

ABC OF ALLERGOLOGY

SORRY, BUT YOU DON'T HAVE AN ALLERGY!

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Although allergic diseases are on the rise and present a major health problem, many people are incorrectly labelled or self-diagnosed as being allergic or food intolerant.

It is all too easy to assume that any persistent non-specific symptom must be an allergy. The lay media and growing Internet culture breed self-diagnosis, and alternative allergy practices thrive on making diagnoses of food allergies, environmental intolerances and chemical sensitivities to a wealth of common substances. Very often these can never be substantiated or absolutely disproved. Non-specific symptoms linked to poor lifestyle such as tiredness, poor concentration, weight gain, food cravings, mood swings and polymyalgia are not allergy related.



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Allergic diseases should be diagnosed by a qualified doctor and not a lay practitioner armed with a short correspondence course in health, nutrition or allergy. Syndromes such as fibromyalgia, chronic candidiasis, myalgic encephalomyelitis, reactive hypoglycaemia, attention deficit disorder/hyperactivity (ADDH) and depression are not allergic in nature. Diagnostic labels of allergy tend to stick for life without reappraisal. For example, most transient viral rashes in childhood are unrelated to penicillin co-prescribed at the time, but often mislabelled as penicillin allergy. Similarly, vomiting attacks after eating spoilt fish are more likely to be food poisoning and not due to 'iodine' allergy.

Diagnosing allergy needs to be an investigative process which involves a comprehensive allergy history exploring onset of symptoms and their causal relationship to allergen exposure. In addition, looking at lifestyle, current medical history and family history of allergies plus concomitant allergen exposure will all help trace the offending allergen. This should be followed by reliable and validated allergy testing and may even necessitate formal allergen challenge testing. Treatment recommendations should be based on scientifically validated allergy management as outlined in the *Good Allergy Practice* guidelines (Table I).¹

Very often, non-specific and transient symptoms receive a reflex response of 'It must be some sort of allergy' from the busy physician. Unsubstantiated statements like these can lead to unnecessary and life-long allergen avoidance. It is extremely important to confirm a suspected allergy by antigen testing either *in vivo* or *in vitro* and if no reliable test exists, then serious consideration should be given to a graded allergen challenge in hospital if necessary.

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Table I. Good Allergy Practice – Principles

- " Symptoms and signs of allergy are based on sound scientific evidence.
- " Testing, including skin testing and immunological blood tests, should be validated and reproducible.
- " Treatment should be evidence-based and universally accepted by allergy opinion leaders.
- " The vast majority of allergic reactions involve IgE immediate hypersensitivity but delayed hypersensitivity (IgG and cell-mediated) does occur.
- " There is a familial predisposition to develop allergies (called atopy).
- " Allergic conditions include: anaphylaxis, hay fever, perennial rhinitis, allergic asthma, skin allergies, food allergy and intolerance, allergies to venoms, drugs, and occupational allergies.

If a patient presents with a number of allergy-like symptoms but no causative allergen is identified with testing or on challenge, then it is important to inform the patient that an allergic disease is unlikely to be present.

A 'grey area' occurs with delayed hypersensitivity reactions, which may occur some time after exposure and are not identified by specific IgE allergy testing. These conditions are not common, despite the media interest and the pattern of symptoms should facilitate the correct diagnosis. Bizarre and atypical symptoms may often be attributed to allergic diseases by self-professed intolerance 'experts'. Lactose intolerance causes primarily gastrointestinal (GI) symptoms and not rashes! Gluten intolerance causes GI symptoms before malnutrition, fatigue, anaemia or rashes. Conditions not related to allergy are listed in Table II.

Table II. Conditions unrelated to allergy

- Obesity or weight gain
- Fibromyalgia and repetitive strain injury (RSI)
- Multiple sclerosis
- Parkinson's disease
- Myalgic encephalomyelitis
- Postviral fatigue syndrome
- Food phobia and aversion
- Anxiety or panic attacks
- Reactive hypoglycaemia
- Depression
- Insomnia
- Rheumatoid arthritis
- Candida* vaginitis and systemic candidiasis
- Irritable bowel syndrome
- Crohn's disease
- Nocturnal enuresis
- Attention deficit disorder/hyperactivity
- Autism
- Hyperosmia on exposure to volatile chemicals and odours

Food-related symptoms may occasionally be T-cell- or IgG-mediated in children, particularly with cow's milk-induced oesophagitis and delayed infantile eczema. Trial-and-error challenges will reproduce symptoms and identify the causal allergen. Food-additive reactions to colouring and preservatives remain controversial and additive allergy testing is unreliable. Thus the medical literature is filled with contradictory case studies and the very existence of this form of allergy remains debatable.

In the final analysis, a healthy, nutritious diet, free of excessive additives, together with plenty of exercise will go a lot further to improve overall health, rather than exhaustive allergy testing and unnecessary elimination diets or supplements. The input of a suitably qualified dietician is worth its weight in gold in resolving nutritional issues.

In these times of medicolegal litigation and liability claims, practitioners are loath to readily discount an allergic disease. However, if the symptoms don't fit a recognised allergic pattern and the appropriate tests are negative, then it is prudent to inform patients that their symptoms are unlikely to be due to an allergy (Table III). A patient with a condition spuriously diagnosed as allergy will not respond well to conventional allergy medication and is therefore highly likely to seek further advice and treatment from 'alternative' practitioners.

Many complementary or holistic centres 'identify' previously undetected intolerances to numerous foods and environmental chemicals. The diagnosis is accompanied by a superficially plausible explanation of symp-

Table III. Allergy or no allergy – that is the question!

- " Symptoms should fit a well-documented allergic condition.
 - " Typical physical signs should be present at examination.
 - " History should implicate well-defined allergens.
 - " Testing should confirm diagnostic hypothesis (skin, blood or challenge testing).
 - " Repeated allergen challenge should trigger reproducible symptoms and allergen withdrawal should improve these symptoms.
 - " Conventional allergy treatment should ameliorate symptoms.
- If not – then review the diagnosis! It may not be an allergy.

toms reinforced and illustrated with simplified physiology.

If a diagnosis of allergy appears unlikely, and all the parameters point away from this diagnosis, inform the patient that no allergy is likely to exist. Excessive allergy testing for the sake of screening will only raise the level of anxiety and serve little purpose at the end of the day.

REFERENCES

1. Royal Colleges of Physicians and Pathologists. *Good Allergy Practice: Standards of Care for Providers and Purchasers of Allergy Services in the NHS*. London: RCP, 1994.

PRODUCT NEWS

XYZAL® (LEVOCETIRIZINE) REDUCES THE COST OF PERSISTENT ALLERGIC RHINITIS

Using the once-daily antihistamine Xyzal (levocetirizine) reduces the cost of persistent allergic rhinitis to employers and to society, and significantly improves symptoms and quality of life for patients, in comparison to no treatment.²

These are the key findings from a detailed cost analysis of the results of the Xyzal in Persistent Rhinitis Trial (XPERT), published in the leading journal *Allergy*.¹ The analysis shows that levocetirizine reduces the societal costs of persistent allergic rhinitis by 43%. For employers, it reduces costs by 45%/working patient/month.

'The costs of untreated persistent allergic rhinitis are substantial – to patients, to healthcare providers, to employers, and to society as a whole,' commented Professor Jean Bousquet, lead author of this important paper. 'The results of this innovative study show that these costs can be significantly reduced through long-term treatment with levocetirizine.'

XPERT is the first clinical study to follow from the reclassification of allergic rhinitis by the Allergic Rhinitis and its Impact on Asthma (ARIA) project, in collaboration with the World Health Organization, in 2001.³

Persistent allergic rhinitis is now defined as allergic rhinitis with symptoms (runny nose, itchy eyes and nose, sneezing and blocked nose) that occur more than four days per week and last for more than four consecutive weeks.³

The new cost analysis of XPERT showed that levocetirizine treatment led to significant reductions in medical resources required to treat persistent allergic rhinitis, compared with no treatment (nasal cromoglycates, -40%; ocular cromoglycates -55%; additional medications, -59%), and in additional medications required to treat comorbidities.¹

Time lost from work and usual daily activities (such as leisure activities and unpaid work) was significantly greater for patients whose persistent allergic rhinitis was not treated, compared with those who took levocetirizine.

Professor Bousquet pointed out that 'given the burden associated with persistent allergic rhinitis, treatment with levocetirizine could substantially improve the life of those who suffer from the disease.'

References available on request. Contact Louise Rabie 011-481-3000.

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