Abstract

Background—A non-invasive test for assessment of fat digestion has been developed based on the intraluminal hydrolysis of cholesteryl-[1-\(^{13}\)C]octanoate by pancreatic esterase.

Aims—To determine the diagnostic performance of this breath test in the assessment of exocrine pancreatic function.

Methods—The test was performed in 20 healthy controls, 22 patients with chronic pancreatic disease (CPD), four with bilio-pancreatic diversion (BPD), and 32 with non-pancreatic digestive diseases (NPD); results were compared with those of other tubeless tests (faecal chymotrypsin and fluorescein diluate test).

Results—Hourly recoveries of \(^{13}\)CO\(_2\) were significantly lower in CPD when compared with healthy controls or NPD. In patients with CPD with mild to moderate insufficiency, the curve of \(^{13}\)CO\(_2\) recovery was similar to that of healthy controls, while in those with severe insufficiency it was flat. In three patients with CPD with severe steatorrhoea, a repeat test after pancreatic enzyme supplementation showed a significant rise in \(^{13}\)CO\(_2\) recovery. The four BPD patients had low and delayed \(^{13}\)CO\(_2\) recovery. Only eight of the 32 patients with NPD had abnormal breath test results. There was a significant correlation between the results of the breath test and those of faecal chymotrypsin, the fluorescein diluate test, and faecal fat measurements. For the diagnosis of pancreatic disease using the three hour cumulative \(^{13}\)CO\(_2\) recovery test, the sensitivity was 68.2% and specificity 75.0%; values were similar to those of the other two tubeless pancreatic function tests. In seven healthy controls, nine patients with CPD, and nine with NPD a second breath test was performed using Na-[1-\(^{13}\)C]octanoate and a pancreatic function index was calculated as the ratio of \(^{13}\)CO\(_2\) recovery obtained in the two tests: at three hours this index was abnormal in eight patients with CPD and in three with NPD.

Conclusion—The cholesteryl-[1-\(^{13}\)C]octanoate breath test can be useful for the diagnosis of fat malabsorption and exocrine pancreatic insufficiency.

(Gut 1998;42:81–87)

Keywords: cholesteryl octanoate breath test; exocrine pancreatic insufficiency; lipid malabsorption; stable isotopes

The ideal exocrine pancreatic function test would be sensitive, specific, easy to perform, non-invasive, and inexpensive. The secretin-cholecystokinin (CCK) or caerulein test, because of its high sensitivity and specificity, is considered the gold standard; unfortunately, this test is complex, time consuming, unpleasant for the patient and, in some conditions, not feasible. For these reasons, its use is limited to a few specialist centres. A large number of tubeless tests have been proposed in recent decades; however, only a few have been fully accepted in clinical practice. The \(p\)-amino-benzoic acid (PABA) and fluorescein diluate tests, and the determination of serum trypsin and faecal chymotrypsin concentrations are widely used, but all lack sensitivity in mild or moderate pancreatic insufficiency.\(^1\) More recently, enzyme linked immunosorbent assay (ELISA) determination of elastase in faeces has been introduced in clinical practice, but this test also seems to have limited sensitivity in patients with mild chronic pancreatitis.\(^2\) \(^{13}\)CO\(_2\) breath tests for fat malabsorption using \(^{13}\)C labelled substrates appeared attractive because they are simple procedures that do not involve handling of faeces; however, they have not been widely adopted due to several drawbacks, including radiation exposure, interference by some metabolic and pulmonary disorders, and the high cost of equipment and markers.

Cholesteryl octanoate is very similar to cholesteryl esters naturally present in food\(^3\); it is specifically hydrolysed by pancreatic cholesterol esterase but not gastric lipase,\(^4\) and is aided in this process by the permissive action of pancreatic lipase, phospholipase, and bile salts.\(^5\) The octanoic acid produced by this hydrolysis is then rapidly and passively absorbed without micellar solubilisation, transported to the liver via the portal vein, and efficiently oxidised to CO\(_2\) and water.\(^6\) A breath test with cholesteryl-[1-\(^{13}\)C]octanoate has been developed for the evaluation of exocrine pancreatic insufficiency and fat malabsorption. Preliminary studies in rats and humans have shown that this test is able to detect severe pancreatic insufficiency\(^7\); the small number of patients enrolled in these studies, however, does not permit conclusive evaluation of its sensitivity and specificity. In addition, use of this test is limited by the need for a radioactive isotope. Encouraged by the results of these preliminary studies, and prompted by the greater accessibility of automated mass spectrometers capable of measuring \(^{13}\)CO\(_2\), we carried out the test using cholesteryl-[1-\(^{13}\)C]octanoate, in order to assess its value in the diagnosis of fat malabsorption and exocrine
pancreatic insufficiency. The test was performed in a large number of healthy subjects and patients with pancreatic or non-pancreatic disease. A control test with Na-[1-13C]octanoate was performed in some cases to ascertain whether this combination could offer improved diagnostic efficiency with respect to the single test.

**Patients and methods**

**SUBJECTS**

After giving written, informed consent, the subjects were enrolled and assigned to one of the following four groups.

**Healthy controls**

Twenty healthy subjects (14 men and six women, median age 28 years, range 16–80) were recruited from medical staff or persons undergoing routine medical check up. For all subjects, reported alcohol consumption was less than 30 g per day; none had evidence of digestive disease or exocrine pancreatic dysfunction, the latter having been excluded by normal faecal chymotrypsin.

**Chronic pancreatic disease**

Twenty two patients (19 men and three women, median age 51 years, range 16–80) with chronic pancreatic disease (CPD) were studied; 17 had chronic pancreatitis, three cystic fibrosis, one pancreatic cancer, and one had undergone resection of the head of the pancreas for ampullary carcinoma six years prior to the study. The aetiology of chronic pancreatitis was alcoholic in 11 (alcohol consumption more than 100 g per day) and idiopathic in the remaining six. The diagnosis of chronic pancreatitis was based on typical clinical history (recurrent upper abdominal pain with hyperamylasemia), and on positive findings at ultrasonography in 15 patients, computed tomography in nine, and endoscopic retrograde cholangiopancreatography (ERCP) in eight. The diagnosis was further confirmed by radiological evidence of pancreatic calcification in eight cases and by surgical and histological findings in six. Based on morphological findings at ultrasonography or ERCP, 10 patients were considered to have mild to moderate chronic pancreatitis, and seven, a severe form of the disease. All patients with severe pancreatitis had steatorrhoea and six also had diabetes. All patients were studied during a stable pain free period, and those with pancreatic insufficiency stopped their enzyme supplementation five days before the study. The diagnosis of cystic fibrosis was made on the basis of the clinical picture (chronic pulmonary disease, fat malabsorption) and was confirmed by the sweat test. In the patient with pancreatic cancer, malignancy was confirmed by surgery performed two months later.

**Biliopancreatic diversion**

Four patients (one man and three women, median age 41 years, range 34–48) who had undergone biliopancreatic diversion (BPD) according to Scopinaro et al.13 for the treatment of obesity were also studied. Surgery had been performed from a minimum of one to a maximum of 11 years prior to the study.

**Non-pancreatic digestive disease (NPD)**

Thirty two patients (17 men and 15 women, median age 46 years, range 19–73) suffering from various digestive diseases with symptoms or laboratory data also common to CPD (steatorrhoea and/or diarrhoea in 30, abdominal pain in 14, weight loss in 12, hyperamylasemia in two) were studied. The final diagnoses were: inflammatory bowel disease (seven), coeliac disease (six), chronic gastritis (four), food allergy (three), chronic hepatic disease (three), gastrectomy (two), ischaemic colitis (two), intestinal giardiasis (one), carcinoid tumour of the ileum (one), scleroderma (one), irritable bowel (one), and colon diverticula (one).

**TEST MEAL AND EXPERIMENTAL PROCEDURES**

Cholesteryl-[1-13C]octanoate and [1-13C]octanoic acid (atom percentage excess 13C 99%) were purchased from Mass Trace and CIL, USA. Unlabelled cholesteryl octanoate and octanoic acid were obtained from Sigma Chemical Co., USA. [1-13C]octanoic acid was used as a sodium salt, prepared by a titrimetric method, in order to improve its taste. The substrates were given as an emulsion in an isotonic liquid meal. For the cholesteryl-[1-13C]octanoate breath test, labelled (500 mg) and unlabelled (800 mg) substrate was dissolved in 20 ml of olive oil heated to 90°C. For emulsification of the substrate, 5 ml of glycerol (Merck, Germany) and 5 g of lecithin (Gazzoni, Italy) were dissolved in 100 ml of water, to which 200 ml of normal saline solution and 60 ml of vegetable broth were added. The oil was poured gently into the aqueous phase and emulsified by stirring with a high speed mixer for 10 minutes. Prior to mixing, 5 g of d-xylene (Carlo Erba, Italy) was also added in order to assess gastric emptying of the meal. For the control test, an equimolar dose (163 mg) of Na-[1-13C]octanoate along with 260 mg of this substrate, unlabelled, was used instead of cholesteryl-[1-13C]octanoate. All subjects received the same amount of substrates; the quantities given were previously found to be the minimum necessary to achieve adequate discrimination of 13CO2 outputs above baseline.

Subjects were studied after a 12 hour overnight fast. Breath samples were obtained using a disposable plastic straw placed approximately 1 cm from the bottom of an open 10 ml vacutainer. Patients exhaled down the straw until condensation appeared. While the patient continued to exhale, the vacutainer was slowly moved away from the straw and quickly resealed. Samples were taken immediately before the meal and every 15 minutes thereafter for six hours; the subjects were asked to remain seated, and smoking and eating were forbidden for the duration of the test.

The 13C/12C isotopic ratio was measured using a fully automated continuous flow isotope ratio mass spectrometer (TracerMass, Europa Scientific, UK). Isotope ratios were
**Results**

**Breath Test Variability and Repeatability**

Intra-assay variability was excellent: the coefficient of variation among the $^{13}$C determinations carried out on multiple breath samples from three patients was less than 4%. Repeatability of the test was fairly good: variations in the cumulative three and six hour recovery were small and overall results remained in their respective normal or abnormal ranges (fig 1).

**Cholesteryl-$[1-^{13}C]$Octanoate Breath Test**

**Healthy controls**

$^{13}$CO$_2$ excretion in breath generally began to rise within 30 minutes, but the time at which peak values were reached varied widely among individuals (median 225 minutes, 10–90th centile range 105–315 minutes). After reaching peak values there was a progressive decline, but none returned to baseline within the six hour observation period (fig 2). The median $^{13}$CO$_2$ cumulative recoveries at three and six hours were 12.0% (7.4–26.3%) and 30.4% (18.3–47.2%), respectively (fig 1).

**Patients with Pancreatic Disease**

The $^{13}$CO$_2$ output was significantly reduced (p<0.01) for each hour with respect to the values of healthy controls or patients with NPD (fig 2). The median cumulative recoveries at three and six hours were 2.5% (0.1–14.6%) and 6% (0.4–30.2%), respectively, values which were significantly lower (p<0.001) than those of healthy controls or patients with NPD (fig 1). The time at which peak output was achieved (210 minutes, 120–255) did not differ from that observed in healthy controls.

The behaviour of expired $^{13}$CO$_2$ in single patients varied greatly: in those with mild chronic pancreatitis the curve of $^{13}$CO$_2$ output was very similar to that of controls; among the patients...
with severe chronic pancreatitis, pancreatic cancer, or cystic fibrosis, it was flat, or nearly so. The $^{13}$CO$_2$ cumulative six hour recovery was significantly lower (p<0.01) in patients with severe chronic pancreatitis (1.2%, 0.1–22.5%) than in those with mild to moderate disease (20.2%, 9.7–34.2%).

The $^{13}$CO$_2$ cumulative output in the six hour period was found to be directly correlated with faecal chymotrypsin concentration (n=78, r=0.46, p<0.001), and fluorescein dilaurate test results (n=68, r=0.56, p<0.001); moreover, it was inversely correlated with faecal fat excretion (n=69, r=-0.56, p<0.001) (fig 3).

In the three patients with severe exocrine insufficiency, pancreatic enzyme supplementation significantly improved the recovery of $^{13}$CO$_2$ and reduced the steatorrhoea (table 1).

**Biliopancreatic diversion**

In these four patients the $^{13}$CO$_2$ output was both reduced and delayed compared with healthy controls (fig 4).

**Patients with non-pancreatic disorders**

The median $^{13}$CO$_2$ cumulative outputs at three and six hours were 8.7% (2.3–18.0%) and 21.6% (4.7–40.1%), respectively. The differences with respect to CPD were significant (p<0.01) (fig 1). The median peak time (180 minutes, 105–315) did not differ significantly from those of the other two groups.

**DIAGNOSTIC SENSITIVITY AND SPECIFICITY**

Because the distribution of values of cumulative outputs was not normal, we arbitrarily chose the lowest values found in healthy subjects as cut off levels. Patients with CPD were best discriminated from healthy controls and patients with NPD using the three hour $^{13}$CO$_2$ cumulative output value with a cut off of 5.7%; this resulted in abnormal values for 15/22 patients with CPD (diagnostic sensitivity for CPD: 68.2%), and for 8/32 patients with NPD (specificity: 75.0%). The diagnoses of these latter eight patients were as follows: gastrolesis in two, gastrectomy in two, and coeliac disease, irritable bowel disease, hepatic cirrhosis, and scleroderma in one each. The six hour $^{13}$CO$_2$ cumulative recovery with a cut off of 15.2% indicated abnormal results for the same number of patients with CPD as the three hour test (15/22), but gave abnormal results for a higher number (12/32) of those with NPD (specificity: 62.5%). Faecal chymotrypsin was abnormally low in 17/22 patients with CPD (sensitivity: 77.3%) and in 10/32 with NPD (specificity: 68.8%); the fluorescein dilaurate test gave abnormal results in 15/22 of the former group (sensitivity: 68.2%) and in 10/31 of the latter (specificity: 67.7%). Table 2 summarises the diagnostic sensitivity and specificity of the cholesteryl-[1–$^{13}$C]octanoate breath test.

![Figure 2](image-url)  
**Figure 2** Hourly time course $^{13}$CO$_2$ recovery shown as median values in healthy controls and in patients. The 10–90th centile ranges are shown in the table below the graph.  
*Significance of the differences between chronic pancreatic disease and healthy controls or non-pancreatic digestive disease: p<0.01.

![Figure 3](image-url)  
**Figure 3** Relations between the six hour $^{13}$CO$_2$ recovery of the cholesteryl-[1–$^{13}$C]octanoate breath test and faecal chymotrypsin concentration (A), fluorescein dilaurate test results (B), and faecal fat (C). In graph C, the curve was drawn manually and represents the best fit for the points. Inverted triangle, mild to moderate CPD; upright triangle, severe CPD.
test (three hour $^{13}$CO$_2$ cumulative recovery), faecal chymotrypsin, and fluorescein dilaurate test.

Twenty three of the 36 patients (63.9%) with steatorrhoea showed abnormal three hour $^{13}$CO$_2$ cumulative recovery (14/16 CPD; 9/20 healthy controls + NPD + BPD); 31/33 (93.9%) patients without steatorrhoea had normal cholesteryl-$[^{13}$C]octanoate breath test results (5/6 CPD; 26/27 healthy controls + NPD + BPD).

**PANCREATIC FUNCTION INDEX**

The pancreatic function index (the ratio between the $^{13}$CO$_2$ recovery after cholesteryl-$[^{13}$C]octanoate and after Na-$[^{13}$C]octanoate) was calculated for values obtained at three and six hours in seven healthy controls, in nine patients with CPD, and in nine with NPD (fig 5). Eight of nine with CPD had abnormally low index values at both three and at six hours, while among those with NPD, three and four had an abnormal index at three and six hours, respectively. In comparison, $^{13}$CO$_2$ recoveries after cholesteryl-$[^{13}$C]octanoate were low at both three and six hours in 7/9 patients with CPD and 3/9 patients with NPD.

**BLOOD XYLOSE**

The xylose appeared rapidly (within 30 minutes) in the serum in all subjects. There were no differences in median peak concentration times among healthy controls (90 minutes, 50–120), CPD (60 minutes, 60–120), and NPD (90 minutes, 60–120).

**Discussion**

Few studies have thoroughly investigated the utility of breath tests that include non-radioactive labelled substrates for the evaluation of lipid digestion. In 1982 Watkins et al compared the effectiveness of trioctanoin, triolein, or palmitic acid breath tests in children with malabsorption and reported that pancreatic insufficiency could be readily differentiated from mucosal disease or bile salt deficiency by abnormal triolein or trioctanoin breath test but normal palmitic acid breath test results.9 A mixed triglyceride breath test using 1,3-diesteroyl, 2[$^{13}$C]octanoyl glycerol was described by Vantrappen et al in 1989 as a sensitive and specific means of diagnosing pancreatic insufficiency.21 In 1993 Kato et al performed a breath test using trioctanoin in patients after pancreateoduodenectomy and found it to be as sensitive as the secretin test as well as more reliable than conventional tubeless tests.22 More recently, a new $^{13}$C breath test using hiolein (a mixture of different uniformly labelled triglycerides) has proved to be highly sensitive and specific for detecting steatorrhoea.23

Cholesteryl octanoate has been proposed as a substrate for the study of lipid malabsorption.8 The test, performed using $^{14}$C as a marker, has seemed to be very useful for assessing exocrine pancreatic insufficiency and monitoring the efficacy of pancreatic replacement therapy.24 The recent availability of automated mass spectrometry for $^{13}$C has given us the possibility of performing the test without exposing patients to radioactivity.

In our study this test proved to have good reproducibility and low variability, which may be partly accounted for by the easy absorption and the simple and rapid metabolism of octanoic acid.
To assess the sensitivity of the cholesteryl octanoate breath test in the diagnosis of exocrine pancreatic insufficiency, we compared its results with those of simple tubeless tests (faecal chymotrypsin, fluorescein dilaurate test, and faecal fat); these techniques measure different digestive activities and, considered together, represent a valid determination of pancreatic exocrine function. Use of the CCK-secretin test would have been ideal, but this procedure was avoided because it is invasive and unpleasant for the patient. For greater certainty, the severity of chronic pancreatitis was also assessed on the basis of morphological features (ultrasound, computed tomography, and ERCP).

The majority of patients (14/18, 77.8%) with exocrine pancreatic insufficiency determined by faecal chymotrypsin and the fluorescein dilaurate test showed decreased excretion of \(^{13}\text{CO}_2\) after cholesteryl-[1-\(^{13}\text{C}\)]octanoate ingestion. These patients could be best discriminated from healthy controls by the three hour cumulative \(^{13}\text{CO}_2\) values. This may reflect the fact that most of the digestive processes involving the substrate used in the test take place within this time period. As indicated both by \(^{13}\text{C}\) recovery and xylose curves, patients with CPD did not show different gastric emptying with respect to healthy controls. The earlier peak of plasma xylose with respect to the peak of \(^{13}\text{CO}_2\) suggests that the oil phase containing the substrate may have separated in the stomach and emptied later.

Recovery of \(^{13}\text{CO}_2\) was found to be related to the severity of the exocrine pancreatic insufficiency; in fact, all but one of the seven patients with severe chronic pancreatitis as assessed by morphological findings and functional tests (steatorrhea and abnormal faecal chymotrypsin and fluorescein dilaurate test) showed very low recovery, and in all three patients with cystic fibrosis it was virtually absent. Moreover, the \(^{13}\text{CO}_2\) excretion proved to be closely correlated with the degree of pancreatic insufficiency as determined by faecal chymotrypsin and the fluorescein dilaurate test. The breath test results were also compared with faecal fat output and found to be inversely correlated. Figure 3C shows the disposition of the values of \(^{13}\text{CO}_2\) output plotted against faecal fat: steatorrhea does not occur until there is about a 90% reduction in \(^{13}\text{CO}_2\) recovery; this is an indirect demonstration of the great functional reserve of the exocrine pancreas. In fact, in the pioneering study of DiMagno et al it was clearly shown that steatorrhea does not occur until there is at least a 90% reduction in pancreatic lipase output.\(^{12}\)

In three patients with severe pancreatic steatorrhea, the total \(^{13}\text{CO}_2\) recovery over the six hour test period was significantly improved during administration of pancreatin; however, the recovery normalised only in the two with chronic pancreatitis, while it remained abnormal in the patient with cystic fibrosis. This latter finding was probably due to alterations of the intestinal contents typically associated with cystic fibrosis, such as precipitation of bile acids and impaired micellar formation, at reduced intraluminal pH.\(^{13}\) Mundlos et al\(^{14}\) also reported incomplete correction of malabsorption by pancreatin formulated in enteric coated microspheres, as shown by this test, in patients with pancreatic insufficiency, but attributed this finding to retention of spheres in the stomach.

The cholesteryl octanoate breath test was also found to be abnormal in some patients with NPD. It is well known that hydrolysis of the substrate requires both pancreatic enzymes and bile acids. When bile acids are deficient, as occurs in liver disease, irritable bowel disease, or coeliac disease (because of impaired CCK release) the test will be positive despite normal pancreatic function. In such cases a control test with bile acid administration might be useful for excluding bile acid deficiency. Furthermore, other factors, such as alteration of intestinal mixing of the lipid phase (in gastrectomy and scleroderma) and/or impaired octanoic acid oxidation (in hepatic cirrhosis), may also account for the pathological results.

\(^{13}\text{CO}_2\) recovery was abnormally low in all four patients with BPD performed for obesity. These patients also showed moderate to severe steatorrhea (range 8.9–71.9 g lipid/24 hours), and had had considerable weight loss. The curves of \(^{13}\text{C}\) appearance in the breath were flat or shifted to the right, showing a significant impairment or delay in fat digestion. This may be dependent on anatomical diversion of pancreatic secretion and/or impaired CCK release.\(^{15}\)

According to the results of this study, the breath test with cholesteryl-[1-\(^{13}\text{C}\)]octanoate as a test of fat malabsorption appears to have a good diagnostic specificity, but limited sensitivity in steatorrhea of non-pancreatic origin. Likewise, the sensitivity of the breath test in the diagnosis of exocrine pancreatic insufficiency was not optimal; indeed, abnormal results were found in only 15/22 patients with CPD (68.2%). However, the presence in our series of cases with mild chronic pancreatitis (with normal faecal chymotrypsin or fluorescein

---

**Figure 5** Individual values of the pancreatic function index (cholesteryl-octanoate/Na-octanoate \(^{13}\text{CO}_2\) recovery ratio). Inverted triangle, mild to moderate CPD; upright triangle, severe CPD.
13C labelled cholesteryl octanoate breath test
dilute test and slight morphological changes) may account for the less than excellent diagnosti-
c performance of the test. Nevertheless, the sensiti-
vity and specificity of this breath test for chronic pan-
creatic disease were similar to those of the other tubeless tests performed for compari-
son. The combination of the cholesteryl octanoate breath test with the faecal chymot-
rypsin and fluorescein dilute test did not in-
crease diagnostic capacity for exocrine pan-
creatic insufficiency, since the gain in sensitivity was
counterbalanced by a loss of specificity.

In a limited number of cases we performed a
combined test, first with cholesteryl-[1-
13C]octanoate and subsequently with Na-
[1-13C]octanoate. The combination of the two
tests should have (theoretically) improved the
diagnostic performance of the cholesteryl-[1-
13C]octanoate breath test, because the ratio of
13CO2 recovery from the first and second test
should correct the abnormality of octanoic acid
absorption and metabolism in patients with NPD. In our study, however, we saw no advan-
tage in diagnostic specificity with the combined
test. One reason for this finding may be the
presence of associated pancreatic insufficiency in
the NPD group, as shown by low faecal chymo-
trypsin in one patient with coeliac disease.

In conclusion, the present study has shown
that the cholesteryl-[1-13C]octanoate breath
test has some validity in the assessment of lipid
malabsorption. It can also be used for the diag-
nosis of exocrine pancreatic insufficiency, for
which its sensitivity and specificity are compa-
rable to those of two commonly used tubeless
pancreatic function tests. The test is easy to
carry out and can be performed in three hours.
Unfortunately, at present the cost of the labelled
substrate (US$50–75 for each test) and appar-
atus, greatly exceeds that of the cur-
cently used pancreatic function tests. However,
the potential uses of isotopic mass spec-
metry in gastroenterology (such as for
urea and liver function breath tests), and the
possibility of performing the test at the
patient’s home and mailing the specimens to a
test centre may eventually make the test more
cost effective. In addition, the use of non-
radiative substrate means that this procedure
is suitable for infants, children, and pregnant
women.

The preliminary results of this study were presented in Oslo (Norway) at the 3rd United European Gastroenterology Week, 25–29 June 1994. This study was partially supported by the University and Technological and Scientific Research Ministry of Italy in 1994.

9 Cole SG, Rossi S, Sterr A, Hofmann AF. Cholesteryl octanoate breath test. Preliminary studies on a new non-
11 Bolondi L, Priori P, Gullo L, et al. Relationship between
tests should have (theoretically) improved the
diagnostic performance of the cholesteryl-[1-
13C]octanoate breath test, because the ratio of
13CO2 recovery from the first and second test
should correct the abnormality of octanoic acid
absorption and metabolism in patients with NPD. In our study, however, we saw no advan-
tage in diagnostic specificity with the combined
test. One reason for this finding may be the
presence of associated pancreatic insufficiency in
the NPD group, as shown by low faecal chymo-
trypsin in one patient with coeliac disease.

In conclusion, the present study has shown
that the cholesteryl-[1-13C]octanoate breath
test has some validity in the assessment of lipid
malabsorption. It can also be used for the diag-
nosis of exocrine pancreatic insufficiency, for
which its sensitivity and specificity are compa-
rable to those of two commonly used tubeless
pancreatic function tests. The test is easy to
carry out and can be performed in three hours.
Unfortunately, at present the cost of the labelled
substrate (US$50–75 for each test) and appar-
atus, greatly exceeds that of the cur-
cently used pancreatic function tests. However,
the potential uses of isotopic mass spec-
metry in gastroenterology (such as for
urea and liver function breath tests), and the
possibility of performing the test at the
patient’s home and mailing the specimens to a
test centre may eventually make the test more
cost effective. In addition, the use of non-
radiative substrate means that this procedure
is suitable for infants, children, and pregnant
women.

The preliminary results of this study were presented in Oslo (Norway) at the 3rd United European Gastroenterology Week, 25–29 June 1994. This study was partially supported by the University and Technological and Scientific Research Ministry of Italy in 1994.

13C labelled cholesteryl octanoate breath test for assessing pancreatic exocrine insufficiency

M Ventrucci, A Cipolla, G M Ubalducci, A Roda and E Roda

Gut 1998 42: 81-87
doi: 10.1136/gut.42.1.81

Updated information and services can be found at:
http://gut.bmj.com/content/42/1/81

These include:

References
This article cites 20 articles, 8 of which you can access for free at:
http://gut.bmj.com/content/42/1/81#BIBL

Email alerting service
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Topic Collections
Articles on similar topics can be found in the following collections
Pancreas and biliary tract (1949)

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/