

Correspondence

Cetirizine in patients with seasonal rhinitis and concomitant asthma

To the Editor:

I read with interest the article by Dr. Grant and colleagues, published in the May 1995 issue of the JOURNAL (*J ALLERGY CLIN IMMUNOL* 1995;95:923-32). They describe the results of a 6-week, multicenter, double-blind, placebo-controlled, parallel-group study of cetirizine, 10 mg daily, in patients with seasonal allergic rhinitis (SAR) and concomitant asthma. They show, unsurprisingly, that cetirizine was effective in relieving most of the symptoms of SAR, aside from nasal congestion. However, in addition to SAR, all patients in the study were required to have asthma with suboptimal pulmonary function and a history of reversibility to an inhaled bronchodilator. The authors report that in line with improvements in rhinitis symptoms, asthma symptoms were also improved in the cetirizine-treated group. However, they report no improvement in the objective measurements of domiciliary peak expiratory flow rate or in office spirometry. The authors conclude their article by stating that, "Cetirizine may be considered an additional agent for treating patients with asthma."

Although histamine is undoubtedly an important mediator in asthma,¹ antihistamines have been previously shown to have inconsistent effects in asthma challenge models on bronchial hyperresponsiveness and symptoms of seasonal and perennial asthma.² Although it has been suggested that newer antihistamines deserve a reevaluation as therapy for asthma,³ to date, antihistamines have not been shown to provide clinically relevant benefit in "wild" asthma.²

The study performed by Grant et al. does not lend itself to providing any conclusive evidence for the claim that H₁ antagonists should be used as adjunctive therapy in asthma, and it highlights the difficulties in clinical trials, of study populations with two different (albeit related) diseases. Although not discussed in their article, it seems impossible to discount the intuitively reasonable theory that the asthmatic symptoms improved as the functional state of the patients improved with effective treatment of their rhinitis. This would be supported by lack of improvement in the objective assessments of asthma control, peak expiratory flow rate and FEV₁. One could envisage a trial with similar design in which patients with rhinitis and concomitant depression were studied; a clinically relevant improvement in rhinitis might lead to general improvement in well-being and a lessening of depressive symptoms. However, in this instance it would appear inappropriate to label the antihistamine as an antidepressant. From the actual study performed by Dr. Grant and colleagues, it appears equally misleading to erroneously label cetirizine as an anti-asthma agent. It would seem appropriate to consider cetirizine or other H₁ antagonists as agents for the

treatment of asthma if clinically relevant efficacy, safety, and value were demonstrated in methodologically sound clinical trials.

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Reply

To the Editor:

We appreciate Dr. Nieman's interest in our article "Cetirizine in patients with seasonal rhinitis and concomitant asthma: prospective randomized, placebo-controlled trial" (*J ALLERGY CLIN IMMUNOL* 1995;95: 923-32). He accurately summarizes our findings that cetirizine, 10 mg daily, is effective in reducing symptoms of seasonal allergic rhinitis, and in our study also the symptoms of asthma. Peak flow and spirometry measurements did not show differences between the placebo and cetirizine groups.

The goal of our investigation was to explore the safety and efficacy of cetirizine in the treatment of patients with rhinitis and asthma. We believe that contrary to the extensive literature regarding the potential harm of antihistamines in asthma, which we have reviewed, no safety issues were found in our study. In addition, there is the matter of the efficacy of cetirizine for treatment of asthma.

The author of the letter addressed the prior evaluations of antihistamines in the treatment of asthma, and we submit that the discussion section of our article exhaustively reviewed this subject. We concur that few studies support the efficacy of this class of compounds in the management of asthma. Although terfenadine was shown to be beneficial for asthma in some investigations, the doses necessary to achieve this effect were quite high (240 to 540 mg daily) and are now considered contraindicated because of potential cardiac effects. In contrast, we selected a dose of cetirizine (10 mg daily) previously shown to relieve most symptoms of rhinitis to determine its effects (both beneficial and harmful) in patients with asthma. There are many reports in the literature that support our conclusion that cetirizine is of some value