The Relationship between Asthma and Allergic Rhinitis in the Iraqi Population

Abdulghani Mohamad Alsamarai1, Ammar M Alwan1, Amina Hamed Ahmad1, Mohib Ahmad Salih1, Jawad Ali Salih1, Mohamad Abdulsatar Aldabaghi1, Safa Alturaihi1, Zainab Hashim Abdulaziz1, Anas Ahmad Salih1, Sana Khalaf Salih1 and Mossa Mahmood Murbat1

ABSTRACT

Background: Recently, extensive research has established that epidemiologic and therapeutic links exist between allergic rhinitis and asthma. The objective of this study was to clarify this association in Iraq.

Methods: The data included in this study were collected from five surveys for asthma and allergic rhinitis that were performed during the period from September 2000 to July 2008. These surveys were parts of Tikrit University College of Medicine PHC program.

Results: The frequency of allergic rhinitis (AR) was 61.6% among individuals with asthma versus 6% among non-asthmatic (control) subjects (Odd Ratio [OR] = 25.5; P < 0.0001). All studies indicated a significant frequency of AR among asthmatic patients in comparison with non-asthmatic subjects, whether the patients were adults or children (OR for adults = 14.9 and 22.5, for children 34.7 and 48.4; P < 0.001 for all). Furthermore, the high frequency of AR in asthmatic patients was seen whether the study was a community based study (CBS) (OR = 14.9 and 48.4; P < 0.0001) or a hospital based study (HBS) (OR = 22.5 & 34.7; P < 0.0001). The frequency of current asthma was 51.8% among individuals with AR versus 5.4% among control subjects (OR = 23.1; P < 0.0001).

Conclusions: This study provided evidence that AR and asthma are strongly associated with each other and the treatment approach should consider the entire airway rather than only a part.

KEY WORDS

allergen, allergic rhinitis, allergy, asthma

INTRODUCTION

Asthma is one of the most common chronic diseases worldwide.1 A large percentage of children and adults with asthma also have allergic rhinitis (AR).2 The link between AR and asthma has long been of interest to physicians. Recently, extensive research has established that epidemiologic and therapeutic links exist between AR and asthma.3 A number of epidemiologic studies have shown an association between asthma and allergic rhinitis. In a review of five large studies that included populations of children and adults,4 the prevalence of asthma ranged from 3.6% to 5% in subject without rhinitis versus 10.8% to 32% in subject with rhinitis. In a 23 year follow-up study in university students,5 asthma developed in 10.5% of subjects with AR, whereas it developed in only 3.6% of subjects without AR. In addition, the reported lifetime prevalence of AR among adults with asthma ranges from 50% to 100%, varying by study design and geographical areas.6 Asthma and AR are both inflammatory diseases of the airways. The similarities between AR and asthma in epidemiologic and pathophysiologic features suggest that AR and asthma represent the same syndrome, the chronic allergic respiratory syndrome.7 A report of the American Academy of Allergy, Asthma, and Immunology8 estimated that up to 78% of patients with asthma have nasal symptoms and 38% of patients with AR have asthma. While there are several surveys assessing the association between AR and asthma in different geographical areas worldwide, none were performed in large scale studies. Thus, this study was performed to clarify this association in Iraq.
METHODOLOGY

STUDY POPULATION

The data included in this study was collected from five surveys for asthma and allergic rhinitis that were performed during the period from September 2000 to July 2008. These surveys were part of Tikrit University College of Medicine PHC program. (Table 1).

The first survey was a community-based study that was performed in Al-Hijaj village (rural area) to determine the prevalence of bronchial asthma in adults. 1384 individuals were included in this cross-sectional study. This number represents all adults of the village. The village was located 40 miles from Tikrit city. This study was carried out during the period from September 18, 2002 to December 3, 2002. The age range of the study population was from 18 to 45 years and 760 (54.9%) were men and 624 (45.1%) were women.

The second survey was a hospital-based study that included a mixed population from urban and rural areas. This included the patients attending the Tikrit Allergy and Asthma Centre during the period from September 2000 to July 2008. 12467 patients were included in the study, of them 8687 (69.7%) were adults, and 3780 (30.3%) were children.

The third survey was a community-based study that included primary school children in Samara city (urban area). The children were all preadolescent school age children. The total number of primary school children in Samara city was 10820 children, 5397 boys and 5423 girls. We chose 2875 children in grade 5 and 6, 1624 (56.5%) boys and 1251 (43.5%) girls. These two grades were selected because these grades performed the exercise challenge and peak flow metric measures better than younger age groups and the questionnaire data obtained from them were more accurate.

The fourth survey was a hospital-based study performed at Tikrit Teaching Hospital to determine the epidemiological characteristic of allergic rhinitis. The study population was a mixture of rural and urban inhabitants. A total number of 9317 individuals were included in the study, of them 5198 (55.8%) were men and 4119 (44.2%) were women.

The fifth survey was a hospital-based study performed in Samara General Hospital during the period from September 2000 to July 2008 to determine the epidemiological characteristics of AR in Samara. A total of 8748 patients were included in the analysis, of them 5608 (64.1%) were men and 3140 (35.9%) were women.

ASTHMA AND ALLERGIC RHINITIS DIAGNOSIS

The diagnosis of asthma and classification was performed by specialist physicians based on the National Heart Blood and Lung Institute/World Health Organization (NHLBI/WHO) workshop on the Global Strategy for Asthma. Allergic rhinitis diagnosis was performed according to previously reported guidelines. Patients were excluded if they were smokers, if they had respiratory infection within the month preceding the study, a rheumatological illness, malignancy, diabetes, heart failure, history of venous embolisms, coronary heart disease and liver or kidney diseases. At enrollment, they all underwent a full clinical examination, pulmonary function test, and blood sampling.

DETERMINATION OF TOTAL ANTIOXIDANT CAPACITY

The method for serum TAC determination as previously described by Kampa M et al. was used.

DETERMINATION OF MALONDIALDEHYDE

Serum MDA concentration was determined by measuring the thiobarbituric acid reactive substances (TBARS) according to the spectrophotometric method of Janero. The TBARS was determined using OXITEK TBARS Assay kit from Zeptometrix Corporation (Buffalo, NY, USA).

DETERMINATION OF OXIDATION INDEX

The index was determined by the following equation.
Non-asthmatic patients was seen whether the study was CBS (OR = 14.9 and 48.4; 0.0001) or HBS (OR = 22.5 and 34.7). Therefore, the high frequency of AR in asthmatic patients was still a positive association between frequency of AR and asthma (< 0.0001). For adults the frequency of AR was 70.3% among adults with asthma versus 7.2% among non-asthmatic adults, (OR = 16.9; P < 0.0001), while in children the frequency of AR among asthmatic patients was 56.9% versus 5.1% among non-asthmatic children (OR = 30.5; P < 0.0001) as shown in Table 2. All studies indicated a significant frequency of AR among asthmatic patients in comparison with non-asthmatic subjects, whether the patients were adults or children (OR for adults = 14.9 and 22.5, for children 34.7 and 48.4; P < 0.001 for all). Furthermore, the high frequency of AR in asthmatic patients was seen whether the study was CBS (OR = 14.9 and 48.4; P < 0.0001) or HBS (OR = 22.5 and 34.7; P < 0.0001).

The information for 1682 subjects with AR and asthma was still a positive association between frequency of AR and asthma (< 0.0001) as shown in Table 2. All studies indicated a significant frequency of AR among asthmatic patients in comparison with non-asthmatic subjects, whether the patients were adults or children (OR for adults = 14.9 and 22.5, for children 34.7 and 48.4; P < 0.001 for all). Furthermore, the high frequency of AR in asthmatic patients was seen whether the study was CBS (OR = 14.9 and 48.4; P < 0.0001) or HBS (OR = 22.5 and 34.7; P < 0.0001).

When data of AR was evaluated for each survey alone, frequencies were of 32.8%, 42.5%, and 63.4% for asthma among individuals with AR in surveys 4, 5 and 2 respectively. These frequencies were significantly higher (OR = 11, 13.8, and 24.4; P < 0.0001) than those of individuals without AR (Table 3). Furthermore, the differences in frequency of asthma among AR individuals were significantly higher (P < 0.0001), whether the patients were adults (62.5%; OR = 22.5) or children (68.4%; OR = 34.2).

Comparison of mean serum level of ECP, MDA, and TAC in patients with AR alone, asthma alone and presence of both conditions in the same group indicated differences in their values between groups (Table 4). The mean serum level of ECP was significantly higher in the three groups as compared to control (P < 0.0001). However, there were significant differences (P < 0.0001) in the mean serum ECP values between the AR alone group (14.85 ± 8.23 μg/l, Confidence Interval 13.25-16.45 μg/l), the asthma alone group (36.12 ± 12.76 μg/l, Confidence Interval 32.6-39.6 μg/l) and the group of patients with both AR and asthma together (58.21 ± 13.6 μg/l, Confidence Interval 55.5-60.9). Concerning MDA there was a significant increase in serum level mean values between the three groups and the control (P < 0.0001). In addition, patients with both AR and asthma (7.23 ± 2.82 μmol/l, Confidence Interval 6.6-7.8) had a mean value of serum MDA significantly (P < 0.0001) higher than that in patients with AR alone (3.49 ± 1.84 μmol/l, Confidence Interval 3.1-3.9) or patients with asthma alone (4.41 ± 1.9 μmol/l, Confidence Interval 4.04-4.78).

However, the difference between mean serum MDA values in patients with asthma alone (4.41 μmol/l) and patients with AR alone (3.49 μmol/l) was not significant. TAC shows a lower level of mean value in patients with AR and asthma (771 ± 162 μmol/l, CI 739-803) as compared to patients with asthma alone

### Table 2 Frequency distribution of allergic rhinitis in asthmatic patients and non-asthmatic patients

<table>
<thead>
<tr>
<th>Study</th>
<th>Age</th>
<th>Frequency of allergic rhinitis</th>
<th>OR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Asthmatic patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No.</td>
<td>AR</td>
</tr>
<tr>
<td>1</td>
<td>Adult</td>
<td>104</td>
<td>65</td>
</tr>
<tr>
<td>2</td>
<td>Adult</td>
<td>1036</td>
<td>490</td>
</tr>
<tr>
<td></td>
<td>Children</td>
<td>308</td>
<td>91</td>
</tr>
<tr>
<td>3</td>
<td>Children</td>
<td>256</td>
<td>192</td>
</tr>
<tr>
<td></td>
<td>Adult</td>
<td>1140</td>
<td>555</td>
</tr>
<tr>
<td></td>
<td>Children</td>
<td>564</td>
<td>283</td>
</tr>
<tr>
<td>Total</td>
<td>All</td>
<td>1604</td>
<td>838</td>
</tr>
</tbody>
</table>

### RESULTS

Information for 1704 (1140 adults and 564 children) subjects with asthma and 15032 non-asthmatic (control) subjects were analyzed concerning the presence of allergic rhinitis in asthmatic patients (Table 2). The frequency of allergic rhinitis (AR) was 61.6% among individuals with asthma versus 6% among non-asthmatic (control) subjects (OR = 25.5; P < 0.0001). When data of AR was evaluated for each survey alone, frequencies were of 32.8%, 42.5%, and 63.4% for asthma among individuals with AR in surveys 4, 5 and 2 respectively. These frequencies were significantly higher (OR = 11, 13.8, and 24.4; P < 0.0001) than those of individuals without AR (Table 3). Furthermore, the differences in frequency of asthma among AR individuals were significantly higher (P < 0.0001), whether the patients were adults (62.5%; OR = 22.5) or children (68.4%; OR = 34.2).

Comparison of mean serum level of ECP, MDA, and TAC in patients with AR alone, asthma alone and presence of both conditions in the same group indicated differences in their values between groups (Table 4). The mean serum level of ECP was significantly higher in the three groups as compared to control (P < 0.0001). However, there were significant differences (P < 0.0001) in the mean serum ECP values between the AR alone group (14.85 ± 8.23 μg/l, Confidence Interval 13.25-16.45 μg/l), the asthma alone group (36.12 ± 12.76 μg/l, Confidence Interval 32.6-39.6 μg/l) and the group of patients with both AR and asthma together (58.21 ± 13.6 μg/l, Confidence Interval 55.5-60.9). Concerning MDA there was a significant increase in serum level mean values between the three groups and the control (P < 0.0001). In addition, patients with both AR and asthma (7.23 ± 2.82 μmol/l, Confidence Interval 6.6-7.8) had a mean value of serum MDA significantly (P < 0.0001) higher than that in patients with AR alone (3.49 ± 1.84 μmol/l, Confidence Interval 3.1-3.9) or patients with asthma alone (4.41 ± 1.9 μmol/l, Confidence Interval 4.04-4.78).

However, the difference between mean serum MDA values in patients with asthma alone (4.41 μmol/l) and patients with AR alone (3.49 μmol/l) was not significant. TAC shows a lower level of mean value in patients with AR and asthma (771 ± 162 μmol/l, CI 739-803) as compared to patients with asthma alone

### DETERMINATION OF SERUM EOSINOPHILS CATIONIC PROTEIN

Serum ECP was determined by ELISA kit (MBL MESCACUP ECP TEST) from Medical and Biological Laboratories Co, LTD, Nagoya, Japan.

### STATISTICAL ANALYSIS

Data concerning the comparisons among the various parameters in the study groups are given as mean (SD) with 95% confidence intervals for the differences. Student’s unpaired one tailed test was used for significant testing.

### RESULTS

Information for 1704 (1140 adults and 564 children) subjects with asthma and 15032 non-asthmatic (control) subjects were analyzed concerning the presence of allergic rhinitis in asthmatic patients (Table 2). The frequency of allergic rhinitis (AR) was 61.6% among individuals with asthma versus 6% among non-asthmatic (control) subjects (OR = 25.5; P < 0.0001). When data of AR was evaluated for each survey alone, frequencies were of 32.8%, 42.5%, and 63.4% for asthma among individuals with AR in surveys 4, 5 and 2 respectively. These frequencies were significantly higher (OR = 11, 13.8, and 24.4; P < 0.0001) than those of individuals without AR (Table 3). Furthermore, the differences in frequency of asthma among AR individuals were significantly higher (P < 0.0001), whether the patients were adults (62.5%; OR = 22.5) or children (68.4%; OR = 34.2).
Table 3 Frequency distribution of asthma in patients with and without allergic rhinitis

<table>
<thead>
<tr>
<th>Study</th>
<th>Age</th>
<th>Allergic rhinitis patients</th>
<th>Asthma</th>
<th>Non-AR patients</th>
<th>Asthma</th>
<th>OR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>No.</td>
<td>Asthma</td>
<td>%</td>
<td>No.</td>
<td>Asthma</td>
</tr>
<tr>
<td>4</td>
<td>Mixed</td>
<td>363</td>
<td>119</td>
<td>32.8</td>
<td>8954</td>
<td>381</td>
</tr>
<tr>
<td>5</td>
<td>Mixed</td>
<td>402</td>
<td>171</td>
<td>42.5</td>
<td>8345</td>
<td>426</td>
</tr>
<tr>
<td>2</td>
<td>Mixed</td>
<td>917</td>
<td>581</td>
<td>63.4</td>
<td>11550</td>
<td>763</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>1682</td>
<td>871</td>
<td>51.8</td>
<td>28849</td>
<td>1570</td>
</tr>
</tbody>
</table>

Table 4 Serum eosinophilic cationic protein, MDA, TAC and oxidation index in patients with AR and asthma

<table>
<thead>
<tr>
<th>Group</th>
<th>ECP μg/l</th>
<th>MDA μmol/l</th>
<th>TAC μmol/l</th>
<th>Oxidation Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients with asthma alone</td>
<td>36.12 ± 12.76</td>
<td>4.41 ± 1.9</td>
<td>897 ± 178</td>
<td>4.9</td>
</tr>
<tr>
<td>(32.64-39.6)</td>
<td>(4.04-4.78)</td>
<td>(862-932)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients with AR alone</td>
<td>14.85 ± 8.23</td>
<td>3.49 ± 1.84</td>
<td>986 ± 112</td>
<td>3.5</td>
</tr>
<tr>
<td>(13.25-16.45)</td>
<td>(3.13-3.85)</td>
<td>(964-1008)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients with AR and asthma</td>
<td>58.21 ± 13.6</td>
<td>7.23 ± 2.82</td>
<td>771 ± 162</td>
<td>9.4</td>
</tr>
<tr>
<td>(55.54-60.88)</td>
<td>(6.53-7.83)</td>
<td>(739-803)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>7.68 ± 5.63</td>
<td>2.24 ± 0.26</td>
<td>1047 ± 207</td>
<td>2.1</td>
</tr>
<tr>
<td>(6.08-9.68)</td>
<td>(2.16-2.30)</td>
<td>(1015-1133)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(897 ± 178 μmol/l, CI 862-932) and patients with AR alone (987 ± 112 μmol/l, CI 964-1008). However, all three groups had significantly (P < 0.1 to 0.001) lower serum values as compared to the control group. The oxidation index was 4 times higher in patients with AR and asthma together than in the control group (2.1), 1.5 times than in patients with AR alone (3.5) and 2 times than in patients with asthma alone (4.9).

**DISCUSSION**

The results from our analysis of a large cohort consisting of two community-based and hospital-based studies show that there was a relationship between asthma and allergic rhinitis (OR = 11-48.4). The relationship was seen whether the analysis was performed for each survey alone or when the patients were classified into adults and children, or when the five surveys were combined together. The present study showed a prevalence rate of 61.6% of AR in asthmatic patients and there was a significant difference in prevalence rate whether the patients were adults or children or the survey was community-based or hospital-based as compared to subjects without asthma. This result is consistent with the percentage reported for other geographical areas.6

Allergic rhinitis is very common in patients with asthma,13 with a reported prevalence of up to 100% in those with allergic asthma.14 In a recent review,6 the point prevalence of AR ranged from 24% to 94% and lifetime prevalence ranged from 50% to 100% among adults with asthma in Europe and in the United States. These findings have been corroborated in more recent studies from Europe and Japan.15,16 In this study the prevalence rate of AR was 70.3% among adults, 56.9% among children and 61.6% among total patients with asthma. The variability in the reported prevalence of comorbid AR in patients with asthma in the reported studies was attributable in part to differences in diagnostic criteria, study design6 and perhaps geographical variations due to influence of air pollution.

Geographical differences may exist also.17 One study from China reported a lower (6%) prevalence of comorbid AR in people with asthma.18 Among school age children surveyed in the international study of asthma and allergy in children, there are striking variations in the prevalence of asthma and allergic rhinoconjunctivitis symptoms recorded among different centers worldwide17; nonetheless, significant correlations are noted between the prevalence of asthma and allergic rhinoconjunctivitis symptoms.19,20

Several reported studies have examined the association between AR and asthma. In the Rochester, Minnesota, USA study,21 the overall prevalence of AR was 52% among their study population. In the UK, Medline-plus general practice databased studies22,23; concomitant AR was documented in medical records of only 17% of adult patients and in 20% of children with asthma. Similarly in Norway, AR was documented in 27% of asthmatic children.24 Recently a study25 of survey results from four countries each in the Asia-Pacific region and Europe documented that most patients (73%) had pre-existing symptoms of AR when their asthma was first diagnosed.

It is possible that the prevalence of comorbid AR among patients with asthma in these retrospective studies was underestimated because the diagnosis of AR was restricted to that recorded in medical re-
cords, with the exception of that reported by Valovirta, in which the adult patients and parents of children filled a formulated questionnaire which is a potential limitation.

In this study, the team members examined the recruited subjects by surveys (1, 2, and 3) during the study periods and thus the prevalence of comorbid AR may be not underestimated. The possibility that in part may lead to underestimation of AR prevalence in patients with asthma was that many people with AR self manage the condition with over the counter products, and do not seek a physician’s help or indeed do not recognize AR as a condition needing treatment.15 There was a significantly higher frequency of AR in asthmatic children in survey 3 (74.9%) compared to survey 2 (29.5%). This variation may be due to the difference in the study design, since survey 2 was a hospital-based study and while the survey 3 was a community-based study. Concerning epidemiological studies, the community-based studies are more accepted since the individuals in the selected sites are recruited subjects by surveys (1, 2, and 3) during the study periods and thus the prevalence of comorbid AR may be not underestimated. The possibility that in part may lead to underestimation of AR prevalence in patients with asthma was that many people with AR self manage the condition with over the counter products, and do not seek a physician’s help or indeed do not recognize AR as a condition needing treatment.15 There was a significantly higher frequency of AR in asthmatic children in survey 3 (74.9%) compared to survey 2 (29.5%). This variation may be due to the difference in the study design, since survey 2 was a hospital-based study and while the survey 3 was a community-based study. Concerning epidemiological studies, the community-based studies are more accepted since the individuals in the selected sites are examined.

Asthma is often present in patients with AR. The present study documented a prevalence rate of 51.8% of asthma in patients with allergic rhinitis versus 5.4% in non-AR subjects (OR = 23.1). Linneburg et al. reported asthma in 25% of patients with AR who were pollen sensitive and in 50% of those AR patients who were mite-sensitive or animal sensitive. Greisner et al. reported a history of asthma among 21% of former college students with a cumulative history of AR over 23 years of follow-up. In the European Community Respiratory Health survey, an association between asthma and rhinitis was observed even in non-atopic individuals. This finding implies that the relationship cannot be fully explained by shared risk factors and supports the hypothesis that upper-airway disorders may directly affect the lower airway. However, the reported studies combined indicate that AR is a risk factor for the development of asthma.

Bronchial hyper-responsiveness is common in people with AR, even if they have no asthma symptoms and asymptomatic airway hyper-responsiveness is associated with increased risk for developing asthma. Bronchial inflammation can result from nasal allergen challenge in patients with AR in the absence of obvious asthma. Conversely, patients with asthma can have eosinophilic infiltration of their nasal mucosa without reporting the symptoms of rhinitis.

Bronchial asthma and AR are both chronic inflammatory diseases of the upper and lower airway, and the cells mainly responsible for causing this inflammation are eosinophils. Therefore, assessment of serum ECP may be determined to reflect pulmonary inflammation. Studies of asthmatic patients, especially adults, indicated a relationship between the serum ECP level and severity and nature of the disease. The present study showed that mean serum ECP levels were higher in subjects with asthma alone, AR alone, or both asthma and AR compared to controls.

This study indicates the role of eosinophilic inflammation in asthma and allergic rhinitis suggesting a significant impact on the management of AR and asthma with anti-inflammatory medication increasingly being recommended as first line therapy. It is clear that our results are consistent with the previous studies that reported a high serum ECP in asthmatic patients and AR when compared with healthy subjects. Serum mean ECP value was significantly higher in patients with the two conditions (AR and asthma) and patients with asthma alone as compared with patients with AR alone, possibly reflecting less activated eosinophils in patients with AR compared to patients with asthma and patients with both conditions.

The present study shows that the three groups of patients had reduced antioxidant capacity as shown by decreased TAC in comparison with the control. In addition, there was a highly significant difference in serum TAC between the three groups. Others have reported the reduction in serum TAC in asthmatic and AR patients. The decreased TAC is related to attack and severity of asthma and the decrease in TAC may result from different mechanisms in patients with asthma and AR as a consequence of increased oxidative stress. Accordingly as a result of the imbalance between oxidative and antioxidant materials, reduction in TAC was achieved. Therefore, it seems that measurement of TAC in serum could be a simple and useful tool in the evaluation of AR and asthma attack and severity. The supplementary administration of antioxidants in the future needs further study and clarification.

The present study indicated that lipid peroxidation as measured by serum MDA level, was increased in patients with AR alone, asthma alone or with both conditions. Furthermore, the increased mean serum levels were significantly different between the three groups of patients. However, the difference in mean serum MDA values between patients with AR alone and asthma alone had marginal significance (P < 0.05). Previous reports indicated that plasma and serum MDA levels were higher in patients with asthma and AR as compared to controls.

The findings from this study suggest that in patients with both asthma and AR, there is local and systemic inflammation, which is more severe when present together. These findings highlight the possibility that comorbid AR may lead to more difficult to control asthma and worsened asthma outcome. The increased serum levels of MDA and decreased TAC observed in the present study indicate increased oxidative stress in AR and asthmatic patients.

In the present study the oxidant/antioxidant bal-
ance seems to be disturbed in asthma and AR as compared to controls. The imbalance between oxidant and antioxidant presented as oxidation index. It was 1.74 times higher in AR, asthma and both disease groups than that in controls. That means the oxidative stress is a prominent event in asthma and AR and its extent is more when the two conditions are present in the same patient. In this respect, the imbalance was higher in patients with both conditions as compared to those with AR alone (3 times) or asthma alone (2 times). This finding suggests that oxidative stress plays an important role in the pathogenesis of AR and asthma and there is a positive correlation between oxidative stress and disease severity. The inflammatory process was the likely source for this imbalance. Both airway and intravascular inflammatory cells contribute to elevated oxidative stress in AR and asthma and this explains why oxidation indexes were high in individuals with comorbid AR in asthmatic patients.

Not all patients with asthma have rhinitis; however, not all patients with rhinitis have asthma. Genetic differences contribute to this discrepancy.

Possible mechanisms for the influence of AR on lower airways include disturbance of the beneficial role of nasal mucosa in conditioning the air entering the respiratory tree, neural interaction between upper and lower airways; irritant effects on nasal secretions directly entering the lower airways; and systemic propagation of nasal inflammation to the bronchial mucosa (or vice versa) via effects of mediators and inflammatory cells on bone marrow-systemic cross-talk.

In conclusion, this study provided evidence that allergic rhinitis and asthma are strongly associated with each other and the treatment approach should consider the entire airway rather than only a part.

REFERENCES


26. Greisner WA, Settipane RJ, Settipane GA. Co-existence of asthma and allergic rhinitis: a 23 year follow up study of


