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/identifying-individualized-treatment-approaches-for-eoe-patients/15394/

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

Identifying Individualized Treatment Approaches for EOE Patients

Dr. Buch:
Welcome to *GI Insights* on ReachMD. I'm your host, Dr. Peter Buch, and here to discuss treatment approaches for patients with eosinophilic esophagitis, or EOE for short, is Dr. Brooks Cash. Dr. Cash is Chief of the Division of Gastroenterology, Hepatology, and Nutrition at the University of Texas Health Sciences Center at Houston. He's also the Dan and Lillie Sterling Professor of Medicine at the University of Texas McGovern Medical School.

Welcome back to the program, Dr. Cash.

Dr. Cash:
Thanks so much, Dr. Buch. It's a pleasure to be here.

Dr. Buch:
Pleasure to have you with us. To start out, Dr. Cash, since there are several ways to treat EOE, what treatment algorithm would you recommend for your patients?

Dr. Cash:
Well, as you mentioned, there are a number of therapies, and there's not a single algorithm that fits every single patient, so you really have to individualize therapy. I will point out to the audience that there is an open-access update to the guidelines for the management of eosinophilic esophagitis that was published by the American College of Gastroenterology within the last couple of years. Now what those guidelines will recommend would be treatment for esophageal eosinophilia with proton pump inhibitors, typically either once, sometimes twice a day depending on patient response. Specifically for eosinophilic esophagitis, it is recommended to use topical steroids, and these can be inhaled nasal steroids or something like viscous budesonide. And then finally, we do have a newly approved therapy that works through the immune system, and that is also included as a therapy for patients with eosinophilic esophagitis. And I will also mention that it is recommended that these patients be treated with a six-food elimination diet as well as an adjunctive therapy.

Dr. Buch:
And can you just comment on a six-food elimination diet as opposed to some people recommend a four-food elimination diet?

Dr. Cash:
Yeah. There's a lot of controversy about how much you need to restrict. There's even some people that espouse a one-food elimination diet. So, when we say a six-food elimination diet, we're talking about, really, food sensitivities here. These are not necessarily a classic food allergy like you would think of with anaphylaxis and angioedema that some patients have with certain foods, especially tree nuts, like peanuts. This is more of a food sensitivity, although it is on the allergy spectrum. And the foods that seem to be the primary culprits would include dairy, legumes, tree nuts, wheats, and certain grains, shellfish, and soy, and so those are the six major food groups that are recommended for restriction in a six-food elimination diet. Now as you mentioned, there is a four-food elimination diet, which drops out a couple of those, so patients don't have to be so restrictive. The primary culprit for a lot of patients is actually dairy, so when we even mention the one-food elimination diet, that is eliminating milk and dairy products from the diet, and those are the last things that we introduce.

I typically will recommend a six-food elimination diet. I use quite liberally our dietitians and nutritionists that we have in our clinic that are wonderful, and they can really work with patients to help them create this diet. And these diets don't necessarily have to be forever. So, if we get patients in symptomatic and endoscopic control with regards to their eosinophilic esophagitis, we generally will gradually reintroduce certain classes of foods one at a time, and then reassess their response as we introduce those foods.

Dr. Buch:
And would you recommend allergy testing for these patients?

Dr. Cash:
That's a great question. The allergy testing comes up a lot in GI, and we see a lot of patients who do go and get food allergy testing. Generally speaking, food allergy testing is not recommended, not for EOE nor for other conditions, like chronic abdominal pain or irritable bowel syndrome. When patients go to allergy testing, what they're testing for is antibodies, generally speaking, to certain classes of foods and specific foods. Most human beings have antibodies to certain foods. That does not necessarily mean that they have an intolerance or a sensitivity to those foods. They have been exposed to the foods, and their immune system has made antibodies to them, but that doesn't translate into symptoms or pathophysiology, so by and large allergy testing is not helpful in the management of eosinophilic esophagitis. It doesn't help us direct our dietary therapy for patients, and it doesn't help us direct our medical therapy to patients.

Now the one caveat that I would include in terms of that topic is if you do suspect or patients have symptoms of true food allergies—they have swelling of their mucous membranes, especially if they have asthma exacerbations after certain food intake—then those patients may very well have an important food allergy. Asthma is really the thing to look for in patients. And in those patients, it is appropriate to send them for allergy testing or a formal diagnostic evaluation. It's not so much the skin testing, or as we classically think of allergy testing, but really more an evaluation by an allergist. The best way to diagnose a true food allergy is actually through a blinded food challenge test, but it's really the minority of patients with EOE or other conditions that are going to benefit from food allergy testing.

I do, however, ask about symptoms of atopy, such as urticaria, hives, eczema asthma especially. Those are important symptoms to assess because that may take you down a different treatment algorithm, and we may be more likely to use something like dupilumab, that newer therapy that I alluded to, in those patients.

Dr. Buch:
And we're going to come back to dupilumab. So, Dr. Cash, how does early intervention benefit our patients?

Dr. Cash:
Well, what we've realized over the last several decades with regards to eosinophilic esophagitis is it's not just the eosinophils in the superficial lining of the esophagus that are causing the problems. There's actually remodeling of the extracellular matrix and fibrosis within the wall of the esophagus. And that takes time, so the sooner we are able to diagnose patients with this condition and, hopefully intervene, we believe that we can hopefully, stave off some of those long-term effects that fibrosis that occurs that causes patients to have symptoms like food getting stuck or dysphagia strictures and other complications from eosinophilic esophagitis. So, we don't have great outcomes data on that, although, there are some provocative data that do suggest that earlier identification and earlier treatment can prevent or help stave off having to do interventions, which are inherently risky in these patients when we have to dilate the esophagus or stretch that out and hopefully, help us manage their symptoms better as well.

Dr. Buch:
So coming back to dupilumab, where do you see that that fits into the categorization of treatment? And I am sure you've read the literature. There may be a niche for dupilumab to prevent some of the early stricturing.

Dr. Cash:
Yes. So dupilumab is an exciting new class of therapy. It really is classified as a biologic therapy. It's a subcutaneous injection that patients use weekly. And where I use dupilumab and where many clinicians I think use this is in patients with EOE who we're unable to get them either responsive or under control in terms of their symptoms of dysphagia with six-food elimination diet, proton pump inhibitor, acid suppression, and topical steroids, so patients who were refractory to therapy, I think this is a very good option. In addition, in patients who we can't wean off some of these therapies—so patients who respond perhaps to topical steroids, such as budesonide or fluticasone, but yet, when we try to discontinue these therapies, their symptoms come back—I think dupilumab fits that niche. And finally, in patients who have other atopic conditions, such as asthma or eczema or chronic urticaria or recurrent urticaria, I think dupilumab potentially has a nice role in those patients as well because it's a therapy especially for eczema.

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. Brooks Cash about treating patients with eosinophilic esophagitis, or EOE.

Now, Dr. Cash, should we be changing our EOE treatment paradigm to no longer rely on symptom relief? And in addition to that, should we be employing more aggressive endoscopic reassessments?

Dr. Cash:

Those are great questions, and those specifically were addressed in the updated guidelines, and it is recommended now that when we are treating patients with EOE, that we treat them very much like we are doing and have been doing in patients with inflammatory bowel disease, and that's a term that we use, called treat to target. And what that means is we not only want to see patients' clinical response—of course, that's what's most important to a patient, and it's very gratifying to a clinician when patients have a clinical response to our therapy—however, the clinical response can be misleading because there's a threshold at which patients feel and/or complain of symptoms, and so what we believe as important is to make sure that there is a histologic response. So very much like inflammatory bowel disease, it is recommended that we do repeat endoscopies in patients who are on therapy for EOE and take biopsies of their esophagus at multiple different levels specifically assessing whether or not those eosinophils have diminished below the thresholds that we would use to diagnose EOE, and that's what we want to see. We want to see not only clinical remission but also histologic response, and ideally, histologic remission in patients. So yes, the answer is that we do believe that we should be a bit more aggressive with endoscopy, and this has been a longstanding position from our professional societies as well as experts in this field that we can be a bit more aggressive in terms of dilating strictures if we need to in patients with eosinophilic esophagitis.

Dr. Buch:
And have there been any studies that compare the combination of treatments, such as PPI plus diet or PPI plus steroids?

Dr. Cash:
There's not been a lot of studies that have evaluated combination of therapies relative to other therapies. We do have some head-to-head data with regards to the different topical steroids, so fluticasone versus budesonide, and what these studies have shown is basically near equivalence of those different therapies. Now there are cost differences. There are tolerability differences. In terms of ranking the different therapies head-to-head, we don't have great data, but generally, we do feel like the topical steroids are more effective than proton pump inhibitors, but because proton pump inhibitors are relatively inexpensive and they are very, very safe based on decades of experience, that is our first choice. The six-food elimination diet, while it's inconvenient, can be embraced by some patients and, hopefully, many patients, and that also can be an effective therapy. So, we try to be minimalistic first, but we also, again, keeping in mind that need to reassess the both clinical as well as the histologic response. We don't have any data looking necessarily at topical steroids and dupilumab in patients. Those are all placebo-controlled studies.

Dr. Buch:
And as we conclude, Dr. Cash, are there any final thoughts you'd like to share with our audience today?

Dr. Cash:
Well, I want to thank you first for allowing me to spend time with you and answer these important questions. I think in terms of final thoughts that I would convey is that dysphagia, solid food dysphagia, is never a normal symptom, so when you have patients complaining of that or if they bring that up, please send them to a gastroenterologist for further evaluation. We are recognizing this condition, eosinophilic esophagitis, more frequently. And for many years we really didn't have a lot to offer these patients other than topical steroids and PPIs and unpleasant diets, but now we are understanding the disease more, and we're actually having more directed therapies in the form of biological therapies that seem to be quite effective as well as well-tolerated. So, I think there's a lot of options for patients. So, if you do uncover a patient with these types of symptoms, please send them to us so we can further evaluate them, and hopefully, improve their quality of life as well.

Dr. Buch:
This was a superb update on eosinophilic esophagitis. I want to thank my guest, Dr. Brooks Cash, for an excellent discussion.

Dr. Cash, thanks so very much for joining us today.

Dr. Cash:
It was my pleasure. Thank you for having me.

Dr. Buch:
For ReachMD, I'm Dr. Peter Buch. To access this and other episodes in this series, visit ReachMD.com/*GIInsights* where you can Be Part of the Knowledge. Thanks for listening, and I look forward to learning with you next time.