Transcript Details
This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/gi-insights/evaluating-the-increasing-incidence-of-eosinophilic-esophagitis-what-you-need-to-know/13748/

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Evaluating the Increasing Incidence of Eosinophilic Esophagitis: What You Need to Know

Dr. Buch:
Eosinophilic esophagitis, or EOE for short, is an allergy-mediated inflammatory disease. As the incidence rates of this disease rise, what do we need to know?

Welcome to *GI Insights* on ReachMD. I'm your host, Dr. Peter Buch. Joining us today is Dr. Kathryn Peterson, Associate Chief of the Division of Gastroenterology at the University of Utah Health. Dr. Peterson specializes in diagnosing and treating digestive system diseases, including eosinophilic esophagitis.

Welcome to the program, Dr. Peterson.

Dr. Peterson:
Thank you, Dr. Buch. I'm really glad to be here today.

Dr. Buch:
Let's start out by laying some of the groundwork. Dr. Peterson, can you tell us a little bit about the incidence rate of EOE and why you think it's rising?

Dr. Peterson:
Yes. Thank you for that. That is a great question. So the incidence rate currently is relatively low. So we identify anywhere from maybe 5–15 cases per 100,000, but that may be an under recognition. However, even knowing that, we do know that it's rising, and the idea behind why it's rising we think is related to the fact that we know that this disease has a genetic underpinning but has a huge environmental kind of influence on it, so the thought is that probably there's something going on in the environment that plays a role in how we're identifying eosinophilic patients or how they're presenting now and increasing the, the risk for patients to develop eosinophilic esophagitis. That could be anywhere from pollution to dietary constituents, to how, you know, changes in antibiotic use and changes in childbirth and changes in even prenatal times. We just don't—We're still currently studying a lot of that as to why we think it's rising, but we know atopic disease in general is rising throughout the world, especially in developed countries, and the thought is maybe it has to do with these detergents or emulsifiers or dietary kind of, constituents that may be playing a role in epithelial permeability that we know is a risk factor for developing allergy.

Dr. Buch:
Dr. Peterson, do you think it might be related to the foods and the ingredients in foods and biologically altered foods that we're taking?

Dr. Peterson:
So that's a really good question. I think—and, this is one of those things that we're still trying to tease out, what we know is we know that, as you said, the incidence is increasing, and they have controlled for that. What we know is that there are relationships between foods and emulsifiers and byproducts in the foods that we're eating and other immune-mediated diseases. They're still teasing out whether that could be potentially a role in eosinophilic disease as well, but we know that certain things, such as detergents or emulsifiers, alter your membrane, your epithelial barrier, and anything that alters your epithelial barrier can predispose you to allergic reactions or immune-mediated reactions.

Dr. Buch:
Thank you. With that in mind, do you think all patients with EOE should receive allergy testing?

Dr. Peterson:
That's a really good question but a very complicated question. So EOE is considered, just as you mentioned at the beginning of the program, as a Th2-mediated disease, and in such it is often associated with other allergic diseases, such as, you know, asthma, food allergy, classic food allergy, anaphylaxis or—which isn't necessarily Th2, but other diseases that are considered allergic. The issue with allergy testing is that right now allergy testing has not really been associated with a high accuracy in predicting the foods in EOE. So there's skin prick testing, and there's something called patch testing, and even with skin prick testing and patch testing, we're not really getting good outcomes necessarily or high predictive values for the foods in EOE, so I do think involving an allergist is important, but I think potentially getting allergy testing could cause patients a lot of worry and a lot of kind of medical visits because if they test positive to 32 foods, chances are maybe only one or two of those 32 foods are positive, and they may undergo a very rigid elimination diet to try to get rid of the disease.

Dr. Buch:
So moving on from there, could you please discuss elimination diets in the therapy of EOE?

Dr. Peterson:
What we do now is that often many gastroenterologists—and not everybody needs to do it—and sometimes even allergists will actually offer a patient what's called an empirical elimination diet. And back several years ago out of Northwestern, they published a six-food elimination diet study where they showed that if you could eliminate the top six causative foods, which are wheat and the soy-egg-dairy products, seafood and then tree nuts and peanuts, if you eliminated those out of your diet, they had about a about around a 75 percent chance of actually responding, so resolving the EOE.

Dr. Buch:
Thank you. For those just tuning in, you're listening to *GI Insights* on ReachMD. I'm Dr. Peter Buch, and I'm speaking with Dr. Kathryn Peterson about eosinophilic esophagitis.

Dr. Peterson, let's dive into treatment. Can you tell us what treatment options are available for patients with EOE?

Dr. Peterson:
That's a good question. So right now the Joint Task Force guidelines came out and discussed all of the treatment options. And even though not everything is FDA-approved as yet, there are options that patients have. Proton pump inhibitors believe it or not actually are offered as an option for treatment for eosinophilic esophagitis, and they have about a cumulative efficacy of about 42 percent in patients. Usually, that's high dose, so using proton pump inhibitors, that you use like as you would normally use twice a day or a double dose that you would normally use and give that to a patient for about eight weeks. You have a chance that you actually can get a response, but the only way to actually accurately tell if you have a response is to repeat that endoscopy, take a look and do biopsies.

Other options are topical steroids. And there is not an FDA-approved topical steroid out there yet, but there are formulations that people have put on YouTube or have published on their websites at their programs to explain how to take some of these topical steroids, and some of these are where you take almost like a nebulized form and you mix it into apple sauce and drink it down, or you can use some aerosolized forms of topical steroids and swallow those down as well. And they have some publications to demonstrate that they have been effective in treating eosinophilic esophagitis.

Dr. Buch:
And as a quick follow-up to that, what are some advantages and disadvantages of these treatment options, and in particular, thinking about the patient's approach to this on a long-term basis?

Dr. Peterson:
That's a great question. That is where shared decision-making really needs to play a big role in having a conversation with your patient. And remember that eosinophilic disease is still a very young disease, so we don't know a lot about long-term, but we do know from data that's been out there that the disease does not tend to go away, so that if we stop the therapy, that ultimately the disease will likely come back. How rapidly it comes back is unclear, in some patients very rapidly, in some patients much more slowly, but we do know that if we don't take care of it, there are long-term complications, such as strictures and food impactions.

Topical steroids, I think people always worry it's the same thing as when you take a steroid for, you know, absorption, and there's probably in the randomized controlled trials that have been published out there about a 3 percent chance of some absorption and maybe some adrenal suppression that's identified chemically, and so a lot of patients or a lot of people will actually monitor their patients by maybe doing a yearly cortisol if people are going to stay on topical corticosteroids. One approach also is to always try to reduce, again, those drugs to the lowest effective dose. The issue that we always deal with, and this is the complicating issue, is every time we do that the thought is that we need to do another endoscopy to make sure they stay under control, so it can get somewhat burdensome for a

patient, so those decisions need to be kind of a combination of the patient and the physician having that conversation at the bedside.

The final thing is diet, and diet they have shown in adults, diet does really well in children. In adults, over time, people tend to fall off the wagon a little bit, and I usually explain it as, you know, you've experienced these lovely foods, and then suddenly they're removed from your diet, so it's difficult for you to, you know, imagine going the rest of your life without having some of those really delicious foods. I think one of those conversations, and this has not been well-studied, but I think that one thing that you can discuss with your patients is if they do want to do diet, then having that what we call like a holiday periodically where they eat the foods and then just following them closely and monitoring them then is potentially an option so that they can maintain control, and you don't lose, their follow-up in case they do decide to come off that diet. The last thing you want to do is have your patient come back with a food impaction or a very strictured esophagus.

Dr. Buch:
Thank you. And that's a wonderful segue for this question. Should the average gastroenterologist be repeating an endoscopy and biopsy after treatment for EOE to assess effectiveness of therapy?

Dr. Peterson:
Actually, that is recommended. It's not necessarily done all the time. And the reason it's been recommended is because we know that symptoms don't track with the disease, and especially if somebody has undergone a dilation at some point, so that symptoms don't track with the severity of the disease at times because people also either a dilation has changed things or they have accommodated their disease or the way they eat so that they're really unaware of what they are doing to accommodate having a very narrow esophagus, so the recommendation is to really know how your therapy is working. Any change in therapy or any initiation of therapy should be followed up with an endoscopy, and usually we follow up about, anywhere from 6 to 12 weeks after making that change in therapy.

Dr. Buch:
Thank you. And if we look ahead for a moment, how do you think monoclonal antibody therapies will fit into the future therapy of EOE?

Dr. Peterson:
So I think the way monoclonal antibodies will possibly fit in in the future is that, you know, we know we have medications that can control the disease in patients, so we have proton pump inhibitors and we have topical steroids, and so we'll have those medications, but they have a failure rate, and they have even a recurrence rate. So even in the long-term data, patients that have maintained on topical steroids and open-label extension arms, some of them do recur while they're on the steroids, so that group is going to be the group that you're looking at using stronger therapy, potentially monoclonal antibodies, because they're not under control with conventional therapy.

The other group that I foresee potentially being a group that we would be looking at using monoclonal are the patients that are using multiple other medications to control multiple other comorbidities that are atopic or Th2-mediated, such as asthma or eczema, and those are the patients where, instead of taking multiple medications, you could potentially try to use one medication to control them.

Dr. Buch:
Thank you. This was an excellent discussion. I want to thank my guest, Dr. Kathryn Peterson, for sharing her insights on eosinophilic esophagitis. Dr. Peterson, it was a pleasure having you on the program today.

Dr. Peterson:
Thank you so much for having me. I really appreciate it.

Dr. Buch:
For ReachMD, I'm Dr. Peter Buch. To access this and other episodes in this series, visit reachmd.com/gi-insights where you can be Part of the Knowledge. Thanks for listening, and see you next time.