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## Letter to the editor: Are we missing pancreatic exocrine insufficiency in 'at-risk' groups?

Editor – We read with great interest the article by Jalal *et al.*[1] asserting the need to screen for exocrine pancreatic insufficiency (EPI) using the elastase test among at risk groups, ie people with diabetes mellitus (DM), those with a heavy alcohol intake (HAI) and people living with HIV (PLWHIV). They documented EPI in 10/49 (20.4 %), 12/53 (22.6 %), and 4/26 (15.4 %), in DM, HAI and PLWHIV, respectively. The prevalence of EPI in PLWHIV reported in this paper compares favourably with our own experience in a study of 25 PLWHIV.[2] Our seminal work demonstrating EPI in 3/25 subjects (12.0 %) was performed using a 14C breath test combined with the *N*-Benzoyl-tyrosyl-p-amino benzoic acid (NBT-PABA) test to simultaneously measure fat absorption and exocrine pancreatic function, respectively. The NBT-PABA test predates the introduction of elastase in clinical practice. Fat malabsorption was present in 12/25 (48 %) including the three individuals with EPI. The latter suffered comorbidities (disseminated Kaposi sarcoma, pneumocystis carinii infection, ano-rectal carcinoma and cryptosporidiosis). None of the subjects with normal fat absorption ($n = 13$) had EPI.

While we acknowledge the value of elastase test, it is important to consider screening for coincidental HIV enteropathy (HIVE) which is more common in PLWHIV. Therefore, we feel that perhaps future studies should explore testing for both conditions by combining the faecal elastase test with a surrogate biomarker of enterocyte damage, such as plasma citrulline levels (CL).[3] The rationale for including CL test in the differential diagnosis of malabsorption is that timely intervention for HIVE and EPI has the potential to mitigate the risk of subsequent serious disease. The UK government's recent announcement to expand the opt-out HIV testing scheme to 46 more A&E departments across England is likely to compound the situation by adding an extra 4500 people with undiagnosed HIV infection.[4]

The return of samples was lowest among PLWHIV compared to individuals with DM or HAI. This finding is not unexpected. PLWHIV have multi-departmental follow-up hospital appointments, stigmatisation and immigration issues. They may miss appointments considered of less value to them. Other factors associated with non-engagement were being treated in a big hospital, younger age, less time in treatment, injecting drug use, and unemployment.[5] The cost of inaction to routinely screen for EPI and HIVE in PLWHIV will surely be greater than the smaller additional investment needed to make the two tests more widely available.

### References

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