INTRODUCTION

Although it often is remarked that everyone is allergic to something, in truth, only about 25–30% of the population is allergic to anything. This frequency is enough to make the allergic patient a common visitor in every medical setting. In addition, many disorders mimic allergy symptoms. Therefore, the differential diagnoses of various disease states must include allergy as a possibility.

Allergy can affect virtually any organ system. Common types of presentation include conjunctivitis (eyes), rhinitis (nose), urticaria and angioedema or atopic (allergic) dermatitis (skin), asthma (lungs), and anaphylaxis (multiorgan). Evaluation of suspected allergy must include a detailed medical history, comprehensive physical examination, and appropriate diagnostic tests.

SUMMARY

Allergic disease is protean in its manifestations, affecting single or multiple organ systems. It may also mimic other conditions. The clinician must be prepared to take an in-depth history, make a comprehensive physical examination, and seek appropriate objective measures in order to adequately consider the differential diagnosis and arrive at a proper diagnosis.

No less important is the conference with the patient once the diagnosis has been established. At that meeting, findings and impressions should be summarized in language understandable to the patient. Terminology should be carefully chosen and prognosis phrased optimistically whenever possible. Likewise, medication regimen (including inhaler technique) and rationale, environmental and lifestyle modifications, and/or follow-up may be discussed.

Key Words: Allergic; asthma; atopic; diagnostic; examination; history; rhinitis; skin testing.
HISTORY

The most important component of the evaluation of a possible allergic problem is the patient’s history. It is from the history that salient physical examination and tests follow. An allergy history is made up of a chief complaint, determination of seasonality or diurnal variation of symptoms, identification of triggers, occupational exposure, response to medication, family history, and other pertinent medical history. It may not be obvious to the patient what historical factors are important; thus, it is recommended that a questionnaire that screens for contributory factors be used (Fig. 1).

The history is the most important element in the evaluation of allergy. Key features of the history are:

- Worsening of symptoms on exposure to aeroallergens
- Seasonal variation in symptoms related to pollination of trees, grasses, and weeds
- A family history of atopic disease
- An environmental history assessing exposure at workplace and home
- The presence of associated allergic conditions

An allergy history seeks to define the patient’s chief complaint(s) and focuses on the details concerning those complaints. If the chief complaint is narrow in scope, for instance, “I sneeze all the time,” then the clinician may be tempted to direct the majority of the questions toward a given organ system. This approach should be avoided and the patient given ample opportunity to expound on the extent of the complaint.

There is a lexicon common to patients with allergy complaints. Many state that they have “sinus” or “hay fever.” They describe a wide array of symptoms ranging from itchy nose, eyes, or palate to runny nose or postnasal drainage to nasal congestion. Sinus pressure and headaches are frequently cited as symptoms. “Popping or fullness of the ears,” implying eustachian tube dysfunction, is an often heard complaint. Asthma symptoms may be overt and present as wheezing, but descriptions may be more subtle, such as cough, tightness in the chest, or inability to get a good breath or let all the air out of the lungs.

The history taker should be attuned to the patient’s perspective as a potential allergy sufferer. Where and when do the symptoms occur? Do they interfere with daily activities, school or work, or exercise? Is there seasonal variation to the symptoms, or are they of a perennial nature? Are the symptoms worse at a particular time of day? During sleep?

At first, questions searching for triggers should be open-ended. For instance, “What seems to trigger your symptoms?” rather than “Does this or that bother you?” If patients are reticent or rambling in their responses, direct questions may be appropriate. In most cases, the patient will stipulate if symptoms are worse inside the house or outdoors.

Increasingly, indoor allergens are recognized as important triggers and sensitizers of the allergic patient. Type of home and the presence of a basement may be important. For example, a wet environment tends to produce growth of molds and dust mites. House dust mite is likely the most common allergen in our society. It is found in greatest abundance in bedding, pillows, carpet, and upholstered furniture. Therefore, the kind of bedding and