

LETTER TO THE EDITOR

**SPECIFIC IMMUNOTHERAPY FOR ALLERGIC RHINITIS IN ITALY:
THE DOCTORS' POINTS OF VIEW**

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Specific immunotherapy (SIT) is the unique causal treatment for allergy, but its prescription is quite restricted. A perspective and cross-sectional survey based on telephone interviews was carried out in Italy to evaluate the profile of doctors prescribing SIT for allergic rhinitis. A total of 540 doctors were interviewed, 200 of whom are GPs, 60 allergists, 60 ENT specialists, 100 familial paediatricians, 60 hospital paediatricians and 60 pulmonologists. Significant differences concern diagnostic and therapeutic management of allergic rhinitis, mainly regarding SIT prescription. The allergist is the most important consultant who prescribes SIT, as opposed to the paediatrician. This study therefore provides the evidence that doctors' behaviour towards SIT depends on the type of graduate studies.

Allergen-specific immunotherapy (SIT) is the unique causal treatment of allergic disorders that is capable of modifying the natural history of the allergic patient (1-2). Numerous factors may affect doctors prescribing SIT. The diagnostic pathway may be very complex, especially for non-specialists, mainly concerning the evaluation of poly-sensitisations, the choice of the causal allergen extract, the route of administration, the duration schedule, the adverse events management, and the total complexity of management.

Although guidelines have been extensively and widely spread, SIT prescription usually remains in the hands of allergists (3-4). The route of administration represents a crucial issue for patient acceptance

and compliance. The appearance of sublingual immunotherapy (SLIT) has changed the conditions of prescription, mainly in Europe as most of SIT treatments concern this route of administration. Nevertheless, the total number of SIT prescriptions remains substantially unchanged over time.

Therefore, to evaluate the profile of doctors prescribing SIT for allergic rhinitis, a perspective and cross-sectional study survey based on telephone interviews was performed in Italy. In particular, two main aims were considered:

- 1) the level of knowledge of SIT both of specialists and GPs regarding its perception and use, the profile of ideal patients, and the expectations;
- 2) to describe the different therapeutic strategies

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followed by GPs and specialists for treating allergic rhinitis, including the perception of SIT

MATERIALS AND METHODS

The survey was conducted by an International specialised company (Stethos Italy, Milan, Italy), ordered by Stallergenes, Italy. The phone interviews were carried out according to the valid and very rigorous CATI method (5) which carefully defines the criteria for the selection process, including randomisation, source of database, replacement of refusing doctors, and analysis of non-responders,

The interview started with a question of whether the doctor usually visits patients suffering from allergic rhinitis; if the answer was positive the interview proceeded. Doctor samples were homogeneous concerning age and geographic area as they were randomly selected by consulting registers of provincial physician associations.

Numerous items considered many aspects of the disease, including duration, symptom severity and chronology, time of consultancy, performed diagnostic procedures, and prescribed treatments.

A total of 540 doctors were interviewed: 200 of whom are GPs, 60 allergists, 60 ENT specialists, 100 family paediatricians, 60 hospital paediatricians, and 60 pneumologists.

Statistical analysis was performed by using Student's T-test and Wilcoxon's test.

RESULTS

The first finding clearly shows that there is a significant difference ($p < 0.05$) concerning the latency

time between symptom onset and consultation: the earliest consulted is the GP, the latest, the allergist (Fig. 1).

Diagnosis was made using tests by 54.1% of specialists, 36.3% of paediatricians, and 17.4% of GPs ($p < 0.01$), whereas 82.6% of GPs considered clinical history alone.

The most common test used is skin prick: performed by 89.1% of paediatricians and 85.2% of specialists, serum specific IgE were evaluated mainly by GPs (60.1%). Eosinophil count was considered by 21.2% of GPs and 10.4% of Specialists. Spirometry was requested by 21.8% of GPs, 14.3% of Specialists, and 6.4% of Paediatricians ($p < 0.05$).

The treatment of allergic rhinitis was analysed on the basis of the symptoms: mild, moderate, and severe, classified according to previous validated criteria (6). An antihistamine is the most prescribed drug for mild symptoms, followed by nasal corticosteroid alone or associated with antihistamine, with no substantial differences between doctors ($p = n.s.$). However, SIT is prescribed by allergists in 14.1% of patients, while GPs prescribed it in 5% and family paediatricians in 1.4% ($p < 0.01$).

For moderate symptoms, the difference between doctors becomes more evident concerning both drugs and SIT. Antihistamines alone are notably prescribed by GPs ($p < 0.05$), corticosteroids alone by ENT specialists and pneumologists ($p < 0.05$). SIT is mainly prescribed by allergist, whereas it is rarely prescribed by paediatricians. For severe rhinitis, antihistamine plus corticosteroid is the most

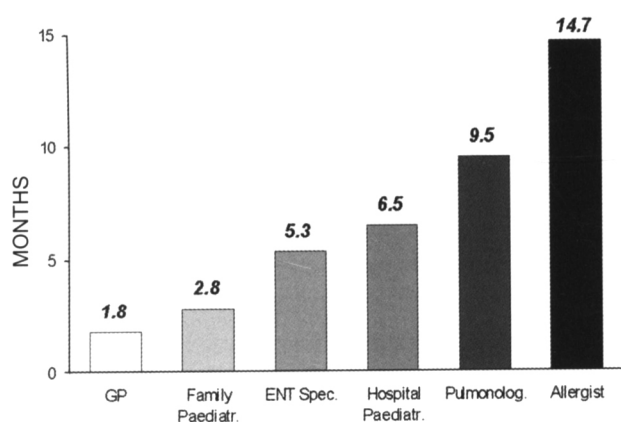


Fig. 1. Latency time between symptom onset and consultation among various categories of physicians.

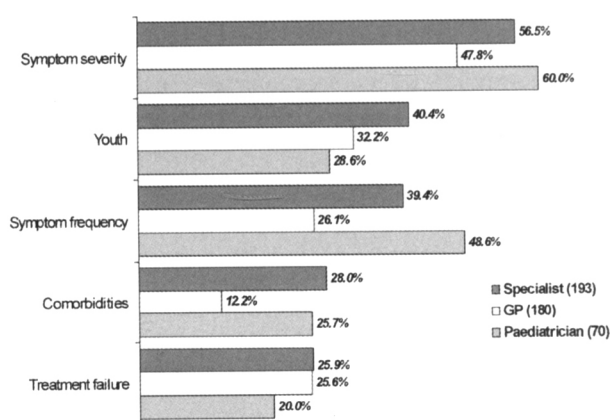


Fig. 2. Clinical characteristics for SIT eligibility by various categories of physicians.

relevant therapy for all doctors; SIT is significantly more prescribed by allergists ($p < 0.01$), but there is no difference between other doctors.

Concerning expectations, the issues most hoped for are: a definitive resolving treatment (for 85.1% of specialists, 64.4% of paediatricians, and 37.4% of GPs), a well-tolerated therapy (for 20.7% of GPs, 19.8% of paediatricians, and 12.4% of specialists), and a quick symptomatic relief (for 15.8% of paediatricians, 9.1% of specialists, and 5.1% of GPs). In reality, almost all doctors know that SIT may be used for allergic rhinitis, except for 9.1% of GPs, 2.2% of paediatricians, and 2% of specialists (non-allergists).

There is a significant difference between GPs and paediatricians regarding the profile of patients eligible for SIT: paediatricians fundamentally consider symptom severity and frequency, GPs scarcely consider co-morbidity ($p < 0.05$), whereas specialists consider symptom intensity and age of patients (Fig.2).

Both subcutaneous and sublingual SIT (in Italy SLIT is preferred: about 60% of prescriptions), are considered as helpful treatments for 95.3% of allergists, 88.9% of paediatricians, 82.6% of other specialists, and 78.7% of GPs. However, SIT is prescribed by 93.3% of allergists, 48.6% of other specialists, 38.4% of paediatricians, and 28.3% of GPs ($p < 0.01$).

Finally, the latency period between the first visit and SIT prescription is 7 months for specialists, 8 for GPs, and 13 for paediatricians.

DISCUSSION

This study investigates the different approaches of doctors in managing allergic rhinitis in Italy. The survey was carried out through telephone interviews by a specialized international company.

Firstly, the latency between symptom onset and medical consulting significantly depends on the kind of doctor. It may be due to the different levels of consultation: GP and family paediatricians are at the primary care level and, at least in Italy, directly consulted without appointment; whereas for specialists at the secondary care level the patient receives an appointment on a waiting list.

The diagnostic pathway is significantly different:

the specialist recurs to skin prick test, whereas the GP prefer serum IgE dosage. However, the most conspicuous difference concerns the therapeutic approach, mainly regarding moderate and severe rhinitis. The specialist, particularly the allergist, opts for a pathogenic choice, whereas GP especially considers symptomatic relief. Moreover, SIT prescription marks the difference between doctors: allergists are the most important health care providers in prescribing, whereas other doctors prefer drug therapy. It is surprising that almost all doctors know that SIT is useful in allergic rhinitis, but prescribe it very rarely. It may depend on the different specific cultural level existing between the allergist and non-allergist, mainly regarding knowledge of the mechanism of action and its management. Other factors may be the different patients' characteristics, type of allergy, symptom specificity versus the detected allergen, symptom severity, comorbidities, different behaviour among patients in undertaking SIT because of lack of trust, inconvenience and high costs, different cultural approach and confidence in cost/effectiveness evidence of SIT, and last, but not least, national and regional regimen on the SIT coverage by the National Health Service.

In conclusion, this study provides evidence that doctors' behaviour towards SIT depends on specific educational levels. Thus, intensive and specific preparation should be available to adequately educate non-allergists.

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