

## LETTER TO THE EDITOR

**SPECIFIC IMMUNOTHERAPY FOR ALLERGIC RHINITIS IN ITALY:  
THE PATIENTS' POINTS OF VIEW**

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**Specific immunotherapy (SIT) is the unique causal treatment for allergy, but its use is quite limited. A perspective, cross-sectional telephone interview survey was carried out in Italy to evaluate the characteristics of 500 patients with allergic rhinitis (250 of whom treated with SIT). Relevant differences were found concerning therapeutic management of allergic rhinitis, mainly regarding the use of drugs and co-morbidities. The allergist is the most important consultant who prescribes SIT. This study therefore provides evidence that the course of allergic rhinitis may depend on the therapy prescribed by and the level of allergy awareness of the physician.**

Allergen-specific immunotherapy (SIT) is the unique causal treatment regimen for allergic disorders which is capable of modifying the natural history of the allergic patient (1). Its use, however, is quite limited even though the prevalence of allergic disorders is still increasing (2).

Numerous factors may affect the use of SIT: they may be related to both the health care provider as well as the patient. The overall diagnostic pathway may be very challenging for the non-specialist physician, particularly concerning the evaluation of poly-sensitisations, the choice of the causal allergen extract to be used, the route of administration, the duration schedule, and the management regimen for adverse effects. Moreover, the patients may have difficulty in understanding recommendations for SIT provided by the physician, including duration,

possible effects with co-administered drugs, the possibility of adverse effects, cost, and the total complexity of the management scheme.

Although guidelines have been extensively and widely spread, SIT prescription usually remains in the hands of allergists (3-4). The present study was carried out to evaluate the profiles of patients with allergic rhinitis receiving SIT and those not receiving SIT in a perspective and cross-sectional telephone survey in Italy.

#### MATERIALS AND METHODS

The survey was conducted by Stethos Italy, an international specialised company in Milan commissioned by Stallergenes, Italy. The telephone interviews were carried out according to the valid and very rigorous CATI method (5) which carefully defines the criteria for the

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selection process, including randomisation, source of database, replacement of refusing patients, and analysis of non-responders,

A total of 500 patients with allergic rhinitis completed the interview: 50% of them (250) were being treated with SIT. Patient characteristics were homogeneous concerning age, sex, and geographic area, as they were randomly selected consulting register offices of all Italian regions and had to have a doctor's diagnosis of allergic rhinitis.

The interview began with the questions related to the degree of disability associated with allergic rhinitis; any significant impairment in quality of life provided the major entry criterion into the study. Numerous items were considered, including duration of the disease, symptom severity [classified as mild, moderate, and severe as previously described (6)] and chronology, impact on quality of life, type and time for doctors consultancy, diagnostic tests, and treatments, including drugs and SIT.

Statistical analysis was performed by using Student's T-test and Wilcoxon's test.

## RESULTS

More than 75% of the patients considered their symptoms as moderately severe, whereas <25% of the patients considered them as light, with no differences observed between SIT and non-SIT treated subjects ( $p=n.s.$ ). Moreover, about 40% of patients referred having a relevant limitation in

their daily activities, independently of SIT therapy ( $p=n.s.$ ).

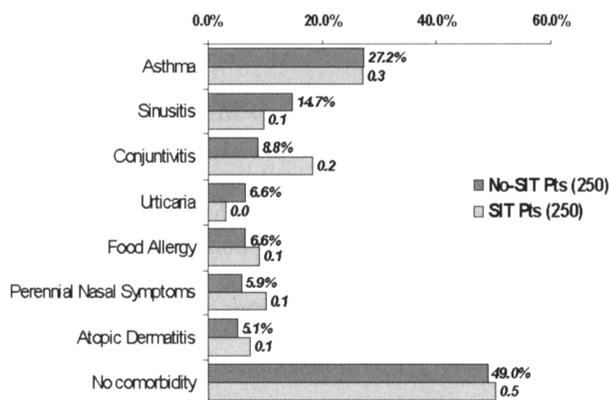
Most patients were polysensitized, the most relevant sensitising allergens were: pollens (76.5% of SIT patients and 82.4% of not-SIT ones), mites (58.8% and 58.2 respectively), and pets (11.8% and 17.2%) without significant difference in the groups. These findings confirm previous epidemiological surveys conducted in Italy (7).

Concerning the latency time between onset of symptoms and doctor consultancy, two main alternatives were observed: the patient may spontaneously take medications (12.5% and 11% of all patients, respectively) or not. In the first circumstance, the most frequently used drugs are: antihistamines and decongestants, and the latency-time is 13 months for no-SIT patients and 15 for SIT-treated ones ( $p=n.s.$ ). In the second case, the delay for medical consulting is 9 and 10 months respectively ( $p = n.s.$ ).

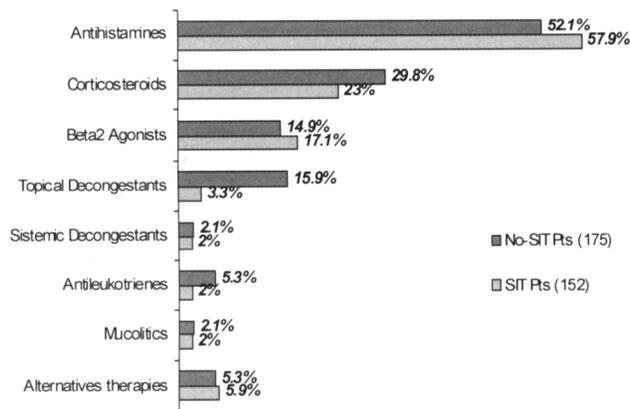
There were significant differences concerning the first consulted specialist: non-SIT treated patients firstly consulted a GP (53.7%), an allergist (33%) or a paediatrician (4.4%); whereas SIT treated ones were initially evaluated by an allergist (44.1%), a GP (26.6%) or a paediatrician (16.8%) ( $p<0.05$ ). The diagnosis of allergic rhinitis was made by the first consulted doctor (>80% of cases).

Fig. 1 shows co-morbidities: about 50% of patients have an associated disease. The most common is asthma (27%), underlining the close relationship between upper and lower airways, but without difference between groups. Instead, SIT-treated patients more frequently complain of ocular symptoms (18.4% versus 8.8%;  $p<0.05$ ) and perennial non-allergic rhinitis (10.2% versus 5.9%;  $p<0.05$ ). On the other hand, sinusitis (14.7% versus 9.8%;  $p<0.05$ ) was more common in non-SIT-treated patients. Non-SIT patient used more drugs than SIT-treated patients ( $p<0.05$ ), as reported in Fig. 2. In particular, non-SIT patients resorted more frequently to decongestants ( $p<0.01$ ), intranasal corticosteroids ( $p<0.05$ ; moreover, used on demand in 81.8% of cases), and anti-leukotrienes ( $p<0.05$ ) than SIT-treated patients.

Concerning patient perception of what was lacking in current treatments, about 66% of all patients considered as a major shortcoming the



**Fig. 1.** Co-morbidities referred by patients with allergic rhinitis, treated with SIT (dark grey) or not (light grey); \* =  $p<0.05$



**Fig. 2.** Different treatments used by patients with allergic rhinitis, treated with SIT (dark grey) or not (light grey); \* =  $p < 0.05$ ; \*\* =  $p < 0.01$

inability to determine when therapy definitely resolved the disease; 28% of patients complained about its slowness, but without difference between the SIT and non-SIT groups. Moreover, only 48.9% of non-SIT treated patients knew about SIT. In the group of SIT-treated patients, 83.3% were satisfied by SIT.

Finally, the latency time lasting between the onset of symptoms, early diagnosis, and prescription of SIT represents a relevant issue. Ten months passed on average from symptom occurrence to diagnosis (without difference between children and adults), whereas 15 months elapsed from diagnosis to SIT prescription for children and 23 months for adults ( $p < 0.05$ ).

## DISCUSSION

The present study investigates the different profiles of patients with allergic rhinitis in Italy, considering the possible use of SIT. The methodology used was rigorous and thorough concerning the refusals, the different demographic characteristics, treatments, geographic area, and answers. In this regard, the telephone interviews were carried out by a specialized international company (Stethos) with expertise in epidemiological studies. Several results appear from this survey. Firstly, it is evident that allergic rhinitis is generally considered a moderate-severe disorder that has a limited impact on daily activities. Secondly, the recourse to self-medication

retards the consultation time and the most used drugs are obviously for symptomatic-relief, such as decongestants and antihistamines.

The choice for SIT depended on the first physician being consulted; it is not surprising that the allergologists are the most important consultants who prescribe SIT. Indeed, the SIT prescription is obviously conditioned by allergological test results and, at least in some Italian regions, partially refunded by the National Health Service only when prescribed by allergologists. However, GPs frequently do not prescribe SIT. Pollens were the most frequent cause of allergic rhinitis, followed by mites; findings that confirm previous surveys (6-7).

Regarding co-morbidities, it is interesting to observe that there is a significant difference between SIT and non-SIT patients: ocular and perennial nasal symptoms seem to influence the choice for SIT. This issue could underline the relevance of ocular discomfort as a critical symptom that significantly affects the quality of life of patients, as previously reported (8), as well as the relevance for nasal obstruction.

The non-SIT patients more frequently required symptomatic relievers and generally overused decongestants. These findings therefore support the important role of SIT as a curative therapy for allergic rhinitis. In this regard, a critical aspect is the wish to resolve the problem. Fortunately, SIT largely satisfies this issue. In conclusion, this study shows that there is a difference between SIT- and non-SIT-treated patients both concerning the clinical picture and the type of drugs used.

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