

# CMAJ • JAMC

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Susan Launier-Bourque

## COVER

Many Canadians suffer from hay fever triggered by ragweed pollen. In this issue (page 1123) Elizabeth Juniper and colleagues offer some guidance in selecting a first-line treatment by comparing the effect of 2 different types of medication on patients' quality of life. In an accompanying editorial Samuel Freedman (page 1141) looks at the variety of medications available and the need for an individualized approach to treatment.

## COUVERTURE

Un grand nombre de Canadiens souffrent de la fièvre des foins causée par le pollen de l'herbe à poux. Dans ce numéro (page 1123), Elizabeth Juniper et ses collègues comparent les effets de 2 types de médicaments sur la qualité de vie des patients pour conseiller un traitement de première ligne. Dans l'éditorial accompagnant l'article (page 1141), Samuel Freedman examine les divers médicaments offerts et parle de la nécessité de personnaliser le traitement.

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To foster curiosity and debate about all aspects of medicine, to promote excellence in research, peer review, authorship and health care, and to provide a Canadian voice in the international health care community.

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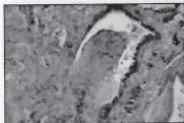
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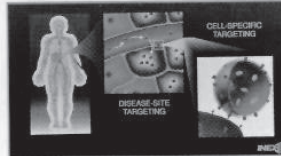
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Many people use wood-burning stoves, but burning the wrong materials can be hazardous. One serious health problem, bronchiolitis obliterans, is featured in a case report (page 1171) and discussed in an accompanying editorial (page 1147).

**Research Update • Le point sur la recherche**

Getting drugs to where they're needed — Researchers in Vancouver are working on delivery systems to bring drugs right to the cells they need to affect. "Transmembrane carrier systems" can target specific cells and deliver drugs to them at optimal rates. This technology holds promise for many hard-to-treat forms of cancer (page 1110).



Most undergraduate courses in medical ethics fail to address the issues medical students face. Joye St. Onge, who won third prize in the 1996 Logie Medical Ethics Essay Contest, says this is a mistake (page 1175).

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## Editor's preface

Français à la page suivante



The misery of seasonal allergies was first described in 1565 by the Italian anatomist Leonardo Botallo, physician to the rich and powerful and to an unfortunate person who could not tolerate roses. This "rose fever" was described in 19th-century England as "summer catarrh," and culprits ranging from sunshine to ozone to grass pollen were suspected. In 1871 an asthmatic physician, Charles Blackley, gave credibility to the pollen theory when a self-administered skin test elicited a strong reaction. By trapping airborne pollen on kites flown at 500 m he demonstrated how far-ranging the allergen can be. He advised evasive action: spend the summer on a yacht.<sup>1</sup>

A more feasible approach is to relieve the symptoms of hay fever with medication. Given the wide range of prescription and over-the-counter remedies available, how should physicians approach first-line treatment? In this issue (page 1123) Elizabeth Juniper and colleagues report on their randomized management study of terfenadine, a non-sedating antihistamine, and fluticasone, a nasally administered topical steroid. They found no significant difference in benefit between starting treatment with terfenadine and adding fluticasone as required, and starting with fluticasone and adding terfenadine as required. Samuel Freedman (page 1141) responds to these findings by noting the recent move by the US Food and Drug Administration to withdraw approval for terfenadine (because of its rare but life-threatening cardiotoxic effects). He suggests starting therapy with drugs that are safer than terfenadine and cheaper

than both terfenadine and fluticasone.

Aboriginal people in Canada are 3 to 4 times more likely to commit suicide than nonaboriginal people. Brian Malchy and colleagues (page 1133) report that from 1988 to 1994 suicide rates in Manitoba were almost 7 times higher among aboriginal adolescents than among nonaboriginal adolescents, and that there were striking differences between these groups in help-seeking behaviour. Their study represents an important first step in addressing a serious public health problem.

Many of us in this country have wood-burning stoves. Although their most evident hazard is accidental fire, using these stoves to burn inappropriate materials can also have devastating results. David Janigan and colleagues (page 1171) describe the case of a man who had been renovating his family room and decided to burn scrap building materials in his wood-burning stove. Within hours he was taken to hospital with bronchiolitis obliterans. The authors review the toxicity of combusted building materials and point out that the presence of life-threatening fumes is not always signalled by smoke. James Hogg (page 1147) reviews the pathology of bronchiolitis obliterans and provides us with stunning photomicrographs. — JH

## Reference

- Walton J, Barondess JA, Lock S, editors. *Oxford medical companion*. Oxford (UK): Oxford University Press; 1994.



# First-line treatment of seasonal (ragweed) rhinoconjunctivitis

## *A randomized management trial comparing a nasal steroid spray and a nonsedating antihistamine*

Elizabeth F. Juniper,\* MCSP, MSc; Gordon H. Guyatt,\*† MD, MSc; Penelope J. Ferrie,\* BA; Lauren E. Griffith,\* MSc

### Abstract

**Objective:** To determine whether better health-related quality of life (HRQL) is achieved by initiating treatment of seasonal (ragweed) rhinoconjunctivitis (hay fever) with a nasal steroid (fluticasone) backed up by a nonsedating antihistamine (terfenadine) or whether it is better to start with the antihistamine and add the nasal steroid when necessary.

**Design:** Randomized, nonblind, parallel-group management study during the 6 weeks of the ragweed pollen season in 1995.

**Patients:** Sixty-one adults with ragweed pollen hay fever recruited from patients who had participated in previous clinical studies and from those who responded to notices in the local media.

**Setting:** Southern Ontario.

**Interventions:** Nasal steroid group: 200 µg of fluticasone nasal spray when needed (up to 400 µg/d) starting about 1 week before the ragweed pollen season and continued throughout, with 1 to 2 tablets of terfenadine daily (maximum 120 mg/d) if needed. Antihistamine group: 1 60-mg tablet of terfenadine when needed (maximum 120 mg/d) starting about 1 week before the ragweed pollen season and continued throughout, with 200–400 µg/d of fluticasone nasal spray (maximum 400 µg/d) if needed.

**Outcome measures:** HRQL before, at the height of and toward the end of the ragweed pollen season; HRQL was measured using the Rhinoconjunctivitis Quality of Life Questionnaire.

**Results:** Overall, HRQL tended to be better in the group of patients whose first-line treatment was with fluticasone ( $p = 0.052$ ), but the difference between the 2 groups was small and not clinically important. Just over half (52% [16/31]) of the patients in the fluticasone group did not need additional help with terfenadine, whereas only 13% (4/30) of those in the terfenadine group did not need additional help with fluticasone ( $p = 0.002$ ).

**Conclusions:** There is little difference in the therapeutic benefit between the 2 approaches for the treatment of ragweed pollen hay fever. Therefore, the approach to treatment should be based on patient preference, convenience and cost. Regardless of the treatment, at least 50% of patients will need to take both types of medication in combination to control symptoms adequately.

### Résumé

**Objectif :** Déterminer si l'on améliore la qualité de vie liée à la santé par un traitement initial de la rhinoconjonctivite (fièvre des foins) saisonnière (herbe à poux) aux stéroïdes par voie nasale (fluticasone) appuyé par un antihistaminique non sédatif (terfénadine), ou s'il est préférable de commencer par l'antihistaminique et d'ajouter les stéroïdes par voie nasale au besoin.

**Conception :** Étude randomisée, non à l'insu, de traitement en groupe parallèle au cours des 6 semaines de la saison du pollen de l'herbe à poux en 1995.



### Evidence

### Études

From the Department of \*Clinical Epidemiology and Biostatistics and †Medicine, McMaster University Health Sciences Centre, Hamilton, Ont.

*This article has been peer reviewed.*

*Can Med Assoc J 1997;156:1123-31*

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