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Allergic Rhinitis: Doctors Respond To High Caseload

More patients than ever before are expected to come to NewYork-Presbyterian Hospital this year seeking treatment for allergic rhinitis.

The Hospital's 2 well-known experts in the field—William Reisacher, MD, and Hector P. Rodriguez, MD—anticipate an unprecedented number of referrals in 2007.

“There is no question that more people are going to their primary care doctors with allergic rhinitis, and those doctors are sending patients here so they can have proper testing and treatment,” said Dr. Reisacher.

This year, both Columbia University Medical Center and Weill Cornell Medical Center are for the first time offering specialized allergy services within the Department of Otorhinolaryngology at Weill Cornell and the Department of Otolaryngology/Head and Neck Surgery at Columbia. Both Centers provide patient education, extensive allergy testing, and the newest treatments for adults and children with allergic rhinitis. Among the therapies offered at the Hospital are unique, minimally invasive treatments for persons with severe symptoms.

“This is an increasingly prevalent, life-affecting disease that, more and more, we recognize cannot be treated simply with
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Experts Investigate Sinister Implications of Hoarseness

Transient hoarseness is a common complaint and, in most cases, it's nothing to worry about. Persistent hoarseness is another story, however.

“Vocal cord paralysis is something we've known about for over 100 years, but we still can't answer basic questions for our patients,” said Lucian Sulica, MD. “We're interested in elaborating its natural history: We want to know how many cases resolve on their own, how many need help, and how early we can predict it. Up to now, physicians have asked patients to put up with extremely limiting hoarseness for as long as a year before intervening. That could cost some patients their jobs. We're interested in early intervention, using laryngeal [electromyography] to try and figure out prognosis.”

One of the factors complicating a determination of prognosis is that vocal cord paralysis is often associated with other illnesses or medical problems. “We see lots of patients who have had other types of procedures, such as thyroid surgery, or lung or chest surgery,” Dr. Sulica explained. “Some of these patients have a limited life expectancy and some have completely unlimited life expectancy, and they have different requirements.”

When a vocal cord is paralyzed, the cords don't meet; most treatment strategies involve moving the paralyzed cord closer to the functional one. This can be accomplished surgically, but Dr. Sulica is searching for alternatives. “Obviously, the less you have to do to the patient to get them functional again, the better it is,” he said.

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A carcinoma in a non-smoker. The patient had been hoarse for 4 months before seeking medical attention.

Photo courtesy of Lucian Sulica, MD

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Pediatric Otolaryngology

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UPDATES

Children Benefit From Improved Care in Pediatric Otolaryngology

Children with head and neck conditions are being offered more treatment options as the specialty of pediatric otolaryngology grows. At NewYork-Presbyterian Hospital, a new clinic and expansion of services are offering children improved patient care.

Children with velopharyngeal insufficiency (VPI), a rare disorder of the pharyngeal sphincter that severely impedes a child's speech, now have a specialized clinic at NewYork-Presbyterian/Columbia University Medical Center where they can go for diagnosis and treatment.

Pediatric otolaryngologist Eli Grunstein, MD, and speech therapist Julie Goldstein opened the clinic in 2006.

"Velopharyngeal insufficiency is a fairly unique condition. It is clear when the child speaks that something is wrong because there is too much air coming out of the nose. They are difficult to understand," said Dr. Grunstein. "That's why we felt it was important that kids have a place to go where we can make the diagnosis and talk to children and their parents about all the different options."

VPI most often develops in children with a cleft palate. It can also result from adenoid surgeries and is estimated to occur in approximately 1 in every 1,500 to 10,000 cases. The majority of VPI sufferers are usually diagnosed around the age of 5. The diagnosis is difficult to confirm in children younger than 3 years of age.

Once a child is referred to the clinic, the speech therapist performs a perceptual speech assessment to gauge the severity of

the problem. Dr. Grunstein then carries out a video nasopharyngoscopy while Ms. Goldstein asks children to pronounce a series of sounds. The pair compares the speech and velopharyngeal sphincter movement to make the diagnosis.

Children are usually treated with a combination of surgery and speech therapy, although mild cases can often be resolved with speech therapy alone.

Dr. Grunstein performs several surgical procedures to correct the physical malfunction. A common surgical procedure for VPI is the Furlow procedure. Other surgical treatments include a velopharyngeal sphincter pharyngoplasty, which narrows the velopharynx and creates a "speed bump" in the back of the pharynx for the soft palate to contact during speech.

Those children who are not surgical candidates or who do not wish to have surgery can be fitted with a prosthesis or retainer to be worn during the day.

Dr. Grunstein described VPI as a "very, very difficult condition for a child." Studies have shown that children with VPI tend to have fewer friends and a lower quality of life than other children.

The specialized clinic runs one Friday afternoon every month.

The Pediatric Otolaryngology Department at NewYork-Presbyterian/Weill Cornell Medical Center has entered a period of growth that will eventually make it one of the largest American centers for the treatment of children with head and neck conditions. In January 2007, a pair of nationally and internationally renowned specialists in pediatric otolaryngology—Robert Ward, MD, and Max April, MD—returned to full-time practice at NewYork-Presbyterian/Weill Cornell. Dr. Ward started the original Pediatric Otolaryngology Division there in 1987 but left for private practice in 1995. He collaborated with Dr. April a decade ago to start the New York Otolaryngology Institute.

Now at Weill Cornell Medical College full time, the pair plans to expand the pediatric otolaryngology program to offer a broad spectrum of clinical services to children with complex conditions.

"We really want to strengthen the pediatric otolaryngology program here. In the past, many of the complex cases would have been sent out from Weill Cornell. We want to be able to offer a place where we can get everything accomplished for even the most complex cases," said Dr. Ward.

Since January, the department has grown quickly. The surgeons are seeing more patients and more complex cases referred. The program is actively recruiting another pediatric otolaryngologist for the service.

The surgeons specialize in the treatment of pediatric congenital head and neck problems, particularly airway abnormalities. Dr. April is also involved in the management of pediatric sinus disorders and obstructive sleep apnea and was one of the first pediatric otolaryngologists to perform partial or intracapsular tonsillectomies.

Long term, Dr. Ward plans to expand research efforts in pediatric otolaryngology at Weill Cornell. He also wants to establish a fellowship in pediatric otolaryngology. It would be one of a few fellowships in this specialty in the United States.

"I see this as an opportunity to really develop pediatric otolaryngology, which is a relatively new field. Twenty years ago, there were only 2 specialists in the metropolitan area. Things have grown but there is still a lot more we would like to see accomplished," he said.

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Allergic Rhinitis

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allergy medication. These patients need something more," said Dr. Rodriguez.

The rising incidence of allergic rhinitis has been accompanied by an increasing prevalence of severe chronic rhinosinusitis and chronic hypertrophic rhinitis, which results from sustained irritation and enlargement of the nasal turbinates. Once the enlargement becomes chronic, the condition is irreversible without surgical intervention. Primary care providers often miss signs of chronic hypertrophic rhinitis and may exacerbate the condition by having patients use allergy medication for an extended time, said Dr. Rodriguez.

"Referring physicians really need to be educated about this condition. When they give treatment with antihistamines, they get a partial response because they are only taking care of the partial problem of the turbinate," he said.

Individuals with long-term allergic rhinitis should be referred to a specialist who can diagnose and treat the condition. Treatments include laser surgery, cautery, and somnoplasty, a method of radiofrequency ablation that Dr. Rodriguez helped pioneer.

Dr. Reisacher's area of expertise is the diagnosis and management of allergies to airborne substances and foods in adults and children. He uses the latest desensitization techniques, including sublingual immunotherapy, along with minimally invasive methods of skin testing.

Allergic rhinitis is strongly linked to comorbidities such as asthma, depression, and migraines and is estimated to account for 100 million days of absence from work, 28 million days of lost productivity, and 1.5 million days of absence from school per year. Although the true prevalence of allergic rhinitis remains unknown, the condition has become alarmingly common during the last generation. The numbers are nothing to sniff at—in the United States, current estimates suggest that more than 50 million adults and children have allergic rhinitis, making it the most prevalent chronic condition in children in this country.

Experts cannot pinpoint what is driving the rise. Some researchers have speculated that the prevalence of allergic rhini-

tis is increasing less quickly than recent figures suggest. Thanks to better knowledge and improved reporting systems, they argue, the rate of diagnosis is improving. Historically, the condition was underrecognized, underestimated, and undertreated, they say.

On the other hand, few specialists believe that the allergy epidemic merely reflects growing awareness about the condition. "There is no question that more people today have allergic rhinitis than 20 years ago. It's not because we're talking more about it," said Dr. Rodriguez.

The most common and most widely accepted theory accounting for the rise is the "hygiene hypothesis," said Dr. Reisacher. The hygiene hypothesis is supported by studies conducted after the fall of the Berlin Wall, which revealed significantly higher levels of allergic rhinitis and asthma among children raised in West Germany than among those who grew up in East Germany (*Int Arch Allergy Immunol* 1999;118:403-407). Studies of children who grew up on farms show that allergic rhinitis is less likely to develop in children exposed to animals (*Allergy* 2006;61:414-421).

Other likely factors contributing to the rise include a buildup of allergens and chemicals in the air we breathe as a consequence of tightly sealed and/or poorly ventilated offices and increasing air pollution. Some controversial theories suggest that dietary changes, the decreased use of aspirin and rising use of antibiotics, and shifts in breastfeeding patterns may have left people more susceptible to allergies.

"We cannot say exactly what is causing the increase. There are a lot of theories that exist. But certainly our environment is having an effect," said Dr. Reisacher.

The growing problem of asthma has raised awareness of allergic rhinitis and its effects, said Dr. Reisacher. More than half of asthma patients have allergic rhinitis. Allergic rhinitis exacerbates asthma, whereas the treatment of allergic rhinitis reduces both the incidence and severity of asthma. "The rise in asthma has caused us to be more vigilant about allergies and has focused more attention on finding the most effective method for detecting allergies," said Dr. Reisacher.

"We know a lot more about allergic

rhinitis today, how to diagnose, how to test. We are slowly coming around to the idea that there is something more complex going on than a little bit of hay fever. We know that it can be severe and have a serious effect on quality of life. That's why it is important that we do not just keep giving patients allergy medications to treat their symptoms," said Dr. Rodriguez.

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Hoarseness

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“We’re working with office injection of substances like Radiesse, which is a calcium hydroxylapatite paste, to bulk up the paralyzed cord and rehabilitate people quickly and easily.”

In addition to his focus on neurologic disorders of the voice, Dr. Sulica is involved in improving the infrastructure that supports ear, nose, and throat research and patient care at NewYork-Presbyterian Hospital/Weill Cornell Medical Center. “We’re still assembling all the components of our team,” he said. “We’re aiming to offer complete diagnostic testing in house as well as voice therapy, which we should have up and running in the next couple of months.”

In-house diagnostics and treatment are also a focus at NewYork-Presbyterian Hospital/Columbia University Medical Center. Jonathan Aviv, MD, and Thomas Murry, PhD, have developed a cutting-edge in-office diagnostic procedure for patients suffering from hoarseness and coughing, warning signs for esophageal adenocarcinoma. Rather than performing a standard esophagoscopy with the patient under general anesthetic or conscious sedation, Drs. Murry and Aviv opt for transnasal esophagoscopy with the patient awake and alert.

“We use a topical anesthetic in the nose only,” said Dr. Aviv. “The patient is

sitting upright in a chair. The scope goes through their nose, we do the procedure, and then they can go back to work immediately, as opposed to general anesthesia, where they’re out for at least a day or 2, or conscious sedation, where you’re giving the patient intravenous narcotics. It’s much, much safer for the patient, and the diagnostic yield is as accurate going through the nose as it is going through the mouth.”

Dr. Murry’s focus is on voice disorders, so he often sees the patients first and makes sure their concerns about voice function are addressed.

“When people have this procedure done in the [gastroenterologist’s] office, by and large the gastroenterologist passes up the vocal folds,” he said. “We typically stop at the level of the larynx, look at the vocal folds, make sure there are no lesions, and look at the larynx in general to see if there are any indications of significant laryngopharyngeal reflux. Quite often these patients are coming first to me with a complaint of hoarseness or change in their voice. Our concern is whether we’re treating something that’s covering up a bigger problem in the esophagus.”

Hoarseness and coughing may seem common and harmless, but Dr. Aviv noted that when they persist despite treatment, the risk of cancer is quite real. “We have seen many patients whose sole complaint is either cough or hoarseness,”

he said, “and they have persistent symptoms despite anti-acid therapy, and when we do a transnasal esophagoscopy, 10% to 15% of the time we see this short segment of Barrett’s esophagus, which is potentially either premalignant or malignant. We routinely look at the esophagus when patients have these complaints, because we could pick up things that normally would have silently progressed to a life-threatening illness.”

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Important news from the Ear, Nose, and Throat Centers of NewYork-Presbyterian Hospital—current research projects, clinical trials, and advances in the diagnosis, treatment, and rehabilitation of ear, nose, and throat disorders.

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