

Dr. Mariam Hanna

Hello, I'm Dr. Mariam Hanna , and this is the Allergist, a show that separates myth from medicine. Deciphering allergies and understanding the immune system. Food, it's integral to so much that we do, whether it's sustenance, celebration, or social.

Food is so much a part of our everyday. We get heavily involved in this relationship when we diagnose food allergies. We have patients that develop intolerances. And then there's others that have negative associations with food and maybe just some anxiety. Is it fear? A food allergy? An intolerance? Or none of those and I need a gastroenterologist.

I have this patient that sticks out in my head, was panel tested to many foods very early on in her life. She had a very restricted diet. No milk, no egg. And no nuts. Lots of problems eating food and trouble gaining weight as you could imagine. I saw her actually for food immunotherapy, but here's the thing.

Her skin tests were totally negative. Her blood work was also negative. I thought I was being a good pediatric allergist by doing a celiac screen because of her weight gain.

Abdominal symptoms as well, I would have to say. And somehow it came back positive. So now you have this positive celiac screen and I made a referral to GI for further assessment.

Now guess what? Here's the kicker on this whole story. Biopsy turns out she has EOE and not celiac disease.

Seriously? I'm not joking. I was actually utterly confused and so glad to just be an allergist and be able to call my fellow gastroenterologist.

So over these years, we've gone through this series of food challenges with her for her food allergies, but also perhaps to remove the trigger food that's fueling her EOE. Her story sticks out and makes me respect a lot having subspecialists that are also involved in food allergies to help us with our assessments and our management. I've learned in the evaluation in food allergies a trick over the years.

I'm an expert in IGE mediated food allergies and I have a good nose for sniffing out what may need to be evaluated by a friend like a gastroenterologist. Today, I'm especially excited to be able to reach out and invite a friendly gastroenterologist for our discussion on the slew of presentations that may come to my office, but help us in understanding how to differentiate and point patients onto the right path.

It's my absolute pleasure to introduce today's guest. Dr. Vish Avinashi is a Pediatric Gastroenterologist and Clinical Associate Professor in the Department of Pediatrics at the University of British Columbia, based at BC Children's Hospital in Vancouver. His clinical and

research focus centers on complex gastrointestinal conditions in children, particularly eosinophilic esophagitis, where he explores its diagnosis, management, and links to food allergies. Dr. Avinashi co-directs the EOE clinic and contributes to the complex feeding and nutrition service. Sounds like exactly the right guy I need to talk to.

Reflecting his commitment to multidisciplinary and patient-centered care, he is the head of the division and an active clinical investigator. He's okay to be actually called the poop and vomit doctor. I don't know.

As long as you also specify it's actually for kids. Dr. Avinashi, thank you so much for joining us today and welcome to the podcast.

Dr. Vishal Avinashi
Thank you so much, Mariam.

Dr. Mariam Hanna
We're going to start out with a condition that I think popped out over the past decade.

We didn't have a name for it when I graduated initially. So it goes by the name ARFID and I'll let you explain it. But what is ARFID?

A-R-F-I-D.

Dr. Vishal Avinashi
Thank you. Yes. So this is something that's evolved in our careers.

And the ARFID stands for Avoidant Restricted Food Intake Disorder. Now, it actually has a good name because it really is descriptive of people who don't want to eat. They're very rigid on what they eat.

And typically it relates to the intake. So not enough going in. So it's well beyond the failure to thrive.

And appropriately, it's come up with this nomenclature through the DSM, which we all know is the psychiatric diagnosis. So it is within the category of eating disorders. And what, of course, makes it different is it has nothing to do with body image, shape or size, but how problematic the process of eating is.

In fact, there's like, if you want a fancy medical term, you can call it food neophobia, which means like ultimately, they're like it actually scares them to see or touch or even be involved with trying a different food. These are also the kids that may have had something happen to maybe they had a small choking episode and thereafter they refuse to try anything.

And this is something that although there's no test, I have to prove it. We know that through whether it's neurochemical imbalances, different functional MRI type studies are different parts of the brains that normally light up with food. These kids do not get driven or in fact, they get driven in the opposite way there's fear signals with eating where most of us have enjoyment or dopamine or whatever, especially with our food.

And so really, this only standard therapies are not pharmacological, they're really cognitive behavioral therapy, there are specific types, there's even some ARFID specific therapies, and believe it or not, even family therapies, because often it's so tense, and emotionally laden, that ultimately, you have to work with them. So if you're older, you can even, I know, it depends on your site and your center, you can work with psychologists, counselors, well, I'd say more psychologists, behavioural therapists, and the younger kids often as OTs, speech language pathologists who can really work and play with food.

It doesn't mean you give up on them, there is treatments and counselings and therapies you can go to, but getting towards there so that you're not leaving it in your medical clinic as in next specialist, next specialist, yeah.

Dr. Mariam Hanna

That's very helpful. Is there a particular age or demographic that's most prone to ARFID?

Dr. Vishal Avinashi

We do think it's more common in younger, but it's also harder to differentiate in infants, preschoolers, at the early stage of what's a toddler type thing versus a true problematic thing. So it becomes more clear with age and time. Boys are actually described to be more likely to affect it.

And then those prone to anxiety or obsessive-compulsive may be more likely to have that. But otherwise, we really don't know. And many of these kids are in every other way, socially, developmentally very normal.

It's just the foods that turn them off, yeah.

Dr. Mariam Hanna

I love these like new diagnoses that come during my time in my career, because then I'm like, what, we didn't have this before? But you're very good in saying it now just has a label. These patients were always there, but it has a good name that describes what's happening, and now there's tools and resources that we can point them to.

Okay, back to my training years. When I was training, I also learned about how long it takes us to finally get a proper diagnosis of celiac in patients. And I remember learning like it would take a whole decade of having symptoms before you finally got appropriately diagnosed.

Is that still the case today? Like, what are common pitfalls in diagnosing celiac?

Dr. Vishal Avinashi

I'd like to think we're doing better. I can comment that the sensitivity and specificity of our screening tests, particularly the TTG tissue transglutaminase is improved without a doubt. And I think the threshold is getting less and less to even check.

I think we used to almost wait for the wasting, the failure to thrive, the thin kid with diarrhea, then we're like clueing in. But I think there's so many presentations. In fact, it's almost an overly extensive list of conditions and symptoms now associated with celiac disease.

So I also think just the general knowledge that it's 1% of the population. So you're not wrong to be ordering TTGs on pretty much anybody with GI symptoms and sometimes not even GI symptoms like iron deficiency and other things.

So although I think we're better at looking at it, I think I'm going to add a couple things. I think the pitfall, number one, is while the test is better, a minorly positive test does not equal celiac disease still. Okay.

So you all have your upper limit of normal, whether it's 12 or 20 depends on the type of test you do. But as much as it's a better test, the gold standard still remains the endoscopy. So we have shifted and adopted some criteria even that were validated in Europe to say if you have 10 times the upper limit of normal times two readings that's 95% chance you have real celiac.

And that's why sometimes people are choosing and with guidance and appropriate information to not go for the biopsy. But I'd still say that's a big pitfall, to make sure if your level is coming back at 21, there's still probably just as high a chance you don't have celiac than you do. And people are making some pretty big decisions based on that.

So I think that's really important. In my pediatric lens, the other pitfall, I would say, there's no such thing as being too young to get a diagnosis other than, like, less than six months where they haven't had exposure. But a lot of people say they're two, you can't have a scope, they're too young for that.

That's not true either. And even the accuracy of the testing for those infants is better than it's ever been. And then I think the other one I would say is people who are screened, maybe this is your patient where there's kind of questions of the validity of they don't have the right profile of symptoms.

It doesn't matter. I mean, in the sense that we are picking up now even asymptomatic one, which is what ties into your next questions about screening, and you still have to follow up and treat celiac in the same way and be as strict. So the patient who eats one little sliver of gluten and say, oh, this definitely has been a cross contamination or whatever, versus the person who eats two, three pieces of pizza feels fine.

The weirdest thing, we don't understand that phenotype connection in the sense that both can have celiac, but they have different thresholds of having symptoms. So that was about the kind of pitfalls. So hopefully that answered your question.

Dr. Mariam Hanna

Wait, hold on. Now it's stirred up more. See, this is the problem.

I have a lot of very aware families that start a gluten-free diet or they're like, we're gluten light. How much gluten does one need in their diet before blood work can show an appropriate positive?

Dr. Vishal Avinashi

That's a good question. So, yeah, this is another area of pitfall of like, are you taking enough gluten to actually see the changes? And will they symptomatically tolerate that? And we do get into some tricky situations where we say if they've gone all the way to the point where they're off, we do say for our gluten challenge, typically at least one serving of gluten a day, which, again, I know most people don't think that way, but that'd be the equivalent of a piece of bread per day for a couple months before we should be seeing the changes.

Dr. Mariam Hanna

A couple months? Oh, wow.

Dr. Vishal Avinashi

Months. So then that's to get your accuracy up. Now, again, what if somebody can't tolerate that?

That's where you get into tricky situations. But if the TTG maintains high up on even less, then it's still accurate. But if it's normalizing when they're on, they can't take more, then sometimes you have to kind of go for the presumptive diagnosis.

But it may not be the black and white gold standard diagnosis.

Dr. Mariam Hanna

See, so many pitfalls still, but we're getting earlier in the time of diagnosis, so I guess that's okay.

Dr. Vishal Avinashi

I think so, yeah.

Dr. Mariam Hanna

Okay, so what's the role or guidance on screening for first-degree family members in celiac disease?

Dr. Vishal Avinashi

Okay, so now we've gone through and gotten the diagnosis. It is to screen first-degree relatives. I usually do that after the patient's been confirmed.

And just to give you an idea, I'd mentioned the general patient population, as 1% of people have celiac. In a core family member, you have as high as 10%. So it really is a worthwhile screen.

It's very unpopular. Usually the parents are quick to get screened. The asymptomatic siblings are very hesitant.

Dr. Mariam Hanna

And how frequently do they need to get screened or re-screened for celiac disease? Is it one and done, or is it a repeat test?

Dr. Vishal Avinashi

Great question. So that's not really in the guidelines, meaning we know that ultimately it's a cross-sectional test, right? So the genetics is not really helpful because typically it's positive, and the positive HLA testing won't mean that you're going to get it.

You're at risk, like a third of the population is. But I would say one and done unless you have symptoms is kind of my approach. But I'm sure if you surveyed other gastroenterologists, it'll differ, right?

So I think it's too much of a stress burden to say every two years for life, you have to wait because it almost seems like it's an inevitable in that situation. But yeah, I think once and then keep a low threshold for testing again if there's a change in clinical status.

Dr. Mariam Hanna

Perfect. Now, I've learned over the years that I'm also only as good as the history and the stories I get off my patients. And they often tell me that they're like a, non-celiac gluten sensitivity, Dr. Avinashi. I don't even know that that's a diagnosis. But anyways, they have non-celiac, but they're gluten sensitive. How do you approach these patients diagnostically or therapeutically?

Dr. Vishal Avinashi

So this is a tough one. I ultimately like the word sensitivity because I say this is a diagnosis for you as the patient to make. I'm not there to give you the diagnosis.

That's based on what you're telling me. Means you feel fantastic when you're on gluten, or sorry, off gluten and really rotten when you're on gluten. But my screening tests are normal. So I've turned it as a positive, at least you don't have a lifelong autoimmune condition.

You know, there's probably a certain threshold that which your body's less happy with it, but you can figure that out on your own. So I really turn it back to them and say, this is your diagnosis to make. And I like that term sensitivity.

I think it validates that it's not in their head. And like, how come I can't explain, maybe one day we'll have a better test, but currently we don't. But if it makes them happy to have that diagnosis, it's just really important to clear that it's not celiac.

And if you feel better off gluten, knock yourself out.

Dr. Mariam Hanna
I love that.

Okay. We're going to move along to functional GI disorders. Do you see how excited I am that you said yes to this podcast, Dr. Avinashi?

I really appreciate this. Okay. IBS and bloating.

Okay, let's talk about it.

Dr. Vishal Avinashi
I've never heard someone so excited about bloating and IBS. Even the gastroenterologists, we roll our eyes sometimes on this topic. But all right.

I love it. I'm so glad, Mariam.

Dr. Mariam Hanna
Well, they land in the allergy clinic and not IGE mediated, but food is often suspected. How do you guide clinicians in distinguishing this from other immune mediated conditions?

Dr. Vishal Avinashi
Good question. So, I typically, even on my review of systems, don't ask much about bloating in the sense that it's not something I get excited about. It's fine as OK, you have belly pain and bloating and change in your stools.

That's the picture we're usually seeing. Same as belching, same as mucus. These are like almost not noteworthy from the gastroenterologist's side.

But again, these are big complaints from the patient's perspective. Even sometimes I'll talk about the change in stool color and I kind of boil it down to the ones I need to know. Is it white, black, red or maroon?

And about that, not really interested in the colors, but they'll still tell you a long story and even show you pictures and bring a diary. And ultimately, I think the things that we need to do is make sure it's not celiac, as we talked about in our previous little questions. I think that's something that is very reasonable and all IBS patients should be screened for that.

I do think when it's diarrhea dominant, there is the reasonable responsibility to rule out Crohn's, colitis or inflammatory bowel conditions. And these days it's easier than before in the sense with our fecal calprotectin test. It's quite good.

There is some new guidelines related to IBS. And I think what's cool is even there's less, you probably get asked about FODMAP diet. So that's like the foods that produce more gas.

And often asked about panel testing, I think the new guidelines actually focus dietary interventions less. So still focusing on exercise, keeping yourself busy, cognitive behavioral therapy again. And like even now the term is gut related hypnosis.

And that actually is the highest level of evidence for any intervention in the IBS world. So yes, we still use some of our supportive medications, but it actually deemphasizes that. And you know, what's really cool, Mariam, this now the other most evidence based intervention is actually something we're not even doing in Canada at this point.

It's related to nerve stimulation.

And interestingly, that has been shown to modify pain and GI symptoms the most. So it's really kind of very different than what we're used to. But it's really nice that we're, yes, it's still our basic same understanding, but that's kind of like where I actually see some new excitement advancements for our disorders of gut brain interaction. So chronic pain and dyspepsia and IBS. And so I think you'll be hearing a lot more about it in months and years to come.

Dr. Mariam Hanna

That's very exciting. And I always appreciate learning new terms, disorders of gut brain interaction, and I'm leaving away my functional GI disorders. I'm getting with the lingo.

OK, I want to move to the buzz around microbiome next,

So are there any interventions that you find right now with the evidence that we have clinically meaningful?

Dr. Vishal Avinashi

There is a link I do like fundamentally being a GI specialist, I think it's our second brain. And I think there's a lot of interaction crosstalk between the microbiome and our health state. And that's interestingly, now it's not even just gut conditions, as you know, it's linked into obesity, it's linked into psychiatric conditions.

And there's no end to the associations and descriptions of how the pattern of the microbiome differs in disease versus non-disease patients. So there is something to it. What I'll still say is we're at our infancy in truly understanding what to do and how to intervene in a sustainable way.

So keep in mind, if you changed your diet, and ate a high fat diet, that you change your flora and your microbiome just by that alone. So it's not just I know people think a lot about probiotics and what can I take to modify it.

We also do think there's a relatively steady state. And yes, you can take tons of probiotics, and yes, millions or billions, and billions have got to be better than millions. That's not always necessarily true.

But typically, when we stop, we do think it sets backwards. And I think that's the hard part where we're not really understanding how to make that sustainable change. There's reasonable evidence, Mariam, for probiotics and even certain things like, for example abdominal pain, colic, antibiotic-associated diarrhea.

Actually, even in kind of an allergy-related, like what I call cow milk protein allergy, but you might call F-PIPs or food protein-induced proctocolitis, that bacteria have shown to do good. But it's really hard to know which strain, the amount, how long. I usually refer patients to a really useful resource, and it's meant more actually for clinicians, but it's called probioticchart.ca. Have you heard of that one?

Dr. Mariam Hanna
No, I haven't.

Dr. Vish Avnashi
It's awesome. Check it out. But we still got to be humble in the sense that it's not so easy as you give a probiotic, you're done and you're cured. So more to come.

Dr. Mariam Hanna
More to come and a great evidence-based resource.
Okay, I want to actually move ahead with eosinophilic esophagitis because this is a condition that's big for you. And I really want to get your input on this. So EOE really represents a major overlap between where GI and allergy often have a lot of crosstalk on it.

What do you see as being kind of the most important updates in how let's first with how it's being diagnosed?

Dr. Vishal Avinashi
All right, so we are still yeah, I totally agree with you, Mariam. This is an overlap condition. What diagnosis wise, we're still stuck with probably more people out there having this condition that don't even know they have it.

So it's still an increased job to increase awareness. I don't think we're any cooler with the tools that we have. Unfortunately, we're still stuck with having patients come for endoscopy.

And it takes a whole process. We know the delay to diagnosis is often a couple years at least, partly because people adapt to their symptoms, partly because nobody's heard of this less sexy name that they can't pronounce. So ultimately, and we also deal with a lot of I'm included in the party being a man of stubborn men who don't want to go to see the doctor.

So I think a lot of those factors make it hard to increase the diagnosis, but yet still are seeing more and more common. And the incidence and prevalence are really increasing.

Dr. Mariam Hanna

Are there situations where you would advise against dietary eliminations?

Dr. Vishal Avinashi

For sure. So in general, as you know, we try to do the kind of group council of here are all the options and get a patient-centered input in which one do you prefer to do. So a few circumstances where I'll skip diet altogether.

To be honest, if a patient's already presenting with severe symptoms and a stricture, I say, if you want to talk about diet, we'll do it later. But let's use meds right now. And maybe when things are settled and there's no longer a narrowing, then we can come back to the diet.

This one's not an absolute, but I have to say when it's only the parents saying they'll do the diet intervention and, oh, we can do that and he'll do it, don't worry. I say he because the teenage boy is not at the appointment. He's at some soccer practice.

And I say, no, I need to hear from the kid himself that they're willing to do that. So I know that's a very pediatric specific example. And then ultimately, I think it's one of those things.

If they have numerous IgG anaphylactic conditions and we're worried about their intake or their weight's relatively low because already they're quite restricted, I'm very cautious. I'll mention that the approach, but I'll tend to persuade them towards medications. And I think that's something that our allergist hearers support that, especially knowing that they're already battling other things.

And sometimes if you eliminate very strictly, you may be setting yourself up for other anaphylactic type reactions. So I think those are circumstances. One, the stricture is the absolute one.

There's some other relative ones. The other comment I don't do, this is a dietary intervention, but I don't do elemental formula. I don't do ever more than six.

In fact, I barely, we usually are kind of one or two foods to start. And that's where I skew it. Now, if they really want to do four, I'm not going to stop them.

But as you know, there's very little control we can have on patients' dietary implementation. But I try to say really go for gold. And I'd rather you do one or two foods really well than try to do so many and find a non-sustainable treatment option where they'll say, I can't even make it to the scope.

Well, if you can't make it to the scope for re-evaluation, it's probably not something you could do long term.

Dr. Mariam Hanna

Right. It's probably not sustainable.

Dr. Mariam Hanna

Okay, I remember the first scope that I got back the results where it said fibrosis, and I panicked because I hadn't for the longest time seen EOE, as a comment, having fibrosis. And then I was like, oh my gosh, do they all progress to fibrosis?

Dr. Vishal Avinashi

Yes, so I think there's two parts to the fibrosis. One is your biopsy, while your gastroenterologist got a biopsy that's deep enough to get probably the submucosa, and that's where they saw the fibrosis. That's actually not uncommon.

In fact, it mostly comments that previously you probably aren't getting to the depth. So if you did a follow-up and didn't have it, it doesn't mean it's not there. So I do believe while we are able to monitor the true mucosal level, there is likely a chronic inflammatory component, and over time, that's fibrosis.

I think that's what's relating to your trachealization or your rings you get to your strictures. And I think in the many early years, I think all that fibrosis is completely reversible with our standard treatment. I think most people think fibrosis is there for life, and what we're seeing on the scopes is those can go away with your appropriate histologic remission.

And so I think one of the mindsets that's bigger than just monitoring the mucosa is maybe there'll be these adjunct tools. I don't know if you've ever heard of EndoFlip. It's another cool technology thing, but it actually will tell you.

It's something you can play. It's like a tube, a balloon that can be placed during endoscopy, but it'll actually tell you about pressures at different points, as well as if there's any pinching. And that's the type of thing.

It talks about the distensibility. And that's actually a really useful metric that you can't just appreciate by looking under the microscope. So I think the fibrosis that develops does influence even how it stretches or the motility or how coordinated things are.

But the most dreaded consequence or side effect is the stricture, and I think that is, quote-unquote, scar tissue. So I think it's important to know that it's not game over. You still have an opportunity to deal with the active inflammation, and this is one of the reasons we want to be relatively proactive and at least advocate for some maintenance therapy and not just let me know when things are really bad.

Dr. Mariam Hanna

Fair enough. And the challenge in these discussions is that we often have the parent in the room who likely has EOE, but has never been diagnosed, and says, well, I'm fine, so why is it such an issue for this younger generation? So are there different subtypes of EOE that you guys describe, or how do you respond?

Dr. Vishal Avinashi

Really good question, Mariam. So ultimately, I think because we've never had a scope, most likely, we don't know what they have going on. But I think what we'd say is if we control the inflammation, we know we can prevent food bolus impactions and need to come for emergency things.

To the parents' point, I think some of our data is saying okay, if you don't do anything within 20 years, 80% will have narrowing. I think there is a bias in many of the retrospective studies to represent the more severe patients.

So, I do say look, at the end of the day, I describe this as a chronic condition. I can't tell you if Johnny's going to be the guy who's going to have repeated strictures, but there's a lot we can do to avoid getting there. And it can change the way your relationship is with food and eating.

We know there's not a great association between how bad symptoms are with the disease activity.

And that's why I say, well, let me just be part of your journey. And I want to be there to monitor the condition with you.

Dr. Mariam Hanna

Fair enough. All right, time to wrap up and ask today's gastroenterologist, Dr. Vish Avinashi, for his top three key messages to impart to patients and physicians on today's topic, gastroenterology potpourri. That's what I'm calling it, potpourri.

Dr. Avinashi, over to you.

Dr. Vishal Avinashi

Okay, so I got three top takeaways. Number one, get to know your local GI doc, I know this is obviously targeted at the allergist, and develop a relationship. So of course, you can send referrals back and forth saying, pet skin panel is negative or scope is normal. But ultimately,

your conversation, especially for this overlap type condition, especially EOE, OIT, you're going to do a lot better.

So I know it's hard sometimes, but certainly work and see who's interested in these topics. And there is more and more docs interested in this, GI especially. So that's lesson number one.

Point number two, I kind of used a quote, if your only tool is a hammer, you tend to see every problem as a nail. And what I'm saying about that is many people almost get referred to a service expecting the test to give you the answers. But my point there is, whether it's your blood testing or your skin testing, or from our point of view, the endoscopy, not all things will be revealed.

And of course, we have lots of other explanations. And it's really about listening. And when we're talking about positive diagnosis, whether it's functional GI or disorders of gut-brain interaction, your irritable bowel syndrome, your ARFID, telling them that you've heard these patterns, that you understand it.

I'm sorry, in this current day and age, we don't have a test. But ultimately, I know one day we will. But I know what it is.

And this is the diagnosis, is really a positive tool, as opposed to, I don't have the tests are negative, good luck to you. Then the family doctors are really in a tough place. So anyway, that's, tools are great, but you can't just rely on the tool itself.

And then the last takeaway, I would say, is another quote, the more you learn, the less you know.

We have a lot to know and learn. So I think I'm excited that we're into this new realm of adaptation, changing the natural history, hopefully dealing with one more condition, not just separated, but like overlapping treatments for more than one condition. But we'll find out with time some of the body's adaptations and complex interplays. So, I'm excited to work.

I think there's a long history, a future I should say, of GIs continuing to work with allergy. And I think we'll do better together.

Dr. Mariam Hanna

Absolutely. Thank you, Dr. Avinashi for joining us on today's episode of The Allergist.

Dr. Vishal Avinashi

Thanks so much for having me.

Dr. Mariam Hanna

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Sincerely, The Allergist.