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Perspective

Infections of the Upper Respiratory Tract and Allergic Rhinitis Medication

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DESCRIPTION

The common cold, sore throats, epiglottitis, and laryngotracheitis are all examples of acute Upper Respiratory Infections (URI). Even while laryngotracheitis and epiglottitis can be life-threatening conditions in children and young infants, these infections are typically benign, transient, and self-limited. Organisms gain entry to the respiratory tract by inhalation of droplets and invade the mucosa. Epithelial destruction may ensue, along with redness, edema, hemorrhage and sometimes an exudate Common colds may typically be diagnosed clinically based on a microbiologic analysis. For pharyngitis, epiglottitis, and laryngotracheitis, throat swab specimens are cultured for bacteria and viruses. In epiglottitis instances, blood cultures are also taken [1-3].

Symptomatology and anatomic involvement are used to categorise respiratory tract infections. Pharyngitis, epiglottitis, laryngotracheitis, and the common cold are all examples of acute Upper Respiratory Infections (URI). Despite the fact that epiglottitis and laryngotracheitis can be devastating illnesses in children and young infants, these infections are typically benign, transient, and self-limited. Viruses, bacteria, mycoplasma, and fungi are some of the etiologic agents linked to URI. When school starts in the fall and winter, respiratory infections are more prevalent, and indoor congestion makes them more infectious [4-6]. The most frequent cause of medical visits, absences from work and school, and the most prevalent respiratory infection overall are common colds. Viruses are the main cause of colds. The most prevalent infections, rhinoviruses with more than 100 serotypes, are responsible for at least 25% of colds in adults. More than 10% of cases may be brought on by coronaviruses. The common cold syndrome has been associated with parainfluenza viruses, respiratory syncytial virus, adenoviruses, and influenza viruses. These organisms all exhibit seasonal fluctuations in frequency. It is unknown what causes 30% to 40% of cold symptoms.

Traditional remedies have become more common in recent years for both medical and financial reasons, in both developed and developing nations. According to the country and the patient's condition, different people employ Herbal Therapy (HT) more frequently. According to general literature, up to 70% of youngsters and 25%-50% of the general population have tried a Complementary and Alternative Medicine (CAM) approach at least once. According to a research conducted among Americans, 29% of people utilize HT to treat rhinosinusitis. In a Spanish study, 34.4% of 400 patients with allergic illnesses (allergic rhinitis, asthma, and atopic dermatitis) reported using at least one form of complementary medicine, and 31.5% of these patients reported using natural remedies. Herbal treatments can have a range of different pharmacological effects, as well as negative side effects and possible drug interactions. Certain HTs result in haemorrhage, heart instability, or changed blood sugar levels. Others have the power to accelerate the postoperative medication metabolism and amplify the sedative effects of anesthesia. Hence, the American Society of Anesthesiology advises against using HTs 2-3 weeks before to surgery [7-9].

Studying the usage of HTs for diverse illnesses would be helpful for physicians given the extensive and expanding use of HTs and their possible pharmacologic and pharmacokinetic consequences. Many studies have backed this viewpoint, one of which found that general practitioners and allergy/immunology experts need to learn more about complementary medicine. Several people provided information on HTs they had used to treat their allergic rhinitis symptoms in our earlier study on the prevalence of allergic rhinitis in world [10].

REFERENCES

1. Simpson EL, Bieber T, Guttman-Yassky E, Beck LA, Blauvelt A, Cork MJ, et al. Two phase 3 trials of dupilumab versus placebo in atopic dermatitis. N Engl J Med 2016;375(24):2335-2348.
2. Beck LA, Thaçi D, Deleuran M, Blauvelt A, Bissonnette R, de Bruin-Weller M, et al. Dupilumab provides favorable safety and sustained efficacy for up to 3 years in an open-label study of adults with moderate-to-severe atopic dermatitis. N Engl J Med. 2020;21(4): 567-577.
3. de Bruin-Weller M, Thaçi D, Smith CH, Reich K, Cork MJ, Radin A, et al. Dupilumab with concomitant topical corticosteroid treatment in adults with atopic dermatitis with an inadequate response or

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intolerance to ciclosporin A or when this treatment is medically inadvisable: A placebo-controlled, randomized phase III clinical trial (LIBERTY AD CAFÉ). Br J Dermatol. 2018;178(5):1083-1101.

4. Thaci D, Simpson EL, Beck LA, Bieber T, Blauvelt A, Papp K, et al. Efficacy and safety of dupilumab in adults with moderate-to-severe atopic dermatitis inadequately controlled by topical treatments: A randomised, placebo-controlled, dose-ranging phase 2b trial. Lancet. 2016;387(10013):40-52.
5. Blauvelt A, Simpson EL, Tyring SK, Purcell LA, Shumel B, Petro CD, et al. Dupilumab does not affect correlates of vaccine-induced immunity: A randomized, placebo-controlled trial in adults with moderate-to-severe atopic dermatitis. J Allergy Clin Immunol Pract. 2019;80(1):158-167.
6. Muñoz-Bellido FJ, Moreno E, Dávila I. Dupilumab: A review of present indications and uses out of indication. J Investig Allergol Clin Immunol. 2021;32(2):1-36.
7. Süßmuth K, Traupe H, Loser K, Ständer S, Kessel C, Wittkowski H, et al. Response to dupilumab in two children with Netherton syndrome: improvement of pruritus and scaling. J Eur Acad Dermatol Venereol. 2021;35(2):e152-155.
8. Steuer AB, Cohen DE. Treatment of Netherton syndrome with dupilumab. JAMA dermatol. 20201;156(3):350-351.
9. Andreasen TH, Karstensen HG, Duno M, Lei U, Zachariae C, Thyssen JP. Successful treatment with dupilumab of an adult with Netherton syndrome. Clinic Experim Dermatol. 2020;45(7): 915-917.
10. Springston EE, Smith B, Shulruff J, Pongracic J, Holl J, Gupta RS. Variations in quality of life among caregivers of food allergic children. Annals of Allergy, Asthma & Immunology. 2010; 105(4):287-294.