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Editorial

Who should treat patients with seasonal allergic rhinitis?

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Allergic rhinitis represents a global health problem. It is an extremely common disease worldwide, affecting 10–25% of the population (1). However this figure probably underestimates the prevalence of the disease, since many patients do not recognize rhinitis as a disease and therefore do not consult a physician (2, 3). The increasing prevalence of allergic rhinitis over the last decades has been recognized in the western world (4). Allergic rhinitis was identified as one of the top-ten reasons for visits to primary care clinics (5). Although allergic rhinitis is not usually a severe disease, it has a significant effect on patients' social lives (6–8) and affects school learning performance (9, 10) as well as work productivity (11, 12). Moreover, the costs incurred as a result of rhinitis are substantial (13). The direct annual cost of allergic rhinitis is estimated to be in the range of EUR 1.0–1.5 billion while the indirect cost is thought to be between EUR 1.5 and 2.0 billion in Europe (14). Optimal treatment can significantly reduce these indirect costs (15, 16).

Clinical guidelines are systematically developed statements designed to help practitioners and patients make decisions about appropriate health care for specific circumstances (17). There have been guidelines for allergic rhinitis in various countries for decades (1, 18, 19). In recent years there has been interest in guidelines as a tool for implementing health care, based on proof of effectiveness (1). In the new ARIA guidelines (1) allergic rhinitis is subdivided into "intermittent" and "persistent" disease, with "intermittent" being defined as symptoms of less than four days per week or less than four consecutive weeks per year. Moreover, symptoms are divided into mild or moderate/severe. In this classification, moderate/severe implies an impact on work, school, daily activities or sleep. The first point of contact for many patients presenting with allergy symptoms is the primary care physician.

In this issue of *Allergy*, Demoly and colleagues (20) report on the management of intermittent allergic rhinitis in everyday general medical practice in France (ERASM). The paper centres around two main issues. The first is how diagnosis and treatment are delivered by general practitioners. The second is the effect of the disease and its management from a patient perspective. Demoly states that the diagnosis of allergy was confirmed by allergic tests, like skin prick testing or measurements of specific IgE, in only half of the patients. The diagnosis of allergy is based on the correlation between the clinical history and diagnostic tests for allergy. The ARIA paper points out that it is not possible to diagnose allergy on the basis of clinical history alone. Although this is clear for allergic rhinitis in general, it has been argued that a clear clinical history of seasonal allergic rhinitis combined with a good response to the initiated treatment means that further diagnostic tests are unnecessary (21).

The choice of treatment by general practitioners is a very interesting issue. More than 90% of patients were treated with oral H_1 antihistamines, as opposed to 45% with local corticosteroids. These figures are in accordance with the advice given by consensus groups on seasonal/moderate to severe intermittent allergic rhinitis (1, 19). On the other hand, a recent meta-analysis has shown that nasal corticosteroids are more effective than antihistamines (22). Nasal corticosteroids are also more cost-effective than the most commonly prescribed antihistamines (23). Moreover, in the consensus reports, local corticosteroids are advised if symptoms are not brought sufficiently under control with an antihistamine. Given the fact that the allergic rhinitis had a severe impact on sleep and daily activities in 90% of these patients, a higher prevalence for the prescription of nasal corticosteroids could be expected.

It is fascinating to see that almost 75% of the patients were prescribed more than one medication. In other

words, a considerable number of patients received an antihistamine and a topical corticosteroid simultaneously, even though the literature has not shown this combination to give significantly better treatment effects than single medication (24). Combined treatment has been advised only in special cases where single treatment fails. It is not clear from the PRAGMA study whether a single medication was tried before the period of this study. In the discussion, it is suggested that general practitioners use this combined treatment in an effort to obtain the maximum reduction in the symptoms of the patient. However, no increase in treatment efficacy has been shown, and there are increases in costs and possibly side-effects. It can be argued, moreover, that increasing medication might reduce patient compliance.

The second aim of the study centred on the effect of the disease and its management from the patient perspective. Again, in this ERASM study, a striking feature is the negative effect of allergic rhinitis on patients' quality of life. Moreover, the considerable impairment in occupational and school activities stresses a need for optimal therapy with minimal side-effects. Although 78% of the patients were satisfied with the efficacy of the treatment, only half scrupulously followed the instructions given by the general practitioner, and 44% added other medication themselves.

A vital question arising from this paper is what we want from doctors who treat allergic rhinitis. On the one hand, Lund et al. have shown, broadly speaking, that general practitioners who use guidelines are more effective in treating their patients than general practitioners who are not advised about treatment selection (25). On the other hand, data from a number of double-blind studies, in which compliance is usually higher than in daily practice, has shown that patient satisfaction with treatment ranges from 60 to 90% (24, 26–28). This is in the same range now found in the ERASM study. Satisfaction is important because it increases the probability of patient compliance. Demoly states that only half of the patients followed the instructions of the general practitioner and more than half wanted more advice from their GP. Would this percentage be higher if patient education was increased (29)? Although patient education has been a hot topic in some areas like asthma – with a number of conflicting papers about the effects – data on patient education in rhinitis is scarce (30, 31). An ENT paper stated that lack of patient education accounted for 28% of patient treatment failures (31). We need more studies to determine the effects of patient education in allergic rhinitis patients.

What is the maximum possible reduction in patient symptomatology? What percentage of satisfied patients can be achieved? How can these goals can be achieved in daily practice? Increased knowledge (22, 23) and adherence to guidelines (1, 18, 19, 25) have been shown to increase the quality and cost-effectiveness of our medical care.

Thus we should try in every way to encourage doctors who treat allergic patients (32) to observe the latest guidelines. Efforts are required from specialists in terms of teaching and encouragement of others who treat allergic patients.

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