**INTRODUCTION**

For individuals with gluten-related disorders (GRD) eating out has traditionally been difficult, and socially impacting, due to concern over the lack of public awareness regarding GRD and a gluten-free diet (GFD). However, the recent rise in media coverage highlighting these conditions may have altered knowledge amongst community members.

**Aims**

To assess whether there has been a change in awareness of GRD, and a GFD, amongst the general public and chefs over a ten year period.

**Methods**

A face-to-face questionnaire survey about coeliac disease (CD) and gluten sensitivity (GS) was performed on the general public and chefs based in Sheffield, United Kingdom. The assessment was first conducted in 2003 and repeated in 2013. Chefs were also asked about their workplace (takeaway or restaurant) and whether or not they had formal qualifications. Additional questions for the 2013 cohort included correct recognition of the cross-grain symbol to identify gluten-free products and whether they displayed a notice/sign for gluten-free products.

**Results**

Public survey: 513 public members in year 2003 (mean age 49.2, 62% female) were compared to 575 public members in year 2013 (mean age 37.8, 57% female). Adjusting for age and sex, there was a significant rise in the awareness of GRD from the years 2003 to 2013; CD (44.2 to 74.4%, OR 3.94 [CI: 2.99–5.19]) and GS (58.2 to 89%, OR 7.09 [CI: 5.9–9.98]), p value < 0.0001.

Chef Survey: 322 chefs in year 2003 (mean age 37.6, 15.2% female, qualified 51.2%, restaurant chefs 50%) were compared to 265 chefs in year 2013 (mean age 27.1, 38.1% female, qualified 93.2%, restaurant chefs 83%), p < 0.0001. Adjusting for age, sex, workplace and qualifications, there was a significant rise in the awareness of GRD from the years 2003 to 2013; CD (17.1 to 78.1%, OR 12.5 [CI: 7.9–19.6]) and GS (9.3 to 87.5%, OR 65.7 [CI: 35.4–122]), p < 0.001.

Whereas in 2003 the public were significantly more aware of GRD than chefs, by 2013 there was a similar prevalence of awareness in both groups. In addition, the correct recognition of the gluten-free symbol was 44% for the public and 40% for chefs (p 0.28). Furthermore, in the year 2013, 41% of restaurants and 27% of takeaways displayed selling gluten-free products (p 0.07).

**Conclusion**

There has been a dramatic rise in both the public and chefs awareness of GRD. This suggests that individuals with GRD can take greater confidence discussing and ordering a GFD whilst eating out.

**Disclosure of Interest**

None Declared.
patients with CD and the British Society of Gastroenterology guidelines state that DEXA should only be done after introduction of a gluten-free diet on the subgroup of patients in whom the risk of osteoporotic fracture is high. This was however followed up by a guidance document in 2010 stating that BMD assessment should always be performed at diagnosis. Meanwhile the American guidelines suggest testing for vitamin and micronutrient deficiencies. The aims of this study were to determine, the prevalence of osteopenia and osteoporosis among patients who are newly diagnosed with CD, and any risk factors which would increase patients' risk of osteopenia and osteoporosis.

Methods We carried out a prospective cohort study, where newly diagnosed CD patients were recruited. DEXA scanning was done at diagnosis. Data with regards to smoking, BMD and histology was entered into a database and analysed using SPSS software package.

Results 137 patients with a histological diagnosis of CD were recruited. 76.6% were females. Mean age at diagnosis was 37.1 years (95% CI: ±3.19 years). 21.9% (n = 30) of patients were osteoporotic and another 51.1% (n = 72) were osteopenic at diagnosis. A total of 14.9% (n = 17) had a previous history of fracture/s prior to diagnosis. Osteoporosis at the spine was significantly associated with the female gender (p = 0.04) and with an older age at diagnosis (50.3 years p = 0.01; 95% CI: ±6.6 years). Patients with Marsh 3c disease at diagnosis were also more likely to have an abnormal BMD at the spine than patients with Marsh 3a or 3b (p = 0.04). Mean BMI between osteopenic (24.15 kg/m²) 95% CI: ±1.29) and osteoporotic (23.37 kg/m² 95% CI: ±2.81) patients was slightly different but not statistically significant (p = 0.07).

Conclusion This data demonstrates a high rate of osteopenia and osteoporosis among CD patients at diagnosis. DEXA scanning should therefore be considered at diagnosis. This is of greater importance in female patients diagnosed at or above the age of 50 years and with Marsh 3c disease.

REFERENCES

Disclosure of Interest None Declared.

Introduction Endoscopic markers of coeliac disease (CD) lack sensitivity; therefore many centres take routine duodenal biopsies or have a low threshold for biopsy, ensuring high detection rates. Newly available, point of care tests (POCT) provide rapid findings unlike conventional serological markers, potentially reducing the need for duodenal biopsies. This study evaluates a new POCT (Simtomax) which detects IgA and IgG deamidated gliadin peptide (DGP) with comparisons made to conventional serological markers and histology.

Methods Patients referred for a gastroscopy to a specialist CD list were prospectively recruited between March and November 2013. Patients were excluded if they were on a gluten free diet at the time of the test or if they had previously been diagnosed with seronegative villous atrophy. All patients had a duodenal biopsy as the gold standard for detecting CD. Concurrently serological testing for IgA tissue transglutaminase (TTG), endomysial antibody (EMA), total immunoglobulin A level and the DGP based rapid test was performed. Sensitivity, specificity, positive predictive (PPV) and negative predictive values (NPV) were calculated.

Results 354 patients met the inclusion criteria (45.8% male mean age 53.3 ±18.5). Of these, 52 (14.7%) 11.2 – 18.9) had newly diagnosed CD and 302 were controls with a normal duodenal biopsy. The sensitivity, specificity, PPV and NPV for the POCT were 94, 83, 49 and 99% respectively. This compares with results for TTG of 92, 88, 57, 99 and EMA of 88, 97, 85, and 98% respectively. In a second cohort, 43 patients with known CD for re-assessment were recruited (20.9% male, mean age 49.4 ±16.6). 16 (37%) 23 ±53) of these 16 patients (37%) had persistent villous atrophy despite a gluten free diet. POCT compared to histology showed sensitivity of 88% and specificity of 41%. TTG showed sensitivity and specificity of 63 and 70% respectively and EMA 56 and 78% respectively. However agreement between histology and POCT was poor with concordance between results in only 60% (κ=0.274). TTG and EMA were marginally better with κ=0.321 and κ=0.345 respectively.

Conclusion This is the first study to prospectively demonstrate the value of a novel POCT for adult CD in endoscopy compared to the gold standard of histology. The sensitivity and specificity of the POCT is comparable to conventional serology. Simtomax could be used to appropriately identify patients requiring a duodenal biopsy within the endoscopic setting. This strategy may be cost effective by reducing the number of routine duodenal biopsies taken. Further work is required to clarify the role of POCT for the assessment of histological remission in patients with known CD.

Disclosure of Interest None Declared.