Post Event Q&A

Thank you to all who participated in the Q&A sessions during APFED’s conference in Denver in July 2018.

While most questions were asked and answered onsite, a few questions remained, and our speakers have graciously volunteered to answer them post-show.

Below are the questions and presenter responses.

Dr. Evan Dellon: GI Questions

1.) Is there concern that PPI use inhibits nutrient absorption for patients with already compromised diets?

This hasn’t been specifically studied in EoE and EGIDs, but the concern would be most related to the compromised or restricted diet rather than to the PPI. This is the situation where it would be key to work with a dietician or nutritionist to make sure the restricted diet is nutritionally complete and determine whether supplements are needed.

2.) Many people experience ongoing symptoms even when the scope is normal. How do you get your doctor to adequately evaluate, treat, and address ongoing symptoms?

Ongoing symptoms in the setting of normal endoscopy findings and normal biopsy findings can happen relatively commonly. Ongoing symptoms could be due to many things, both related to or unrelated to EGID. Having a clinic appointment to discuss these symptoms and concerns in detail is probably the best approach, and asking specific questions, such as “What do you think could be causing my symptoms?” might help to guide the conversation.

3.) At what age does dilation become an acceptable treatment? Is there a specific size of the esophagus at which dilation is needed for small caliber esophagus? Is there a minimum size a patient must be to undergo dilatation?

Esophageal dilation is an acceptable treatment for patients of any age with esophageal strictures causing symptoms of trouble swallowing. There is literature in EoE that dilation is safe and effective for children and adults, thought the literature is less extensive in children. There no restriction on patient age or size for esophageal dilation, but the specific size of the esophagus depends on age. There is also not a specific stricture size that would trigger a dilation. Some cases are obvious – the regular endoscope won’t pass the stricture (i.e., the esophageal diameter is smaller than the scope diameter) – but other cases are more subtle, so the decision to dilate is individualized. It is important to make sure that a doctor has experience with esophageal dilation and is comfortable doing this in EoE.
4.) If you have a clean scope while using PPI and topical steroids, do you need to stay on both medications forever? Which medicine should be eliminated first?

My general strategy is to try to decrease any medicine treatment to the lowest effective dose, and when possible just use one medication, thought this may not be possible for every patient. In the situation where the scope is clean on both PPI and steroids, if there is a prior scope on just one medication, that will help make the decision as to which medication to stop first. For example, if there was some improvement with a PPI but complete improvement with a steroid, then the PPI could be stopped first. However, if both were started at the same time, there’s not a right answer as to which to try to stop first – there are no studies looking at this question, so the approach would have to be individualized in each situation.

5.) What causes coughing while eating? Does this happen in adults as well as children?

There are many causes of coughing while eating. There could be related to swallowing dysfunction in the mouth and upper throat (“oropharyngeal dysphagia”) that leads to swallowing down the wrong pipe (“aspiration”), problems with the esophagus such as strictures very high up in the esophagus, problems with esophageal motility, reflux disease, and many others. Often this requires a very thorough history to get a sense of the underlying issue, and sometimes evaluation with both GI and ENT. This is not typically a symptom of EoE in adults or adolescents and would be unusual in children as well.

6.) Is it possible to achieve long-term remission? Is relapse random or always triggered by an exposure? What triggers the relapse? Puberty? Growth? Stress?

It is possible to achieve long-term remission in EGIDs, but this remission requires what is called “maintenance therapy” – essentially ongoing treatment to suppress the condition. If treatment is stopped, the disease will flare up again, and stopping therapy is a major cause of relapse or flares. Otherwise, EGIDs are chronic and are not thought to spontaneously resolve in the absence of treatment. Relapses can be triggered by stopping medication, mediation becoming less effective over time (though the reasons for this are not really understood), inadvertent food contamination in the setting of dietary elimination, and many other things. If symptoms come back, it is also possible there is another condition (either related or unrelated) that could have developed. There are not really any studies looking at whether puberty, growth, or stress could lead to a relapse or disease flare, so this is still unknown.