Eosinophilic Esophagitis

Many of the diseases we see as gastroenterologists and hepatologists have been written about for many decades or even over a century. Ulcerative colitis, for example, was first described in the 19th century. In comparison, eosinophilic esophagitis could be considered a "young" disease. The first reports of this condition, a chronic food-allergic disease with symptoms of esophageal dysfunction and esophageal eosinophilia, were published in the early 1990s. Throughout the past decade, however, eosinophilic esophagitis has become more prevalent, with increasing diagnoses by gastroenterologists, primary care physicians, and pediatricians. The first consensus recommendations for diagnosis and management of this condition were released in 2007 and revised as recently as last year.

In this month's issue of *Gastroenterology & Hepatology*, a feature article by Drs Nathalie Nguyen, Glenn T. Furuta, and Calies Menard-Katcher examines novel pediatric- and adult-specific clinical outcome metrics for eosinophilic esophagitis. Specifically, the authors discuss new symptom measurement assessments, the use of radiographic imaging as a metric for therapeutic interventions, recently developed standardized methods for endoscopic assessment, new techniques to evaluate esophageal mucosal inflammation, and ways to evaluate esophageal function.

Another focus this month is diverticular disease of the colon. Colonic diverticula are common and have been written about for some time; the first anatomic description of a diverticulum was published in 1700, according to Drs Alberto O. Barroso and Eamonn M. M. Quigley. In their feature article, the authors explore recent research that has called into question long-held beliefs and classic teachings. They offer a new perspective on the role of fiber and other foods in diverticular disease, risks for diverticulitis and its recurrence, the use of antibiotics in uncomplicated diverticulitis, quality-of-life issues, and the role of colonoscopy after an acute diverticulitis attack.

In this month's third feature article, Drs Sushila R. Dalal and Russell D. Cohen explore the challenges of managing patients who do not respond, or who lose response, to a biologic therapy for inflammatory bowel disease (IBD). According to the authors, when a patient is experiencing symptoms despite treatment with a biologic agent, the first objective should be to determine whether the symptoms are caused by active inflammation or by other factors, such as infection. The next steps are detailed in the article.

Our IBD coverage continues with a discussion of targeting the preclinical phase of IBD. In the Advances in IBD column, Dr Jean-Frédéric Colombel examines the status of this emerging concept and highlights several recent and ongoing studies.

Our other columns cover a variety of topics in gastroenterology and hepatology. In the Advances in Hepatology column, Dr Fred Poordad discusses hepatitis C virus genotype 3, which is considered one of the harder-to-treat genotypes. In the Advances in Endoscopy column, Dr Bret T. Petersen examines the use of covered self-expandable metal stents for the management of nonstricture biliary disorders. In the Advances in GERD column, Dr Prateek Sharma discusses Barrett esophagus, focusing on its relationship with gastroesophageal reflux disease and the use of endoscopic mucosal resection as primary therapy when these patients have dysplasia. The HCC in Focus column returns with a discussion by Dr Jean-Francois H. Geschwind on the use of locoregional therapy in patients with hepatocellular carcinoma.

I hope you find this issue interesting and informative.

Sincerely,

Gary R. Lichtenstein, MD, AGAF, FACP, FACG