Eosinophilic esophagitis in a father and a daughter

To the Editor:

I was intrigued by the article about 3 brothers with eosinophilic esophagitis in the January 2005 edition of Gastrointestinal Endoscopy, in which the investigators suggest potential hereditary or genetic features in the pathogenesis of eosinophilic esophagitis.1 This correspondence should add further speculation to a familial risk. This documents an adult, father and daughter combination with eosinophilic esophagitis. It also gives strength to the recommendation of swallowed fluticasone propionate treatment for this disease.

In the first case, an 80-year-old man presented in November 2003 with stable dysphagia for 30 years. His only complaint of heartburn was if he were to eat pizza or eat late in the evening. At endoscopy, a stricture was noted, biopsied, and dilated with ease. The biopsy specimen showed up to 40 eosinophils/high-power field (HPF). His differential white blood cell count revealed 10% eosinophils (normal: 0-4%) in November 2003; an immunoglobulin (Ig) E was normal at 20 U/mL (Nl < 140 U/mL). His mild heartburn was not affected by proton pump inhibitors, so they were discontinued in August 2004. He has not wanted to take oral steroids and remains asymptomatic.

In the second case, his daughter, a 52-year-old nurse, reported, in February 2004, that she had a history of dysphagia for 12 years, becoming more severe over the preceding 2 years. At endoscopy with a GIF-160 (diameter 8.6 mm) (Olympus America, Melville, New York), there was resistance at 16 cm from the incisors, but, after gentle pressure, it yielded with a popping sensation. The distal esophagus had a hint of rings but not dramatically so. Further resistance was met at the esophagogastric junction. A through-the-scope 10- to 12-mm balloon was inserted, and dilation was performed. Eosinophilia was significant in biopsy specimens taken at 25 cm (>40/HPF) and 35 cm (>60/HPF) but not at 40 cm from the incisors. She received fluticasone propionate, 220 mcg/puff, 2 puffs twice daily, into the mouth and swallowed. She did well for several months and then chose to discontinue her steroids, about June 2004. She continued to do well for 6 months but developed dysphagia again in December 2004. She resumed fluticasone propionate, (2 puffs twice a day), and, within 3 weeks, her dysphagia disappeared. She was seen 6 weeks later and remains asymptomatic. She has had intermittent peripheral eosinophilia with normal IgE levels.

This letter documents a father/daughter kinship with eosinophilic esophagitis and documents the salutary benefit of topical steroids.

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REFERENCE

NEWS & NOTICES

ENDOSCOPIC ULTRASONOGRAPHY FOR NURSES

This course will be held July 14-15, and October 6-7, 2005 in Charleston, South Carolina. The course is designed for endoscopy nurses and assistants who have an interest in basic endoscopic ultrasonography (EUS). Through didactic lecture and live case demonstrations, the course teaches anatomy and physiology, equipment and accessories, maintenance and care of equipment. For more information, contact Sylvia Holmes, MUSC Digestive Disease Center, 96 Jonathan Lucas Street, 210 CSB, Charleston, SC 29425; phone 843-792-7821; e-mail holmess@musc.com.

6TH ANNUAL UPDATE IN GASTROENTEROLOGY—UNIVERSITY AT SEA

This course will be held July 21-30, 2005 on a 2-day land/7-day cruise of Tahiti, French Polynesia. The agenda includes updates in GERD, Barrett’s esophagus, endoscopic therapy for GERD, hepatitis C, celiac disease, probiotics, IBD, colon cancer screening, and other GI topics. Clinical faculty is from George Washington University School of Medicine and the University of California at San Francisco. For more information, contact Continuing Education, Inc, 5700 4th Street North, St. Petersburg, FL 33703; phone 800-422-0711, or visit www.continuingeducation.net.