



Eosinophilic Oesophagitis

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There is a progressive rise in the number of cases of Eosinophilic Oesophagitis being diagnosed. In part this may be due to better recognition but there is a real increase in incidence as with many other allergy based disorders. Patients with Eosinophilic Oesophagitis present with dysphagia, often present over a long time and with very slow progressions. Many adults in their late twenties or thirties will recall being "the slowest at the table" since childhood.

At endoscopy fine concentric rings are often seen, sometimes of sufficient severity to cause marked stricturing. Milder cases may show only non specific erythema or a "cobblestone" pattern of mucosa. Biopsy will show dense infiltration of eosinophils in the oesophageal mucosa and submucosa. Characteristically the mucosa springs apart at the biopsy site. A half match head sized biopsy increasing to a thumb nail size. After dilation rupture of the mucosal rings will leave large areas of exposed submucosa (elastic band sign).

The single most important principle is not to rush into enthusiastic dilation at initial endoscopy. Full thickness rupture of the oesophagus may occur.

The initial treatment of Eosinophilic Oesophagitis should be medical. There is a very marked difference between paediatric and adult treatment responses. Paediatric practice usually involves dietary restriction with or without prior allergy testing. This approach has not been found to be very useful in the majority of adults. Elimination diets, elemental diets, disodium cromoglycate, azathiaprine, steroids and monoclonal antibody preparations such as mepolizumab have all been used in severe paediatric disease.

In adults it is usual to commence with a trial of locally applied steroids particularly Fluticasone in a pulmonary inhaler (without the spacer) which is puffed into the mouth but NOT inhaled. A very small quantity of water is swirled around the mouth and swallowed. The mouth is rinsed again with a very small amount of water but then spat out (to reduce the incidence of oral thrush). Two to four applications per day are usual. For more severe or unresponsive cases, Prednisone or a derivative can

be mixed by a compounding pharmacist with a surface adherent preparation eg: an alginate or some mucilaginous substance. It is usual to take a 5 ml dose containing 5mg of Prednisone 2-3 times per day. I personally found this preparation much more effective.

In some patients, the addition of a Proton Pump Inhibitor is helpful. Failure to respond adequately to local steroids with or without a PPI is very uncommon. Recurrence however can be a problem but immunosuppressant's are only rarely required.

Dilatation is only used when significant dysphagia persists after medical treatments. Dilatation must commence with a dilator estimated to be no larger than one size greater than the lumen. Inspection is required after the passage of each dilator to assess mucosal damage. Usually no more than three dilator sizes should be used on any one occasion.

Many patients with Eosinophilic Oesophagitis have other allergy associated disorders including asthma, eczema, eosinophilic enteritis and systemic auto immune disorders.