II. Allergic Rhinitis Impact on Asthma (ARIA)


The 2008 full publication includes updated information with sections on definition and classification of rhinitis; risk factors, mechanisms, burden, diagnosis, and management of rhinitis; primary prevention of atopic disease; links between rhinitis and asthma; other comorbidities and complications; and rhinitis in children.

Several ancillary papers have been published including Cruz AA, Popov T, Pawankar R, et al. Common characteristics of upper and lower airways in rhinitis and asthma: ARIA update, in collaboration with GA2LEN. *Allergy* 2007;62 (suppl 84):1–41.

As originally proposed in the 2001 publication, the 2008 ARIA guidelines recommend the following classification of allergic rhinitis. (Seasonal rhinitis and perennial rhinitis are not, respectively, synonymous with intermittent rhinitis and persistent rhinitis.)

**Classification of allergic rhinitis according to ARIA. Adapted with permission.**

1. ‘Intermittent’ means that the symptoms are present
   - <4 days a week
   - Or for <4 consecutive weeks
2. ‘Persistent’ means that the symptoms are present
   - More than 4 days a week
   - And for more than 4 consecutive weeks
3. ‘Mild’ means that symptoms are present but not troublesome and that none of the following items are present:
   - Sleep disturbance
   - Impairment of daily activities, leisure and/or sport
   - Impairment of school or work
4. ‘Moderate/severe’ means that one or more of the following items are present:
   - Sleep disturbance
   - Impairment of daily activities, leisure and/or sport
   - Troublesome symptoms

With regard to pharmacologic treatments, the recommendations are summarized as follows in the pocket guide:

“Intranasal corticosteroids are the first-line therapy in patients with moderate to severe disease. H1-antihistamines are important treatments for all patients, and leukotriene receptor antagonists (LTRAs) are particularly important for patients with both rhinitis and asthma. Sublingual specific immunotherapy (SIT) has proven to be a safe and effective treatment.”

As reported on the *Allergy* website:

Prof. Bousquet, Chairman of ARIA and GA/LEN Vice-President [noted], "Evidence shows a clear relation between rhinitis and asthma but the link may be stronger than we thought. Allergic rhinitis is not only a risk factor for asthma but could be a risk factor for asthma exacerbations”.

The ARIA guidelines are intended to serve as a resource for health-care professionals and health-care organizations to develop local guidelines for rhinitis. Treatment decisions must take into consideration the availability, affordability, and labeling variations between countries.

The pocket guide and paper include a diagnosis and management algorithm for allergic rhinitis:

**Algorithm for allergic rhinitis diagnosis and management from Bousquet et al. Allergy. 2008;63 Suppl 86:8-160. Reprinted with permission.**
Diagnosis of allergic rhinitis

Check for asthma especially in patients with severe and/or persistent rhinitis

Intermittent symptoms

Persistent symptoms

Mild
Not in preferred order
oral H1-blocker or intranasal H1-blocker and/or decongestant or LTRA

Moderate-severe
Not in preferred order
oral H1-blocker or intranasal H1-blocker and/or decongestant or intranasal CS or LTRA (or cromone)

In persistent rhinitis review the patient after 2-4 weeks

If failure: step-up If improved: continue for 1 month

Moderate-severe

in preferred order intranasal CS
H1-blocker or LTRA

Review the patient after 2-4 weeks

Improved
Step-down and continue treatment for >1 month

Failure
Review diagnosis Query infections or other causes

Prepare: add or increase intranasal CS dose
Phenylephrine add ipratropium

Failure: referal to specialist

Allergen and irritant avoidance may be appropriate

If conjunctivitis
Add
oral H1-blocker or intraocular H1-blocker or intraocular cromone (or saline)

Consider specific immunotherapy