aga American Gastroenterological Association

AMERICAN ACADEMY OF ALLERGY ASTHMA & IMMUNOLOGY

American College of Allergy, Asthma & Immunology

Management of Eosinophilic Esophagitis

Key Points

- **Eosinophilic esophagitis (EoE) was first characterized in the early 1990s and understood to be a food antigen-driven Th2 inflammatory condition.**
- **A large body of evidence suggests that EoE subjects have aeroallergen sensitization and concurrent atopic diseases including asthma, allergic rhinitis and eczema.**
  - There is a close interaction between these organ-specific diseases and a potential for common triggering antigens in EoE and other atopic conditions.

GRADE Strength of Recommendations and Implications

Grade	Quality of Evidence
High	We are very confident that the true effect lies close to that of the estimate of the effect.
Moderate	We are moderately confident in the effect estimate. The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.
Low	Our confidence in the effect estimate is limited. The true effect may be substantially different from the estimate of the effect.
Very low	We have very little confidence in the effect estimate. The true effect is likely to be substantially different from the estimate of effect.
Knowledge Gap	May vary depending upon the severity of initial clinical presentation.

Grade	Strength of Recommendation	
	For the Patient	For the Clinician
Strong	Most individuals in this situation would want the recommended course of action, and only a small proportion would not.	Most individuals should receive the recommended course of action. Formal decision aids are not likely to help individuals make decisions consistent with their values and preferences.
Conditional	The majority of individuals in this situation would want the suggested course of action, but many would not.	Different choices will be appropriate for different patients. Decision aids may be useful in helping individuals in making decisions consistent with their values and preferences. Clinicians should expect to spend more time with patients when working towards a decision.
No recommendation		The confidence in the effect estimate is so low that any recommendation is speculative at this time.

Management

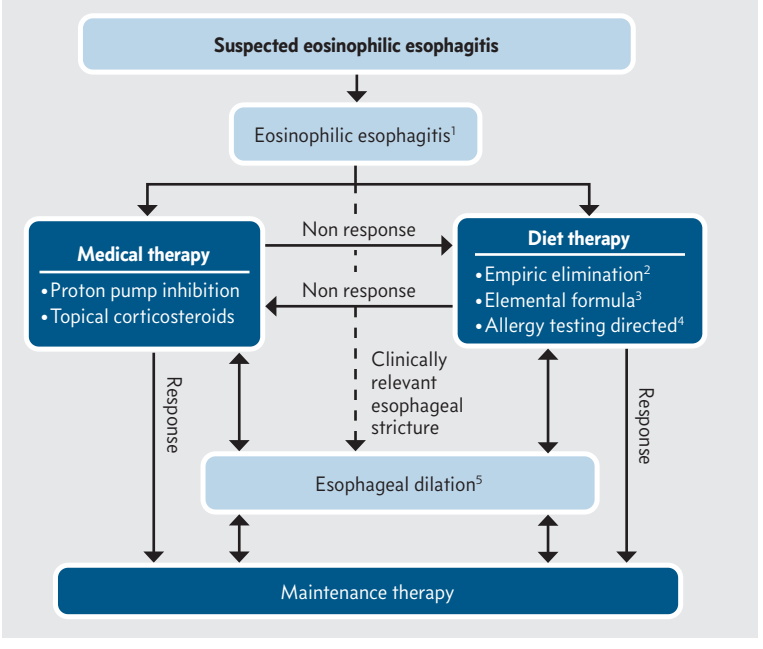
Recommendations on the Management of EoE

Statement	Strength of recommendation	Quality of evidence
1. In patients with symptomatic esophageal eosinophilia, the AGA/JTF suggests using proton pump inhibition over no treatment.	Conditional	Very low
2. In patients with EoE, the AGA/JTF recommends topical glucocorticosteroids over no treatment.	Strong	Moderate
3. In patients with EoE, the AGA/JTF suggests topical glucocorticosteroids rather than oral glucocorticosteroids.	Conditional	Moderate
4. In patients with EoE, the AGA/JTF suggests using elemental diet over no treatment. *Comment: Patients who put a higher value on avoiding the challenges of adherence to an elemental diet and the prolonged process of dietary reintroduction may reasonably decline this treatment option.*	Conditional	Moderate
5. In patients with EoE, the AGA/JTF suggests using an empiric, 6-food elimination diet over no treatment. *Comment: Patients who put a higher value on avoiding the challenges of adherence to diet involving elimination of multiple common food staples and the prolonged process of dietary reintroduction may reasonably decline this treatment option.*	Conditional	Low
6. In patients with EoE, the AGA/JTF suggests using an allergy testing-based elimination diet over no treatment. *Comment: Due to the potential limited accuracy of currently available, allergy-based testing for the identification of specific food triggers for EoE, patients may prefer alternative medical or dietary therapies to an exclusively testing-based elimination diet.*	Conditional	Very low
7. In patient with EoE in remission after short-term use of topical glucocorticosteroids, the AGA/JTF suggests continuation of topical glucocorticosteroids over discontinuation of treatment. *Comments: Patients who put a high value on the avoidance of long-term topical steroid use and its possible associated adverse effects, and/or place a lower value on the prevention of potential long-term undesirable outcomes (ie, recurrent dysphagia, food impaction, and esophageal stricture), could reasonably prefer cessation of treatment after initial remission is achieved, provided clinical follow-up is maintained.*	Conditional	Very low

Recommendations on the Management of EoE *(cont'd)*

Statement	Strength of recommendation	Quality of evidence
8. Recommendation: In adult patients with dysphagia from a stricture associated with EoE, the AGA/JTF suggests endoscopic dilation over no dilation. *Comment: Esophageal dilation does not address the esophageal inflammation associated with EoE.*	Conditional	Very low
9. In patients with EoE, the AGA/JTF recommends using anti-IL-5 therapy for EoE only in the context of a clinical trial.	No recommendation	Knowledge gap
10. In patients with EoE, the AGA/JTF recommends using anti-IL-13 or anti-IL-4 receptor a therapy for EoE only in the context of a clinical trial.	No recommendation	Knowledge gap
11. In patients with EoE, the AGA/JTF suggests *against* the use of anti-IgE therapy for EoE.	Conditional	Very low
12-15. In patients with EoE the AGA/JTF suggest using montelukast, cromolyn sodium, immunomodulators, and anti-TNF for EoE only in the context of a clinical trial.	No recommendation	Knowledge gap

Treatment of Eosinophilic Esophagitis (EoE) Clinical Decision Support Tool



[1] **Secondary causes of esophageal eosinophilia:**

- Gastroesophageal reflux disease
- Eosinophilic gastrointestinal disease
- Achalasia
- Hypereosinophilic syndrome
- Esophageal Crohn's disease
- Infections (fungal, viral)
- Connective tissue disorders
- Autoimmune disorders
- Vasculitis
- Drug hypersensitivity reactions
- Pill esophagitis
- Stasis esophagitis
- Graft versus host disease
- Marfan syndrome type II
- Hyper-IgE syndrome
- PTEN hamartoma tumor syndrome
- Netherton's syndrome
- Severe atopy metabolic wasting syndrome

[2] Recommendation in favor of empiric elimination diets is based on the published experience with the six food elimination diet (SFED). Patients who put a higher value on avoiding the challenges of adherence to diet involving elimination of multiple common food staples and the prolonged process of dietary reintroduction may reasonably decline this treatment option. Emerging data on less restrictive diets (4 food, milk elimination, 2-4-6 step up diet) may increase both provider and patient preference for diet therapy.

[3] Patients who put a higher value on avoiding the challenges of adherence to an elemental diet and the prolonged process of dietary reintroduction may reasonably decline this treatment option.

[4] Due to the potential limited accuracy of the currently available, allergy-based testing for the identification of specific food triggers for EoE, patients may prefer alternative medical or dietary therapies to an exclusively testing-based elimination diet.

[5] Esophageal dilation does not address the esophageal inflammation associated with eosinophilic esophagitis.

American Gastroenterological Association and the Joint Task Force on Allergy-Immunology Practice Parameters Clinical Guidelines for the Management of Eosinophilic Esophagitis

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Abbreviations

AGA/JTF, American Gastroenterological Association/Joint Task Force; **EoE**, Eosinophilic esophagitis; **IgE**, Immunoglobulin E; **Il**, interleukin; **SFED**, six food elimination diet; **TNF**, tumor necrosis factor

Source

Ikuo Hirano, Edmond S. Chan, Matthew A. Rank, Rajiv Sharaf , Neil H. Stollman , David R. Stukus, Kenneth Wang, Matthew Greenhawt, Yngve Falck-Ytter. American Gastroenterological Association and the Joint Task Force on Allergy-Immunology Practice Parameters Clinical Guidelines for the Management of Eosinophilic Esophagitis. *Ann Allergy Asthma Immunol.* 2020;124:416-423.

Disclaimer

This pocket guide attempts to define principles of practice that should produce high-quality patient care. It focuses on the needs of primary care practice, but also is applicable to providers at all levels. This pocket guide should not be considered exclusive of other methods of care reasonably directed at obtaining the same results. The ultimate judgment concerning the propriety of any course of conduct must be made by the clinician after consideration of each individual patient situation. Neither IGC, the medical associations, nor the authors endorse any product or service associated with the distributor of this clinical reference tool.

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