

Markers of non-coeliac wheat sensitivity in patients with myalgic encephalomyelitis/chronic fatigue syndrome

We recently reported in *Gut* that non-coeliac wheat sensitivity (NCWS) is associated with a state of systemic immune activation in conjunction with a compromised intestinal epithelium.¹ Patients with NCWS experience GI symptoms, most commonly including abdominal pain and bloating, as well as extraintestinal symptoms, among which fatigue, headache and cognitive difficulties feature prominently.^{1,2} A principal component analysis of the generated data from our study, including markers of antibody reactivity to wheat gluten, intestinal cell damage and systemic innate and adaptive immune responses to microbial components, found clustering of the patients and controls into discernible groups and demonstrated the potential utility of the identified biomarkers for identifying patients with NCWS.¹

Extreme fatigue, in particular one that does not improve with rest, is a hallmark of myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS).³ Immune system abnormalities have been found to be associated with symptoms in a substantial number of patients with ME/CFS.^{4,5} Furthermore, many patients complain of GI symptoms of unknown aetiology.⁶⁻⁸ We considered whether a subset of patients with ME/CFS may exhibit serologic markers associated

with NCWS, which might explain some of the corresponding symptoms. We screened serum samples from 131 patients with ME/CFS and 86 healthy controls (table 1), recruited as previously described,⁹ for the same markers as those in the above-mentioned study on NCWS.¹ Questionnaires were used to assess GI symptoms within the past 6 months, including abdominal pain, bloating and nausea. Severity of individual symptoms was scored from 1 to 5 (1=absent; 2=mild; 3=moderate; 4=severe; 5=very severe), and a total score, based on the sum of individual symptom scores, was calculated for each subject.

Using the previously generated data from the original cohorts of NCWS, coeliac disease and control subjects (table 1),¹ we configured a discriminant function to identify potential cases of NCWS and coeliac disease among the subjects in the ME/CFS and associated control groups. Linear discriminant analysis (Minitab 17 (Minitab) software) was used to calculate the probability of each ME/CFS and control subject belonging to any one of the three categories of NCWS, coeliac disease and healthy control. The threshold for assigning a subject to a category was arbitrarily set at a calculated probability of 0.75. Accordingly, the algorithm identified one (0.76%) patient with ME/CFS and two (2.3%) control subjects as belonging to the coeliac disease group (P=0.3). In contrast, 20 (15.3%) patients with ME/CFS and 4 (4.6%) control subjects were categorised in the NCWS group (P=0.015). There was also a significant correlation between the calculated NCWS probability and the GI symptom severity total score in patients with ME/CFS (r=0.231, P=0.011).

Our results suggest that there may be a subset of patients with ME/CFS who have sensitivity to wheat and related cereals in the absence of coeliac disease, with potential relevance to some of their symptoms.

ME/CFS is recognised as a condition with a spectrum of clinical phenotypes and underlying aetiologies. Characterisation of patients into subsets based on clinical and biological data is essential to gaining a better understanding of the condition and identifying useful biomarkers and therapeutic targets. The results of this analysis provide a rationale for examining the clinical and therapeutic relevance of food sensitivity, particularly NCWS, in the context of ME/CFS in future studies.

Melanie Uhde,^{1,2} Alyssa C Indart,¹ Xuechen B Yu,^{1,3} Sophie S Jang,^{1,3} Roberto De Giorgio,⁴ Peter H R Green,^{1,2} Umberto Volta,⁴ Suzanne D Vernon,⁵ Armin Alaedini^{1,2,3}

¹Department of Medicine, Columbia University Medical Center, New York, New York, USA

²Celiac Disease Center, Columbia University Medical Center, New York, New York, USA

³Institute of Human Nutrition, Columbia University Medical Center, New York, New York, USA

⁴Departments of Medical and Surgical Sciences and Digestive System, Centro di Ricerca Biomedica Applicata (C.R.B.A.), University of Bologna, St. Orsola-Malpighi Hospital, Bologna, Italy

⁵Bateman Horne Center, Salt Lake City, Utah, USA

Correspondence to Dr. Armin Alaedini, Department of Medicine, Columbia University Medical Center, New York, NY 10032, USA; aa819@columbia.edu

Contributors AA had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis. Study concept and design: AA, SDV. Contribution to study design: MU, ACI, RDG, PHRG, UV. Acquisition of data: MU, ACI, XBY, RDG, UV. Analysis and interpretation of data: MU, ACI, XBY, RDG, PHRG, UV, AA. Drafting of the manuscript: MU, AA. Critical revision of the manuscript for important intellectual content: MU, ACI, XBY, RDG, PHRG, UV, AA. Statistical analysis: MU, AA. Administrative, technical or material support: RDG, PHRG, UV, SDV, AA. Obtained funding: AA. Study supervision: AA.

Funding This study was supported by the National Institute of Allergy and Infectious Diseases, National Institutes of Health, through Grant Number R21AI121996 (AA), the Solve ME/CFS Initiative (AA) and the National Center for Advancing Translational Sciences, National Institutes of Health, through Grant Number UL1 TR000040 (to AA). The funding agencies had no role in the design and conduct of the study; in the collection, analysis and interpretation of the data or in the preparation, review or approval of the manuscript.

Competing interests None declared.

Patient consent Not required.

Ethics approval Columbia University Medical Center institutional review board.

Provenance and peer review Not commissioned; internally peer reviewed.

Data sharing statement Data will be shared in a transparent fashion with all investigators requesting such information.



OPEN ACCESS

Table 1 Demographic characteristics of study cohorts

Subject group	Number of subjects	Mean age—years (SD)	Female sex—no. (%)	White race—no. (%)
Original cohorts*				
NCWS	80	34.6 (10.3)	62 (78)	80 (100)
Coeliac disease	40	34.5 (13.7)	30 (75)	40 (100)
Healthy†	40	35.0 (12.8)	30 (75)	40 (100)
Secondary cohorts‡				
ME/CFS	131	50.0 (11.4)	89 (68)	117 (91)
Healthy†	86	50.0 (12.8)	68 (79)	80 (93)

*Cohorts used to generate the discriminant function. For more information about these cohorts, see reference 1.

†There is no subject overlap between the two healthy control cohorts.

‡Cohorts on which the discriminant analysis was performed.

ME/CFS, myalgic encephalomyelitis/chronic fatigue syndrome; NCWS, non-coeliac wheat sensitivity.

Open access This is an open access article distributed in accordance with the Creative Commons Attribution Non Commercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited and the use is non-commercial. See: <http://creativecommons.org/licenses/by-nc/4.0/>

© Article author(s) (or their employer(s) unless otherwise stated in the text of the article) 2019. All rights reserved. No commercial use is permitted unless otherwise expressly granted.



To cite Uhde M, Indart AC, Yu XB, *et al.* *Gut* 2019;**68**:377–378.

Received 29 January 2018

Revised 21 February 2018

Accepted 26 February 2018

Published Online First 17 May 2018

Gut 2019;**68**:377–378. doi:10.1136/gutjnl-2018-316133

REFERENCES

- 1 Uhde M, Ajamian M, Caio G, *et al.* Intestinal cell damage and systemic immune activation in individuals reporting sensitivity to wheat in the absence of coeliac disease. *Gut* 2016;**65**:1930–7.
- 2 Volta U, Bardella MT, Calabrò A, *et al.* An Italian prospective multicenter survey on patients suspected of having non-celiac gluten sensitivity. *BMC Med* 2014;**12**:85.
- 3 Fukuda K, Straus SE, Hickie I, *et al.* The chronic fatigue syndrome: a comprehensive approach to its definition and study. International Chronic Fatigue Syndrome Study Group. *Ann Intern Med* 1994;**121**:953–9.
- 4 Lorusso L, Mikhaylova SV, Capelli E, *et al.* Immunological aspects of chronic fatigue syndrome. *Autoimmun Rev* 2009;**8**:287–91.
- 5 Gerwyn M, Maes M. Mechanisms Explaining Muscle Fatigue and Muscle Pain in Patients with Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS): a Review of Recent Findings. *Curr Rheumatol Rep* 2017;**19**:1.
- 6 Whitehead WE, Palsson O, Jones KR. Systematic review of the comorbidity of irritable bowel syndrome with other disorders: what are the causes and implications? *Gastroenterology* 2002;**122**:1140–56.
- 7 Komaroff AL, Buchwald D. Symptoms and signs of chronic fatigue syndrome. *Rev Infect Dis* 1991;**13**(Suppl 1):S8–11.
- 8 Aaron LA, Herrell R, Ashton S, *et al.* Comorbid clinical conditions in chronic fatigue: a co-twin control study. *J Gen Intern Med* 2001;**16**:24–31.
- 9 Irlbeck DM, Vernon SD, McCleary KK, *et al.* No association found between the detection of either xenotropic murine leukemia virus-related virus or polytropic murine leukemia virus and chronic fatigue syndrome in a blinded, multi-site, prospective study by the establishment and use of the SolveCFS BioBank. *BMC Res Notes* 2014;**7**:461.