

^fDivision of Allergy and Immunology, Department of Pediatrics, Cincinnati Children's Hospital Medical Center, University of Cincinnati College of Medicine, Cincinnati, Ohio

^gDepartment of Pediatrics, Gastrointestinal Eosinophilic Diseases Program, Section of Pediatric Gastroenterology, Hepatology and Nutrition, University of Colorado School of Medicine, Aurora, Colo

^hDigestive Health Institute, Children's Hospital Colorado University of Colorado School of Medicine, Aurora, Colo.

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Corresponding author: Amanda B. Muir, MD, MSTR, Division of Gastroenterology, Perlman School of Medicine, University of Pennsylvania, Abramson Research Center, 3615 Civic Center Blvd 902E, Philadelphia, Pa 19104-6160. E-mail: muira@email.chop.edu.

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Reply to "Do rural health disparities affect prevalence data in pediatric eosinophilic esophagitis?"



To the Editor:

We thank Sabet et al¹ for their interest in our study² and for their insightful comments. The authors note the discrepancy between our findings and previous studies with regard to the prevalence of eosinophilic esophagitis (EoE) in rural communities, because we found that EoE is less prevalent among children living in rural America. We agree that the data are consistent with the authors' hypothesis that this could be due to decreased access to care among children living in rural areas. We further agree that poverty within rural communities could also have a role, because parents, particularly those enrolled in Medicaid, may be unable to afford

the costs associated with travel to subspecialty care or procedures necessary to diagnose EoE. Our results showing that the prevalence of EoE is lower in areas with greater neighborhood-level poverty support this hypothesis and suggest that rather than truly being less prevalent, EoE may be underrecognized or underdiagnosed in these communities.

We also agree that we should be cautious about conclusions regarding the epidemiology of EoE when basing it on studies using administrative data, pathology databases, or cohort studies at tertiary care centers. These methodologies have poor sensitivity³ and only account for those who present for medical care; therefore, they may not capture the full spectrum of disease. For example, our study and others consistently report that EoE is more common in non-Hispanic Whites. This is contrary to the epidemiology of other allergic diseases, in which the prevalence and/or morbidity is higher in patients of Black race/ethnicity.⁴ This may be the result of underlying genetic determinants of disease, but it also suggests possible underdiagnosis of EoE in non-Hispanic Black patients. Future studies designed to screen large populations at risk for EoE would give us further insight into the clinical predictors and phenotypic variability of this disease in the community.

Finally, although we agree that increasing access to subspecialty care is an important step to mitigate this likely health disparity, the development of a safe, inexpensive, and accessible tool to accurately diagnose patients with EoE is another critical unmet need in this field. Whereas noninvasive techniques such as the esophageal string test,⁵ the Cytosponge,⁶ and transnasal endoscopy⁷ are starting to be used to detect esophageal eosinophils in academic centers, they are not widely available for the practicing physician. Many patients with EoE have symptoms for years prior to their diagnosis, which increases the risk for fibrostenotic complications, leading to decreased quality of life and increased resistance to available therapies. Thus, a safe and accessible diagnostic tool could assist providers in identifying and treating patients at risk for EoE early in the course of disease, before the development of these fibrotic complications.

Emily C. McGowan, MD, PhD^{a,b}

Joshua P. Keller, PhD^c

Evan S. Dellon, MD, MPH^d

Roger Peng, PhD^e

Corinne A. Keet, MD, PhD^f

^aDivision of Allergy and Immunology, University of Virginia School of Medicine, Charlottesville, Va

^bDivision of Allergy and Clinical Immunology, Johns Hopkins University School of Medicine, Baltimore, Md

^cDepartment of Statistics, Colorado State University, Fort Collins, Colo

^dDivision of Gastroenterology, University of North Carolina School of Medicine, Chapel Hill, NC

^eDepartment of Biostatistics, Johns Hopkins Bloomberg School of Public Health, Baltimore, Md

^fDivision of Pediatric Allergy and Immunology, Johns Hopkins University School of Medicine, Baltimore, Md.

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Corresponding author: Emily C. McGowan, MD, PhD, Division of Allergy and Immunology, University of Virginia School of Medicine, PO Box 801355, Charlottesville, VA 22908. E-mail: ekc5v@virginia.edu.

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