



reCAPture the
Allergy Asthma Connection

Asthma

Asthma, the chronic and complex inflammatory disorder that narrows the airways, is a serious public health problem that affects both children and adults. Approximately 250,000 people worldwide die each year from asthma; avoidable/preventable.¹ Exposure to allergens or irritants to which patients are sensitized may increase asthma symptoms and precipitate asthma exacerbations in patients who have asthma.

Up to **90%** of children
and **60%** of adults
with asthma have underlying allergies
that **trigger their asthma.**^{2,3}



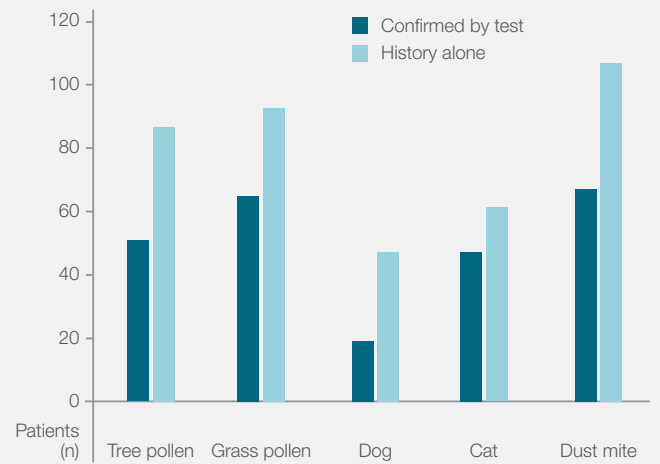
Identifying and managing allergic triggers in addition to pharmacological management, can have a significant impact on control.^{4,5} When managing asthma, it is important to identify and provide appropriate advice to help your patient reduce exposure to their confirmed triggers.⁴

Allergic Asthma

Guidelines recommend that factors that trigger or exacerbate asthma must be elicited routinely and documented in the medical records and action plans of all patients with asthma.⁶ A few key questions will provide you with a detailed history and help you create an effective management plan for your patient.

History alone is often not enough to accurately identify all of the patient's allergic triggers. For example, a patient can present with a history suggestive of house dust mite or cat allergy but actually may not be sensitized.⁷ Likewise, a patient can present with a few non-specific symptoms that are not connected to a clear history of allergen exposure, but the cat may be the primary trigger.

Allergen sensitization testing improves accuracy of results vs. patient history alone⁸



History alone may lead to both under-diagnosis and over-diagnosis.

References: 1. Pawankar R, Holgate S, Canonica G, et al. World Allergy Organization. White Book on Allergy (WAO). 2011. http://www.worldallergy.org/UserFiles/file/WAO-White-Book-on-Allergy_web.pdf. Accessed December 2017. | 2. Allen-Ramey F, et al. J Am Board Fam Pract 2005;18(5):434-439. | 3. Host A, Halcken S. Allergy 2000;55:600-608. | 4. Janssens T, Ritz T. Perceived Triggers of Asthma: Key to Symptom Perception and Management. Clin Exp Allergy. 2013;43(9):1000-1008. doi:10.1111/cea.12138. | 5. Wickman M. When allergies complicate allergies. Allergy. 2005;60 (suppl79):14-18. | 6. National Asthma Education and Prevention Program. Expert Panel Report 3 (EPR-3): guidelines for the diagnosis and management of asthma: summary report 2007. J Allergy Clin Immunol. 2007;120:Suppl: S94-S138 | 7. Smith HE, Hogger C, Lallemand C, et al. Is structured allergy history sufficient when assessing patients with asthma and rhinitis in general practice? J Allergy Clin Immunol. 2009;123:646-650 | 8. Egan M, Bunyavanich S. Allergic rhinitis: the "Ghost Diagnosis" in patients with asthma. Asthma Research Pract. 2015;1:8. doi:10.1186/s40733-015-0008-0.



Expert Panel Report - 3

Guidelines for the Diagnosis and Management of Asthma

The Expert Panel* recommends that, given the importance of allergens and their control to asthma morbidity and asthma management, patients who have persistent asthma should be evaluated for the role of allergens as possible contributing factors as follows (ERP-3, 2007)

- Determine the patient's exposure to allergens, especially indoor inhalant allergens
- Assess sensitivity to the allergens to which the patient is exposed:



Use the patient's medical history, as the starting point to assess seasonal allergies



History should be the starting point for all allergy assessment and specific IgE results should always be interpreted in the context of symptoms and history. Allergy testing is the only reliable way to determine sensitivity to perennial indoor allergens.



For selected patients who have asthma at any level of severity, detection of specific IgE sensitivity to seasonal or perennial allergens may be indicated as a basis for education about the role of allergens for avoidance and for immunotherapy.

*The Expert Panel Report 3 (EPR 3): Guidelines for the Diagnosis and Management of Asthma was developed by an expert panel commissioned by the National Asthma Education and Prevention Program (NAEPP) Coordinating Committee (CC), coordinated by the National Heart, Lung, and Blood Institute (NHLBI) of the National Institutes of Health.

[View guidelines](#)

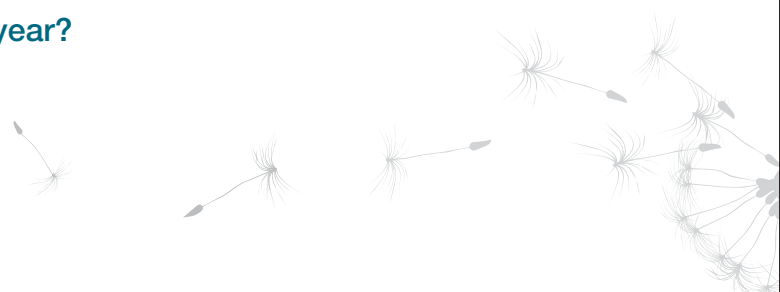
Assessment questions for allergens that can make asthma worse

Which inhalant allergens does the patient have symptoms of year round?






- Does the patient keep pets indoors or, has horse back riding as a recreational activity or has someone in his or her family engaged in some work that involves animals, etc?
- Does the patient have moisture or dampness in any room of his or her home (e.g., basement)? (Suggests house-dust mites, molds)
- Does the patient have mold visible in any part of his or her home? (Suggests molds)
- Has the patient seen cockroaches or rodents in his or her vicinity (eg. home, schools, residential buildings, etc) in the past month? (Suggests significant cockroach exposure)
- Assume exposure to house-dust mites unless patient lives in a semiarid region. However, if a patient living in a semiarid region uses a swamp cooler, exposure to house-dust mites must still be assumed

Do symptoms get worse at certain times of the year?

- Early spring? (**Trees**)
- Late spring? (**Grasses**)
- Late summer to autumn? (**Weeds**)
- Summer, monsoon, post monsoon? (**Alternaria, Mites**)



ImmunoCAP™ Specific IgE Asthma/Rhinitis/Wheeze Panel

Serial no.	Sources	Allergen
1.	<i>Dermatophagoides farinae</i>	 Dust mite
2.	<i>Periplanata americana</i> (species prevalent in India)	 Cockroach
3.	Cat	 Dander
4.	Dog	
5.	Bermuda grass	 Pollen
6.	Common ragweed	
7.	Mesquite	
8.	<i>Aspergillus fumigatus</i>	 Mold
9.	<i>Alternaria alternata</i>	

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