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Allergic rhinitis is a global health problem affecting at least 10 to 25 % **[1]** of the population and up to 40% of children but is commonly undiagnosed
[2]
. Childhood rhinitis may be classified into non-allergic and allergic. Allergic Rhinitis (AR) is the most common chronic atopic disease and is associated with considerable cost and co-morbidity. It is classed as Inter-mittent or Seasonal Allergic Rhinitis (SAR) or Persistent or Peren-nial Allergic Rhinitis (PAR). Seasonal Allergic Rhinitis is triggered by pollen from trees, grasses and weeds, is characterized by sneezing, nasal congestion, nasal itching, rhinorrhea, and pruritic, watery, red eyes. Perennial Allergic Rhinitis is triggered by allergens which are commonly found at any time of year in the indoor environment such as dust mite or cat , dog, cockroach allergens.

Seasonal rhinitis is a disease particularly of teenagers and young adults and appears to be less

common in primary and pre school age children. In seasonal rhinitis, with relevant grass pollen sensitization, the link between the allergen exposure and rhinitis is clear cut. However, in other situations such as perennial rhinitis and house dust mite allergen sensitization, the link between symptoms and allergen exposure is less certain. Avoidance of allergens often proves to be difficult in practice.

Intranasal steroids are the treatment of choice for persistent moderate-severe allergic rhinitis and are more effective than antihistamines for relief of nasal obstruction. Antihistamines are effective for control of histamine related symptoms such as itching, rhinorrhoea and sneezing **[2]** .

Careful assessment of nasal symptoms allows for the most appropriate therapeutic options to be chosen. Pharmacotherapy is the most used therapeutic modality, especially in allergic rhinitis. The first step to successful management is the accurate diagnosis of the type of AR (intermittent or persistent) and assessment of its severity (mild or moderate to severe). Although objective measurements of the nasal airway have great value to evaluate and follow up the cases, in most centers they are not done in routine clinical practice.

Allergen avoidance is often difficult in practice. Antihistamines are of limited benefit in allergic rhinitis caused by house dust mite and other perennial allergens, where symptoms,

predominantly nasal obstruction, are not histamine mediated. In contrast, symptoms triggered by pollen, such as nasal itch, rhinorrhoea and sneezing, are relieved by antihistamines. Intranasal steroids are the treatment of choice for persistent moderate-severe allergic rhinitis and are more effective than antihistamines for relief of nasal obstruction. Failure to respond to intranasal medications is often caused by poor compliance or inefficient use of nasal sprays. Children with persistent rhinitis must be evaluated for asthma. Early treatment of allergic rhinitis may avoid asthma onset. Sublingual immunotherapy (SLIT) was introduced in the 1990s as a possible solution to the problem of adverse systemic reactions to subcutaneous immunotherapy and has been demonstrated by more than 50 trials and globally evaluated thus far by five meta-analyses as an effective and safe treatment for allergic rhinitis. **[3, 4, 6]**.

Sublingual immunotherapy using standardized dermatophagoides farinae extract is safe and effective in the treatment of children with combined allergic rhinitis and asthma syndrome **[5].**

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