, vomiting, diarrhea, and constipation (1). Prevalence of secondary amyloidosis in BD has been reported to vary between 0.04 and 3% (2). Mutations in the MEFV gene might be among the risk factors for more severe disease and development of amyloidosis (3). We describe a patient with BD, chronic diarrhea, amyloidosis, and heterozygous M694V mutation (gene mutation for familial Mediterranean fever) on exon 10.

A 54-year-old male patient with BD was admitted with arthralgia of both knees, ankles, elbows, and hips, diarrhea, and swelling of both legs. On physical examination, pretibial edema (+++) and scrotal ulcer scars were detected. Laboratory analysis revealed: erythrocyte sedimentation rate: 84 mm/h, C-reactive protein: 91 mg/L, hemoglobin: 8.4 g/dl, blood urea nitrogen: 32 mg/dl (6-20 mg/dl), creatinine: 7.2 mg/dl (0.6-1.3 mg/dl), albumin: 2.6 g/dl (3.4-5 g/dl), total protein concentration: 5.4 mg/dl (6.4-8.3 mg/dl), and urinary protein excretion: 11 g/24 h.

A percutaneous renal biopsy showed deposition of amyloid by gentian violet in the glomeruli and walls of the blood vessels. Immunohistochemically, the glomeruli and walls of the blood vessels showed cytoplasmic reactivity for P component and amyloid A (Figure 1). The case was diagnosed as renal amyloidosis and interpreted as consistent with reactive systemic (secondary) amyloidosis.

DNA sequence analysis showed heterozygous M694V mutation on exon 10. Upper and lower gastrointestinal endoscopies were performed for prolonged diarrhea, and prepyloric ulcers on the duodenum were detected. Ileal biopsy also showed amyloid deposition in the submucosal blood vessels.

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