

Editorial

Nasal corticosteroids, first choice in moderate to severe allergic rhinitis. What prevents general practitioners from using them?

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Allergic rhinitis is a major chronic respiratory disease because of its prevalence, its impact on the quality of life, its impact on work/school performance and productivity, its economic burden, and its links with asthma and other co-morbidities (1). An increase in the prevalence of allergic rhinitis over the last decades has been recognized in the West (1). Allergic rhinitis has been identified as one of the top 10 reasons for visits to primary care clinics (2). Yet many people with allergic rhinitis are never diagnosed by a physician or treated with prescription medication (3). Moreover it is questionable whether those who do receive care are satisfied with the results (4, 5).

Clinical guidelines are systematically developed statements designed to help practitioners make decisions about appropriate health care for specific circumstances (6). Valid clinical guidelines provide an overview of the management of a condition or the use of an intervention. They usually have a broader scope than systematic reviews, which tend to focus on an individual problem or intervention. They may also provide a more coherent integrated view on how to manage a condition (7). In the past decade a number of guidelines have been proposed for the diagnosis and treatment of allergic rhinitis (1, 8–11). The first point of contact for many patients presenting with allergy symptoms is the primary care physician. To increase the chance of effective use of guidelines by primary care clinicians, the guidelines need to be simple, patient specific and user friendly.

The implementation of clinical practice guidelines in primary care generates great interest at the moment. General practitioners are bombarded with guidelines and the selection of the once relevant guidelines in daily practice must be an awful job. Studies have shown that

often used ways of communication/implementation like didactic educational meetings (lectures) and education materials like clinical practice guidelines are not very effective (12). Very limited studies have shown the value of adhering to clinical guidelines compared with treatment regimes used in daily practice (13–15). Only one study was found showing in a randomized way that therapeutic results could be improved by implementing clinical practice guidelines with primary care physicians (16).

In this issue of *Allergy*, our editor in chief, Jean Bousquet, describes the results of an international multi-centre randomized trial to determine the effect of following guidelines in the treatment of allergic rhinitis in general practice. Randomly selected general practitioners in Belgium, France and the UK were asked to treat the first two patients seeking advice for their intermittent allergic rhinoconjunctivitis. They were asked to use either existing guidelines (the guidelines group) or exercise their own free choice (free choice group). The severity of the nasal and ocular symptoms was determined by using a visual analogue scale (VAS). A VAS of 50 or more was categorized as moderate to severe disease for nasal and ocular disease separately. This categorization was used in the guidelines group as base of the treatment. Simple treatment advices were derived from the Consensus statement on the treatment of allergic rhinitis of the European Academy of Allergology and Clinical Immunology (11). The patients with mild rhinitis were treated with an antihistamine; the patients with moderate to severe disease received an antihistamine and a nasal corticosteroid. Patients with moderate to severe conjunctivitis additionally received an ocular chromone. In the free choice group, the general practitioner did not use the

VAS to categorize the patient but decided on the severity of the disease him(her)self. Necessary treatment was administered in the usual way.

Recent guidelines on the treatment of allergic rhinitis all give approximately the same treatment advices for intermittent (seasonal) allergic rhinitis: antihistamines in mild disease and nasal corticosteroids in moderate to severe rhinitis (1, 9, 11). The addition of an antihistamine to a nasal corticosteroid is questionable. Although at least two meta-analyses have shown increased effectiveness of local corticosteroids compared with antihistamines (17, 18), there are no double-blind placebo-controlled studies showing the added value of addition of an antihistamine to treatment with local corticosteroids (19). However, many experts feel that such added value exists. It is also advised as optional in some guidelines (1, 11).

As predicted from earlier studies concerning the diagnosis and treatment of allergic rhinitis by general practitioners (3, 4), the Bousquet study shows that general practitioners following guidelines are more effective in their treatment of patients with intermittent allergic rhinitis than those choosing their own treatment regimes.

We might wonder what the differences will be in more complicated cases of diagnosis and treatment of allergic rhinitis as is seen in persistent allergic rhinitis or in children.

A number of European guidelines for specialists and general practitioners are already available. However, apparently general practitioners in a number of European countries are not using the advices in these guidelines to diagnose and treat their patients. It is interesting to see that, as in the ERASM study (4), a very limited number of general practitioners use nasal corticosteroids in moderate to severe allergic rhinitis. One might wonder what the reason is for this behaviour. A possible explanation is that a fear for systemic side-effects of local corticosteroids still exists. In adults, modern nasal corticosteroids have been shown to be absolutely safe (20). One might wonder how this message is finally conveyed to the doctors treating patients with allergic rhinitis. Hopefully the study of Bousquet proving that following guidelines including nasal corticosteroid is more effective than other choices of treatment is another drop filling the bucket.

References

1. BOUSQUET J, VAN CAUWENBERGE P, KHALTAEV N. Allergic rhinitis and its impact on asthma. *J Allergy Clin Immunol* 2001;**108**(5 Suppl):S147–334.
2. GREGORY C, CIFALDI M, TANNER LA. Targeted intervention programs: creating a customized practice model to improve the treatment of allergic rhinitis in a managed care population. *Am J Manag Care* 1999;**5**:485–496.
3. SIBBALD B, RINK E. Labelling of rhinitis and hayfever by doctors. *Thorax* 1991;**46**:378–381.
4. DEMOLY P, ALLAERT FA, LECASBLE M. ERASM, a pharmacoepidemiologic survey on management of intermittent allergic rhinitis in every day general medical practice in France. *Allergy* 2002;**57**:546–554.
5. FOKKENS WJ. Who should treat patients with seasonal allergic rhinitis? *Allergy* 2002;**57**:469–471.
6. JACKSON R, FEDER G. Guidelines for clinical guidelines. *Bmj* 1998;**317**:427–428.
7. FEDER G, ECCLES M, GROL R, GRITHS C, GRIMSHAW J. Clinical guidelines: using clinical guidelines. *Bmj* 1999;**318**: 728–730.
8. International Consensus Report on the diagnosis and management of rhinitis. International Rhinitis Management Working Group. *Allergy* 1994; **49**(19 Suppl):1–34.
9. DYKEWICZ MS, FINEMAN S, SKONER DP, NICKLAS R, LEE R, BLESSING-MOORE J, LI JT, BERNSTEIN IL, BERGER W, SPECTOR S, SCHULLER D. Diagnosis and management of rhinitis: complete guidelines of the Joint Task Force on Practice Parameters in Allergy, Asthma and Immunology. American Academy of Allergy, Asthma, and Immunology. *Ann Allergy Asthma Immunol* 1998;**81**(5 Pt 2):478–518.
10. MALM L, GERTH VAN WIJK R, BACHERT C. Guidelines for nasal provocations with aspects on nasal patency, airflow, and airflow resistance. International Committee on Objective Assessment of the Nasal Airways, International Rhinologic Society. *Rhinology* 2000;**38**:1–6.
11. VAN CAUWENBERGE P, BACHERT C, PASSALACQUA G, BOUSQUET J, CANONICA GW, DURHAM SR, FOKKENS WJ, HOWARTS PH, LUND V, MALLING HJ, MYGIND N, PASSALI D, SCADDING GK, WANG DY. Consensus statement on the treatment of allergic rhinitis. European Academy of Allergology and Clinical Immunology. *Allergy* 2000;**55**:116–134.
12. BERO LA, GRILLI R, GRIMSHAW JM, HARVEY E, OXMAN AD, THOMSON MA. Closing the gap between research and practice: an overview of systematic reviews of interventions to promote the implementation of research findings. The Cochrane Effective Practice and Organization of Care Review Group. *BMJ* 1998;**317**:465–468.
13. MARSHALL JL, MEAD P, JONES K, KABA E, ROBERTS AP. The implementation of venous leg ulcer guidelines: process analysis of the intervention used in a multi-centre, pragmatic, randomized, controlled trial. *J Clin Nurs* 2001;**10**:758–766.
14. SIMON GE, LUDMAN E, UNUTZER J, BAUER MS. Design and implementation of a randomized trial evaluating systematic care for bipolar disorder. *Bipolar Disord* 2002;**4**:226–236.
15. KIRKMAN MS, WILLIAMS SR, CAREY HH, MARRERO DG. Impact of a program to improve adherence to diabetes guidelines by primary care physicians. *Diabetes Care* 2002;**25**:1946–1951.
16. ROSSIGNOL M, ABENHAIM L, SEGUIN P, NEVEU A, COLLET JP, DUCRUET T, SHAPIRO S. Coordination of primary health care for back pain. A randomized controlled trial. *Spine* 2000;**25**:251–258; discussion 258–259.

17. WEINER JM, ABRAMSON MJ, PUY RM. Intranasal corticosteroids versus oral H1 receptor antagonists in allergic rhinitis: systematic review of randomised controlled trials. *BMJ* 1998;**317**:1624–1629.
18. YANEZ A, RODRIGO GJ. Intranasal corticosteroids versus topical H1 receptor antagonists for the treatment of allergic rhinitis: a systematic review with meta-analysis. *Ann Allergy Asthma Immunol* 2002;**89**:479–484.
19. NIELSEN LP, MYGIND N, DAHL R. Intranasal corticosteroids for allergic rhinitis: superior relief. *Drugs* 2001;**61**:1563–1579.
20. PASSALACQUA G, ALBANO M, CANONICA GW, BACHERT C, VAN CAUWENBERGE P, DAVIES RJ, DURHAM SR, KONTOU-FILI K, HORAK F, MALLING HJ. Inhaled and nasal corticosteroids: safety aspects. *Allergy* 2000;**55**:16–33.