

# Ocular and Nasal Allergy: The Overlap and Opportunity!

When these patients knock on your door, be ready.

BY JAI G. PAREKH, MD, MBA

As early spring hits, waiting rooms fill up with patients complaining of itchy, watery eyes. They may also be sniffing and sneezing. Suddenly, practices' schedules are overwhelmed by patients old and new suffering from allergic rhinoconjunctivitis and looking for assistance, diagnosis, and intervention.

As an example, "Sue" is a 38-year-old Hispanic woman with a 6-year history of intermittently itchy and watery eyes. During these bouts, she also endures a runny nose, sneezing, and sometimes coughing. Her symptoms are exacerbated during the spring (pollen) and fall (ragweed). She rarely visits her primary care physician and usually prefers to seek out over-the-counter antihistamines as needed. Now, however, her symptoms—especially the ocular ones—are much worse as the result of her moving into an older home in northern New Jersey. She has missed a couple of days at work because of these symptoms and her associated malaise (Figure 1).

Here are some pearls I have implemented through the years to take care of this typical patient with seasonal allergies.

## PATIENTS WITH OCULAR ALLERGIES

Although patients with ocular allergies may also have upper airway symptoms, itchy, watery, and red eyes bring them to a health care professional. Many times, these individuals have been discharged from school or the office due to fear of pink eye and require an evaluation/intervention to get back to their routine.

When examining patients with ocular allergies, seasonal allergic conjunctivitis (SAC), or perennial allergic conjunc-



Figure 1. A patient with allergic rhinoconjunctivitis.

titivitis (PAC), it is important to assess them for other comorbid conditions, including rhinitis, otitis media, sinus disease, nasal polyposis, upper/lower respiratory infections, hyperactive airway disease/asthma, and even eczema. Environmental allergens such as pollen, ragweed, dust, and dander can accumulate on the ocular surface and in nasal passages, inducing the allergic cascade and subsequent symptomatology. Studies have shown that more than 75% of patients with SAC or PAC have either chronic or acute rhinitis; conversely, in excess of 40% of patients with rhinitis have some form of ocular

allergy. This spectrum of disease is termed *allergic rhinoconjunctivitis*. Given the overlap of these conditions that share a common pathogenesis, it is imperative to take a multidisciplinary approach to the patient with ocular allergies.

## DIAGNOSIS

The differential diagnosis of ocular allergy includes SAC, PAC, atopic keratoconjunctivitis, giant papillary conjunctivitis, and vernal keratoconjunctivitis. In arriving at the ocular diagnosis, I also look to see if the patient has any other systemic symptoms.

In the setting of SAC or PAC with nasal symptoms such as a runny nose, sniffles, or sneezing, I will make the diagnosis of allergic rhinoconjunctivitis. Some clues to look for on examination include congestion under the eyes and around the nose and a "nasal salute," which is a horizontal crease in the skin on the nose from chronic, repetitive nose rubbing (Figure 2). Many times, during the ocular examination, the patient will have an irresistible urge to scratch his or her nose, which is another tip-off. Now is the time to intervene!

**INTERVENTION**

**Ocular Allergy**

The first thing I do is make sure the patient is aware of the diagnosis and the disease process (Figure 3); the best way to intervene in allergy is to prevent its onset. Behavioral modification includes environmental abstinence (ie, avoiding freshly cut grass, pets, etc.) as well as using HEPA filters, minimizing contact lens wear, avoiding eye rubbing, maintaining fingernail hygiene to avoid introducing pollen to the eye, and wearing wrap-around sunglasses. Cool compresses do a terrific job of breaking the vicious circle of ocular itching.

My therapeutic armamentarium includes

- cool artificial tears (brand name and/or preservative free)
- combination antihistamine-mast cell stabilizer therapies (this is my go-to category of drugs, and some of the newer ones like bepotastine besilate 1.5% [Bepreve; Ista Pharmaceuticals, Inc.] may even assist with nasal symptoms)
- topical steroids, particularly those that contain loteprednol because of its safety profile
- steroidal ointments (I prefer loteprednol etabonate 0.05% ophthalmic ointment [Lotemax; Bausch + Lomb] effective for associated allergic periocular dermatitis)

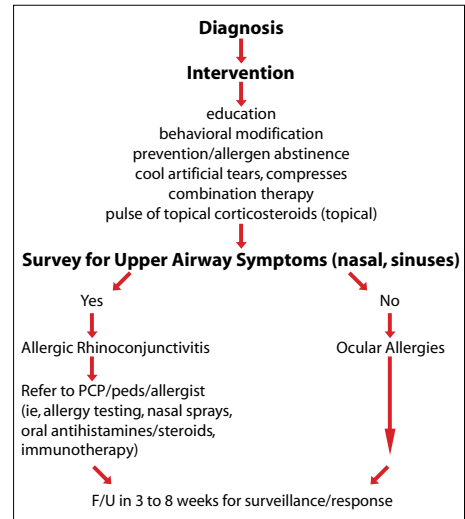
**Allergic Rhinitis**

With this condition, prevention is again key, and the treatments are very similar to those mentioned previously. Patients with allergic rhinoconjunctivitis will often require multiple topical, nasal, and oral therapies as well as multidisciplinary monitoring. I usually counsel these patients and refer them to the appropriate health care professional, who may be a primary care physician, pediatrician, allergist, or otorhinolaryngologist. The patient may require further testing such as a systemic allergy workup (eg, skin-prick test, intradermal testing, and immunoglobulin E assays) and subsequent oral steroids and allergen immunotherapy.

Therapies are nasal sprays containing an antihistamine or steroid, oral antihistamines, oral corticosteroids, and immunotherapy. The oral antihistamines, even those that are non-sedating, tend to dry out the ocular surface or exacerbate underlying dry eye syndrome. During follow-up, I am careful to look for dry eyes and prefer to prescribe cool artificial tears. The sprays do a wonderful job of ameliorating the nasal symptoms of allergic rhinitis; intranasal steroids may even have a moderate effect on the ocular symptoms in patients with allergic rhinoconjunctivitis.



**Figure 2. Some clues to look for on examination include congestion under the eyes and around the nose and a “nasal salute.”**



**Figure 3. Dr. Parekh’s approach to the patient with ocular allergies.**

I see these patients again in the office based on their symptoms, response to treatment, and medical regimen. For example, if they are on steroids in any form, they need to have their IOP monitored.

**CONCLUSION**

Ocular allergies continue to pose a diagnostic and therapeutic challenge to specialists, especially in the setting of allergic rhinoconjunctivitis. Listening to the patient, watching his or her behavior in the examination lane, diagnosing the condition, and intervening in the appropriate fashion can develop a rewarding ocular allergy practice and an increased volume of referrals. Serving these unhappy people is an opportunity to build a practice. When this opportunity knocks, ophthalmologists should be ready to open the door. If ophthalmologists do not take care of these patients, their competition will! ■

*Jai G. Parekh, MD, MBA, is a managing partner at Brar-Parekh Eye Associates in Woodland Park, New Jersey. Dr. Parekh is also chief of cornea and external diseases/director of the Research Institute at St. Joseph’s HealthCare System in Paterson, New Jersey, and clinical associate professor of ophthalmology on the Cornea Service at the New York Eye & Ear Infirmary/New York Medical College in New York. He is a consultant to Bausch + Lomb, Ista Pharmaceuticals, Inc., and IOP Ophthalmics. Dr. Parekh is a member of the speakers’ bureaus for Alcon Laboratories, Inc., and Allergan, Inc., but he acknowledged no financial interest in the products mentioned herein. Dr. Parekh may be reached at (973) 785-2050; kerajai@gmail.com.*

