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Editorial: oesophageal dilation in eosinophilic oesophagitis—can and should, but when and how? Authors' reply

We thank Drs Kia and Hirano for their comments on our recent systematic review and meta-analysis on the efficacy and safety of dilation in eosinophilic oesophagitis (EoE).[1,2] We agree with several points that they make; symptoms in EoE can be challenging to capture accurately owing to behavioural modifications.[3] A limitation of our meta-analysis was that studies did not use validated measures to assess symptom response. The results of any systematic review depend on the quality of the studies retrieved.

One of our aims was to compare the safety and efficacy of different dilators. Overall, we found that the clinical response rate was 95%, and the complication rate was under 1%, regardless of dilator type. We were not able to determine whether reaching a certain threshold of oesophageal diameter would predict clinical response, as this variable was not consistently reported in the studies. Whether concomitant medical therapy helps to improve dysphagia for a longer duration following dilation is not known and should be addressed in future studies.

We agree that initiating medical or dietary treatment is necessary to treat EoE by improving inflammation and possibly reversing fibrostenotic features.[4] Persistence of symptoms despite histologic remission in a patient with EoE requires exclusion of a structural cause of dysphagia, whether it be a dominant stricture or a diffusely narrow calibre oesophagus. In either case, symptoms improve following oesophageal dilation.

We have differences in opinions with regards to other points brought up in the editorial. While Drs Kia and Hirano reserve dilation as a back-up treatment for strictures that do not respond to medical and dietary treatment, its early use as an adjunct treatment for a stricture encountered on index endoscopy should be acknowledged, even if patients have not yet received medical or dietary treatment. This is especially the case if the stricture is suspected to be the major cause or at least contributing to a patient's dysphagia. In most cases, dilation provides nearly immediate improvement of symptoms and, as shown in our meta-analysis, is safe with very low complication rates. As dilation has no effect on oesophageal inflammation in EoE, it should be further combined with anti-inflammatory dietary or drug therapies to maximise its efficacy and avoid repeated dilations.

Regarding which dilator to use for EoE strictures, it remains "dealer's choice" based on an endoscopist's individual experience and comfort level with types of dilators. We did not detect any differences in safety when comparing the three major types of dilators. Savary dilators may be preferred for a diffusely narrow calibre or multi-strictured oesophagus, but a through-the-scope balloon dilator works equally well for a dominant stricture.

We agree that future studies may shed more light on how and when to use dilation in the management of EoE. For now, our meta-analysis emphasises its safety and efficacy as an adjunct treatment for children and adults with EoE.

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LINKED CONTENT

This article is linked to Moaward et al and Kia and Hirano papers. To view these articles visit https://doi.org/10.1111/apt.14216 and https://doi.org/10.1111/apt.14123.

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