Scottish Society of Gastroenterology SSG

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Abstract Submission Form

TITLE	**Eosinophilic Gastroenteritis: a rare gastrointestinal disorder**
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ABSTRACT DETAILS:	
Background:	Eosinophilic Gastroenteritis (EGE) is a rare inflammatory disorder caused by eosinophilic infiltration of the gastrointestinal tract. Pathogenesis may involve a hypersensitivity response as patients often have a history of atopy. Clinical features are non-specific but can reflect the site (oesophagus, stomach, small bowel and/or colon) and depth (mucosal, muscular and/or subserosal layers) of infiltration including vomiting, diarrhoea, abdominal pain, obstruction and ascites.
Method:	We report the case of a 37year old Somalian female who presented with acute vomiting and profuse non-bloody diarrhoea on a background of crampy abdominal pain.
Results:	Examination revealed a soft, mildly tender abdomen with dullness at the flanks. Eosinophil count was initially 6x10^9/L rising to 21x10^9/L during admission. Work-up included stool for bacteria/parasites, Blood-Borne Virus and Tuberculosis screening. Computed Tomography showed features of oesophagitis, gastritis, proximal enteritis, distal colitis and moderate ascites. Bidirectional endoscopies found non-specific mucosal oedema and patchy erythema within the stomach and distal colon. Colonic biopsies, initially reported normal, were re-reviewed and felt to have a slightly higher than expected level of eosinophils within the mucosal layer. Abnormally high numbers of eosinophils were also found within Ascitic fluid. Following input from Haematology and Infectious Disease specialists, a diagnosis of EGE was made. Prednisolone 40mg daily was commenced and over 72hours eosinophil count dropped to 4x10^9/L with simultaneous resolution of symptoms. The patient was discharged on a reducing regimen (5mg/week) of Prednisolone with out-patient follow-up.
Conclusions:	This case highlights the challenges in diagnosing EGE and the need for a high index of clinical suspicion. Secondary causes of eosinophilia must be excluded. Diagnosis requires histological evidence of abnormal eosinophilic infiltration which may be missed with superficial endoscopic biopsies. In this case, subserosal involvement is likely as this can present with either ascites alone or with associated features mimicking acute gastroenteritis. Treatment may involve dietary restrictions if allergic precipitants can be identified. A tapering dose of Prednisolone (20-40mg) is often the mainstay of treatment with ~90% of patients responding. Relapse-rates following cessation of treatment are rare but can be treated with long-term low-dose (5-10mg) Prednisolone.
References:	Mori, A et al. Eosinophilic Gastroenteritis: Review of a Rare and Treatable Disease of the Gastrointestinal Tract. Case Rep Gastroenterology. 2013; 7(2): 293-298