

Table 1. Reflux pattern differences between POEM and LHM. p-value significant if p<0.05

Characteristic	POEM	LHM	p-value
TOTAL			
Number of refluxes /24h	40.0	15.4	< 0.001
Percent time in reflux	9.3%	3.2%	< 0.001
Number of long refluxes /24h	4.0	1.7	< 0.001
Average of longest reflux (mins)	45.7	19.0	< 0.001
UPRIGHT			
Number of refluxes /1h	1.8	0.6	< 0.001
Percent time in reflux	7.8%	2.6%	< 0.001
Number of long refluxes /1h	0.18	0.06	< 0.001
Average of longest reflux (minutes)	19.0	9.9	< 0.001
SUPINE			
Number of refluxes /24h	1.4	0.5	0.003
Percent time in reflux	10.1%	3.5%	< 0.001
Number of long refluxes /1h	0.2	0.1	0.001
Average of longest reflux (minutes)	35.8	12.4	< 0.001
OVERALL			
DeMeester Score	37.2	13.2	< 0.001
% Time reflux in supine/upright >1	41.1%	21.7%	0.007

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Provider Beliefs, Practices, and Perceived Barriers to Dietary Elimination Therapy in Eosinophilic Esophagitis

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Introduction: Physicians prefer to use medications for eosinophilic esophagitis (EoE) even though elimination diet is an effective treatment with growing interest among patients. The beliefs, practices, and barriers that surround this clinical practice are unknown. We aimed to describe provider practice patterns around dietary approaches in EoE, and identify beliefs about, perceived barriers and needed resources to support diet therapy. (Figure)

Methods: We conducted a cross-sectional web-based survey of providers to assess the perceived effectiveness and barriers to starting dietary therapy, as well as practice patterns.

Results: Respondents included a primary cohort of gastroenterologists (n=94) recruited from professional societies and a secondary validation cohort of Medscape provider members (n=195; 76.9% gastroenterology, 23.1% allergy) with comparable spread across various practice settings, geographic regions, and access to dietitian support. Dietary therapy was viewed as the least effective short (46.8%, p ≤ 0.01) and long-term (49.5%) treatment compared with topical corticosteroids (74.3%) and proton pump inhibitors (56.5%). The greatest barrier to recommending or starting diets in EoE was the perception that patients are not interested in, unlikely to accept, or adhere to diet therapy (58%). In contrast, few providers (14%) felt that their own lack of knowledge and experience in the diet was a barrier. While the majority of providers reported that dietitians should be primarily responsible for diet-focused education, private practice providers have less access to dietitians (55.6% vs 84.6%, p ≤ 0.05) and are more likely try to manage dietary therapy alone compared to providers in academic centers. (Table)

Conclusion: Providers often lack dietitian support and prefer using medications because of a perceived lower efficacy and beliefs about patient acceptance and adherence to dietary therapy. With growing evidence that patients with EoE do accept dietary therapies and value shared decision making in electing treatments, our findings highlight discordances between provider and patient preferences, incomplete communication, and potentially unrecognized provider knowledge gaps. Given the dearth of approved medications for EoE, educating providers with evidence-based knowledge about non-pharmacologic options, understanding patient views and preferences for treatment, and improving dietitian-led education are essential in providing high-quality EoE care.

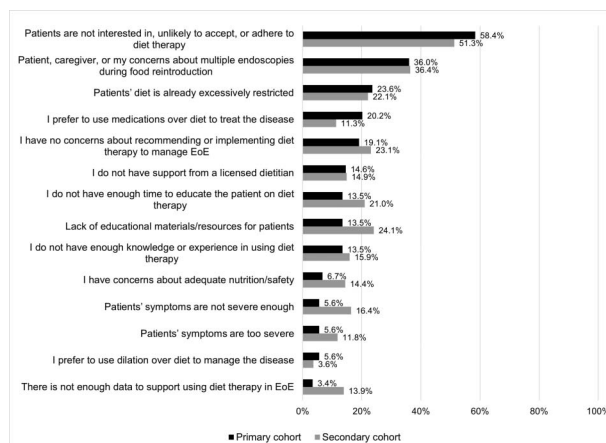
[O415] **Figure 1.** Barriers to recommending or starting EoE dietary therapy

Table 1. Overall provider characteristics

		Primary cohort		Secondary cohort	
Provider type	GI Allergy	94 0	70 (80.5%) Faculty/staff 10 (11.%) APP 5 (5.8%) Trainees	150 45	153 (78.5%) Faculty/staff 23 (11.8%) APP 19 (9.7%) Trainees
Practice setting	Private Academic VA Military/govt Hospital-based		43 (53.8%) 26 (32.5%) 0 (0.0%) 0 (0.0%) 11 (13.8%)		113 (64.2%) 34 (19.3%) 3 (1.7%) 3 (1.7%) 23 (13.1%)
Location	Northeast Midwest South West Undisclosed		15 (16.0%) 20 (21.3%) 26 (27.7%) 22 (23.4%) 11 (11.7%)		30 (15.4%) 29 (14.9%) 52 (26.7%) 46 (23.6%) 38 (19.5%)
Patient volume (number of EoE patients annually)	None 1-5 6-19 20-50 > 50		0 (0.0%) 5 (5.8%) 43 (49.4%) 25 (28.7%) 13 (14.9%)		1 (0.5%) 10 (5.1%) 36 (18.5%) 74 (38.0%) 74 (38.0%)
Patient population	Adults Children Both		62 (71.3%) 16 (18.4%) 8 (9.2%)		96 (49.2%) 15 (7.7%) 84 (43.1%)
Access to dietitian			58 (66.7%)		131 (67.2%)

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Degree of Ineffective Peristalsis Does Not Affect Frequency of Gastroesophageal Reflux, but May Facilitate More Proximal Reflux Events*Christy Chon, MD¹, Michael S. Smith, MD, MBA².*¹Icahn School of Medicine at Mount Sinai Morningside-West, New York, NY; ²Mount Sinai Morningside and Mount Sinai West Hospitals, New York, NY

Introduction: Chicago Classification v4.0 (CC4) describes more stringent criteria for Ineffective Esophageal Motility (IEM), in order to identify patients with clinically significant dysmotility. IEM is a common finding in patients with gastroesophageal reflux disease (GERD). The aim of this study was to evaluate whether patients meeting CC4 IEM criteria also have more severe reflux, as defined by worse outcomes on 24-hour multichannel intraluminal impedance-pH testing (MII-pH).

Methods: A total of 684 patients undergoing GERD evaluation with MII-pH at a single high-volume center between 2019-22 were identified. Patients were included only if they had a diagnosis of either no CC4 abnormality or IEM based on either Chicago Classification v3.0 (CC3) or CC4. For the analysis, patients were divided into three groups: 50-69.9% ineffective swallows (CC3-only IEM), 70-100% ineffective swallows or at least 50% failed swallows (CC4 IEM), and no CC3/CC4 diagnosis (Controls). Demographic data and MII-pH results were collected and analyzed.

Results: Of 153 patients that met criteria, 29 had CC3-only IEM, 98 had CC4 IEM, and 26 were Controls. Age, gender, body mass index and tobacco/alcohol use were similar among groups. The mean total number of normalized reflux events actually was higher in the CC3-only IEM group (66.9) than for CC4 IEM (49.5) and Controls (51.9), but this was not significant ($p=0.61$ between all groups, $p=0.91$ between CC3-only IEM vs CC4 IEM). The mean number of proximal reflux episodes was higher for CC4 IEM patients (18.9) than CC3-only IEM patients (9.3) and Controls (6.3), though this also did not reach significance ($p=0.23$). Both acid exposure times (AETs) and DeMeester scores were higher in IEM patients compared to controls, but the differences also were not significant (Table).

Conclusion: The degree of ineffective peristalsis did not affect the overall number of reflux events seen on MII-pH. This finding is expected, as peristalsis is not thought to be involved in the generation of a reflux event. A trend toward more proximal reflux events in patients meeting CC4 criteria suggests a higher degree of esophageal dysmotility increases the likelihood reflux events are not cleared effectively, and therefore have a greater opportunity to move retrograde. Extended refluxate exposure may predispose to worsened symptoms. Future studies focusing on refluxate exposure times and symptom correlation may provide significant conclusions leading to improved care of these patients with dysmotility.

Table 1. Demographics and 24-hour Multichannel Intraluminal Impedance-pH Testing Parameters By Chicago Classification

	Control	CC3-only IEM	CC4 IEM	p-value (all groups)	p-value (CC3-only IEM vs. CC4 IEM)
Subjects (N%)	26 (17%)	29 (19%)	98 (64%)		
Age (mean, years)	49.5	46.4	46.7	0.68	
Gender				0.62	
Male	14 (54%)	12 (41%)	44 (45%)		
Female	12 (46%)	17 (59%)	54 (55%)		
BMI (mean, kg/m ²)	28.8	27.0	28.4	0.32	
Tobacco Use				0.46	
Never	21 (81%)	22 (76%)	65 (66%)		
Former	4 (15%)	6 (21%)	28 (29%)		
Current	1 (4%)	1 (3%)	5 (5%)		
Alcohol Use				0.1	
Never	7 (27%)	19 (66%)	48 (49%)		
Former	8 (31%)	3 (10%)	11 (11%)		
Current	11 (42%)	7 (24%)	39 (40%)		
Distal AET (%)	0.44	3.02	3.82	0.08	0.32
DeMeester Score	2.77	12.63	16.46	0.26	0.94
Mean Number of Proximal Reflux Events	6.29	9.33	18.88	0.23	0.27
Mean Normalized Total Number of Reflux Events	51.86	66.92	49.46	0.61	0.91

CC3- Chicago Classification v3.0, CC4- Chicago Classification v4.0, BMI- Body Mass Index, AET- Acid Exposure Time