Short Communication

Journal of ENT Surgery Research

Diagnostic Reframing of Dysphagia: From Presumed Reflux to Eosinophilic Oesophagitis in an Otolaryngology Context

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Submitted: 2026, Mar 09; **Accepted**: 2026, Apr 02; **Published**: 2026, Apr 17

Citation: Knox, B. H. (2026). Diagnostic Reframing of Dysphagia: From Presumed Reflux to osinophilic Oesophagitis in an Otolaryngology Context. *J of ENT Surgery Research, 4*(1), 01-02.

Abstract

***Background*:** *Dysphagia presenting to otolaryngology services is frequently attributed to laryngopharyngeal reflux (LPR). However, Eosinophilic esophagitis (EoE) may mimic reflux-related symptoms, leading to diagnostic delay.*

Objective: *To examine the consequences of reflux-based diagnostic anchoring in a patient whose symptoms improved following Gastric peroral endoscopic myotomy yet were ultimately attributable to EoE.*

***Methods*:** *Narrative-informed clinical analysis supported by current literature, with emphasis on ENT-relevant presentation and diagnostic pathways.*

***Results*:** *Symptom overlap between LPR, motility disorders, and EoE contributed to misattribution. Apparent clinical improvement after G-POEM created false diagnostic closure, delaying histological diagnosis.*

***Conclusion*:** *Persistent dysphagia in ENT practice requires early endoscopic evaluation with biopsy. Symptom response to reflux-directed therapy should not exclude EoE.*

1. Introduction

Dysphagia is a common presenting complaint in otolaryngology, often initially attributed to Laryngopharyngeal reflux (LPR) or Gastroesophageal reflux disease (GORD). While reflux-related pathology is prevalent, reliance on symptom-based diagnosis risks overlooking alternative causes, particularly EoE. EoE is increasingly recognised as a major cause of oesophageal dysfunction, yet remains underdiagnosed in ENT settings where upper airway symptoms predominate [1,2]. The overlap between throat discomfort, globus sensation, and dysphagia contributes to diagnostic ambiguity.

2. Clinical Problem

2.1. Symptom Overlap in ENT Practice

Patients presenting to ENT clinics with:

• Dysphagia
• Globus Sensation
• Throat Tightness
• Intermittent Food Sticking are frequently managed as reflux-related disorders.

However, these symptoms are not specific and may reflect:

• Inflammatory oesophageal disease (EoE)
• oesophageal motility disorders
• structural abnormalities

Importantly, laryngoscopic findings may be normal or nonspecific in all three.

3. Impact of Reflux-Based Diagnostic Pathways

Empirical treatment with proton pump inhibitors and lifestyle modification is common. While appropriate as an initial strategy, prolonged reliance on symptomatic response may delay definitive investigation. In this context, improvement in symptoms is often interpreted as confirmation of reflux pathology—an assumption that may be incorrect.

4. Intervention and Diagnostic Confounding

The use of Gastric peroral endoscopic myotomy introduces an additional layer of complexity.

G-POEM improves gastric emptying and may reduce:

- Regurgitation
- Upper Abdominal Pressure
- Reflux-Like Symptoms

From an ENT perspective, this may translate into:

- Reduced Throat Irritation
- Decreased Globus Sensation
- Perceived Resolution Of Dysphagia

However, this improvement reflects gastric physiology, not oesophageal mucosal health. The result is a false negative clinical signal, where persistent oesophageal inflammation remains undetected.

5. Definitive Diagnosis: Eosinophilic Oesophagitis

EoE is defined by:

- Symptoms of oesophageal dysfunction
- ≥15 eosinophils per high-power field on biopsy
- Exclusion of alternative causes [1]

ENT-Relevant Considerations Include:

- Normal or subtle endoscopic findings
- Absence of classic reflux signs
- Poor correlation between symptoms and laryngeal appearance

Failure to obtain oesophageal biopsies in patients with persistent dysphagia represents a key missed diagnostic opportunity.

6. Discussion

6.1.Diagnostic Lessons for ENT Practice

6.1.1 Dysphagia Requires Structural and Histological Evaluation

Persistent symptoms should prompt referral for upper endoscopy with biopsy, regardless of presumed reflux.

6.2. Laryngoscopy Alone Is Insufficient

Normal laryngeal findings do not exclude oesophageal pathology.

6.3. Therapeutic Response Is Not Diagnostic Proof

Improvement following reflux therapy or G-POEM does not rule out EoE.

6.4. EoE Should Be Considered Early

Particularly in patients with:

- Intermittent Dysphagia
- Food Impaction History
- Refractory “Reflux” Symptoms

7. Consequences of Diagnostic Delay

Delayed recognition of EoE is associated with:

- Fibrostenotic Progression
- Oesophageal Strictures
- Recurrent food Impaction

From an ENT perspective, this may manifest as:

- Worsening Dysphagia
- Repeated Referrals Without Diagnosis
- Chronic Symptom Burden

8. Implications for Multidisciplinary Care

Effective management requires coordination between:

- Otolaryngology
- Gastroenterology
- Allergy/Immunology

ENT Clinicians play a critical gatekeeping role in Recognising when symptoms extend beyond the upper airway.

9. Conclusion

In ENT practice, dysphagia attributed to reflux must be approached with diagnostic caution. Symptom improvement following interventions such as G-POEM may obscure underlying oesophageal disease. EoE represents a critical differential diagnosis that requires histological confirmation. Early recognition and appropriate referral are essential to prevent disease progression and long-term morbidity.

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