





## Food bolus obstruction treatment pathway

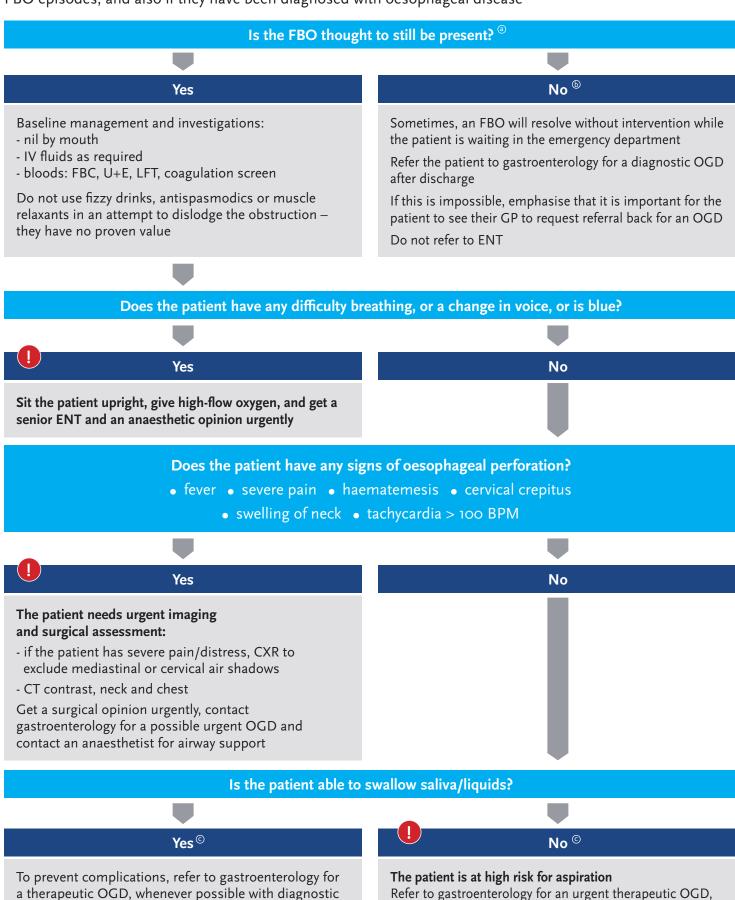
This proposed pathway was developed following a round table discussion of physicians expert in the treatment of food obstruction and/or eosinophilic oesophagitis supported by an educational grant from Dr Falk Pharma

## For patients with a history consistent with a soft food bolus obstruction in the oesophagus

biopsies



Ask about the time of the obstruction, what food the patient was eating, whether they have had prior FBO episodes, and also if they have been diagnosed with oesophageal disease



whenever possible with diagnostic biopsies, within 6 hours

## Please note..



Generally speaking, patients immediately recognise an FBO, experiencing a sensation of squeezing in the chest.

The area of discomfort often does not correlate with the site of obstruction.

Unless the patient is struggling to breathe, most food boluses stick in the body of the oesophagus.

Timing of regurgitation in FBO can be a useful diagnostic aid; immediate coughing and choking following water is suggestive of laryngeal penetration secondary to obstruction at the level of the cricopharyngeus, while delayed regurgitation suggests obstruction lower down.

The sensation of a retained foreign body can last for several hours after a large food bolus has cleared the oesophagus.



Even if the episode was transient and self-resolving, it is likely that a proportion of FBO can be prevented by focusing on appropriate patient diagnostic work-up after the first episode of obstruction.

Eosinophilic oesophagitis, a chronic inflammatory disorder that leads to fibrosis, is the most common underlying cause of FBO.

While symptoms point to EoE, it requires upper GI endoscopy and biopsies to confirm the diagnosis.

EoE is diagnosed when the number of eosinophils in the oesophageal epithelium is  $\geq 15$  per high power field (or  $\geq 15$  eos per 0.3 mm<sup>2</sup> or >60 eos/mm<sup>2</sup>).

Each year EoE goes undiagnosed, the risk of strictures increases, predisposing patients to recurrent FBO and increasing the need for oesophageal dilatation and the risk of perforation.

FBO presents a unique opportunity to diagnose and establish care for patients with EoE. It is important these patients are not lost to follow-up.



Six biopsies of the oesophagus should be taken (above, below and at the site of obstruction) at the index endoscopy to check for EoE.

When biopsies cannot be obtained during initial FBO treatment, empiric PPI medications should be avoided due to the potential risk of masking EoE at later biopsy.

Again, it is important to emphasise the need for follow-up to patients to help avoid future FBOs and long-term complications.

**BPM:** beats per minute **CT:** computed tomography

**CXR:** chest x-ray

**ENT:** ear, nose and throat **EoE:** eosinophilic oesophagitis

**eos:** eosinophils **FBC:** full blood count

**FBO:** food bolus obstruction **GI:** gastrointestinal

**LFT:** liver function tests

**OGD:** oesophagogastroduodenoscopy

**PPI:** proton pump inhibitor **U+E:** urea and electrolytes





## **Supporting references**

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