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LETTER TO THE EDITOR

''Good clinical practice recommendations for the management of gastroesophageal reflux disease''. The PPI test paradigm

''Recomendaciones de buena práctica clínica para el manejo de la enfermedad por reflujo gastroesofágico''. El paradigma de la prueba con IBP

Dear Editors,

We have read the article by Valdovinos-Díaz et al.,[1] titled ''Good clinical practice recommendations for the management of gastroesophageal reflux disease. A Latin American expert review'', published in the *Revista de Gastroenterología de México*, with interest.

We want to specifically refer to Recommendation 3, which says: ''In patients with typical symptoms and no alarm features, we recommend a standard dose proton pump inhibitor (PPI) test for 2–4 weeks, and in cases of noncardiac chest pain, for 4–8 weeks''.

It is clear that this recommendation has been issued for years, including in international guidelines. However, with the emergence of eosinophilic esophagitis (EoE) in Latin America, we believe it is prudent to review the implications said recommendation has for the early diagnosis of EoE.

Reports state that 10–80% of adult patients with EoE present with heartburn and regurgitation, even when GERD has not been demonstrated through ambulatory esophageal pH monitoring.[2] The pathophysiology of the two entities is understood to be different, but reflux may play a role in the early stages of development of EoE. What is relevant is that the two entities have a different natural history and clinical outcome. In addition, 40–70% of patients with EoE have a clinical and histologic response to PPIs.[3] Their mechanism of action is different from that of acid suppression. PPIs may affect pathways involved in EoE inflammation, resulting in effects similar to those of topical steroids.

Therefore, the PPI test carried out in patients with heartburn, no previous diagnosis of GERD, and not taking known clinical risk factors of EoE into account, could mask half or more of the patients with EoE.

EoE is an uncommon disease in Latin America.[4] In comparisons with regions of high prevalence (the United States, Europe, and Canada), probable causes (genetic, environmental, cultural, etc.) have been discussed in other texts. However, low diagnostic suspicion due to a lack of knowledge of the disease, the absence of biopsy samples taken during endoscopies for food impaction, and maneuvers, such as the PPI test, that could lead to an under-diagnosis of the disease, could also be included.

We believe that PPI test administration should be cautiously evaluated in young male patients (20–45 years of age), with intermittent dysphagia, and especially those with an atopic background. Such patients would benefit more from upper gastrointestinal endoscopy with esophageal biopsy, providing them with an accurate diagnosis.[5]

Ideally, the impact of the PPI test on the diagnosis of EoE in Latin America should be measured objectively in a prospective study. Meanwhile, the currently published evidence on the pathophysiology and clinical and therapeutic characteristics of the two entities could reasonably be utilized as a basis for taking a different approach to the prevailing PPI test paradigm.

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Declaration of competing interest

The authors declare that there is no conflict of interest.

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Response to the letter to the editor: ''The PPI test paradigm''

Respuesta a la carta al editor: ''El paradigma de la prueba con IBP''

Dear Editors,

We appreciate the letter sent by Dr. García-Compeán and Dr. Jiménez-Rodríguez,[1] regarding the article ''Good clinical practice recommendations for the management of gastroesophageal reflux disease. A Latin American expert review'', recently published in the *Revista de Gastroenterología de México*.[2]

We are in complete agreement with the arguments expressed concerning eosinophilic esophagitis (EoE), an entity clearly on the rise, epidemiologically, and whose characteristics can be confused or overlap with those of gastroesophageal reflux disease (GERD). Even though there is no robust evidence with clinical trials, the hypothesis on the possible masking of EoE due to the empiric use of PPIs or P-CABs as a diagnostic test is a valid and relevant one, especially in populations with a low prevalence of EoE, as is the case in Latin America.[3]

As García-Compeán and Jiménez-Rodríguez point out, a number of patients with EoE may present with symptoms that are indistinguishable from GERD, and respond, at least partially, to treatment with PPIs, which can delay the definitive diagnosis of EoE. Nevertheless, we consider that the PPI test continues to be a useful diagnostic tool in selected clinical settings, as long as it is performed judiciously, taking into account the individual risk factors and clinical characteristics that may lead to an alternate diagnosis. We emphasize that the PPI test is indicated only in patients with typical GERD symptoms, heartburn, and regurgitation, in young patients, and when there are no alarm symptoms, such as dysphagia, food impaction, weight loss, anemia, or gastrointestinal bleeding. As we pointed out in our statement referring to GERD and EoE, we agree that in the presence of dysphagia, food impaction, a history of atopy, or atypical symptoms in young patients, the performance of early endoscopy, with esophageal biopsies, should be considered, before carrying out a therapeutic test with PPIs.[2]

We appreciate the valuable collaboration of the authors of this letter to the editor, for calling attention to EoE, a condition that should always be considered in the differential diagnosis of GERD. Likewise, these types of contributions bring to light the need for clinical trials that can clearly define the impact the use of a PPI test has on masking or delaying the diagnosis of EoE.

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