



Food Bolus Impaction in the Era of Increased EoE Recognition: Push and Pull, Biopsy and Dilate Before It Is Too Late

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Food bolus impaction of the esophagus (FBE), a common gastroenterological emergency, has been increasingly recognized as a complication of eosinophilic esophagitis (EoE) [1, 2]. The initial management of food bolus impaction is to first and foremost safely expedite relief of obstruction in order to prevent aspiration of gastric contents and esophageal perforation [3]. The second but similarly important priority is to consider the underlying cause in order to inform future management. It is in this latter case where clinical practice is arguably most divergent, and where consensus and future guidelines are also needed. Failure to commence appropriate treatment may not only lead to recurrent food bolus impaction, but also to the fibrostenosing form of EoE [4, 5]. The article by Hiremath et al. published in this issue of *Digestive Diseases and Sciences* [6] emphasizes the variability of the clinical management of food bolus impaction, discusses the significant divergence from “ideal” practice by summarizing the results of a 23 question survey administered to >400 adult and pediatric gastroenterologists (1:1) practicing in a variety of clinical settings including major academic facilities and privately run facilities, and speculates that failure to either correctly diagnose and/or appropriately treat EoE is commonplace [6].

In dealing with acute relief of obstruction, a range of devices were used, perhaps reflecting a preference by some practitioners, in particular pediatric gastroenterologists, to retrieve rather than push the bolus into the stomach. Indeed management guidelines are not uniform, with the American Society of Gastrointestinal Endoscopy (ASGE) cautioning against the “push” technique, while recent European

guidelines recommend advancing the bolus into the stomach as a first-line safe, effective strategy [7, 8]. Interestingly, 28% of respondents reported the availability of the recently tested and promising suction cap in order to facilitate retrieval [9]. Dilation of the esophagus following bolus clearance was reported as a preferred treatment by ~50% of clinicians, foreseeably reflecting an easing of concerns regarding perforation in EoE, given recent reassuring data to this end [8].

With resolution of FBE, consideration of the underlying etiology should inform commencement of treatment. In the era of increased EoE recognition, biopsies have been advocated at the time of food bolus removal [2, 8]. Of concern, biopsies were obtained in all FBE patients by only ~1/3 of clinicians, representing missed opportunities, broadly reflective of actual practice reported elsewhere [2]. Similarly, high-dose proton pump inhibitor (PPI) therapy was prescribed routinely by <50% of respondents. Hiremath et al. compared this to a proposed “ideal” of best practice which quite logically and reasonably includes both biopsy and commencement of PPI therapy.

The methodology used by Hiremath et al. has significant shortcomings, most importantly being that data are theoretical rather than actual and responses are subject to significant bias. Notwithstanding, the real strength of such widespread data acquisition is that useful themes can and do emerge, including an estimation of the number of potential “missed” cases of EoE as a result of management divergent from best practice, which is estimated at 10,000 annually in the USA. Methodological flaws aside, the message is clear: Guidelines are needed, and patients with EoE will have their management compromised until these are instituted by pediatric and adult gastroenterologists *en masse*.

The management algorithm proposed by Hiremath et al. namely that biopsies be performed following relief of food bolus impaction, that PPI therapy is commenced, that repeat endoscopy is performed, and that a clinic appointment is scheduled, is logical and reasonable. Resource

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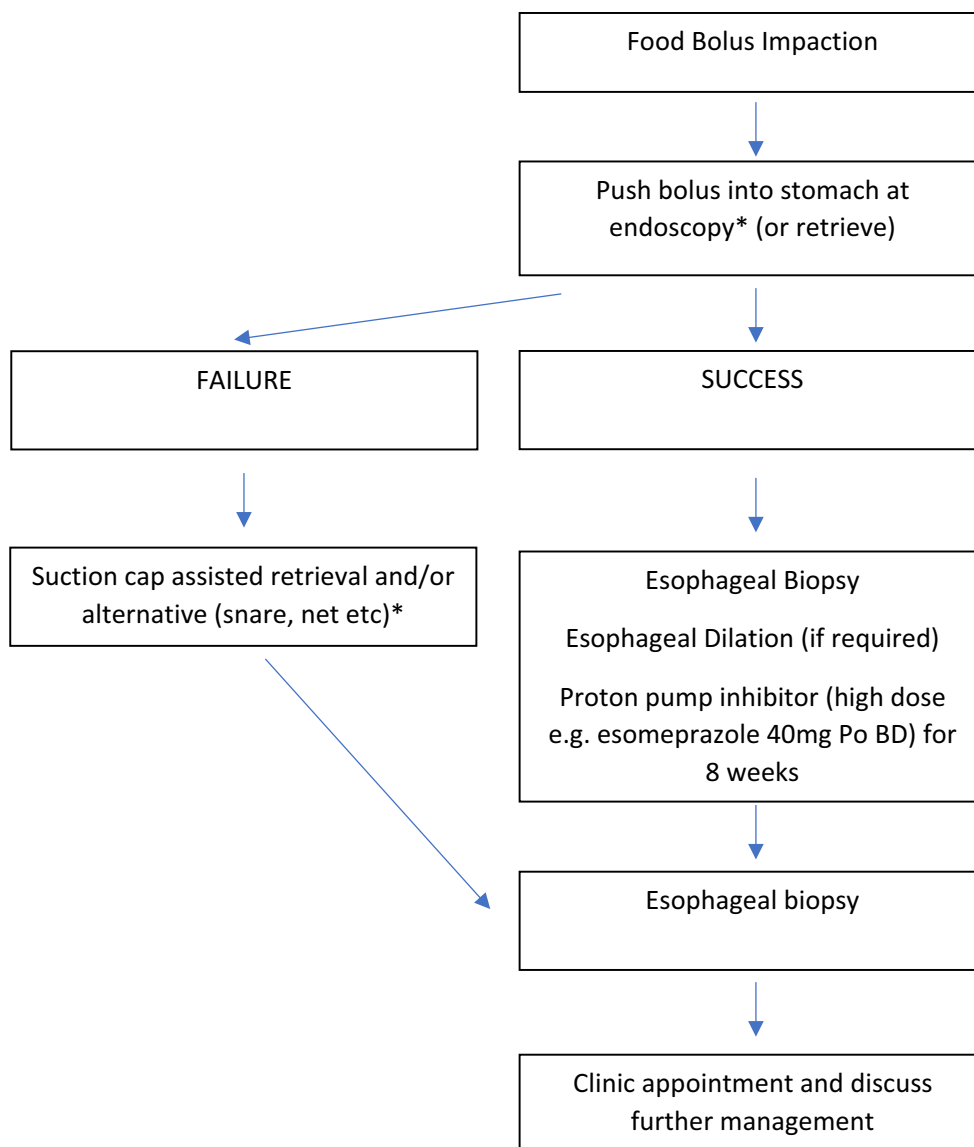


Fig. 1 Proposed ideal management of esophageal food impaction secondary to eosinophilic esophagitis. *Either advancing the food bolus into the stomach or retrieving the bolus is reasonable initial techniques, and individual clinician preference may dictate the approach

constraints aside, there is no major downside to these recommendations. That some patients may have food impaction despite PPI (“repeat offenders”) of course requires separate consideration, aided by the use of alternative treatments such as topical corticosteroids and elimination diets. One indeed could go further, in specifying that a “push” technique should be used initially, that a suction cap should be used if this fails, and that dilation should be performed following relief from food impaction (Fig. 1). In the era of increased EoE awareness, push or pull, dilate, biopsy and PPIs along with rigorous follow-up are essential components of an ideal management strategy.

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