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CONTENTS

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Adding Loratadine to Topical Nasal Steroid Therapy Improves Moderately Severe Seasonal Allergic Rhinoconjunctivitis

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ABSTRACT

This study assessed the efficacy of adding the nonsedating selective H_1 antihistamine loratadine to topical intranasal beclomethasone dipropionate (BDP)

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to treat patients with seasonal allergic rhinoconjunctivitis (SAR). In a double-blind, randomized, parallel-group trial, 154 patients, ages 18 to 65, with moderately symptomatic SAR were treated with intranasal BDP (100 µg in each nostril twice daily) combined with 10 mg of loratadine or placebo for 7 days. Four nasal and four non-nasal symptoms were evaluated following 3 and 7 days of treatment, and patients recorded daily symptoms and possible adverse effects in a diary. BDP alone improved the symptoms of SAR; however, BDP plus loratadine provided further improvement. Patients treated with BDP plus loratadine achieved significantly greater ($P<.05$) relief of both nasal and non-nasal symptoms than those treated with BDP plus placebo. No differences were noted in the incidence or type of adverse effects in the two treatment groups. Loratadine plus topical intranasal BDP controls SAR more effectively than does BDP alone, without any increase in adverse effects.

Keywords: antihistamine; topical corticosteroid; loratadine; beclomethasone dipropionate; allergic rhinitis

INTRODUCTION

Current pharmacologic management of rhinitis provides less than complete relief of symptoms and may be associated with variable degrees of adverse effects.[1] Because many of the drugs currently available affect different components of the allergic response, combinations of drugs with complementary effects can maximize therapeutic efficacy.

Loratadine is an orally effective and long-acting antihistamine.[2] It has a high selectivity for peripheral histamine H_1 receptors and a low affinity for central nervous system H_1, cholinergic, or alpha-adrenergic receptors in vitro or in vivo.[3,4] Loratadine does not readily cross the blood-brain barrier and has an incidence of sedation equal to that of placebo.[5] Loratadine is rapidly absorbed, with peak concentrations in serum reached within 2 hours, an effect consistent with its rapid onset of action.[6] Loratadine relieves most of the symptoms related to SAR[2] and is as effective as terfenadine,[7-9] astemizole,[10,11] and cetirizine.[12]

The nasal response to allergen challenge can be divided into an early reaction (occurring within minutes of allergen exposure) and a late-phase reaction (occurring 4 to 10 hours after allergen challenge in about half of patients). A rechallenge reaction may occur with a second exposure to allergen 10 hours after the first challenge, resulting in increased symptoms and associated physiologic effects.[13] Systemic corticosteroids reduce symptoms and mediator release in the late and rechallenge phases of the process but have little effect on the early phase. Intranasally applied steroids are effective in all three phases of the response, however.[1,14] Studies on their mode of action have shown that they reduce the number of eosinophils, the presence of eosinophil cationic protein, and the number of mast-cell progenitors in the nasal mucosa.[1]

Topical steroids, including BDP, flunisolide, budesonide, triamcinolone acetonide, fluticasone propionate, and mometasone furoate, are efficacious agents for all the nasal symptoms of SAR.[1] H_1-receptor antagonists relieve the ocular symptoms that

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