

CORRESPONDENCE

Adenoidal hypertrophy and allergic rhinitis

DOI:10.1111/j.1399-3038.2011.01175.x

Editor,

We read with interest the review article by Scadding G. entitled 'Non-surgical treatment of adenoidal hypertrophy: The role of treating IgE-mediated inflammation' (1).

The association between adenoidal hypertrophy (AH) and allergic rhinitis cannot be debated, and we agree that the use of intranasal corticosteroids (INS) should be the first line treatment for AH and ought to be recommended before the surgical option.

As reported, INS suppress inflammatory mediators involved in the allergic reaction; for this reason it is of primary importance to discover the allergen/s responsible for the allergic inflammation (the etiologic agent).

For many years, it has been well known that house dust mites are the main cause of intermittent allergic rhinopathy (2), however the article in question does not mention the relevance of hypersensitivity to mites in children. The author hypothesized the importance of allergic reaction to mold even if *Alternaria* and other molds are responsible for only few cases of allergic rhinitis (AR) in children (3).

Today, the role of mites in AR is probably underestimated since symptoms are often much less evident than those caused by hypersensitivity to pollens. Nevertheless, the minimal persistent inflammation present in patients without symptoms, who are sensitized to mites and continuously exposed to the natural allergens, provokes long-term complications such as AH.

Moreover, skin prick tests using commercially available allergen extracts often give a false negative result. A recent publication reported that immunochemical analysis of mite extracts produced by different manufacturers showed a heterogeneous amount of component/s. For this reason, the Authors suggested that the absence of relevant allergens could strongly affect diagnosis in some of the patients tested (4).

In order to avoid this problem, in our clinical practice, patients affected by AH are firstly treated with nasal rinsing (hypertonic solution), INS and oral antihistamines. After 3 weeks, the majority of patients show a reduction in nasopharyngeal cavity volume obstruction (an example of

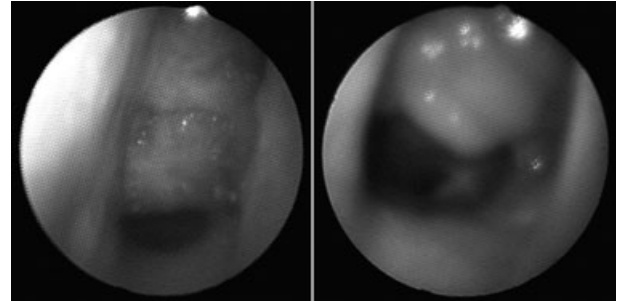


Figure 1 An example of rhinofibroscopy before and after treatment.

rhinofibroscopy before and after treatment is reported in Fig 1) and a decrease in clinical symptoms of AH. These patients subsequently undergo first level allergic tests (skin test and serum specific IgE production test). If these prove to be negative, a second-line diagnosis is carried out with a specific nasal provocation test (5) in order to evaluate a possible association between AH and allergy.

Treatment for allergic diseases includes allergen avoidance, pharmacotherapy, allergen specific immunotherapy and patient education.

Therefore, we might add to the conclusion of the review article that it is very important to define the responsible allergens and to consider specific immunotherapy in order to change the natural history of the disease, in particular when mites are the causative agent. Treatment of allergic disease should be considered in the non-surgical treatment of AH options to avoid prolonged treatment with INS.

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