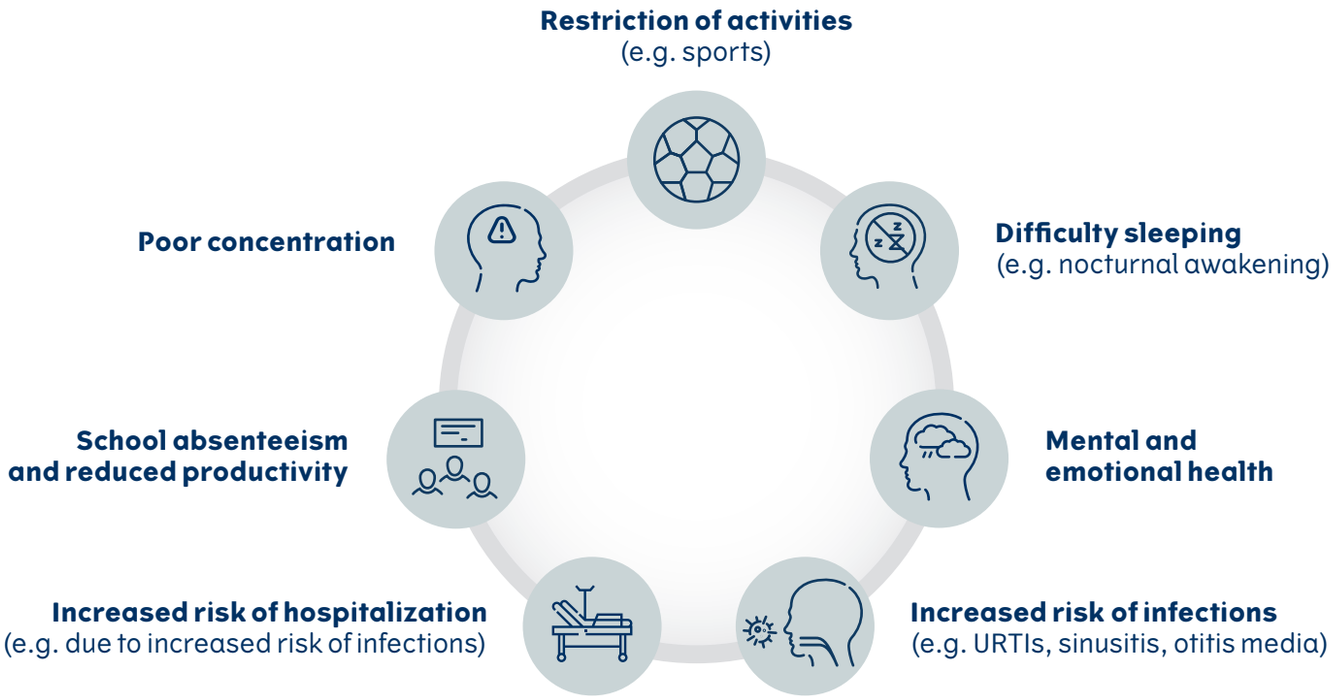
Childhood allergic rhinitis (AR) may place a burden on a child's life and might only be the beginning[1,2]

Globally, as many as 40% of children suffer from allergic rhinitis[3]

The burden of allergic rhinitis[1]



Adapted from Hamelmann E, et al.[1]

URTI=upper respiratory tract infection.

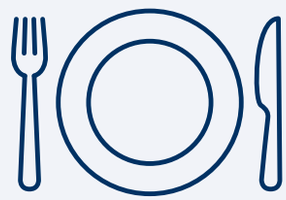
Comorbidities may develop over time in children with allergic rhinitis[1]

The "Allergy March" is progressive – children with one atopic condition can go on to exhibit others[2,4]

The Allergy March: Atopic dermatitis, IgE-mediated food allergies, asthma and allergic rhinitis have been shown to have common genetic predispositions, environmental risk factors and pathophysiology – albeit with substantial heterogeneity between individuals[1,2]

Up to 80%
of children with **atopic dermatitis** will develop AR or asthma[4]*

~50%
of children with AR have **asthma**[1,5†]



40%
of children with a **food allergy** will develop AR later in life[6‡]

* 7-member panel of specialists in Dermatology, Allergy, Asthma, Immunology and Pediatrics reviewed current literature and evolving data on atopic dermatitis (AD); conducted in US in 2002. Reviews included epidemiology of asthma and AD, genetic predisposition to allergic disease and current understanding of AD immunopathophysiology.[4]

† Observational, cross-sectional multicentre study conducted in Spain that included 1,275 patients aged 6-12 years with previous AR diagnosis and without any AR treatment during last 2 weeks prior.[5]

‡ Longitudinal birth cohort study conducted in Sweden that included 3,382 patients born in 2003. Data on asthma/allergic manifestations were collected from 6 months until 8 years of age.[6]

Most common symptoms of allergic rhinitis are brought on by the body's immunologic inflammatory response to allergen exposure:[7]

- Nasal congestion (stuffy nose)
- Rhinorrhea (runny nose)
- Repeated sneezing
- Nasal itching
- Allergic conjunctivitis (eye itching, tearing, redness, lid puffiness)

AR=allergic rhinitis; IgE=immunoglobulin type E.

While INCS remains the standard of care for AR, nearly 25% of parents were dissatisfied or somewhat dissatisfied with their children's current treatment due to:[7]*

- Loss of efficacy over a 24-hour dosing period
- Reduced efficacy over weeks or months of use
- Bothersome side effects
- Bad taste and/or medication dripping down the throat

* A national, US telephone screening of 35,757 households to identify children (aged 4-17 years) with nasal allergy (n=500). Parents of children aged 4-9 years and both the parents and their children aged ≥10 years were questioned about AR morbidity and disease management.[7]

When symptomatic therapies are not enough, AIT may be an option[8]

More flexibility to meet patient needs with two approved AIT treatment modalities:

Sublingual immunotherapy tablets (SLIT-tablets)

Subcutaneous immunotherapy (SCIT)

AIT=allergen immunotherapy;
INCS=inhaled nasal corticosteroid.

According to the Canadian Society of Allergy and Clinical Immunology:

> "Allergen immunotherapy is an effective treatment used by allergists for a wide range of common allergic conditions. Currently, it is the only identified disease-modifying intervention for allergic disease. It is one of the only patient treatments that is the primary purview of our specialty, and it has historically given the specialty its identity.[9]"

> "Many patients with allergic rhinitis or asthma do not experience adequate relief from allergen avoidance strategies and appropriate medical therapy. Allergen immunotherapy may provide an effective alternative or adjunct treatment for these patients.[9]"

References:

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