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ЕЖЕМЕСЯЧНЫЙ НАУЧНЫЙ ЖУРНАЛ

Медицинские новости Грузии

საქართველოს სამედიცინო სიახლენი

GEORGIAN MEDICAL NEWS

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GMN: Georgian Medical News is peer-reviewed, published monthly journal committed to promoting the science and art of medicine and the betterment of public health, published by the GMN Editorial Board since 1994. GMN carries original scientific articles on medicine, biology and pharmacy, which are of experimental, theoretical and practical character; publishes original research, reviews, commentaries, editorials, essays, medical news, and correspondence in English and Russian.

GMN is indexed in MEDLINE, SCOPUS, PubMed and VINITI Russian Academy of Sciences. The full text content is available through EBSCO databases.

GMN: Медицинские новости Грузии - ежемесячный рецензируемый научный журнал, издаётся Редакционной коллегией с 1994 года на русском и английском языках в целях поддержки медицинской науки и улучшения здравоохранения. В журнале публикуются оригинальные научные статьи в области медицины, биологии и фармации, статьи обзорного характера, научные сообщения, новости медицины и здравоохранения. Журнал индексируется в MEDLINE, отражён в базе данных SCOPUS, PubMed и ВИНИТИ РАН. Полнотекстовые статьи журнала доступны через БД EBSCO.

GMN: Georgian Medical News – საქართველოს სამედიცინო სიახლენი – არის ყოველთვიური სამეცნიერო სამედიცინო რეცენზირებადი ჟურნალი, გამოიცემა 1994 წლიდან, წარმოადგენს სარედაქციო კოლეგიისა და აშშ-ის მეცნიერების, განათლების, ინდუსტრიის, ხელოვნებისა და ბუნებისმეტყველების საერთაშორისო აკადემიის ერთობლივ გამოცემას. GMN-ში რუსულ და ინგლისურ ენებზე ქვეყნდება ექსპერიმენტული, თეორიული და პრაქტიკული ხასიათის ორიგინალური სამეცნიერო სტატიები მედიცინის, ბიოლოგიისა და ფარმაციის სფეროში, მიმოხილვითი ხასიათის სტატიები.

ჟურნალი ინდექსირებულია MEDLINE-ის საერთაშორისო სისტემაში, ასახულია SCOPUS-ის, PubMed-ის და ВИНИТИ РАН-ის მონაცემთა ბაზებში. სტატიების სრული ტექსტი ხელმისაწვდომია EBSCO-ს მონაცემთა ბაზებიდან.

WEBSITE

www.geomednews.com

К СВЕДЕНИЮ АВТОРОВ!

При направлении статьи в редакцию необходимо соблюдать следующие правила:

1. Статья должна быть представлена в двух экземплярах, на русском или английском языках, напечатанная через **полтора интервала на одной стороне стандартного листа с шириной левого поля в три сантиметра**. Используемый компьютерный шрифт для текста на русском и английском языках - **Times New Roman** (**Кириллица**), для текста на грузинском языке следует использовать **AcadNusx.** Размер шрифта - **12**. К рукописи, напечатанной на компьютере, должен быть приложен CD со статьей.

2. Размер статьи должен быть не менее десяти и не более двадцати страниц машинописи, включая указатель литературы и резюме на английском, русском и грузинском языках.

3. В статье должны быть освещены актуальность данного материала, методы и результаты исследования и их обсуждение.

При представлении в печать научных экспериментальных работ авторы должны указывать вид и количество экспериментальных животных, применявшиеся методы обезболивания и усыпления (в ходе острых опытов).

4. К статье должны быть приложены краткое (на полстраницы) резюме на английском, русском и грузинском языках (включающее следующие разделы: цель исследования, материал и методы, результаты и заключение) и список ключевых слов (key words).

5. Таблицы необходимо представлять в печатной форме. Фотокопии не принимаются. **Все цифровые, итоговые и процентные данные в таблицах должны соответствовать таковым в тексте статьи**. Таблицы и графики должны быть озаглавлены.

6. Фотографии должны быть контрастными, фотокопии с рентгенограмм - в позитивном изображении. Рисунки, чертежи и диаграммы следует озаглавить, пронумеровать и вставить в соответствующее место текста **в tiff формате**.

В подписях к микрофотографиям следует указывать степень увеличения через окуляр или объектив и метод окраски или импрегнации срезов.

7. Фамилии отечественных авторов приводятся в оригинальной транскрипции.

8. При оформлении и направлении статей в журнал МНГ просим авторов соблюдать правила, изложенные в «Единых требованиях к рукописям, представляемым в биомедицинские журналы», принятых Международным комитетом редакторов медицинских журналов - http://www.spinesurgery.ru/files/publish.pdf и http://www.nlm.nih.gov/bsd/uniform_requirements.html
В конце каждой оригинальной статьи приводится библиографический список. В список литературы включаются все материалы, на которые имеются ссылки в тексте. Список составляется в алфавитном порядке и нумеруется. Литературный источник приводится на языке оригинала. В списке литературы сначала приводятся работы, написанные знаками грузинского алфавита, затем кириллицей и латиницей. Ссылки на цитируемые работы в тексте статьи даются в квадратных скобках в виде номера, соответствующего номеру данной работы в списке литературы. Большинство цитированных источников должны быть за последние 5-7 лет.

9. Для получения права на публикацию статья должна иметь от руководителя работы или учреждения визу и сопроводительное отношение, написанные или напечатанные на бланке и заверенные подписью и печатью.

10. В конце статьи должны быть подписи всех авторов, полностью приведены их фамилии, имена и отчества, указаны служебный и домашний номера телефонов и адреса или иные координаты. Количество авторов (соавторов) не должно превышать пяти человек.

11. Редакция оставляет за собой право сокращать и исправлять статьи. Корректура авторам не высылается, вся работа и сверка проводится по авторскому оригиналу.

12. Недопустимо направление в редакцию работ, представленных к печати в иных издательствах или опубликованных в других изданиях.

При нарушении указанных правил статьи не рассматриваются.

REQUIREMENTS

Please note, materials submitted to the Editorial Office Staff are supposed to meet the following requirements:

1. Articles must be provided with a double copy, in English or Russian languages and typed or compu-ter-printed on a single side of standard typing paper, with the left margin of **3** centimeters width, and **1.5** spacing between the lines, typeface - **Times New Roman** (**Cyrillic**), print size - **12** (referring to Georgian and Russian materials). With computer-printed texts please enclose a CD carrying the same file titled with Latin symbols.

2. Size of the article, including index and resume in English, Russian and Georgian languages must be at least 10 pages and not exceed the limit of 20 pages of typed or computer-printed text.

3. Submitted material must include a coverage of a topical subject, research methods, results, and review.

Authors of the scientific-research works must indicate the number of experimental biological species drawn in, list the employed methods of anesthetization and soporific means used during acute tests.

4. Articles must have a short (half page) abstract in English, Russian and Georgian (including the following sections: aim of study, material and methods, results and conclusions) and a list of key words.

5. Tables must be presented in an original typed or computer-printed form, instead of a photocopied version. **Numbers, totals, percentile data on the tables must coincide with those in the texts of the articles.** Tables and graphs must be headed.

6. Photographs are required to be contrasted and must be submitted with doubles. Please number each photograph with a pencil on its back, indicate author's name, title of the article (short version), and mark out its top and bottom parts. Drawings must be accurate, drafts and diagrams drawn in Indian ink (or black ink). Photocopies of the X-ray photographs must be presented in a positive image in **tiff format**.

Accurately numbered subtitles for each illustration must be listed on a separate sheet of paper. In the subtitles for the microphotographs please indicate the ocular and objective lens magnification power, method of coloring or impregnation of the microscopic sections (preparations).

7. Please indicate last names, first and middle initials of the native authors, present names and initials of the foreign authors in the transcription of the original language, enclose in parenthesis corresponding number under which the author is listed in the reference materials.

8. Please follow guidance offered to authors by The International Committee of Medical Journal Editors guidance in its Uniform Requirements for Manuscripts Submitted to Biomedical Journals publication available online at: http://www.nlm.nih.gov/bsd/uniform_requirements.html
http://www.icmje.org/urm_full.pdf
In GMN style for each work cited in the text, a bibliographic reference is given, and this is located at the end of the article under the title "References". All references cited in the text must be listed. The list of references should be arranged alphabetically and then numbered. References are numbered in the text [numbers in square brackets] and in the reference list and numbers are repeated throughout the text as needed. The bibliographic description is given in the language of publication (citations in Georgian script are followed by Cyrillic and Latin).

9. To obtain the rights of publication articles must be accompanied by a visa from the project instructor or the establishment, where the work has been performed, and a reference letter, both written or typed on a special signed form, certified by a stamp or a seal.

10. Articles must be signed by all of the authors at the end, and they must be provided with a list of full names, office and home phone numbers and addresses or other non-office locations where the authors could be reached. The number of the authors (co-authors) must not exceed the limit of 5 people.

11. Editorial Staff reserves the rights to cut down in size and correct the articles. Proof-sheets are not sent out to the authors. The entire editorial and collation work is performed according to the author's original text.

12. Sending in the works that have already been assigned to the press by other Editorial Staffs or have been printed by other publishers is not permissible.

Articles that Fail to Meet the Aforementioned Requirements are not Assigned to be Reviewed.

ავტორთა საყურადღებოდ!

რედაქციაში სტატიის წარმოდგენისას საჭიროა დავიცვათ შემდეგი წესები:

1. სტატია უნდა წარმოადგინოთ 2 ცალად, რუსულ ან ინგლისურ ენებზე,დაბეჭდილი სტანდარტული ფურცლის 1 გვერდზე, 3 სმ სიგანის მარცხენა ველისა და სტრიქონებს შორის 1,5 ინტერვალის დაცვით. გამოყენებული კომპიუტერული შრიფტი რუსულ და ინგლისურენოვან ტექსტებში - **Times New Roman (Кириллица)**, ხოლო ქართულენოვან ტექსტში საჭიროა გამოვიყენოთ **AcadNusx.** შრიფტის ზომა – 12. სტატიას თან უნდა ახლდეს CD სტატიით.

2. სტატიის მოცულობა არ უნდა შეადგენდეს 10 გვერდზე ნაკლებს და 20 გვერდზე მეტს ლიტერატურის სიის და რეზიუმეების (ინგლისურ, რუსულ და ქართულ ენებზე) ჩათვლით.

3. სტატიაში საჭიროა გაშუქდეს: საკითხის აქტუალობა; კვლევის მიზანი; საკვლევი მასალა და გამოყენებული მეთოდები; მიღებული შედეგები და მათი განსჯა. ექსპერიმენტული ხასიათის სტატიების წარმოდგენისას ავტორებმა უნდა მიუთითონ საექსპერიმენტო ცხოველების სახეობა და რაოდენობა; გაუტკივარებისა და დაძინების მეთოდები (მწვავე ცდების პირობებში).

4. სტატიას თან უნდა ახლდეს რეზიუმე ინგლისურ, რუსულ და ქართულ ენებზე არანაკლებ ნახევარი გვერდის მოცულობისა (სათაურის, ავტორების, დაწესებულების მითითებით და უნდა შეიცავდეს შემდეგ განყოფილებებს: მიზანი, მასალა და მეთოდები, შედეგები და დასკვნები; ტექსტუალური ნაწილი არ უნდა იყოს 15 სტრიქონზე ნაკლები) და საკვანძო სიტყვების ჩამონათვალი (key words).

5. ცხრილები საჭიროა წარმოადგინოთ ნაბეჭდი სახით. ყველა ციფრული, შემაჯამებელი და პროცენტული მონაცემები უნდა შეესაბამებოდეს ტექსტში მოყვანილს.

6. ფოტოსურათები უნდა იყოს კონტრასტული; სურათები, ნახაზები, დიაგრამები - დასათაურებული, დანომრილი და სათანადო ადგილას ჩასმული. რენტგენოგრამების ფოტოასლები წარმოადგინეთ პოზიტიური გამოსახულებით **tiff** ფორმატში. მიკროფოტოსურათების წარწერებში საჭიროა მიუთითოთ ოკულარის ან ობიექტივის საშუალებით გადიდების ხარისხი, ანათალების შეღებვის ან იმპრეგნაციის მეთოდი და აღნიშნოთ სურათის ზედა და ქვედა ნაწილები.

7. სამამულო ავტორების გვარები სტატიაში აღინიშნება ინიციალების თანდართვით, უცხოურისა – უცხოური ტრანსკრიპციით.

8. სტატიას თან უნდა ახლდეს ავტორის მიერ გამოყენებული სამამულო და უცხოური შრომების ბიბლიოგრაფიული სია (ბოლო 5-8 წლის სიღრმით). ანბანური წყობით წარმოდგენილ ბიბლიოგრაფიულ სიაში მიუთითეთ ჯერ სამამულო, შემდეგ უცხოელი ავტორები (გვარი, ინიციალები, სტატიის სათაური, ჟურნალის დასახელება, გამოცემის ადგილი, წელი, ჟურნალის №, პირველი და ბოლო გვერდები). მონოგრაფიის შემთხვევაში მიუთითეთ გამოცემის წელი, ადგილი და გვერდების საერთო რაოდენობა. ტექსტში კვადრატულ ფჩხილებში უნდა მიუთითოთ ავტორის შესაბამისი N ლიტერატურის სიის მიხედვით. მიზანშეწონილია, რომ ციტირებული წყაროების უმეტესი ნაწილი იყოს 5-6 წლის სიღრმის.

9. სტატიას თან უნდა ახლდეს: ა) დაწესებულების ან სამეცნიერო ხელმძღვანელის წარდგინება, დამოწმებული ხელმოწერითა და ბეჭდით; ბ) დარგის სპეციალისტის დამოწმებული რეცენზია, რომელშიც მითითებული იქნება საკითხის აქტუალობა, მასალის საკმაობა, მეთოდის სანდოობა, შედეგების სამეცნიერო-პრაქტიკული მნიშვნელობა.

10. სტატიის ბოლოს საჭიროა ყველა ავტორის ხელმოწერა, რომელთა რაოდენობა არ უნდა აღემატებოდეს 5-ს.

11. რედაქცია იტოვებს უფლებას შეასწოროს სტატია. ტექსტზე მუშაობა და შეჯერება ხდება საავტორო ორიგინალის მიხედვით.

12. დაუშვებელია რედაქციაში ისეთი სტატიის წარდგენა, რომელიც დასაბეჭდად წარდგენილი იყო სხვა რედაქციაში ან გამოქვეყნებული იყო სხვა გამოცემებში.

აღნიშნული წესების დარღვევის შემთხვევაში სტატიები არ განიხილება.

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ACUTE CELIAC CRISIS PRESENTING AS SEVERE MALABSORPTIVE DIARRHEA AND HEMODYNAMIC INSTABILITY IN AN ADULT MALE: A CASE REPORT

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Abstract.

Celiac crisis is a rare and life-threatening manifestation of celiac disease characterized by acute severe diarrhea, dehydration, and metabolic disturbances requiring hospitalization. Although commonly described in children, it is infrequently reported in adults and may pose a diagnostic challenge.

We report the case of a 31-year-old previously healthy male who presented with profuse watery diarrhea, profound weight loss, hypotension, electrolyte imbalance, hypoalbuminemia, and metabolic acidosis. Extensive infectious and inflammatory evaluations were negative. Serologic testing revealed markedly elevated anti–tissue transglutaminase and anti-endomysial antibodies. Upper endoscopy demonstrated scalloping and atrophic duodenal mucosa, while histopathology confirmed villous atrophy with crypt hyperplasia and increased intraepithelial lymphocytes. A diagnosis of celiac crisis was established. The patient was successfully managed with aggressive fluid resuscitation, electrolyte correction, nutritional support, and strict gluten-free diet, resulting in rapid clinical recovery.

This case highlights the importance of considering celiac crisis in adults presenting with severe unexplained diarrhea and metabolic derangements to enable early diagnosis and timely management.

Key words. Acute celiac crisis, malabsorptive diarrhea, hemodynamic instability, male.

Introduction.

Celiac disease is an immune-mediated enteropathy triggered by dietary gluten in genetically predisposed individuals, leading to small intestinal mucosal inflammation and villous atrophy. It commonly presents with chronic diarrhea, malabsorption, weight loss, and micronutrient deficiencies, although extraintestinal manifestations may also occur [1,2].

While most patients exhibit a chronic or subclinical course, a rare and severe presentation known as celiac crisis can occur. This condition is characterized by acute onset of profuse diarrhea, severe dehydration, electrolyte disturbances, metabolic acidosis, and hypoproteinemia requiring hospitalization [3,4].

Celiac crisis is well recognized in pediatric populations but remains uncommon in adults, where it may be underdiagnosed due to its nonspecific presentation and overlap with other causes of acute severe diarrhea [4,5]. Early recognition is critical, as delayed diagnosis may result in significant morbidity and potential mortality.

In this report, we describe a case of newly diagnosed celiac disease presenting as celiac crisis in a previously healthy adult male, highlighting the diagnostic challenges and management considerations.

Case report.

A 31-year-old Egyptian male with no known past medical history presented with a 20-day history of severe diffuse abdominal pain and profuse watery, non-bloody diarrhea occurring more than 10 times daily. The diarrhea was explosive in nature and associated with progressive generalized weakness and significant unintentional weight loss of approximately 15 kg. He denied fever, nausea, vomiting, recent travel, dietary changes, medication use, or exposure to infectious contacts. There were no respiratory or urinary symptoms, and no similar prior episodes or relevant family history.

On presentation, he appeared ill, emaciated, and dehydrated, with a body mass index of 17.3 kg/m². He was markedly weak and barely able to ambulate. Vital signs showed hypotension and tachycardia (BP 90/60 mmHg, HR 110 bpm, RR 22/min, oxygen saturation 97% on room air, afebrile).

Physical examination revealed normal cardiovascular and respiratory findings. The abdomen was distended with hyperactive bowel sounds but without organomegaly or tenderness. Mild bilateral lower limb pitting edema (grade 1) was noted. No skin rash or lymphadenopathy was present.

Initial laboratory investigations demonstrated normocytic anemia (hemoglobin 11.6 g/dL), hyponatremia (129 mmol/L), hypokalemia (2.8 mmol/L), hypoalbuminemia (28 g/L), and normal renal and hepatic profiles. Arterial blood gases showed normal anion gap metabolic acidosis. Inflammatory markers were negative. Thyroid function was normal. Comprehensive stool analyses, including bacterial, viral, parasitic, and Clostridioides difficile testing, were negative.

Contrast-enhanced abdominal computed tomography revealed diffuse small bowel wall thickening with mucosal enhancement, free intraperitoneal fluid, and mesenteric lymphadenopathy.

Further workup for chronic diarrhea demonstrated normal fecal calprotectin and negative autoimmune and infectious screening (ANCA, ASCA, tuberculosis, viral hepatitis, HIV). Celiac serology showed markedly elevated anti-tissue transglutaminase antibodies (anti-tTG IgA 4021 CU; anti-tTG IgG 126 CU) and positive anti-endomysial antibodies. Repeat testing remained persistently positive.

Upper gastrointestinal endoscopy (Figure 1) revealed nodular, erythematous, and atrophic mucosa with prominent scalloping of the folds in the second portion of the duodenum. Colonoscopy was normal.

Histopathology of duodenal biopsies demonstrated subtotal to total villous atrophy, crypt hyperplasia, and markedly increased intraepithelial lymphocytes (>40 per 100 enterocytes), consistent with active celiac enteropathy.

Based on severe acute gastrointestinal symptoms, hemodynamic instability, significant weight loss, electrolyte derangements,

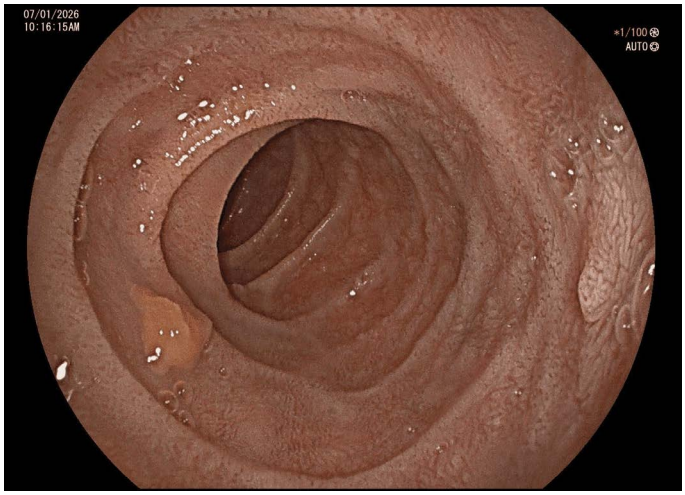

Figure 1. *Upper GIT Endoscopy Showing Scalloping and fissuring of the duodenum.*

hypoalbuminemia, positive serology, characteristic endoscopic findings, and confirmatory histopathology, a diagnosis of newly recognized celiac disease presenting as celiac crisis was established.

The patient was admitted for inpatient stabilization and managed according to evidence-based principles for severe malabsorptive diarrhea and suspected celiac crisis. Initial treatment focused on prompt hemodynamic resuscitation with aggressive intravenous isotonic fluid replacement and careful correction of electrolyte disturbances, particularly hypokalemia. Intravenous albumin supplementation was administered to address significant hypoalbuminemia, and close monitoring of fluid balance, renal function, and metabolic parameters was maintained. Nutritional rehabilitation was initiated early through high-calorie, high-protein enteral feeding, and a strict gluten-free diet was commenced immediately upon confirmation of the diagnosis. Given the high risk of micronutrient deficiencies associated with severe malabsorption, comprehensive nutritional assessment was performed, and supplementation with iron, folate, vitamin B12, vitamin D, calcium, and trace elements was started. Due to the severity of dehydration and metabolic abnormalities at presentation, the patient was initially monitored in a high-dependency setting. Corticosteroid therapy was considered; however, it was deemed unnecessary as the patient demonstrated steady clinical improvement with supportive care alone.

Over the subsequent 5–7 days, the patient exhibited gradual clinical recovery, with a marked reduction in stool frequency, improvement in oral intake, and normalization of electrolyte levels. Hemodynamic status stabilized, serum albumin progressively increased, and overall functional capacity improved. By the time of discharge, diarrhea had decreased to one to two formed stools per day, biochemical abnormalities had resolved, and the patient was tolerating a regular gluten-free diet. His strength and mobility returned to baseline, and body weight stabilized.

He was discharged after ten days of admission with instructions to maintain lifelong adherence to a gluten-free diet and received detailed dietary education from a specialized nutrition team. A structured outpatient follow-up plan was arranged, including regular gastroenterology and nutrition clinic visits, serial monitoring of celiac serology (anti-tissue transglutaminase IgA) at 3–6 months to assess treatment response and dietary compliance, and periodic evaluation of weight, serum albumin, and micronutrient status. Bone health assessment with dual-energy X-ray absorptiometry was planned to evaluate for metabolic bone disease, and vaccination status was reviewed, particularly with consideration of potential functional hyposplenism associated with celiac disease. Long-term surveillance for complications related to malabsorption was also scheduled.

At three-month follow-up, the patient reported complete resolution of gastrointestinal symptoms, significant weight gain, and marked improvement in energy levels and functional status. Repeat serologic testing demonstrated a substantial declinein antibody titer (anti-tTG IgA 265 CU; anti-tTG IgG 54 CU), consistent with good adherence to the gluten-free diet and ongoing mucosal recovery.

Discussion.

Celiac disease is an autoimmune enteropathy triggered by gluten proteins in genetically susceptible persons, characterised by malabsorption and villous atrophy [1-2]. The acute, life-threatening form of celiac disease has been described in literature as “celiac crisis” [3-4]. In 1953, the term “celiac crisis” was first reported in the literature when a case series of 35 cases of children presented with persistent or recurrent diarrhoea with a fatality rate of 9% [5]. Generally, the celiac crisis is not very well documented in the literature and no available guidelines included this aspect in children or adults [6]. In most of the cases celiac crisis presents as the initial manifestation of celiac disease [7] as in our case. The onset of CC is often associated with poor adherence to a GFD, particularly in patients with a known diagnosis of CD [6-8]. However, as demonstrated in this case, CC can occur in individuals who have not been previously diagnosed, further emphasizing the importance of early recognition. This underscores the necessity for a high degree of clinical suspicion to ensure timely and accurate diagnosis.

Proposed criteria for its definition require the acute start or rapid progression of gastrointestinal symptoms (severe diarrhoea, vomiting), attributable to celiac disease requiring hospital admission and/or nutrition with at least two of the following: Signs of severe dehydration (hemodynamic instability and/or orthostatic changes); Neurologic dysfunction (peripheral neuropathy and tetany, due to hypocalcemia); Renal dysfunction (creatinine > 176.8 µmol/L [2.0 g/dL]); Metabolic acidosis (pH < 7.35); Albumin < 3.0 g/dL; Electrolyte disturbances (hypokalemia, hyper/hyponatremia, hypocalcemia, hypomagnesemia); Weight loss > 10 lbs (4.5 Kg)[4]. Our patient fulfilled several of these criteria, presenting with significant weight loss (~15 kg), profound electrolyte disturbances (hypokalemia 2.8 mmol/L, hyponatremia), severe hypoalbuminemia (28 g/L), and metabolic acidosis, thereby strongly establishing the diagnosis of celiac crisis.

It remains unclear why some individuals develop celiac crisis, contrary to the majority of adult patients who present a mild course of the disease. In the majority of cases, an immune

stimulus (infection, severe inflammation, surgery, pregnancy or not following a gluten-free diet) happened prior to the crisis, which lead to the hypothesis that a combination of activation of the immune system, severe mucosal inflammation and disruption of normal intestinal motility could be involved [1-3]. Celiac crisis is associated with high morbidity and mortality [9]. Due to its high morbidity rate, a quick diagnosis and treatment is crucial. However, similar to the case herein described, this diagnosis usually occurs later on and after all infectious causes have been excluded. In all reported cases, hospitalization and correction of metabolic imbalance with intravenous fluids was required. About half the patients had to receive corticosteroids for treatment (with different corticoids and dosages being reported, and their reduction over the following period of months) [1-3]. The debate centers on their effectiveness in rapidly reversing severe, life-threatening symptoms against the risks of side effects, potential for steroid-induced metabolic issues (like hypokalemia), and a lack of randomized, prospective trials [10]. Clinicians should have a high index of suspicion of celiac crisis in someone presenting with gastrointestinal disturbances, hypotension, electrolyte and metabolic derangements after common causes have been ruled out.

Conclusion.

Celiac crisis is a rare but potentially life-threatening presentation of celiac disease in adults and should be considered in patients presenting with severe unexplained diarrhoea, hemodynamic instability, and metabolic disturbances after exclusion of infectious causes. Early recognition, prompt supportive therapy, and strict initiation of a gluten-free diet are essential for rapid clinical recovery and prevention of complications. Increased awareness among clinicians may facilitate timely diagnosis and improve outcomes.

Disclosure Statement.

The authors declare no conflicts of interest.

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