Answering Up: *The Evidence on Allergies*

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About one-third of the population suffers from allergies, with severity ranging from trivial to life-threatening.

► *How are allergies diagnosed?*

Some 30% to 60% of patients presenting to primary care providers with nasal symptoms will be diagnosed with allergic rhinitis.[1] The probability increases if there is a history of animal or pollen triggers and if there is a personal or family history of allergy.

► *What about prick skin testing?*

Prick skin testing is very important for diagnosing the allergens involved (*i.e.*, is it the cat or the dog?). Such testing makes specific avoidance advice possible. This information is also necessary if immunotherapy is being considered.

► *Does mite-proof bedding work?*

Mite-proof mattress covers are available, but expensive. Are they worth the cost? A randomized, controlled study of 279 rhinitis patients showed reduced mite exposure with the use of such covers, but no significant symptom improvement.[2]

A seperate double-blind, randomized, controlled study of 1,122 asthma patients found mite-proof bedding clinically ineffective.[2]

Which treatments work for allergic rhinitis?

Allergic rhinitis is a significant problem for many people. The Allergic Rhinitis and its Impact on Asthma Workshop Group, an independent expert panel, has looked at the treatment of rhinitis from an evidence-based approach.[4]

Level 1b evidence (at least one randomized, controlled study) or better exists for most of available therapeutic options (Table 1).[4]

Table 1
Therapeutic options for allergy patients

Antihistamines	Effective; non-sedating; longer acting; are agents of choice
Intranasal/intraocular antihistamines	Only advantage is rapid onset of action; disavantages are they only work where applied, and their cost
Intranasal corticosteroids	Evidence shows superior to antihistamines; drug of choice if congestion is dominant symptom and symptoms persist
Systemic corticosteroids	Effective, but should be used only for very severe symptoms (for a brief time); depot preparations should not be used as risks of long-term corticosteroid usage is not warranted in allergic rhinitis
Intraocular/intranasal chromones	Effective, but less so than antihistamines or topical costeroids; seem cortimore effective for the eye than the nose
Decongestants chromones	Topical decongestants should only be used for a few days due to the cortirisk of rhinitis medicamentosa; avoid oral decongestants for patients who are pregnant, hypertensive, have cardiac disease, hyperthryroidism, glaucoma, psychiatric disorders, the presence of beta blockers and monoamine oxidase inhibitors, and those over 60
Anticholinergics	Only reduces rhinorrhea; may be helpful when rhinorrhea is severe in allergic rhinitis, but rarely necessary; effective for reflex rhinorrhea (*e.g.*, gustatory rhinitis and skier's nose)
Antileukotriene	Montelukast and loratadine togther were more effective than either drug alone in seasonal allergic rhinitis; montelukast can be offered when there is a lackluster response to antihistamines and topical corticosteroids; main disadvantage is cost
Specific	Evidence for the effectiveness of subcutanous specific immunotherapy exists for use in immunotherapy seasonal allergic rhinitis; usually reserved for patients with inadequate relief from-drugs, or who have unacceptable drug side-effects

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References

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