Innovative GI

Understanding & Managing Eosinophilic Esophagitis

A Patient Guide to EoE Care

What Is Eosinophilic Esophagitis?

Eosinophilic esophagitis (EoE) is a chronic, immune-mediated condition in which a type of white blood cell called an eosinophil builds up in the lining of the esophagus (the tube connecting the mouth to the stomach), causing ongoing inflammation. Left untreated, this inflammation can lead to scarring and narrowing of the esophagus over time. Symptoms vary by age: children more often have feeding difficulties, reflux-like symptoms, vomiting, or poor growth, while teens and adults more often experience difficulty swallowing solid food, a sensation of food getting stuck, or chest pain. EoE is the leading cause of emergency room visits for food impaction (food becoming truly stuck in the esophagus), which is why recognizing and treating it matters even when symptoms seem mild or intermittent.

What Causes It?

- **An immune reaction to specific food proteins** — unlike a classic food allergy, this isn't the sudden, antibody-driven (IgE) reaction that causes hives or anaphylaxis. It's a slower, delayed type of immune inflammation, which is why standard skin-prick or blood allergy testing isn't reliable for identifying your specific trigger foods.
- **The most common trigger foods**, based on elimination-diet studies, are dairy (found to be a trigger in about 70% of patients tested), wheat (about 48%), eggs (about 28%), and soy or other legumes (about 21%).
- **Overlap with other allergic (atopic) conditions** — asthma, eczema, environmental allergies, and classic food allergies are all more common in people with EoE, suggesting a shared underlying tendency toward allergic-type inflammation.
- **Genetics and family history** play a role, though the exact inheritance pattern isn't fully understood.

How EoE Is Diagnosed

Diagnosis requires both symptoms of esophageal dysfunction (difficulty swallowing, food getting stuck, chest pain, or reflux-like symptoms not explained by GERD alone) and confirmation on upper endoscopy (EGD): at least six biopsies taken from two different levels of the esophagus, showing 15 or more eosinophils per high-power field under the microscope. During the same endoscopy, we also use a standardized visual scoring system (EREFS) to describe findings like rings, furrows, whitish patches, swelling, or narrowing. Because acid reflux (GERD) can also cause some eosinophils to appear in the esophagus, part of the diagnostic process involves ruling out other explanations. Since 2018, a trial of acid-suppressing medication is no longer required just to make the diagnosis — patients who improve with these medications are now understood to still have EoE, simply a form that responds to this particular treatment.

How EoE Is Treated

Treatment for EoE is often described as the “three D's”: Diet, Drugs, and Dilation. Most patients start with a medication or dietary approach, with dilation reserved for existing narrowing that's already causing symptoms. A study “compared to a dummy pill (placebo)” below means some patients got the real treatment and others a fake version, without knowing which, so researchers could isolate the treatment's true effect. “Histologic remission” means the eosinophil count on a follow-up biopsy has dropped back down to a normal range — the main marker we use to confirm a treatment is actually working, since symptoms alone don't always reflect what's happening at the tissue level.

Proton Pump Inhibitors (PPIs)

Goal: a first-line, low-risk option that works for a meaningful share of patients, regardless of whether reflux is also present.

• **A PPI** (such as omeprazole or esomeprazole), typically at a higher, twice-daily dose to start.

Evidence: Across studies, PPIs bring about clinical improvement in roughly 65% of patients and histologic remission (a normalized eosinophil count on repeat biopsy) in about 45%. Twice-daily, higher-dose treatment produces meaningfully better remission rates than once-daily standard dosing (roughly 52% versus 28% in one analysis), and many patients can step down to a lower maintenance dose once in remission.

Swallowed Topical Steroids

Goal: reduce inflammation directly in the esophagus with a steroid that acts mainly where it's swallowed, rather than throughout the body — the treatment with the strongest guideline backing.

• **Swallowed fluticasone**, delivered from a standard asthma inhaler but swallowed rather than inhaled, or **budesonide** mixed into a thick liquid slurry, taken twice daily.

Evidence: Both formulations have strong trial evidence for inducing remission, with studies showing comparable clinical and histologic response between the two; some studies in children found budesonide slurry somewhat more effective than fluticasone. Technique matters with either one: swallow slowly, and avoid food, water, or rinsing your mouth for 30–60 minutes afterward so the medication has time to coat and act on the esophagus; rinsing your mouth after that window helps prevent oral thrush, the most common side effect.

• **Budesonide oral suspension (Eohilia)** — a newer, thicker formulation designed specifically to coat the esophagus, taken twice daily.

Evidence: FDA-approved in 2024 specifically for EoE in patients 11 and older, making it the first and only oral medication approved specifically for this condition, rather than a steroid product originally designed for asthma that's used off-label by swallowing it instead.

• **Topical steroids also reduce the risk of food impaction** requiring an emergency room visit or endoscopic removal, independent of their effect on symptoms.

Elimination Diet

Goal: identify and remove your specific food triggers — addresses the root allergic driver rather than suppressing inflammation with medication, though it takes more effort and typically several endoscopies to complete.

• **A step-up approach** is generally used: start by removing 1–2 of the most common trigger foods (dairy, and sometimes wheat), then step up to removing more foods only if needed, with an endoscopy to check response at each step.

Evidence: In studies using this approach, removing 2 food groups brought about remission in roughly 43% of patients; stepping up to 4 foods raised that to about 60%, and 6 foods to about 79% — letting most people find their answer while avoiding unnecessary restriction and extra endoscopies.

• **A stricter 1-food (dairy-only) elimination** compared directly with a 4-food elimination in a randomized trial.

Evidence: The two approaches produced nearly identical remission rates (roughly 32% versus 35%), suggesting that starting with just dairy elimination is a very reasonable, less restrictive first step for many patients rather than assuming a broader diet is automatically necessary.

• **Reintroducing foods one at a time**, with a repeat endoscopy after each reintroduction, to pinpoint your specific trigger(s) once remission is achieved.

Evidence: This step is what actually identifies your personal trigger foods, rather than leaving you on a broader elimination diet indefinitely; working with a dietitian experienced in EoE is strongly recommended to keep the diet nutritionally balanced throughout this process.

Biologic Therapy

Goal: for EoE that doesn't respond well enough to the options above, or as an earlier option in more severe disease.

• **Dupilumab (Dupixent)**, an injectable biologic given weekly, that blocks a specific signaling pathway (IL-4/IL-13) driving the type of inflammation seen in EoE.

Evidence: FDA-approved for adults and children 12 and older (2022), later expanded to children as young as 1 year old (2024) based on a placebo-controlled trial in which 66% of children on the higher studied dose reached histologic remission at 16 weeks, compared with just 3% on placebo — one of the larger treatment effects seen in EoE research. It's generally considered after other treatments haven't worked well enough, though guidelines increasingly support using it earlier in more severe or hard-to-control cases.

Esophageal Dilation

If narrowing (a stricture) has already developed and is causing swallowing difficulty, a quick endoscopic procedure can gently stretch the narrowed area, often bringing rapid relief of swallowing symptoms. Dilation addresses the narrowing itself, not the underlying inflammation, so it's typically done alongside — not instead of — one of the medical or dietary treatments above. It's generally safe, though there's a small risk of chest discomfort, bleeding, or (rarely) a tear in the esophageal wall.

Living With EoE: A Few Practical Notes

- **Eat slowly and chew thoroughly**, especially dense or dry foods like bread, meat, and rice, which are more likely to cause a sensation of sticking.
- **Take suspected food impaction seriously.** If you truly can't swallow your own saliva, or food won't pass after a reasonable period of trying to relax and wait it out, seek emergency care rather than continuing to try to push it down — this is a common, treatable emergency, not something to be embarrassed about.
- **Stay on treatment and keep follow-up endoscopies**, even once symptoms feel better — symptoms don't always track with how much inflammation remains, so a repeat biopsy is the only way to confirm the disease is truly under control.

When to Contact Our Office

- Suspected food impaction that doesn't pass — seek emergency care immediately rather than waiting
- New or worsening difficulty swallowing, or increasingly needing to modify your diet to avoid symptoms
- Symptoms that persist despite an adequate trial of treatment
- Unintentional weight loss, or (in children) poor growth or ongoing feeding difficulty
- Before starting, stopping, or combining any medication, supplement, or elimination diet in this guide

This guide supports your personalized plan and isn't a substitute for individualized medical advice. Check with your provider before starting, stopping, or combining anything mentioned here.

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