mouthpiece for oral inhalation. The latter group also received 0.9% sodium chloride intranasal spray.³ Although asthma clinical score, forced expiratory volume in 1's, allergic rhinitis symptom score and nasal inspiratory peak flow improved in both groups from baseline, no statistically significant difference was found between the two treatment groups, except for rhinitis symptom score and nasal inspiratory peakflow at 8 weeks in favour of the experimental group ($p<0.001$ and $p=0.008$). Because all patients were steroid naive, treatment with inhaled corticosteroids could be expected to produce improvements in both groups. I agree with Camargos and coworkers that the larger improvement of the rhinitis symptom score and the nasal inspiratory peak flow in the experimental group confirm that concomitant treatment of allergic rhinitis in asthmatic children is important. In the other article examining simultaneous treatment of asthma and allergic rhinitis in children with asthma using inhaled corticosteroids, there was also no statistically significant difference between the two treatment arms.⁴

In the studies by Camargos *et al* and our study,^{3, 4} improvement of asthma control was noted when treating allergic rhinitis. To confirm these observations, a rigorously designed randomised controlled trial examining the effects of nasal corticosteroid therapy for allergic rhinitis on asthma control should be performed.

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Author's response: allergic rhinitis and asthma require an integrated management

I thank Drs Camargos and colleagues for their comments¹ regarding our paper.² I agree with our Brazilian colleagues that additional randomised controlled trials are needed assessing the effect of allergic rhinitis treatment on asthma control in children.

In the study by Camargos *et al*, steroid naive asthmatic patients received fluticasone propionate either through a face mask, while breathing through their nose with their mouth closed, or through a spacer with a