Salivary IgA antigliadin antibody as a marker for coeliac disease

V Hakeem, R Fifield, H F Al-Bayaty, M J Aldred, D M Walker, J Williams, H R Jenkins

Abstract

In recent years, serum antibodies to gliadin (AGA) have been reported to be useful markers of coeliac disease. IgA AGA have also been found in intestinal secretions and saliva in coeliac disease and may offer a convenient, non-invasive screening test. In order to test this hypothesis, salivary and serum AGA were measured in children with coeliac disease proved by biopsy and compared with several control groups. Measurement of salivary IgA AGA provided excellent discrimination between those children with coeliac disease and the control groups, and our study suggests that it may provide a rapid, non-invasive method of screening for this disease before intestinal biopsy.

Coeliac disease remains an important cause of malabsorption in children. Definitive diagnosis requires histological confirmation by jejunal biopsy showing subtotal villous atrophy, increased numbers of intraepithelial lymphocytes, and crypt cell hyperplasia. Small intestinal biopsy is invasive, involves a period of fasting, and requires exposure to radiation to confirm correct positioning of the capsule. Many children undergo biopsies that subsequently prove to be negative, and thus various non-invasive tests have been proposed as screening tests. Tests such as xylose absorption and differential sugar permeability lack specificity and may be falsely positive in children with other causes of small intestinal mucosal damage. In children, the prevalence of salivary and serum IgA AGA and serum IgG AGA in groups of children with coeliac disease, other gastrointestinal disorders, cystic fibrosis, and in children with no evidence of gut disease.

Patients

There were 141 patients, divided into five groups, in whom AGA were measured. In group A were 19 patients (age range 9 months–14 years, median 5 years) who had coeliac disease proved by biopsy: they comprised 16 studied at presentation and three after gluten challenge. In group B were nine children (age range 2–18 years, median 6 years) who had established coeliac disease and were clinically well on a gluten free diet. Both these groups had satisfied the revised European Society of Paediatric Gastroenterology and Nutrition (ESPGAN) criteria for diagnosis. In group C were 60 children (age range 6 months–15 years, median 4 years) undergoing jejunal biopsy who subsequently proved to have conditions other than coeliac disease (such as cows’ milk or soy protein intolerance or toddler diarrhoea). In group D were nine children (age range 1–13 years, median 9 years) with cystic fibrosis. In group E were 44 children (age range 6 months to 18 years, median 4 years) with no clinical evidence of gastrointestinal disease who were having blood tests for other reasons. Small intestinal histology was not available for the last two groups of children.

It proved impossible to collect both serum and saliva in every patient in each group and the results represent all the data available in each group of patients. Simultaneous saliva and serum data were, however, available in eight patients. The district ethical committee had approved the study and consent was obtained from all parents and from older children if possible.

Methods

Whole unstimulated saliva was collected from the patients. Older children were able to spit directly into sterile containers and, for younger children and infants, a suction catheter attached to gentle wall suction was used to obtain the specimens. At least 1 ml was obtained from each child. The saliva was heated at 56°C for 30 minutes to inactivate complement and enzyme activity, and centrifuged at 1000 g for 20 minutes to remove particulate matter. The supernatant was stored at −20°C until the assays were performed. Salivary IgA AGA were
assayed using a standard enzyme linked immunosorbent assay (ELISA) technique as previously described.\textsuperscript{21}

For the serum assays, a commercial gliadin IgA ELISA test kit (Pharmacia) was used and a similar ELISA technique (in another laboratory) was used to measure serum IgG AGA. The results for each assay were expressed in optical density units and the results of saliva and serum antibodies from each group were compared and analysed by non-parametric means using the Mann–Whitney U test.

**Results**

Table 1 shows the numbers of patients studied and the median IgA AGA values for each group with fig 1–3 showing the individual results.

**Salivary IgA AGA (fig 1)**

It is clear that AGA concentrations were significantly higher in patients with untreated coeliac disease compared with the patients in the other groups (p<0.0001 in each case). All patients with untreated coeliac disease had salivary IgA AGA concentrations >0.31 optical density units. Using this value as an arbitrary limit to achieve 100% sensitivity for the test, there were seven values >0.31 in the other groups (false positive values), giving the test a specificity of 90%. In these seven children, the jejunal histology showed partial villous atrophy in four (clinical diagnosis of cows' milk protein intolerance in each case) and was normal in three (clinical diagnosis of toddler diarrhoea in each case).

**Table 1 Salivary IgA AGA**

| No studied | Optical density units
<table>
<thead>
<tr>
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<tbody>
<tr>
<td></td>
<td>Range</td>
</tr>
<tr>
<td>(A) Untreated coeliac disease</td>
<td>0.309–1.894</td>
</tr>
<tr>
<td>(B) Coeliac disease on gluten free diet</td>
<td>0.089–0.252</td>
</tr>
<tr>
<td>(C) Other gastrointestinal disease</td>
<td>0.010–0.450</td>
</tr>
<tr>
<td>(D) Cystic fibrosis</td>
<td>0.051–0.248</td>
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<tr>
<td>(E) No gastrointestinal disease disorder</td>
<td>0.012–0.300</td>
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**Table 2 Serum IgA AGA**

| No studied | Optical density units
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<tbody>
<tr>
<td></td>
<td>Range</td>
</tr>
<tr>
<td>(A) Untreated coeliac disease</td>
<td>2.136</td>
</tr>
<tr>
<td>(B) Coeliac disease on gluten free diet</td>
<td>4.11</td>
</tr>
<tr>
<td>(C) Other gastrointestinal disease</td>
<td>1.16</td>
</tr>
<tr>
<td>(D) Cystic fibrosis</td>
<td>1.17</td>
</tr>
<tr>
<td>(E) No gastrointestinal disease disorder</td>
<td>1.49</td>
</tr>
</tbody>
</table>

**Table 3 Serum IgG AGA**

| No studied | Optical density units
<table>
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<tbody>
<tr>
<td></td>
<td>Range</td>
</tr>
<tr>
<td>(A) Untreated coeliac disease</td>
<td>1.84–18.80</td>
</tr>
<tr>
<td>(B) Coeliac disease on gluten free diet</td>
<td>0.7–5.42</td>
</tr>
<tr>
<td>(C) Other gastrointestinal disease</td>
<td>0.32–11.30</td>
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<tr>
<td>(D) Cystic fibrosis</td>
<td>0.3–26.40</td>
</tr>
<tr>
<td>(E) No gastrointestinal disease disorder</td>
<td>1.09–14.00</td>
</tr>
</tbody>
</table>

**Serum IgA AGA (fig 2)**

As data for both salivary and serum IgA AGA were not available from all patients, the patient
numbers are different from those shown in table 1. The results in untreated coeliac disease were significantly higher than in all other groups (fig 2). The 'normal' reference range quoted for the test by Pharmacia is 0–25 and, using this range, three of the 15 patients with untreated coeliac disease had normal values (false negative results), giving the test a sensitivity of 80%. All the patients in the other groups, with one exception, gave results within the quoted normal range, yielding a specificity of 99%.

In the eight patients with coeliac disease in whom saliva and serum AGA were studied simultaneously, there was no correlation between the individual results for salivary and serum IgA. Thus some patients registered high levels of AGA in saliva and low levels in serum, and vice versa.

Serum IgG AGA (fig 3)
Unfortunately, data were available from a relatively small number of patients and, although the median value in the group with untreated coeliac disease was much higher than in the other groups, there was considerable overlap with very high values occurring in children who did not have coeliac disease.

There were no age related differences in values of AGA in saliva or serum in any of the groups (data not shown).

Discussion
The definitive diagnosis of coeliac disease still requires small intestinal biopsy, which is invasive and time consuming, and many negative biopsies are performed each year. Early diagnosis of the condition is important, not only in avoiding the clinical consequences of malabsorption and suboptimal growth, but also because treatment with a gluten free diet appears to reduce the subsequent risk of small intestinal malignancy.23

In order to minimise the number of negative biopsies, several non-invasive screening tests have been employed and, of these, the use of serological markers has proved to be the most fruitful.24 Thus measurement of serum antibodies to gliadin, reticulin, smooth muscle endomysium, and human jejunal have been employed and various researchers have reported acceptable levels of sensitivity and specificity.2–15

Little is known about mucosal immunity in this condition and the relationship between the antibody concentrations in blood and those in intestinal secretions. Gliadin in the gut lumen is thought to stimulate IgA precursor lymphocytes in the gut associated lymphoid tissue. The precursor lymphocytes differentiate into IgA-producing plasma cells and secrete IgA AGA that enter the intestinal secretions. These precursor lymphocytes also populate mucosal tissues and remote secretory glands such as the salivary glands, resulting in the appearance of IgA AGA in saliva.25 The salivary glands are considered part of the common mucosal immune system although it has been recently suggested that, in adults, salivary antibodies may not reflect intestinal humoral immunity.26 Other data suggest that the measurement of salivary antigliadin antibodies may be a reliable marker for coeliac disease in adult patients21 and the aim of our study was to assess their usefulness in childhood.

Our results suggest that measurement of IgA AGA in saliva may be very useful as a screening test for coeliac disease with acceptable levels of sensitivity and specificity. Indeed, using an arbitrary cut off level for our assay in order to obtain 100% sensitivity for coeliac disease, the test remained highly specific. The measurement of serum IgA antibodies using a widely available commercial test kit was less sensitive and, using the kit's quoted reference range, would have missed an unacceptable number of biopsy proved cases of coeliac disease. In the context of screening children for coeliac disease, a salivary IgA AGA test with 100% sensitivity but with 10% false positives is preferable to serum IgA AGA assay with 20% false negative findings. Interestingly, there was poor correlation between salivary and serum IgA AGA in individual patients with untreated coeliac disease and, in our hands, as other workers have suggested, measurement of IgG AGA is too non-specific to

*Figure 3* IgG antibodies to gliadin in serum.
be of clinical usefulness if considered in isolation. 

The incidence of IgA deficiency is said to be increased in coeliac disease\(^2\)\(^,\)\(^3\)\(^,\)\(^4\) and measurement of IgA antibodies alone may theoretically miss these cases. For this reason measurement of both IgA and IgG antibodies may be more helpful.

Measurement of salivary antibodies is simple, rapid and non-invasive, which would be of great benefit in the investigation of children. Although further studies are needed to confirm the usefulness of salivary antibody measurement and its superiority over serum antibody measurement, a test involving saliva may well prove to be a more acceptable screening tool for coeliac disease before jejunal biopsy than one involving venepuncture.

We would like to thank Dr Robert Newcombe for his assistance with statistical analysis and Miss Leith Gallivan for typing the manuscript.


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Arch Dis Child 1992 67: 724-727
doi: 10.1136/adc.67.6.724

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