Eosinophilic oesophagitis treatment pathway

for patients with a histologically confirmed diagnosis (≥15 eos/hpf or 0.3 mm² or >60 eos/mm²)[1]

Mild to Moderate

Initial Rx

- PPI full dose bd
- Diet supervised by a dietician

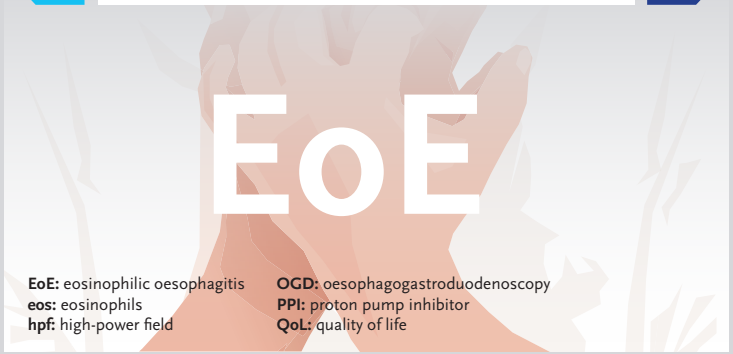
Evaluation at 12 weeks
OGD/biopsy on treatment
Clinical assessment

- Responder: No symptoms + <15 eos/hpf → Continue therapy → Ongoing monitoring e.g. with a symptom severity questionnaire
- Non-responder: Continued symptoms ± ≥15 eos/hpf → Follow moderate to severe pathway

Choosing the pathway **for moderate disease**

The answers to these questions tend to favour the direction of decision indicated but are not absolute. They help the patient and the clinician to consider the issues that affect their decision on which therapy might be best suited to their circumstances.

No	Are symptoms present most days/daily?	Yes
No	Is their QoL significantly affected?	Yes
No	Do they avoid eating out/other social interactions for fear of symptoms?	Yes
No	Are they avoiding food consistencies that stick?	Yes
No	Is their eating behaviour compromising their nutritional health?	Yes
No	Do they have strictures?	Yes
No	Would a recurrence of bolus obstruction be likely to require emergency hospitalisation?	Yes
No	Would a recurrence of bolus obstruction be potentially life threatening? (In the case of perforation)	Yes



EoE: eosinophilic oesophagitis
eos: eosinophils
hpf: high-power field
OGD: oesophagogastroduodenoscopy
PPI: proton pump inhibitor
QoL: quality of life

Moderate to Severe

Initial Rx: Topical steroid

Licensed: Jorveza (orodispersible budesonide)
Unlicensed: swallowed inhaled fluticasone
1 mg bd, 6-12 weeks

Evaluation at 12 weeks
OGD/biopsy on treatment
Clinical assessment

- Responder: No symptoms + <15 eos/hpf → Maintenance therapy 0.5 mg or 1 mg bd → Ongoing monitoring e.g. with a symptom severity questionnaire
- Non-responder: Continued symptoms ± ≥15 eos/hpf → Jorveza 1 mg bd for naïve patients, diet for Jorveza failures → Symptoms → Dilatation if strictures present

Prescribing information can be found on page 3

Considerations

The treatment pathway was developed following a round table discussion of UK physicians expert in the treatment of EoE, supported by an educational grant from Dr Falk Pharma.

References:
1. Dhar A *et al*. Gut 2022; doi: 10.1136/gutjnl-2022-327326.
2. Kia L, Hirano I. Nat Rev Gastroenterol Hepatol 2015; 12(7): 379-86.
3. Molina-Infante J, Lucendo AJ. Curr Opin Gastroenterol 2020; 36(4): 359-63.
4. Goyal A, Cheng E. World J Gastrointest Pharmacol Ther 2016; 7(1): 21-32.
5. Dellon ES *et al*. Gastroenterology 2017; 152(4): 776-86.
6. Dellon ES *et al*. Clin Gastroenterol Hepatol 2020; 18(7): 1483-92.
7. Straumann A *et al*. Gastroenterology 2020; 1591(5): 1672-1685.e5.

EoE: eosinophilic oesophagitis
PPI: proton pump inhibitor

PPI therapy

- PPI therapy is not licensed for the treatment of EoE; the appropriate duration of treatment has not been established[2]
- Symptomatic improvement with PPI treatment might not correlate with endoscopic and histological improvement[2]

Diet therapy

- A step-up empiric elimination diet is currently accepted as the initial dietary approach for EoE[3]
- Elimination of four or more food groups should be reserved for exceptionally motivated patients, as the probable existence of three or more food triggers might make long-term restrictions unfeasible[3]
- Patients need intensive dietetic support to prevent vitamin and nutrient deficiencies[4]

Steroid therapy

- Off-label corticosteroids are not optimised for oesophageal delivery[5]
- With topical viscous steroids, variable drug concentrations are possible when patients mix aqueous forms into slurries; with medication administered into the mouth with metred dose inhalers, inadequate oesophageal delivery and undesired pulmonary deposition can result[5]
- EoE is likely to recur if treatment is discontinued[6,7]
- **Most patients have relapse of endoscopic and histologic features that are not detected reliably by symptoms; therefore, maintenance therapy should be recommended for patients with a histologic response to topical steroids[6]**

Prescribing information

BUDESONIDE
Jorveza®
ORODISPERSIBLE TABLETS

Prescribing Information (refer to full SmPC before prescribing). **Presentations**: Jorveza 1mg and 0.5mg orodispersible tablets containing 1mg or 0.5mg of budesonide. **Indications:** treatment of eosinophilic esophagitis (EoE) in adults (older than 18 years of age). **Dosage:** Induction of remission: one 1mg tablet taken twice daily (morning and evening) after a meal and immediately after removal of the tablet from the blister pack. Usual duration of induction treatment is 6 weeks. Extend up to 12 weeks for non-responding patients. Maintenance of remission: 0.5mg twice daily or 1mg twice daily depending on clinical need. A maintenance dose of 1mg twice daily is recommended for patients with long-standing disease history and/or high extent of esophageal inflammation in the acute disease state. Duration of maintenance treatment - to be determined by the treating physician. Administration: tablet is placed on tip of tongue and pressed to top of mouth then swallowed slowly without liquid or food and without chewing or swallowing undisintegrated. May take 2 to 20 minutes to disintegrate and swallow completely. Wait at least 30 minutes before eating, drinking or performing oral hygiene. **Contra-indications:** hypersensitivity to budesonide or any ingredient of the tablets. **Warnings/precautions:** infections - Suppression of inflammatory response and immune function increases susceptibility to infections and their severity which can be atypical or masked. Oral, oropharyngeal and esophageal candida infections occur at high frequency. Treat symptoms with topical or systemic anti-fungals. Jorveza treatment can continue. Chickenpox, herpes zoster and measles - can be more serious in patients treated with glucorticosteroids. Check vaccination status. Avoid exposure. Vaccines - avoid co-administration of live vaccines and glucocorticosteroids. The antibody response to other vaccines may be diminished. Special populations - monitor patients with tuberculosis, hypertension, diabetes mellitus, osteoporosis, peptic ulcer, glaucoma, cataract, family history of glaucoma. Systemic effects of glucocorticosteroids may occur, depending on duration of treatment, concomitant and previous glucocorticosteroid treatment and individual sensitivity. Patients with reduced liver function - an increased systemic availability of budesonide may be expected, with increased risk of adverse reactions. Patients with hepatic impairment should not be treated. Not recommended for use in patients with severe renal impairment. Angioedema - treatment should be stopped if signs of angioedema are observed. Visual disturbance - patients with blurred vision or other visual disturbances should be considered for referral to an ophthalmologist. Causes may include cataract, glaucoma or central serous chorioretinopathy resulting from corticosteroid use. Others - glucocorticosteroids may cause suppression of the hypothalamic–pituitary–adrenal (HPA) axis and reduce the stress response. When patients are subject to surgery or other stresses, supplementary systemic glucocorticosteroid treatment is therefore recommended. Concomitant treatment with ketoconazole or other CYP3A4 inhibitors should be avoided. Serological testing - adrenal function may be suppressed by budesonide so an ACTH stimulation test for diagnosing pituitary insufficiency might show false (low) results. Sodium - contains 52 mg of sodium per daily dose. **Interactions:** CYP3A4 inhibitors - concomitant treatment with ketoconazole or other potent CYP3A inhibitors including grapefruit juice should be avoided to reduce the risk of systemic side effects unless the benefit outweighs the risk. Such treatment should be monitored. Oestrogens, oral contraceptives - may elevate plasma concentrations and enhance effects of glucocorticosteroids. Concomitant intake of low dose combination oral contraceptives has not shown this effect. Cardiac glycosides - action of glycoside can be potentiated by potassium deficiency - a potential and known adverse reaction of glucocorticoids. Saluretics - potassium excretion can be enhanced and hypolalaemia aggravated. Use in pregnancy should be avoided unless there are compelling reasons for therapy. Breast-feeding - budesonide is excreted in human milk. The benefit of breast feeding for the child and the benefit of therapy for the woman should be assessed. Fertility - there are no data on the effect of budesonide on human fertility. **Undesirable effects:** fungal infections in the mouth, pharynx and the oesophagus were the most frequently observed adverse reactions in clinical studies. Long term treatment did not increase the rate. Adverse reactions and frequencies: Very common: esophageal candidiasis, oral and/or oropharyngeal candidiasis, Common: sleep disorder, headache, dysgeusia, dry eyes, gastroesophageal reflux disease, nausea, oral paraesthesia, dyspepsia, upper abdominal pain, dry mouth, glossodynia, tongue disorder, oral herpes, fatigue, blood cortisol decreased. Uncommon: nasopharyngitis, pharyngitis, angioedema, , anxiety, agitation, dizziness, , hypertension, cough, dry throat, oropharyngeal pain, abdominal pain, abdominal distension, , dysphagia, erosive gastritis, gastric ulcer, lip edema, gingival pain, rash, urticaria, sensation of foreign body, osteocalcin decreased, weight increased. . Other (class) effects with unknown frequency that may occur: increased risk of infection, Cushing's syndrome, adrenal suppression, growth retardation in children, hypokalaemia, hyperglycaemia, depression, irritability, euphoria, psychomotor hyperactivity, aggression, pseudotumor cerebri including papilloedema in adolescents, glaucoma, cataract (including subcapsular cataract), blurred vision, central serous chorioretinopathy (CSCR), increased risk of thrombosis, vasculitis (withdrawal syndrome after long-term therapy), duodenal ulcers, pancreatitis, constipation, allergic exanthema, petechiae, delayed wound healing, contact dermatitis, ecchymosis, muscle and joint pain, muscle weakness and twitching, osteoporosis, osteonecrosis, malaise. **Legal category:** POM. **Cost:** 1mg - pack of 90 - £323; 0.5mg - pack of 60 - £214.80. Not currently available in Ireland. **Product licence holder:** Dr. Falk Pharma GmbH. **Product licence number:** IE/NI: 1mg: EU/1/17/1254/004, 0.5mg: EU/1/17/1254/008. GB: 1mg: PLGB08637/0030; 0.5mg: PLGB08637/0032. **Date of preparation:** February 2023.

Further information is available on request.

Adverse events should be reported. In the UK visit www.mhra.gov.uk/yellowcard. In Ireland: https://www.hpra.ie/homepage/about-us/report-an-issue/human-adverse-reaction-form. Adverse events should also be reported to Dr Falk Pharma UK Ltd on pv@drfalkpharma.co.uk or 0044 (0)1628 536600.

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To download your copy of the EoE Treatment Pathway please scan here:

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