

# GUEST EDITORIAL

## SOUTH AFRICAN ALLERGIC RHINITIS WORK GROUP (SAARWG) – UPDATE ON CONSENSUS STATEMENT

Since the publication of the first comprehensive South African Consensus Statement for the 'Diagnosis and management of allergic rhinitis in South Africa' 10 years ago in the *South African Medical Journal*,<sup>1</sup> there have been several new publications on new forms of therapy now available for patients with allergic rhinitis.<sup>2-4</sup> The South African Allergic Rhinitis Working Group (SAARWG) reconvened on 5 May 2006, to consider the new therapeutic options and developments in rhinitis management in order to update the South African Allergic Rhinitis consensus document of 2006. Inadequately controlled allergic rhinitis in asthmatic patients can contribute towards increased exacerbation of asthma, poorer medical control and an increase on the demands of medical resources.

While most of the recommendations of the 1996 document remain sound, the SAARWG wished to highlight and discuss the advances and make appropriate recommendations. An extensive summary has been prepared for publication in the *South African Medical Journal*. However in this edition of *Current Allergy & Clinical Immunology* we have taken the opportunity to include a number of the papers presented for discussion at the consensus meeting and in this editorial a summary of the discussions that followed.

Leukotriene receptor antagonists were not included in the 1996 document and their current status in the treatment of rhinitis, particularly in association with asthma, was introduced to the consensus by Prof. Robin Green. The other major therapeutic modalities of antihistamine, steroids and immunotherapy were reviewed in papers presented respectively by Dr Raymond Friedman, Dr Ahmed Manjra and Prof. Paul Potter.

**The Allergic Rhinitis and its Impact on Asthma (ARIA) document published in November 2001 reclassified allergic rhinitis.** The classification of 'persistent' and 'intermittent' is indeed more relevant to the long pollen seasons prevalent in many regions of South Africa. Most patients with pollen-induced rhinitis have persistent rhinitis. This impacts on length of treatment regimens. In many patients a long term 'maintenance' therapy will then be more appropriate than a short course.

**Considering the investigation of allergy in rhinitis,** it was emphasised that large investigative panels are seldom necessary. In all regions of South Africa a test panel should include house-dust mites (Der p-1, Der f-1), Bermuda grass, rye grass, dog, cat, cockroach and fungal spores. Should the history suggest the possibility,

trees such as plane, oak, cypress and eucalyptus can be added.

This panel should be used for both skin-prick and CAP RASTs.

Skin-prick testing remains the least expensive. The Phadiatop test may be used as a screening blood test particularly if there is no useful history to identify inhalant allergens or when an inhalant allergy needs to be excluded. The CAP RAST is a sensitive and specific blood test.

Some patients with rhinitis are affected by foods and non-IgE-mediated food-induced rhinitis must be considered.

**The quality of life of rhinitis** patients has been reported to be worse than that of asthmatics. This is often not appreciated by the medical practitioner and indeed the patient themselves do not take their rhinitis 'seriously' with consequent adverse effect on therapy. Doctors are encouraged to assess their rhinitis patients as a whole, rather than just focusing on the rhinitis. In this context the sedative effects of first-generation antihistamines should be noted.

**Specific allergen immunotherapy (SIT)** is the only form of therapy which can change the natural history of allergic rhinitis. Two forms of SIT are available, SCIT (subcutaneous immunotherapy) and SLIT (sublingual immunotherapy), both being highly effective in treatment of house-dust mite and grass allergy. Important facts were highlighted: namely, SLIT is safer and can be taken at home while SCIT should only be conducted by doctors trained in the procedure. The specific allergy must be identified by RAST or skin-prick test prior to the patient starting immunotherapy.

At the SAARWG meeting in a review of the combined experience of the SAARWG, representing over 200 patients in South Africa treated with SLIT for up to 3 years, on a named-patient basis, no serious adverse side-effects have been reported. Recent South African data have confirmed that the mean medication cost for patients who have received SLIT has reduced by 75%.

Since immunotherapy vaccines are still unregistered by the MCC, these vaccines must still currently be approved by the MCC on a named-patient basis prior to ordering and administration. It is the prescribing doctor's responsibility to make the application and also provide 6-monthly progress reports on such patients until SLIT is registered fully by the MCC.

**Mandatory substitution of medicine** has been law in South Africa since 2002. The meeting noted with concern that some patients do not improve clinically on certain generic antihistamines and intranasal steroids. SAAWRG recommends that evidence of clinical equivalence be available before such substitution is made.

**Pharmacists play an important role in treating upper respiratory tract infection**, often being the primary care **provider**. The pharmacist therefore needs to distinguish the infective from the allergic nose. The patient too needs to understand the necessity for this distinction thereby limiting the prescription of antibiotics and 'cold mixtures' for allergic rhinitis.

The SAARWG believes that to improve the management of allergic rhinitis in South Africa, not only do the doctors require updated information and training to adequately assess and manage allergic rhinitis, but that further education of the pharmacists and of the general public is also essential in the future.

It is suggested that the above recommendations regarding immunotherapy and pharmacotherapy be used to amplify, update and complement the 1996 SARWG guidelines which remain the foundation for the assessment and treatment of allergic rhinitis in South Africa.

**Maurice Hockman**

**Guest Editor**

## REFERENCES

1. South African Rhinitis Working Group. Consensus Document: Allergic rhinitis in South Africa – diagnosis and management. *S Afr Med J*. 1996; **56**: 1315-1328.
2. Bousquet J, *et al*. Allergic rhinitis and its impact on asthma: A WHO-World Allergy Organization Workshop Report. *J Allergy Clin Immunol* 2001; **108**: Suppl S147-S152.
3. Shekelle PG, Woolf SH, Eccles M, *et al*. Developing guidelines. *BMJ* 1999; **318**: 593-596.
4. Bousquet J. The new ARIA guidelines: Putting science into practice. *Clin Exp Allergy Rev* 2002; **2**: 38-43.

## ONLINE CPD ACCREDITATION NOW AVAILABLE FOR CURRENT ALLERGY & CLINICAL IMMUNOLOGY

*Current Allergy & Clinical Immunology* has been accredited for CPD points in the Clinical category, so you can now earn 2 CPD points for Individual Learning. CPD accreditation is **only** available through the online service; no faxed or mailed responses will receive CPD credits. To obtain CPD credits:

1. Read the journal.
2. Answer the questionnaire on p.211 by accessing the online CPD accreditation on the ALLSA website at [www.allergysa.org/cpd](http://www.allergysa.org/cpd) or follow the links from the home page [www.allergysa.org](http://www.allergysa.org).
3. To register, you will need to enter your name, personal details, HPCSA number and a password.
4. Once you have registered, you will receive an email

confirming your registration. You can either answer the questionnaire immediately or log on at a later date to answer the questionnaire. Please note that each questionnaire has a closing date – the closing date for submission of the November 2006 questionnaire is 28 February 2007.

5. Follow the instructions given on the questionnaire page and online.
6. After you have submitted your answers, they will be marked immediately, and you will be informed of the results and the number of points earned.
7. At any time you will be able to see your current CPD credits from the journal by logging on.