Upper Gastrointestinal Involvement in Pediatric Crohn's Disease Reply

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Reply. In his comment on our recent paper describing the phenotype of childhood-onset inflammatory bowel disease (IBD), Dr Matary highlights several important issues pertaining to the investigation and classification of involvement of the upper gastrointestinal (GI) tract in pediatric Crohn's disease (CD).[1,2] To enable a comparison of the pediatric phenotype with adult-onset disease, we used the Montreal classification of IBD rather than a more detailed, anatomic classification of disease extent which we have previously used in the genotype–phenotype analysis of NOD2/CARD15 variants.[3] Our investigation protocol based on the ESPGHAN Porto-criteria, adhered to by the pediatric gastroenterologists at the 3 recruiting centers, states that biopsies are taken routinely from the upper GI tract during the investigation of pediatric IBD.[4] Involvement of any anatomic location was defined as either macroscopic, microscopic, or both. Macroscopically, the minimum criteria for involvement of a disease location were ulceration or the presence of an aphthous lesion. Erythema and/or edema did not suffice to score a site as affected by CD. Microscopically, nonspecific inflammation or inflammatory changes that could be otherwise explained (eg, reflux esophagitis or *Helicobacter pylori* gastritis) were not classified as CD. Interobserver variability was addressed by the quality control of phenotypic data by a dedicated database manager (HED) after review of the case notes (including endoscopy, pathology, and radiology reports).

The application of the recent Montreal classification, which has addressed some of the difficulties of previous systems in classifying pediatric IBD (specifically the involvement of the upper GI tract, which precluded classification of lower GI disease in the Vienna classification), makes comparisons with historical datasets troublesome.[5,6] In these older datasets, as for example that described in the study by Lenaerts et al,[7] the upper GI tract was typically not investigated in the absence of clear upper GI-related symptoms, as acknowledged in their manuscript. In the absence of clear upper GI symptoms, esophagogastroduodenoscopy is also rarely performed in the investigation of adult-onset CD.[8] However, involvement of the upper GI tract has been reported to be as high as 75% in prospective adult CD studies where esophagogastroduodenoscopy was routinely performed.[9,10] Furthermore, in the Montreal classification, jejunal disease is scored as upper GI disease (the L1 category is limited to ileal disease), which further compromises comparison with older classification systems, dividing the GI tract into the upper, small bowel, and colon.

Our finding that >60% of children affected by Crohn's disease display involvement of the upper GI tract is, therefore, comparable with contemporary prospective studies in adult onset CD and further highlights the importance of a comprehensive assessment of our pediatric CD patients.

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Conflicts of interest

The authors disclose no conflicts.

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In the January 2009 issue of GASTROENTEROLOGY, the Comment From the Editor described 8 cohorts of patients with acute Hepatitis C in North America in an effort to heighten awareness of this interesting patient population. The following letters highlight additional unique and valuable acute hepatitis C cohorts in North America and further emphasize the important window of opportunity to identify at-risk populations within correctional facilities. Collectively, these cohorts provide important opportunities to better understand the epidemiology, natural history, and effective therapeutic approaches of acute hepatitis C in North America, as well as the early pathogenetic mechanisms.

Acute Hepatitis C Infection in Correctional Settings

Dear Sir:

We greatly appreciated the recent spotlight on the important epidemiologic, immunologic, and virologic research that is ongoing in US cohorts of acute hepatitis C infection.[1] We would like to take this opportunity to highlight an additional aspect of acute hepatitis C that is evidenced in our work within the Massachusetts correctional system, where we have initiated screening programs for acute hepatitis C virus (HCV) infection during the medical intake examination for recently incarcerated inmates. More than 3200 inmates have been screened with a short questionnaire eliciting information regarding high-risk behaviors. Through the help of medical providers based in the correctional system, we have identified >140 subjects at high risk of infection; surprisingly, 37 cases of acute HCV infection were subsequently diagnosed over a 15-month period (manuscript in preparation). These results demonstrate that, beyond the well-known epidemic of chronic HCV in the correctional system, there is also a high rate of acute HCV infection, mainly among recently incarcerated new drug users.[2]

The Centers for Disease Control and Prevention mandated in 2003 that primary and secondary HCV prevention efforts should be focused on injection drug users and specifically cited prison facilities as an ideal setting for such efforts.[3] However, the feasibility and the acceptability of such interventions were unknown. Since 2006, we have found widespread acceptance of our interventions, including HIV testing and immunizations against hepatitis A and B infection. We are examining the utility of new algorithms of expanded diagnostic criteria for acute HCV infection in new-onset injection drug users, who often have no prior record of serologic testing. We have also shown that treatment of acute HCV infection in the prisons is feasible, safe, and effective. As noted in our pilot project,[4] we have found that the burden of most new HCV infections is occurring in Caucasian subjects, although there is wide representation of Hispanics and blacks within our prison population. Furthermore, study of these interesting trends is being planned.

Despite some exemplary exceptions,[1] the diagnosis and treatment of acute HCV in injection drugs users has been generally low. However, our concentrated efforts within the structured environment of the correctional setting demonstrate that this avenue of intervention has high yield among a largely underserved patient population. Because more than half of US inmates are incarcerated owing to new drug use offenses, there is indeed a "window of opportunity" to make a difference.[5]

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