

Correspondence

Sublingual immunotherapy

To the Editor:

I was most interested to see the recent study by Professor Durham and colleagues¹ addressing the efficacy of sublingual grass pollen therapy for seasonal allergic rhinoconjunctivitis, but I would be obliged if the authors would kindly clarify some problems with interpretation of their data.

1. When analyzing the primary outcome measures, we are told that “the pooled pollen counts for the two cohorts were comparable” but that “all estimates were adjusted for pollen region.” Table II quotes these “adjusted means” but it is not clear how and why they were “adjusted.”
2. The purpose of allocating individuals with continuing symptoms of allergic rhinitis either active (loratadine) or placebo “Step 1” rescue medication is obscure. In Table II it is stated that the analyses for the entire and the peak grass pollen seasons were performed on participants receiving active Step 1 medication; does this mean that those 150 patients who received placebo, who were still presumably having symptoms, were omitted? With the pooled data, it is not clear how analysis “with Step 1 medication as a fixed effect” was performed. It would be helpful to know what weights were given to the various open-label medications used beyond Step 1 when deriving a medication score, whether there were similar numbers of patients with asthma (presumably needing more medications) in each treatment group, and whether the data were modified by exclusion of patients with asthma.
3. In the legend to Fig 1, it is stated that 748 patients completed the trial, whereas in the results section, it is stated that 790 completed it. Which is correct?
4. It is impossible to determine the actual amount of treatment given to the patients from the data provided. Apparently:

- A total of 640 patients received treatment for at least 56 days preseasonally

- A total of 748 patients (or 790) took at least 80% of the trial medication
- The mean duration of treatment was 126 days, with a range of 1 to 174 days, starting approximately 56 days before the pollen season

This information does not allow one to deduce exactly how much treatment the patients in each group received. The length of the pollen season as well as the SE of the treatment duration have been omitted. In Table II, the greater improvement in symptoms in patients who had received at least 8 weeks of preseasonal treatment is difficult to interpret without knowing how much treatment they received altogether. If they received more treatment overall, it might not be surprising if they had fewer symptoms. As they stand, the data do not clearly ratify the particular benefits of 8 weeks of preseasonal treatment.

5. How is it that “adherence to the treatment was high in all groups (94% to 98%),” yet only 748 (or 790) of the 855 randomized participants took at least 80% of the treatment (“per protocol” group)?

Chris Corrigan, MD, PhD

From King's College London, Division of Asthma, Allergy and Lung Biology, and Medical Research Council and Asthma UK Center for Allergic Mechanisms of Asthma, London, United Kingdom. E-mail: chris.corrigan@kcl.ac.uk.

Disclosure of potential conflict of interest: C. J. Corrigan has consultant arrangements with ALK-Abelló, Allergopharma, and Diagenics and has received grant support from ALK-Abelló and Allergopharma.

REFERENCE

1. Durham SR, Yang WH, Pedersen MR, Johansen N, Rak S. Sublingual immunotherapy with once-daily grass allergen tablets: a randomized controlled trial in seasonal allergic conjunctivitis. *J Allergy Clin Immunol* 2006;117:802-9.

doi:10.1016/j.jaci.2006.09.043