

Letter to the Editor

Are intranasal steroids effective in the treatment of 2–4-year-old children with perennial rhinitis?

Editor,

We have read with interest the article, 'Perennial rhinitis in the under 4s: A difficult problem to treat safely and effectively? A comparison of intranasal fluticasone propionate and ketotifen in the treatment of 2–4 year-old children with perennial rhinitis' (1). The concept of intranasal steroids is an appropriate and safe treatment in all young children with rhinitis and persistent nasal blockage has been advocated in this article. Paediatricians reading this article may take note of the concept that all children with frequent or persistent non-specific upper respiratory tract symptoms such as nasal discharge and nasal blockage whether associated with atopy or not could be labelled as perennial rhinitis, and intranasal steroids could be used as the prophylactic treatment in such children. However, there is no published evidence to support such an assertion in childhood. Moreover, prophylactic treatment with intranasal steroids in perennial rhinitis without any evidence of atopy is still questionable in adult patients (2). There is no doubt that intranasal steroids are the most effective prophylaxis for established allergic rhinitis. However, persistent or recurrent upper respiratory tract symptoms are more likely to be associated with viral infections in the upper airway or adenoid vegetation in many preschool age children. These are not the eosinophilic diseases and are not associated with chronic nasal inflammation. It is clear that steroids would not be a solution for these problems. In addition, we know there are some data from children with virus-induced wheezing suggesting that prophylactic treatment with inhaled steroids have no significant effect on frequency, severity or duration of respiratory tract symptom episodes (3, 4).

In Fokkens and Scadding's study no distinction was made between allergic and non-allergic

patients with perennial rhinitis (1). Therefore, the efficacy of treatment was not separately tested for the non-allergic children. The reported overall efficacy might perhaps be attributed to the known clinical efficacy in patients with allergic rhinitis. If nasal steroids are used regularly in children, especially in young children with perennial rhinitis, consideration should be given to allergy evaluation. Certainly, in young children it is impractical to perform skin prick tests for the diagnosis of allergic rhinitis. It can be differentiated from non-allergic rhinitis on the basis of personal or family history of atopy and the presence of asthma or eczema in clinical practice. However, in clinical studies, it is an obligation to differentiate allergic rhinitis from non-allergic rhinitis in the context of evaluation of the response to treatment. This approach would put it on a more scientific and convincing basis.

Finally, it is important to remember that there might be a difference in response to treatment with nasal steroids depending on eosinophilic inflammation in the nasal mucosa. The management of non-atopic children with perennial rhinitis should be studied separately from allergic rhinitis to determine the most appropriate treatment.

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