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Reply

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It's a great pleasure for us to understand that our colleagues Dr de Beaumont and Dr Yalaoui could find our paper interesting enough to publish their letter (1); it's a honor for us to have the opportunity to answer them on this journal.

As also they reported, the aim of our paper was to evaluate the available trials, at the date of article submission, with Grazax® and Oralair® to support their use in clinical practice.

Our position regarding the pre-seasonal and co-seasonal schedule is not a personal one, but is coming from international reports in literature. According with this administration schedule, we presented all phase III studies about Grazax® and Oralair®, designed in a very similar way because focused to the same objective: to demonstrate efficacy and safety in order to obtain marketing authorization from European Medicine Agency (EMA). Our purpose was not to define if Grazax® used with a pre-co-seasonal schedule was the "best option" in using that, instead we were looking for evidence from the studies for a possible Grazax® use with a pre-seasonal schedule as we usually prescribe in clinical practice. We concluded with a clear position: "*Although no proper pre-seasonal trials with Grazax® are today available, we can be optimistic about the pre-seasonal use of this product because it seems to give worthwhile results since the first months of the first year of treatment, in adult, in children and adolescents, but more evidence is required*".

We have also reinforced this statement, reporting in **table 1** four studies conducted with Grazax® with a range of treatment duration from 5.3 months to 7 months.

We also reported that Oralair® is the only allergen immunotherapy sublingual tablet with demonstrated efficacy and safety using a pre-seasonal and co-seasonal treatment regimen.

We apologize for the mistake about **table 2** and we are very grateful to the colleagues for the opportunity to make correction as they did.

Moreover, we would like to thank the colleagues to give us the opportunity to complete our overview about both immunotherapy drugs because the two studies they mentioned have been completed and published after the submission of our article (2,3).

Lastly, we concluded with the statement: *"Which patient for which grass pollen drug? We have no definite answer today"*. At the moment there are not enough studies to define the best grass allergens to put into a grass pollen immunotherapy. Grass pollen allergy is common worldwide, and group 1 and group 5 allergens (Phl p 1 and Phl p 5) are the dominating grass pollen allergens. More than 90% of subjects with sensitization to grass pollen have IgE abs to Phl p 1 and/or Phl p 5 (4,5). The presence of specific components for grass (like Phl p 1 and/or Phl p 5) is fundamental for a better indication for SIT (6). SIT treatments are expensive and prescribed for several years and a correct diagnosis is therefore important.

In conclusion we would like to thank our colleagues for the opportunity to make correction and to add data to an article that can be very useful to clinical allergists that deal with patients and their daily problems all the time.

References

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