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The role of nasal endoscopy in the prescription of allergen immunotherapy

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Key words
Allergic rhinitis, allergen immunotherapy, nasal endoscopy.

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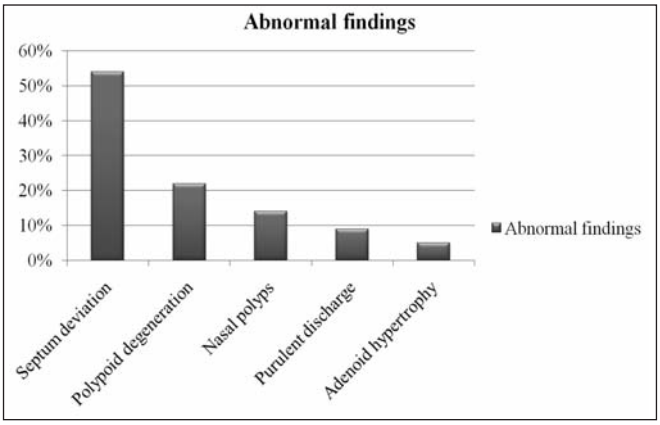
To the Editor

According to the more recent guidelines, allergen specific immunotherapy (SIT), can be prescribed in rhinoconjunctivitis and/or asthma, if an IgE mediated mechanism is well ascertained, if the causal role of a given allergen is uncontrovertibly demonstrated, if the disease is not properly controlled by medications, when an effective allergen avoidance is not feasible (1). In particular, the cause/effect relationship between the responsible allergen and the clinical manifestations is crucial for a successful outcome of the treatment. This association can be easily demonstrated, for instance in patients monosensitized to a pollen allergen, since symptoms will be present only during the pollen season. On the other hand, polysensitization and overlapping pollen seasons may make difficult the choice of the proper allergen extract (2). In patients allergic to pets or house dust mite, the intermittent presence of symptoms during the whole year is not necessarily a reliable diagnostic criterion for the prescription of SIT. In addition, especially in adults, concomitant upper respiratory diseases (e.g. rhinosinusitis, polyps, septal deviation, adenoid hypertrophy) should be ruled out, since their presence can be responsible for the failure of SIT (3). A recent study reports the prevalence of co-morbidities (history of polyps & sinusitis) in HDM-allergic subjects and the little influence of this data on SIT prescription (4).

In this observational study we assessed the decision-making role of nasal endoscopy in the prescription of SIT in patients with house dust mite sensitization. One hundred and fifty seven patients (102 male, age range 18-60 years), suffering from moderate/severe persistent rhinitis (5) were included. They had to have positive skin prick test (mean wheal diameter > 5mm) and/or positive CAP-RAST (> 0.35 kU/L) to house dust mite. Nasal obstruction was present in 82%, rhinorrhea in 76%, sneezing in 73% and smell impairment in 19% of the patients. All of them were not fully controlled by house dust avoidance measures and pharmacotherapy. Only 16 (10.1%) were monosensitized to house dust mite. No contraindication to SIT was documented and, therefore, all where eligible for SIT according to guidelines. All subjects underwent nasal endoscopy with a fiberoptic rhinoscope (Pentax LH 10 RP3, light source Pentax LH 150 II). At the end of the endoscopic procedure, the final diagnosis was shared by an allergist and an ENT specialist. Abnormal endoscopic findings were observed in 52% of patients, being sep-

Figure 1 - Abnormal findings observed in patients selected for IT



tal deviation, adenoid hypertrophy and nasal polyposis the most common abnormal findings (Fig. 1). SIT was prescribed to 64 patients (41%), in 19 (12%) was considered not indicated and in the remaining 74 subjects (47%) a further ENT evaluation was prescribed for possible surgery.

According to these data a nasal evaluation, preferably with an endoscopic procedure, has to be a regular decision-making step for a proper IT prescription. Of course the detection of pathological findings is not per se a contraindication for the IT use, but the allergist and the patients have to share this information, which could affect the final outcome of the treatment. Nasal endoscopy is a safe and comfortable test seldom performed or suggested by allergists (6,7). However a wider use of this diagnostic procedure could be helpful in an comprehensive assessment of severe allergic rhinitis and when it is impracticable a more regular ENT evaluation has to be suggested before starting IT for perennial allergies.

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