Allergic disease is a prevalent problem that affects approximately 20-25% of the population.\(^1\), \(^2\) Diagnosis of this disease process is based on clinical evaluation and quantitative in vitro or in vivo testing necessary before initiating immunotherapy.\(^3\) In addition to allergen avoidance and pharmacotherapy, additional treatment options include subcutaneous immunotherapy. This option has been shown to be effective in multiple randomized controlled trials in patients with allergic disease.\(^2\), \(^4\) Clinically relevant allergen identification and documentation of IgE-mediated disease is necessary prior to starting subcutaneous immunotherapy. Consideration for immunotherapy is based on the severity and duration of disease and response to or tolerance to medical therapy.\(^2\)

The decision to begin allergy immunotherapy might depend on number of factors, including but not limited to: patient preference, adherence, medication requirements, response to avoidance measures, adverse effects of medications, coexisting allergic rhinitis and asthma, and possible prevention of asthma in patients with allergic rhinitis. Additionally, the level of sensitivity will determine the starting dose for safe and effective therapy.\(^5\)

Individual results may vary, however. On average, duration of therapy is usually 3-5 years for adequate immunologic response.\(^6\), \(^7\), \(^8\), \(^9\) A physician or provider must evaluate patients periodically during therapy, to determine safety and efficacy, monitor adverse reactions, and make appropriate adjustment to therapy, especially during the escalation phase. Though extremely rare, the risks for serious potentially life-threatening responses exist.\(^10\) Patients need to be counseled on the potential risks and benefits of immunotherapy with informed consent.\(^11\)

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**Subcutaneous Immunotherapy (SCIT) for Aeroallergen Immunotherapy**

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