Consensus Formed on Eosinophilic Esophagitis

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In the absence of pathologic gastroesophageal reflux disease, young children with esophageal symptoms or feeding problems and older children and adults with dysphagia or esophageal food impaction should be evaluated for eosinophilic esophagitis, particularly if their symptoms are unresponsive or only partially responsive to acid blockade, according to a new consensus report on the inflammatory gastroesophageal disorder. The report appears in the October 2007 issue of Gastroenterology.

Characterized by a range of gastrointestinal symptoms including abdominal pain, nausea, regurgitation, and/or vomiting along with severely elevated levels of eosinophils, eosinophilic esophagitis (EE) is an "enigmatic" disease that is frequently mistaken for gastroesophageal reflux disease (GERD), said Dr. Glenn T. Furuta, cochair of the First International Gastrointestinal Eosinophilic Research Symposium (FIGERS), from which the consensus report was generated.

Because EE and GERD require different treatment strategies and are associated with different long-term consequences, distinguishing between the two is critical, but doing so has been hindered by the absence of definitive diagnostic and treatment guidelines for EE, said Dr. Furuta of Children's Hospital of Denver. "The consensus report is the best first step in providing outstanding care to children and adults who are affected by this newly recognized disease," he said in an interview.

Developed through the collaboration of 32 physicians from multiple disciplines, including pediatric and adult gastroenterology, allergy, and pathology, the consensus report is based on a systematic review of data from 80 studies published between 1977 and 2006 including 754 children and 323 adults, as well as expert opinion.

Among the most important features of the report are its diagnostic guidelines, Dr. Furuta said. In this regard, "the report states that affected patients should have symptoms referable to the esophagus that occur in combination with greater than or equal to 15 eosinophils per high-powered field in the esophageal mucosa with normal gastric and duodenal mucosa," he said. "Most importantly, GERD must have been ruled out as a cause of these findings."

The available data on the natural history of the disease suggest that EE is a chronic condition with persistent or relapsing symptoms. "To date, esophageal strictures and small caliber esophagus, often resulting in food impaction, have been the major complications identified," the authors wrote in the report. "When these findings are encountered, either radiologically or at endoscopy, a high index of suspicion should be raised for EE and mucosal biopsies should be obtained."

Importantly, mucosal pinch biopsies are recommended for all patients in whom eosinophilic esophagitis is in the differential diagnosis, regardless of the gross appearance of the mucosa, the authors wrote. Additionally, multiple biopsies should be obtained from different esophageal locations along the length of the esophagus, and they should be obtained from the stomach and duodenum to rule out other gastrointestinal diseases, they stated.

When endoscopy and biopsy do not provide sufficient information to distinguish between GERD and eosinophilic esophagitis, "intraesophageal pH monitoring may be of use in excluding pathologic reflux as either the primary or a concomitant cause for esophageal eosinophilia," according to the report. "Alternatively, an upper endoscopy after 6-8 weeks of high-dose proton pump inhibitor treatment can help determine the etiology of esophageal eosinophilia."

Regarding diagnostic histopathology, based on the available data and the panel's collective clinical experience, "we conclude that a peak count of 15 intraepithelial eosinophils per high-powered field is an absolute minimum number to make the diagnosis of EE in the proper clinical context," they wrote. For research purposes, it may be useful to use a higher threshold of peak eosinophils in order to increase the specificity of the diagnosis, they noted.

Additional histopathologic features that, while not pathognomonic, may be helpful in establishing a diagnosis, are eosinophil microabscesses, surface layering of eosinophils, basal layer hyperplasia, papillary lengthening, degranulating eosinophils, and lamina propria fibrosis and in-

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flammation, according to the report.

In terms of treating the disease, dietary therapy in particular should be considered in all children diagnosed with the condition, as there is strong circumstantial evidence that food allergens contribute to the pathogenesis of the disease in children. In fact, "the removal of food antigens has clearly been demonstrated to successfully treat both the symptoms and the underlying histopathology in the majority of patients with EE," the authors wrote. Toward this end, allergy testing and clinical history can help guide specific food elimination, they stated, adding that consultation with a registered dietitian is advisable to ensure that proper nutrition is maintained.

Corticosteroids can effectively resolve acute clinicopathologic features of EE, but the disease typically recurs when the steroids are stopped. And while systemic corticosteroids have a role in emergent cases, including dysphagia requiring hospitalization, dehydration because of swallowing difficulties, and weight loss, the potential for significant toxicity over time should preclude their long-term use, the authors stated. Topical corticosteroids have also shown some efficacy and are associated with fewer side effects, they noted.

Although gastric acid is not thought to be the primary mediator of EE, acid suppression may be considered as cotherapy in patients with established disease who have symptoms secondary to GERD.

For patients who present with symptomatic esophageal narrowing secondary to fixed strictures causing food impaction, esophageal dilatation may be a useful treatment option, the authors wrote. To minimize the risk of mucosal tearing and perforation, however, "a diagnostic endoscopy with biopsy followed by medical or dietary therapy for EE should be attempted prior to performing esophageal dilatation," they stressed. And the esophagus should be inspected, either radiographically or by gentle endoscopic examination, after dilation to assess for laceration injury before performing larger caliber dilation.

Biologic agents that specifically target eosinophil activity may present a unique treatment opportunity for some patients with EE; however, they cannot yet be recommended for routine use given the lack of clinical trial data to date, according to the authors.

"The motivating factor for treating all patients should be symptom relief and prevention of complications of esophageal strictures and long-segment narrowing," said Dr. Furuta. ■

Hypnotherapy Beats Standard IBS Care for Kids

WASHINGTON — Children and adolescents with functional abdominal pain or irritable bowel syndrome who were treated with hypnotherapy were cured of their illness in significantly greater numbers than were children given standard medical treatment in a randomized, controlled trial presented at the annual Digestive Disease Week.

Dr. Arine M. Vlieger of St. Antonius Hospital, Nieuwegein, the Netherlands and her colleagues randomly assigned 53 patients (mean age 13 years) with functional abdominal pain (FAP) or irritable bowel syndrome (IBS) to either hypnotherapy or standard medical therapy (SMT).

Hypnotherapy consisted of six half-hour sessions based on the Manchester protocol of gut-directed hypnotherapy, conducted over 3 months (27 patients). The hypnotherapy sessions started with relaxation and abdominal breathing exercises. Other sessions dealt with control of gut function, pain control, and thinking relaxing thoughts. The children in this arm were asked to practice the techniques twice daily. SMT comprised pain medication and avoidance of pain triggers, plus six half-hour sessions of supportive therapy (25 patients); 1 patient did not complete therapy.

Three-fourths of the patients were female, and the mean duration of the abdominal complaints was 3.4 years.

The investigators found that immediately after therapy, 59% of patients given hypnotherapy were cured (defined as having a greater than 80% improvement in pain scores), compared with 12% of patients given SMT. At 1 year, the difference remained, with 85% and 25% classified as cured, respectively.

The proportions of patients who reported no effect of treatment (defined as less than 30% improvement in pain scores) were 56% of the SMT group and 15% of the hypnosis group after therapy; at 1 year, the figures were 46% for SMT patients and 4% for those given hypnotherapy.

Hypnotherapy has been used successfully in adults with IBS, and "the quality of life in these children [pretreatment] is comparable to [that of] those with Crohn's disease or ulcerative colitis," Dr. Vlieger said at a press conference.

—John R. Bell