Getting it Right

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Notes on John

Age: 38
Presentation:
- Seasonal allergic rhinoconjunctivitis
- Previous attempts at treatment have been unsuccessful

Situation:

√ John, a 38-year-old bond trader, presents with seasonal allergic rhinoconjunctivitis. Previous attempts at treatment have been unsuccessful.

√ John developed typical symptoms of rhinoconjunctivitis in the spring and fall when he was 33-years-of-age. For the first few years, symptoms were controlled with over-the-counter non-sedating antihistamines. However, symptoms gradually worsened. He was referred for an allergy assessment and had positive allergy skin prick tests to:

- trees,
- grass and
- ragweed pollens.

Door and window closure during the relevant seasons, with use of air conditioning when outdoor ambient temperatures warranted, was recommended. Treatment with aqueous intranasal corticosteroids, to be used seasonally, in combination with oral non-sedating antihistamines was attempted. Although the intranasal corticosteroids provided excellent symptom relief, John strongly disliked the sensation and taste when the intranasally-administered corticosteroid preparation would drip down the back of his throat. Eventually, he discontinued the intranasal corticosteroid and went back to using only oral non-sedating antihistamines. However, control of his symptoms was clearly suboptimal.

√ John returned to see his allergist. The possibility of allergen immunotherapy (allergy shots) was discussed. Due to his extremely busy work schedule, John did not feel that repeated visits for the injections, including the time required for observation after each injection, would be feasible.

√ John has no history of asthma and has no ongoing chest symptoms, even with cold air exposure, laughter, or vigorous exercise. He was not exposed to animals or cigarette smoke. He has no known food allergies and had only mild eczema, which became worse in the winter. Several family members were also atopic.

√ Excluding sports injuries, his past history was unremarkable. John takes no regular medications.

√ A physical examination done in late winter, before John's allergy season, is totally unremarkable.

How else can John's symptoms be managed?

Possibilities:

√ An unscented aqueous or a dried-powdered intranasal corticosteroid preparation may be helpful. John would likely do well with a dried-powder preparation as it would preclude any liquid dripping into his posterior nasopharyn.

√ Oral leukotriene receptor antagonists (which are also effective in treating allergic rhinitis, though they tend to be less effective than intranasal corticosteroids), combined with oral non-sedating antihistamines may also provide sufficient symptom control, especially when combined with allergen-avoidance strategies.

√ Treatment with oral or depot corticosteroids is discouraged because of potential side-effects. Treatment with other unavailable nasal preparations, including antihistamines and mast cell stabilizers, would also cause problems with liquid dripping into the posterior nasopharynx and the patient, in this scenario, would likely find them intolerable as well. Dx

Oral leukotriene receptor antagonists are effective in treating allergic rhinitis, though they tend to be less effective than intranasal corticosteroids.

Upcoming case...

√ ***February:*** Worsening Cough in an Asthmatic

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