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 513 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 (69.8 to 81.1, % predicted) and FEF 25%–75% (51.3 to 69.9, % predicted) unequivocally improved simultaneously, confirming once more the similar efficacy of 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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