Primary biliary cirrhosis.
Xavier Roblin, Bruno Bonaz

To cite this version:
Xavier Roblin, Bruno Bonaz. Primary biliary cirrhosis.. New England Journal of Medicine, Massachusetts Medical Society, 2005, 353 (25), 2719-20; author reply 2719-20. <inserm-00410568>

HAL Id: inserm-00410568
https://www.hal.inserm.fr/inserm-00410568
Submitted on 10 Sep 2009

HAL is a multi-disciplinary open access archive for the deposit and dissemination of scientific research documents, whether they are published or not. The documents may come from teaching and research institutions in France or abroad, or from public or private research centers.

L’archive ouverte pluridisciplinaire HAL, est destinée au dépôt et à la diffusion de documents scientifiques de niveau recherche, publiés ou non, émanant des établissements d’enseignement et de recherche français ou étrangers, des laboratoires publics ou privés.
Primary Biliary Cirrhosis

TO THE EDITOR: The association between primary biliary cirrhosis and celiac disease should have been emphasized more clearly in the recent review of primary biliary cirrhosis. The prevalence of celiac disease among patients with primary biliary cirrhosis is 10 times as high as in the general population.\(^1\) Moreover, Sorensen et al.\(^2\) found an incidence ratio of primary biliary cirrhosis of 27.6 among patients with celiac disease. Thus, in the event of primary biliary cirrhosis, clinicians should systematically rule out celiac disease. Certain symptoms of primary biliary cirrhosis, such as osteoporosis, asthenia, and liver anomalies, regress with a gluten-free diet in people who also have celiac disease. This screening is made even simpler because there are sensitive and specific markers for each of the two diseases.

Xavier Roblin, M.D.
Bruno Bonaz, M.D., Ph.D.
Grenoble University
38000 Grenoble, France
xroblin@chu-grenoble.fr

1. Sorensen TL, Hommel G, T branching to the editor:
Kaplan and Gershwin conclude that patients with primary biliary cirrhosis should be treated initially by ursodeoxycholic acid (ursodiol). However, that recommendation is based on the results of only four randomized clinical trials, all of which favored the use of ursodiol. Their conclusion is flawed by selection bias. In fact, at least 16 randomized clinical trials have been published, and the results are conflicting.

1. A meta-analysis of these trials indicated that ursodiol has no significant benefit in terms of mortality or disease progression. This was also the case when short-duration trials and long-duration trials were analyzed separately.

1. These results are supported by another meta-analysis.

2. Ursodiol may reduce ascites and serum bilirubin and liver enzyme levels, whereas serum albumin levels and the prothrombin time are unaffected. Thus, the potential benefits are largely "cosmetic." The authors suggest that colchicine and methotrexate are indicated for patients with an incomplete response to ursodiol. These recommendations do not seem to be based on the available evidence.

2-4

4. In fact, methotrexate may increase mortality.

2

We think that a more comprehensive look at the literature leads to conclusions that are different from those reached by Kaplan and Gershwin.

Yan Gong, M.D.
Copenhagen Trial Unit
DK-2100 Copenhagen, Denmark
yangong@ctu.rh.dk

Erik Christensen, M.D.
Bispebjerg University Hospital
DK-2400 Copenhagen, Denmark

Christian Gluud, M.D.
Copenhagen Trial Unit
DK-2100 Copenhagen, Denmark


3.