

# Nasal Steroids, Shots Are Best for Seasonal Allergies

BY BRUCE K. DIXON  
Chicago Bureau

KEYSTONE, COLO. — Nasal corticosteroids remain the first line of treatment for most patients with seasonal allergic rhinitis, according to Dr. Harold S. Nelson.

"Nasal steroids started before the beginning of the season [work well]," Dr. Nelson said at a meeting on allergy/clinical immunology, asthma, and pulmonary medicine. "If people come in during the season and are symptomatic, using 20 mg prednisone three times a day to depress the inflammation greatly enhances the effectiveness of the nasal steroid."

The use of antihistamines as a first line of treatment for seasonal allergic rhinitis is an antiquated approach, said Dr. Nelson, professor in the division of allergy and clinical immunology at National Jewish Medical and Research Center in Denver, which sponsored the meeting. "[They] are something you use for the person who has intermittent symptoms."

Antihistamine-decongestant combinations, and cromolyn sodium nasal solution started 9 weeks before the onset of symptoms, each provide moderate relief, though cromolyn sodium is short acting and has to be taken six times a day, Dr. Nelson said.

Intranasal corticosteroids also outperform antihistamines when the two are compared

on an as-needed (PRN) basis for the reduction of allergic inflammation, Dr. Nelson said (Arch. Intern. Med. 2001;161:2581-7).

Recent findings have shown that seasonal treatment that combined antihistamine and a nasal steroid (levocetirizine as an add-on to fluticasone) was of marginal value and led the authors to deem the practice "inappropriate" (Clin. Exp. Allergy 2006;36:676-84).

**The use of antihistamines as a first line of therapy for seasonal allergies is an antiquated approach.**

DR. NELSON

has been shown to be superior to either drug alone for alleviating nasal obstruction and itchy, sneezy, and runny symptoms (J. Allergy Clin. Immunol. 2000;105:917-27).

According to Dr. Nelson, the choices, from least to most effective, are:

- ▶ Leukotriene-receptor antagonists (less than 10% relief, compared with placebo).
- ▶ Antihistamines, anticholinergics (rhinorrhea only), decongestants (obstruction only), and nasal corticosteroids started during season (less than 20% relief).
- ▶ Cromolyn (six times per day) started before season, antihistamine/decongestant combinations (20%-40% relief).
- ▶ Nasal corticosteroids started before season or after 4 weeks, allergen immunotherapy (greater than 40% relief). ■



# Sleep Problems Dog Many Allergic Rhinitis Sufferers

BY DOUG BRUNK  
San Diego Bureau

SAN DIEGO — People with allergic rhinitis report more sleep problems during winter, compared with the general population, Dr. Eli Meltzer said in a poster session at the annual meeting of the American Academy of Allergy, Asthma, and Immunology.

The finding underscores the importance of asking patients with allergic rhinitis how their symptoms are affecting their sleep quantity and quality.

"[People who] don't get adequate sleep are cognitively impaired and often psychosocially impaired," Dr. Meltzer, an allergist who practices in San Diego, said in an interview.

Dr. Meltzer and his associates mailed a 27-item survey to 6,476 people nationwide between December 2005 and February 2006 who had completed a screening questionnaire during May and June of 2004 to target people with symptoms of allergic rhinitis. The purpose of the follow-up survey was to provide a longitudinal assessment of disease and to capture seasonal variation in disease burden.

Respondents used the Medical Outcomes Study Sleep Scale to rate their

sleep. It measures sleep quality and quantity on two scales, a sleep adequacy scale and a sleep problems index scale, ranging from 0 to 100: Higher adequacy scale scores correspond to more adequate amounts of sleep; higher problems scale scores correspond to poorer sleep quality. The scales' mean general population norms are 60.5 and 26.9, respectively.

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DR. MELTZER

Complete data were available on 5,371 of the respondents. Of these, 1,788 (33%) reported symptoms consistent with seasonal or perennial allergic rhinitis during the previous 4 weeks that were not related to a cold or to the flu, such as runny nose/sneezing, itchy nose, congested nose, and postnasal drainage.

The allergic rhinitis sufferers' mean scores on the sleep adequacy and sleep problems index scales were 51.1 and 35.3, respectively. More than 65% of the allergic rhinitis sufferers reported problems falling asleep or falling back to sleep after awakening, and fewer than half indicated they get enough sleep or feel rested upon awakening.

GlaxoSmithKline funded the study. Dr. Meltzer disclosed he has received research grants and honoraria from the company. ■



# COPD, Comorbid Pneumonia Present Diagnostic and Treatment Challenges

MONTREAL — Exacerbations of chronic obstructive pulmonary disease may need more aggressive therapy when they co-occur with pneumonia, said Dr. Charles Chan, professor of medicine at the University of Toronto and head of respiratory at University Health Network and Mount Sinai Hospital in Toronto.

Chronic obstructive pulmonary disease (COPD) can predispose patients to pneumonia, but differentiating between the two conditions can be difficult, Dr. Chan said at an international conference on community-acquired pneumonia.

"COPD exacerbations alone are generally recognized, but with pneumonia, they may be underappreciated" and thus undertreated, Dr. Chan said in an interview at the meeting, sponsored by the International Society of Chemotherapy.

Guidelines for treating mild exacerbations of COPD (Can. Respir. J. 2004;11[suppl. B]:3B-

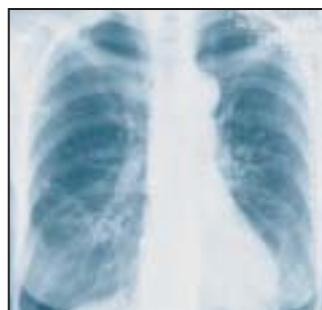
59B) recommend antibiotic treatment with macrolides, but only in the presence of purulent sputum.

In contrast, the guidelines for community-acquired pneumonia (CAP) in older patients with comorbidities such as COPD suggest that fluoroquinolones be administered to the patient (Clin. Infect. Dis. 2007;44:S27-S72).

But recognizing CAP in a patient with COPD exacerbation can be tricky.

"You can see the differences on x-ray, but even this can be subtle, and if you don't do an x-ray, ...it is hard to tell the difference," he said in the interview.

—Kate Johnson



**COPD exacerbation involves hyperinflated lungs (left); concurrent pneumonia involves nodular infiltrates (right).**

PHOTOS COURTESY DR. CHARLES CHAN

# Home Allergy Test Kits Deemed Substandard and Incomplete

SAN DIEGO — An increasing number of allergy tests are available on the Internet, and many are of unproven value, Dr. Helen Smith reported during a poster session at the annual meeting of the American Academy of Allergy, Asthma, and Immunology.

Dr. Smith, professor and chair of primary care at Brighton and Sussex (England) Medical School, and her associates used the search engines Google and Ask (formerly known as AskJeeves) and entered the following phrase: "allergy AND tests AND (home OR self)." The search identified 38 tests that were offered by 26 suppliers, with 61 different test/supplier combinations.

The most common categories of tests were for allergen-specific IgE (11 examples) and other (11), followed by allergy-specific IgG (4), unspecified dust allergens (4), celiac disease antibodies (4), mold from dust (3), and total IgE (1).

The most common sample requirement was blood from a finger stick (17 examples), followed by drawn blood (11), dust (7), and saliva (1). Two other tests did not require a sample, only answers to a questionnaire. The results for 14 tests required self-inter-

pretation; 8 tests reported the results on a Web site, 5 were mailed to the patient's physician, and 3 were mailed to the patient. For two tests, the method of notification was not clear.

Twenty-four tests offered advice on a nutritionist, and 7 provided a telephone help line. In 24 of the 61 test-supplier combinations, no advice was offered. Costs ranged from free questionnaires to \$1,290 for a screen of more than 200 allergens.

"Home allergy tests may have an adverse impact on health by giving false reassurance [without] a structured allergy history and inappropriately linking symptoms to a nonexistent allergy," they wrote.



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DR. SMITH

—Doug Brunk