

CORRESPONDENCE

Allergic rhinitis and asthma require an integrated management

We read with interest and congratulate the authors de Groot *et al* for the article on the impact of comorbid allergic rhinitis (AR) on asthma control in children.¹ We entirely agree with de Groot and coworkers that despite its high prevalence, surprisingly there are few studies on the effects of treatment of AR in asthmatic children and adolescents.

Considering its high frequency and association with poor control of asthma, among untreated and even treated subjects,² it is noteworthy that in low-middle income countries, affordability and availability of both inhaled and intranasal corticosteroids is a well-recognised problem. Driven by these circumstances, we assessed the efficacy of exclusive nasal inhalation for the concomitant treatment of asthma and rhinitis in three randomised controlled trials, one of them³ cited in the paper by de Groot *et al*.¹

In their paper, however, de Groot *et al* stated that 'One study showed that administration of an ICS through a valved holding chamber with facemask improved nasal symptoms but had no influence on asthma symptoms or lung function in children with asthma and AR. Asthma control was not assessed in this study.' Regarding this statement, we would like to point out that, as shown on table 2, page 313 of our paper (cited as reference number 27 by de Groot *et al*), asthma score (8.2 to 2.6 points), forced expiratory volume in 1 s (68.8 to 81.1, % predicted) and FEF_{25%-75%} (51.3 to 69.9, % predicted) unequivocally improved from randomisation to 8th week of the follow-up among patients who inhaled fluticasone propionate (FP, 200 or 300 µg daily depending on the age group) through their nose (mouth closed).³ The magnitude of the beneficial effect of nasal inhalation of corticosteroids over the lower airways was similar to that obtained in the conventional inhalation by mouth control group. Apart from these improvements, nasally inhaled FP controlled AR symptoms as demonstrated by the reduction of AR score and increased nasal inspiratory peak flow.³

With this same unified AR asthma management, equivalent and sustainable results were achieved in two other studies by our group.^{4 5} In the last study, once again, after 6 weeks under FP (500 µg, daily) we confirmed improvement by acoustic rhinometry from 10.1 to 11.7 cm³ and FeNO reduction from 17.7 to 9.5 ppb. Moreover, forced expiratory volume in 1 s and FEF_{25%-75%} (% predicted) increased simultaneously, confirming once more the similar efficacy of this novel approach to treatment as compared with the usual practice of topical

nasal plus inhaled corticosteroids to treat concomitant asthma and rhinitis.

Finally and once again, we entirely agree with de Groot and colleagues that additional randomised controlled trials on the effects of AR treatment on asthma control in children with asthma and AR are urgently needed.

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