

To: All members of Pinnacle Pediatrics
Subject: Allergy Season

Well, you, and your children, survived the ravages of Flu and Norovirus. Almost EVERYBODY had 1 or both of these diseases. Fortunately, in our practice, we had no hospital admissions as a result of this twin pandemic. Now you can breathe a sigh of relief. But, if your children have seasonal allergies, don't breathe Too deeply. Yes, allergy season is upon us. That sound you are hearing in the morning, in addition to the birds chirping, is your little ones sneezing and blowing their noses. (By the way, if anyone has a solution to the early-morning bird chirping, let me know. I'm already up, but it wakes my daughter who has a tree next to her window. We tried the fake owl -- the birds enjoyed sitting on its head, pretty sure they were laughing at me).

Before I discuss how to handle Allergy season, a brief word (in addition to our recent Measles update) on another largely preventable infectious disease, Pertussis (whooping cough). Cases of pertussis have skyrocketed more than 1500% nationwide since 2021 (during the Covid pandemic), according to the CDC. Deaths attributable to this disease have also increased, with 10 recorded last year (mostly in infants), compared to 2-4 in previous years. In 2021 the CDC reported 2,116 cases, last year they recorded 35,435. Four months into 2025, they have reported 7,111 cases, more than double this time last year. I stated in the Measles update that Measles is considered the canary in the coal mine because it is so contagious, and that other vaccine-preventable diseases will also likely start to show increased prevalence. Although our vaccine against pertussis is not quite as effective as the one against Measles, this is still largely a vaccine-preventable disease. But as vaccination rates continue to fall, the natural consequence is that cases of the diseases that we can prevent will continue to rise. Additionally, there have now been 168 pediatric Flu deaths this season, moderately higher than usual, a figure that also could be reduced by better vaccination rates. If you notice a theme here, I assure you it is completely intentional.

Now, what to do with Sneezy (yup, my dad's name for me when I was little. At least I wasn't Grumpy, but I would have preferred Doc).

About 20% of children have environmental allergies. Tree pollen is the usual initial source of discomfort in the Spring, followed in several weeks by grass pollen. Typical environmental allergy symptoms consist of sneezing (especially in the morning, when pollen counts are highest), runny nose, congestion and itchy, watery eyes. In children, the eye symptoms provoke the most complaints, followed by congestion. Sneezing and runny nose tend to bother the parents more than the child. Fever indicates infection, not allergy. Sore throat and cough are more commonly due to infection than allergy.

If a child exhibits runny nose and sneezing only, no treatment is usually necessary. If a child does express discomfort, particularly if they have congestion and/or eye symptoms, first-line treatment is a non-sedating antihistamine. The Big Three products are Zyrtec (Cetirizine), Claritin (Loratidine), and Allegra (Fexofenadine). All three are effective, with Zyrtec proving to be slightly more effective in head-to-head studies, although some children may experience drowsiness with Zyrtec. Older antihistamines, such as Benadryl, are not as effective, and do cause sedation (which may be desirable in the pre-school aged child). Zyrtec is over-the-counter, comes as a liquid and a small tablet, and is given just once per day. The dose is 5 mg. for children age 2-6 years, and 10 mg, for children age 6 and up. The oral decongestant Pseudoephedrine may be added to an oral antihistamine, as in Zyrtec-D or Claritin-D. The other commonly used oral decongestant, Phenylephrine, is no more effective than placebo, so is not recommended.

Nasal antihistamines may also provide relief. Azelastine (Astepro) is also OTC, dose is 1 spray per nostril twice per day. It is approved for children over 5 years of age. Onset of action (15-30 minutes) is more rapid than an oral antihistamine (60 minutes).

If the antihistamine alone does not provide sufficient relief, a nasal-spray steroid can be added. This is particularly effective for congestion. These products were also recently made OTC. There are many products in this field -- Flonase (Fluticasone) appears to be the most effective. The usual dose is 1 spray in each nostril once per day. Although their onset of action typically occurs within 12 hours, maximal effect may not be achieved until 7 days.

Singulair (Montelukast) has commonly been prescribed for allergies. It is not very effective and is associated with neuropsychiatric side-effects, so I do not recommend its use.

Another option for congestion is a decongestant nasal spray, such as Afrin. However, these should only be used for 3 days due to rebound congestion. Nasal saline sprays and drops can be used to relieve nasal dryness and congestion. Nasal irrigation administered by neti pot or bulb syringe can help expel mucus and relieve congestion. Be certain to use sterile saline, or boiled and cooled water, as use of tap water has been associated with amoebic meningitis.

For itchy/watery eyes, antihistamine eye drops provide significant relief for those children who will allow their administration (Hint -- have the child look up, pull the lower lid down, and place the drop in the sulcus you have created. Hint #2 -- be certain your child is not holding sharp objects while you do this :). There are many OTC antihistamine eye drops, the most effective being Ketotifen (brand name Zaditor or Alaway) and Olopatadine (Pataday). The dose for Ketotifen is 1 drop in each eye twice per day, for Pataday it is 1 drop once per day. Onset of action is within minutes. The eyedrops can cause burning and stinging. Refrigerating the drops may lessen these side-effects.

Although avoiding potential allergens is an oft-recommended strategy, in most instances this is not practical. Your child needs to go outside for fun and for exercise. Certainly, there are reasonable steps one can take, such as not asking the grass-allergic child to mow the lawn, avoiding hay rides, and whole-house air-conditioning so the windows can remain

closed. Having the child immediately take off clothes upon coming indoors, and promptly taking a shower to remove any pollen also makes sense. Likewise, allergy testing is superfluous for most children, as knowing specifically what they are allergic to will usually not alter their management "Stay away from the Dutch Elm trees and perennial ryegrass dear!" is not likely to be an effective caveat.

If a child is on maximal medical therapy (oral antihistamine, nasal steroid, antihistamine eye drops) and is still miserable with allergy symptoms, then it is reasonable to see an Allergist for consideration of immunotherapy (usually given as injections, but now also available orally for certain allergens). Fortunately our allergy medications are effective enough currently that we see far fewer children requiring immunotherapy than previously. A recent option now available via an allergist is Xolair (Omalizumab). This is a monoclonal antibody which is given by injection every 2 - 4 weeks.

Spring allergy season generally lasts until mid-June, then Fall allergy season starts in mid-August. However, depending on exactly what the child is allergic to, some kids are symptomatic year-round. Fortunately, many of these children are not terribly uncomfortable, and our current medications provide significant relief for most others. As with many issues in pediatrics, the parents are often more bothered by the symptoms than the child. Recommended treatment is earplugs for the parents and a recording of "Gesundheit" that can be replayed on a continuous loop each morning. Enjoy the Great Outdoors (but bring a box of Kleenex)!

Best regards,

Scott R. Serbin M.D.