proteins can be used as a marker of persistent CMA. The successful linkage of these peptides to a commercial matrix should enable the conduct of large prospective studies and simplify future diagnostic approaches.

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Topical viscous budesonide suspension for treatment of eosinophilic esophagitis

To the Editor:

Eosinophilic esophagitis (EE) is a clinical entity composed of marked diffuse esophageal eosinophilia and basal zone hyperplasia thought to be provoked, in at least a subset of patients, by food and/or aeroallergen exposure.[1,2] In parallel with other atopic disorders, the incidence of EE appears to be increasing.[3,4] Current treatment options for children are limited, and if steroid therapy is initiated for treatment, we routinely use a fluticasone metered dose inhaler (MDI) puffed into the oropharynx and swallowed as topical esophageal therapy.[5] However, we have encountered 2 patients who failed to respond to elemental formula and were unable, because of developmental problems, to perform the puff and swallow technique. We report here treatment of these 2 patients with an oral suspension of budesonide.

Patient 1 was a 6-year-old boy with a history of abdominal pain, failure to thrive, and vomiting since infancy, and developmental delay with isolated EE diagnosed in 2001. His allergic history was significant for allergic rhinitis secondary to cat, dog, and dust mite exposure as well as positive UniCAP radioallergosorbent testing (Pharmacia, Kalamazoo, Mich) for fish and milk. After upper gastrointestinal endoscopy (EGD) with esophageal biopsies demonstrating a maximum eosinophil count of 60 per high-powered field (HPF at 400× magnification), he was diagnosed with EE and treated with oral corticosteroid (prednisone 0.5 mg/kg daily) for 1 month. This resulted in resolution of esophageal eosinophilia with a maximum of 2 eosinophils per HPF on repeat EGD with biopsy. He was subsequently treated with omeprazole (Prilosec, AstraZeneca, Wilmington, Del) 10 mg twice daily and fluticasone (Flovent, GlaxoSmithKline, Research Triangle Park, NC) 220 mcg twice daily as topical esophageal therapy, but repeat EGD with biopsy after 6 months demonstrated a maximum eosinophil count of 50 per HPF. His therapeutic regimen was changed to elemental formula and fluticasone, but repeat EGD with biopsy demonstrated persistent esophageal eosinophils with a maximum eosinophil count of 74 per HPF accompanied by basal zone hyperplasia. He was referred to the Children's Hospital Eosinophilic Gastrointestinal Disorders clinic for further management of EE recalcitrant to usual therapy. At the time of his referral, he continued to have vomiting and poor weight gain, and his mother reported significant difficulty with the puff and swallow technique. He was placed on a regimen of twice-daily oral budesonide suspension (Pulmicort, AstraZeneca) 500 μg mixed with sucralose (Splenda, McNeils Nutritionals, Washington, Pa), a nonabsorbed sugar, to increase fluid viscosity, to be swallowed twice daily. After 3 months of therapy, repeat EGD showed a normal esophagus, and biopsies demonstrated complete resolution of both esophageal eosinophils and basal zone hyperplasia. In addition, his abdominal pain and vomiting resolved, resulting in increased appetite with documented

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weight gain. Eight AM cortisol was 13.2 mcg/dL (normal range for age, 3-15 mcg/dL) after 4 months of therapy.

Patient 2 was a 5-year-old girl with a history of developmental delay, abdominal pain, and RAST positivity for milk, egg, and wheat. EGD showed a normal esophagus, but histopathology of biopsies demonstrated maximal eosinophil counts of 40 per HPF and basal zone hyperplasia. She was placed on a hydrolyzed formula containing milk protein (Peptamen Jr, Nestlé, Glendale, Calif), omeprazole 10 mg twice daily, and oral cromolyn (Gastrocrom, Celltech Pharmaceuticals, Rochester, NY) 100 mg 4 times daily. After 12 months of therapy, repeat EGD demonstrated a pale, furrowed esophagus with maximum eosinophil counts of 94, 65, and 90 per HPF and diffuse basal zone hyperplasia in the distal, mid, and proximal esophagus, respectively. She was referred to the Children's Hospital Eosinophilic Gastrointestinal Disorders clinic for further treatment. Subsequent skin prick testing showed a positive response to her hydrolyzed milk protein–containing formula, and her diet was changed to elemental formula. After 2 months of elemental formula and oral cromolyn sodium, EGD was unchanged, with a pale, furrowed esophagus and maximal eosinophil counts of 100, 90, and 70 per HPF in the distal, mid, and proximal esophagus with diffuse basal zone hyperplasia. Her developmental delay precluded the use of a fluticasone inhaler device with puff and swallow technique. As an alternative, she received oral budesonide 500 μg (Pulmicort) mixed with sucralose (Splenda) twice daily as topical esophageal therapy. After 3 months of budesonide, she had improvement in her abdominal pain, and EGD revealed a normal-appearing esophagus with improved maximum eosinophil counts of 28, 20, and 5 per HPF in the distal, mid, and proximal esophagus and decreased basal zone hyperplasia.

Because long-term systemic steroid therapy can result in significant secondary side effects on growth and bone development, we opted for a topical steroid formulation that is easier to use in young or developmentally delayed children and does not require the use of a MDI inhaler. In one series, 15% of patients with EE had concurrent developmental delay.[6] Although treatment with anti–IL-5 mAb has been reported to be successful, this therapy is currently not approved for use in children.[7] In our experience, a viscous oral suspension of budesonide improved symptoms, resolved endoscopic abnormalities, and markedly reduced or eliminated esophageal eosinophils in 2 patients unable to use a MDI inhaler with a puff and swallow technique. As such, oral budesonide suspension warrants further investigation for the treatment of patients with EE.

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The cradle of IgE autoreactivity in atopic eczema lies in early infancy

To the Editor:

Patients with atopic eczema (AE) are frequently sensitized against a multitude of exogenous allergens and mount high levels of total serum IgE. A great variety of factors, among them cutaneous and gastrointestinal allergen exposure or bacterial and viral superinfections, are associated and are able to induce exacerbations of AE. AE and food allergy belong to those allergic manifestations that occur very early in childhood and frequently proceed to respiratory symptoms of allergy.[1] However, in many cases, it is not possible to identify clearly exogenous or endogenous factors that trigger the chronicity of the disease.

The idea that mechanisms of autoimmunity could also play a role in the pathogenesis of AE gained support by the observation that patients with AE display IgE reactivity to a variety of human protein antigens, of which several have been characterized at a molecular level.[2] The spectrum of IgE-reactive autoantigens seems to be very broad and includes proteins with structural similarities to exogenous allergens such as plant profilins, dog serum albumin, mold-derived manganese, superoxide dismutase, and genuine autoantigens.[2-6] The presence of autoreactivity seems to be associated with the severity of the disease