ALLERGY IN RESPIRATORY AIRWAY DISEASE

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Airway diseases are often like dermatological conditions in that the diagnosis depends on pattern recognition. In respiratory disease, history taking is the most important whilst in dermatology visual inspection allows for the morphology of the skin lesion to lend itself to a diagnosis.

The busy family physician is often confronted with a patient whose respiratory symptoms are ambiguous and can either point to asthma or chronic obstructive pulmonary disease (COPD). Within time constraints, the physician has to take as precise a history as possible to differentiate between the two diseases. It is easy to take the less onerous path and make a quick diagnosis since the treatment is very similar in both cases.

This series of articles hope to plug the gap in knowledge and to translate into better consultation skills and processes when seeing a patient with respiratory symptoms. After reading the articles, it is hoped that the reader gains a better understanding of the differences in both diseases and the nuances in the treatment regimes one can apply.

The interplay of Allergic Rhinitis and Asthma has not been stressed in undergraduate education. For those who have been in practice for some years, it is useful to read about the relationship between the two and how treating both simultaneously can lead to a better quality of life and lower recurrence rate of asthma.

The role of food allergy as the cause of skin problems and airway disease is being recognized. Diagnosis of food allergy is based on history and clinical examination, allergy testing (IgE and skin prick testing) and provocation testing. The double blind placebo-controlled food challenge (DBPCFC), performed in a hospital setting, under strict observation and with all emergency facilities available is still the gold standard for the diagnosis.

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