



Essay

Beyond the gut: screening for coeliac disease in obstetrics

For more on the **symptoms of coeliac disease** see *Gastroenterology* 2024; **167**: 23–33

For more on the **delay in diagnosis of coeliac disease** see *JAMA* 2011; **306**: 1582–92

For more on the **age at diagnosis of coeliac disease** see *Curr Treat Options Gastroenterol* 2022; **20**: 238–49

For more on **adverse pregnancy outcomes and coeliac disease** see *Obstet Med* 2011; **4**: 95–98

For more on **coeliac disease and reproductive health** see *Eur J Gastroenterol Hepatol* 2019; **31**: 425–33

For the **American Gastroenterological Association guidelines** see *Gastroenterology* 2020; **159**: 1085–94

For more on **coeliac disease in first-degree relatives** see *Am J Gastroenterol* 2025; **120**: 1488–501

I was still groggy from the anaesthetic when the doctor entered the recovery room and told me I had coeliac disease. I did not understand—I thought my bowels were fine. But when he showed me photographs of my blackened and scabby intestinal walls, with a complete lack of pink healthy villi, it hit me: I had coeliac disease. The days that followed the biopsy procedure brought waves of intense emotions. Mostly, I was angry that none of my health-care providers up to then had connected the dots between my persistent anaemia, menstrual irregularities, and migraines. Yet, I'm a nurse, and I also missed the connection. There is little consolation in knowing that even though coeliac disease is one of the most common lifelong health conditions globally, affecting between 1–3% of the population, it continues to escape diagnosis largely due to the variation of symptoms.

Like many people, I had associated coeliac disease with abdominal pain, bloating, gas, and diarrhoea. However, coeliac disease affects multiple organ systems, including the integumentary, hepatic, nervous, musculoskeletal, and endocrine systems. This variation of symptoms makes coeliac disease hard to diagnose, resulting in many patients—including myself—experiencing an average wait of 11 years before receiving a diagnosis. Most adults are diagnosed at age 40–60 years, with women being two to three times more likely than men to be diagnosed with the condition.

For women, untreated coeliac disease can have a profound effect on the reproductive system, leading to menstrual irregularities (delayed puberty, irregular periods, or heavy bleeding), infertility, recurrent miscarriage (up to nine-fold relative risk), and early menopause. It is associated with adverse pregnancy outcomes including preterm delivery, low birthweight, and small for gestational age or intrauterine growth restriction (IUGR). Coeliac disease is also associated with endometriosis, polycystic ovary syndrome (PCOS), and reduced bone mineral density. Due to its pervasiveness, women experiencing recurrent unexplained miscarriages, unexplained IUGR, and unexplained infertility should be evaluated for coeliac disease. Additionally, for women with unexplained iron-deficiency anaemia, gastrointestinal symptoms, autoimmune disorders, or a first-degree relative with coeliac disease, a diagnosis of this disease should be ruled out before they attempt to conceive.

The association of coeliac disease with iron-deficiency anaemia is especially relevant from my perspective because anaemia has been a lifelong issue for me, which

ultimately led to my testing and eventual diagnosis of coeliac disease. Iron-deficiency anaemia is the most common form of anaemia in people with coeliac disease, occurring in more than half of individuals at the time of diagnosis. This link has led the American Gastroenterological Association to recommend that any adult with otherwise unexplained iron-deficiency anaemia should be tested for coeliac disease.

After living for years with persistent anaemia, migraines, joint pain, and rashes, these symptoms all resolved once I was following a strict gluten-free diet. But dietary management is not easy, and I felt incredibly underprepared for the mental and emotional impacts that this diagnosis would have on me and my family. The first months after the diagnosis were the most difficult for me, as I was grieving what I viewed as the loss of my life as I knew it. I wallowed in self-pity about the restrictions suddenly imposed by my diet. I stressed over cooking and eating, stopped enjoying food, and felt extremely sad, lonely, and isolated. It took me more than a year to adapt, and I still sometimes struggle. Regardless of these struggles with doubt, fear, and social isolation, I wish I would have been diagnosed sooner.

My diagnosis of coeliac disease has proven to be an unexpected gift. The disease has a genetic component, with one in 14 first-degree relatives also having the condition, and the highest prevalence is among daughters and sisters. Understanding this link sparked conversations about symptoms that might otherwise have been dismissed or normalised, and it led to a diagnosis of coeliac disease in one of my children. I have come to view this diagnosis as a gift of knowledge. It offers the chance to spare my children from potentially enduring years of their own unexplained symptoms and health concerns.

For obstetricians and gynaecologists, incorporating screening for coeliac disease into routine care for women with risk factors, particularly those with high-risk reproductive conditions or iron-deficiency anaemia, could prevent countless patients from enduring years—possibly decades—of unnecessary symptoms, like I did. Perhaps most importantly, an early diagnosis can create a ripple effect of awareness and treatment within families, potentially preventing years of suffering in children and grandchildren. What a gift a simple screening test can provide.

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