

Correspondence

Reply

To the Editor:

The statement by the author of the correspondence that “patients with cosensitization to other common aeroallergens were excluded” is not accurate.¹ In our study, 52% of the patients were polysensitized (ie, sensitized to house dust mite [HDM] allergens and at least 1 other allergen).² To enable evaluation of the efficacy of the HDM sublingual tablet, patients with cosensitizations leading to clinically relevant symptoms and those with sensitization and home exposure to cat or dog allergens were excluded. This is consistent with good clinical trial practice and is in accordance with the European Medicines Agency guideline on the clinical development of products for specific immunotherapy for the treatment of allergic diseases.³

In his statement regarding the prohibition of treatment with intranasal corticosteroids, the author of the correspondence may have been referring to the use of such therapy during a 7-day prerandomization washout period designed to ensure that only symptomatic patients (ie, those with an average rhinoconjunctivitis total symptom score of ≥ 5 out of 12) were enrolled. During the treatment period, rescue medication use including the use of intranasal corticosteroids was permitted. In fact, rescue medication was provided by the study sponsor. Overall, 64% of the patients used rescue medication at some time during the treatment period.

The statement that “It is likely that greater improvements would have been achieved by initially treating patients with intranasal corticosteroids plus antihistamines, in which case immunotherapy would have resulted in little or no further symptom reduction” is speculative. As stated in “Allergen Immunotherapy: A Practice Parameter Third Update,”⁴ patients in whom symptomatic treatments are ineffective, poorly tolerated, or who wish to reduce the long-term use of medications are candidates for allergen immunotherapy.

Finally, the author of the correspondence makes reference to a value of 0.55 as the minimal clinically important difference. This value is calculated with data from 9 studies using a total nasal symptom score.⁵ None were allergen immunotherapy studies, and

none used the average adjusted symptom score. Furthermore, 6 of the studies enrolled patients with only seasonal allergic rhinitis. It is, therefore, uncertain as to whether the proposed value is applicable to allergen immunotherapy studies of perennial, HDM-associated allergic rhinitis.

To date, there are no data defining a minimal clinically important difference for the average adjusted symptom score or to studies of allergen immunotherapy in perennial allergic rhinitis. We welcome further efforts in this area.

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REFERENCES

1. Lipworth B. Clinical relevance of house dust mite immunotherapy. *J Allergy Clin Immunol* 2014;134:XXX-XXX.
2. Bergmann KC, Demoly P, Worm M, Fokkens WJ, Carrillo T, Tabar AI, et al. Efficacy and safety of sublingual tablets of house dust mite allergen extracts in adults with allergic rhinitis. *J Allergy Clin Immunol* 2014;133:1608-14.e6.
3. European Medicines Agency. Guideline on the clinical development of products for specific immunotherapy for the treatment of allergic diseases. 2008. Available at: http://www.ema.europa.eu/docs/en_GB/document_library/Scientific_guideline/2009/09/WC500003605.pdf. Accessed October 7, 2014.
4. Cox L, Nelson H, Lockey R, Calabria C, Chacko T, Finegold I, et al. Allergen immunotherapy: a practice parameter third update. *J Allergy Clin Immunol* 2011;127:S1-S55.
5. Barnes ML, Vaidyanathan S, Williamson PA, Lipworth BJ. The minimal clinically important difference in allergic rhinitis. *Clin Exp Allergy* 2010;40:242-50.

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