

Preface

Allergic rhinitis: an increasing clinical problem

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Rhinitis is characterised by the symptoms of nasal itch, sneezing, rhinorrhoea, obstruction to nasal air-flow and, in some instances, loss of sense of smell (6). As rhinitis is not a fatal condition, it has often been trivialised, but to the sufferers it causes considerable morbidity. In addition to the obvious discomfort of the nasal disorder, patients often feel unwell, have an increased likelihood of headache and sinusitis due to impaired sinus drainage, disturbance of sleep and daytime concentration, social embarrassment, and find that the presence of rhinitis interferes with sport and social activities. Furthermore, it is a condition that is increasing in prevalence and, on account of the seasonality of grass-pollen-induced rhinitis, is often severe at times of public examinations for school children and university students.

Epidemiological studies have identified an increase in the prevalence of allergic rhinitis over the last 20–30 years (1–9, 11). This is evident in studies from Switzerland, England, Wales, Sweden and Finland. Questionnaire surveys have identified an increase in seasonal allergic rhinitis in Switzerland between 1970 and 1984 in 4–6-year olds from 0.5% to 1.1% and in 15-year olds from 4.4% to 6.1% (8, 9). A further survey in the same country conducted in 1989 in 15–24-year olds reported a cumulative prevalence in this older population of 16% (11). The

peak incidence appears to occur in the teenage years (3) and prevalence rates for seasonal allergic rhinitis of 18.0% and 19.7% have been reported in student populations (5, 6). The progressive increase has also been evident from surveys of consultations in general practice in England and Wales. There has been a quadrupling of the annual attendance for grass pollen seasonal allergic rhinitis between the years 1955–56 and 1981–82 (5, 7). In three separate surveys, the annual period prevalence of hay fever consultations increased from 5/1,000 in 1955–56 to 10.6/1,000 in 1970–71 and to 19.8/1,000 in 1981–82. This is unlikely to represent a change in diagnostic ability as the symptoms and seasonality of the disorder are characteristic. Such a doubling in the decade between 1971 and 1981 is also evident in Sweden (1). A questionnaire survey of Swedish army conscripts, involving approximately 55,000 each year, identified a prevalence of 4.4% in 1971 and 8.4% in 1981. Less uniform comparisons also indicate an increasing prevalence in Finland with survey reports of 2.7% in 10–19-year olds in 1970 (2) in contrast to 22% in 15–17-year olds in 1980 (4).

The cause of the increase in rhinitis symptoms is incompletely understood. Any explanation has to account for the allergic nature of rhinitis. Expression of allergic rhinitis depends upon a genetic predisposition to excessive immunoglobulin E (IgE) pro-

duction and the host response to the environment. As it is impossible that a major change in the gene pool could have occurred within the population over the short period in which rhinitis prevalence has increased, most potential explanations have focused on the environment. It has been proposed that atmospheric pollution could be an important variable. This has not, however, been substantiated, at least in relationship to sulphur dioxide and particulate matter. Following German reunification, a well controlled comparative survey between Leipzig and the comparatively less polluted city, Munich, involving more than 7,000 children, identified that both allergic rhinitis symptoms and skin test positivity were lower in Leipzig (2.4% and 18.2%, respectively) than in Munich (8.6% and 36.7%) (10). Attention is currently focusing on the early life events which regulate IgE production, but until this is understood and permits intervention, patients will present with established symptoms that require therapeutic intervention to control.

We are therefore pleased to invite you to read the proceedings of a symposium on the understanding and treatment of allergic rhinitis, sponsored by Glaxo, held at the joint International Congress of Allergology and Clinical Immunology/European Association of Allergology and Clinical Immunology in Stockholm in 1994. The symposium covered the current understanding of the cellular basis of rhinitis, the use of nasal biopsy and nasal cytology studies to monitor nasal cellular events both in relationship to disease expression and therapeutic intervention, an update on the pharmacology and anti-inflammatory effects of the novel, topical, intranasal corticosteroid, fluticasone propionate, and the results of clinical

cal trials involving fluticasone propionate in the treatment of allergic rhinitis.

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