Dojde-li k úlevě po bezlepkové dietě, doporučuje se pomalá reintrodukce glutenu podle tolerance. Ačkoliv je individuální tolerance lepku velmi variabilní, jedinci s NCG/PS se nemusejí obávat kontaminace potravy lepkem, neboť jejich tolerance k stopovým množstvím glutenu bývá většinou dobrá [20]. FODMAP se doporučuje zavádět zpětně do diety po jedné skupině FODMAP týdně [5]. Kvalita důkazů, že dieta s nízkým obsahem FODMAP je při léčbě NCG/PS prospěšná, je slabá [46].

Vhodným dietním opatřením může být konzumace přirozené stravy bez potravinových aditiv a konzervantů (glutamáty, sulfáty, nitráty), které mohou u osob s viscerální hypersenzitivitou vyvolávat gastrointestinální obtíže [20].

Nejasnosti stále vyvolává otázka, zda NCG/PS je permanentní či přechodný stav [20]. Některé klinické studie naznačují, že jen nevelké množství pacientů toleruje opětovné zavedení lepku/pšenice i poté, co dosáhli úplné remise obtíží navozené eliminační dietou [11, 48].

## Závěr

Současné patofyziologické znalosti o syndromu neceliakální glutenové/pšeničné senzitivity jsou limitované, diagnóza je založena na hodnocení subjektivních obtíží a postrádá spolehlivost. Pečlivá diferenciální diagnostika oproti jiným, přesněji definovaným onemocněním je proto nutná. Odlišení skutečné nemoci od domnělého nocebo efektu bezlepkové diety může být v každodenní klinické praxi velice obtížné. Odpůrci existence tohoto syndromu poukazují na jeho problematickou diagnostiku, překryv střevních projevů se syndromem dráždivého tračníku či na možnost, že jde o alergii na pšenici či příbuzné obiloviny, která je řízena non-IgE protilátkami, a proto je obtížně diagnostikovatelná [4, 22, 38].

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