

Seasonal Variation in the Diagnosis of Eosinophilic Esophagitis: There and Back Again

See "Correlation Between Aeroallergen Levels and New Diagnosis of Eosinophilic Esophagitis in New York City" by Fahey et al on page 22.

To the Editor: Although literature has shown conflicting results for aeroallergens as eosinophilic esophagitis (EoE) triggers, a recent systematic review combining data from 16,846 EoE patients (1) did not find significant variations in the seasonal distribution of either the initial diagnosis or clinical recrudescence of EoE throughout the year. As such, we read with interest the retrospective study by Fahey et al (2), which reports a positive correlation between peak levels of grass pollen with the onset of symptoms and diagnosis of new cases of EoE. The authors suggest that the potential role that environmental factors could play in EoE should be investigated as rigorously as that for food triggers. This association was not, however, shown for 10 additional pollen taxa. Beyond the risk of bias inherent to retrospective studies, we would like to make the case for the potential inaccuracy of a seasonal variation in EoE:

1. Diagnostic delay in EoE is common (3) because patients usually minimize symptoms by modifying their eating behavior, whereas endoscopy is often performed after long waiting lists. Therefore, equating the onset of symptoms with the time of endoscopy performance can be somewhat deceiving.
2. Outdoor season leads to different eating customs that might increase the risk of suffering from meat bolus impaction, leading to EoE diagnosis. Likewise, parents may gain increased awareness on their children symptoms during summer holidays because of spending more time together.
3. Most EoE patients experience atopic conditions with regular visits to the allergy clinic during the pollen season. Accordingly, the opportunity of achieving an EoE diagnosis during the same season is highly likely.
4. Although most atopic conditions are rapidly triggered after exposure to allergens by an immunoglobulin E-mediated mechanism, this is not the case for EoE (4). EoE is predominantly an immunoglobulin G4-associated food allergy (5), in which patients do not usually show immediate symptoms after exposure to offending foods.
5. EoE is an antigen-induced disorder, predominantly but not exclusively triggered by food antigens. A 90% remission on an elemental formula (6) underscores a minor etiologic role for aeroallergens in EoE.
6. EoE patients are usually sensitized to indoor perennial aeroallergens. EoE in murine models has only been replicated after exposure to mould, dust, and cockroach (7). Thus, conferring a predominant triggering role to seasonal pollen might be overly simplistic. Indoor allergens were not evaluated in this study.

In any case, whether airborne allergens play a causal or casual role in EoE should be elucidated in high-quality prospective studies.

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Racecadotril May Reduce Diarrhoea in Microvillous Inclusion Disease

To the Editor: Microvillous inclusion disease (MVID) is a rare congenital enteropathy causing secretory diarrhoea. Severe dehydration and metabolic imbalance are life threatening, and the only curative treatment is small bowel transplantation (1).

Racecadotril inhibits enkephalinase-preventing degradation of enkephalins, abundant in the intestinal villi. Enkephalins have an antisecretory effect by inhibiting cyclic adenosine monophosphate (cAMP) (2). Treatment reduces stool losses in acute diarrhoea, acting within the first 24 hours and adverse effects are similar to placebo (3). We report the positive effect of racecadotril in a patient with variant MVID on parenteral nutrition every night who also had persistent familial cholestasis. At the age of 4 years, he had 4 to 6 loose stools per day (Bristol type 7) including 2 at night that required change of bedding. Treatment with loperamide 0.2 mg/kg 4 times a day had no effect. A stool diary was kept before and after treatment with racecadotril 1.5 mg/kg thrice a day. The mean daily number of stools fell from 6.5 to 2.1 and stool consistency improved to Bristol type 6. Parents reported cessation of nocturnal stooling, improved sleep and appetite, and were keen to continue treatment. Withdrawal of racecadotril led immediately to frequent (3.7 daily, type 7) watery stools, with improvement once again after reintroduction (2.9 daily, type 7).

As far as we can ascertain, there have been no reports of racecadotril being used in MVID. Our experience with 1 patient suggests it could have a role in reducing diarrhoea and possibly leads to reduction in parenteral nutrition dependency.