

## EDITORIAL

# Beyond Algorithms: Clinical Judgement in the Management of Allergic Rhinitis

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Allergic rhinitis affects 10%–40% of the global population and represents one of the most frequently managed conditions in allergy and internal medicine practice. International guidelines, particularly ARIA (Allergic Rhinitis and its Impact on Asthma), have successfully standardised diagnosis and treatment through evidence-based algorithms that constitute an undeniable scientific advance [1]. However, after 40 years of outpatient allergy practice, it becomes clear that daily clinical reality reveals a complexity that transcends standardised recommendations. This patient-centred perspective is not new—it echoes the Hippocratic emphasis on studying the patient rather than the disease, on careful observation and on allowing sufficient time to combine contradictory findings [2].

This editorial does not intend to criticise clinical guidelines, whose value is unquestionable. Rather, it aims to explore what guidelines, by their very nature, cannot fully teach: the clinical complexity emerging from the individual patient, the diagnostic ambiguity that escapes algorithms, the variability of therapeutic response and the relational dimension of care.

## 1 | Phenotypic Heterogeneity Beyond the ARIA Classification

The ARIA classification (intermittent/persistent; mild/moderate–severe) represented an important step forward compared with the previous seasonal/perennial distinction. However, in daily practice, we recognise clinical phenotypes that this taxonomy captures only partially: patients with predominant nasal obstruction ('blockers'), others with prevalent rhinorrhea and sneezing ('runners/sneezers'), patients with dominant ocular

symptoms and patients with predominantly nocturnal symptomatology. These phenotypes do not simply reflect quantitative variations in severity, but rather distinct clinical patterns with differential therapeutic responses. Patients with an obstruction-dominant phenotype typically show superior response to intranasal corticosteroids (70%–80% improvement in obstruction), while oral antihistamines offer more limited benefits (30%–40%). In practical terms, this means asking the patient a seemingly simple but clinically decisive question: 'Which symptom bothers you the most?' The answer often provides more useful guidance for treatment selection than algorithmic application of severity categories.

## 2 | Diagnostic Ambiguity and the Role of Clinical Judgement

One of the most insidious challenges concerns patients with symptoms classically suggestive of allergic rhinitis but negative allergy tests, or conversely, patients with weakly positive tests and discordant clinical manifestations. The concept of local allergic rhinitis (LAR)—an entity characterised by IgE production confined to the nasal mucosa, detectable only by specific nasal provocation testing—may account for up to 25% of patients previously classified as having non-allergic rhinitis [3]. The practical problem is that specific nasal provocation testing is not available in most routine clinical settings. Clinicians are therefore confronted with a dilemma: should they trust negative tests or their clinical assessment, which may strongly suggest an allergic mechanism based on seasonality, reproducible triggers and response to anti-allergic therapy? The answer requires a hermeneutic approach—an iterative

dialogue between objective data, clinical presentation, patient narrative and therapeutic trials.

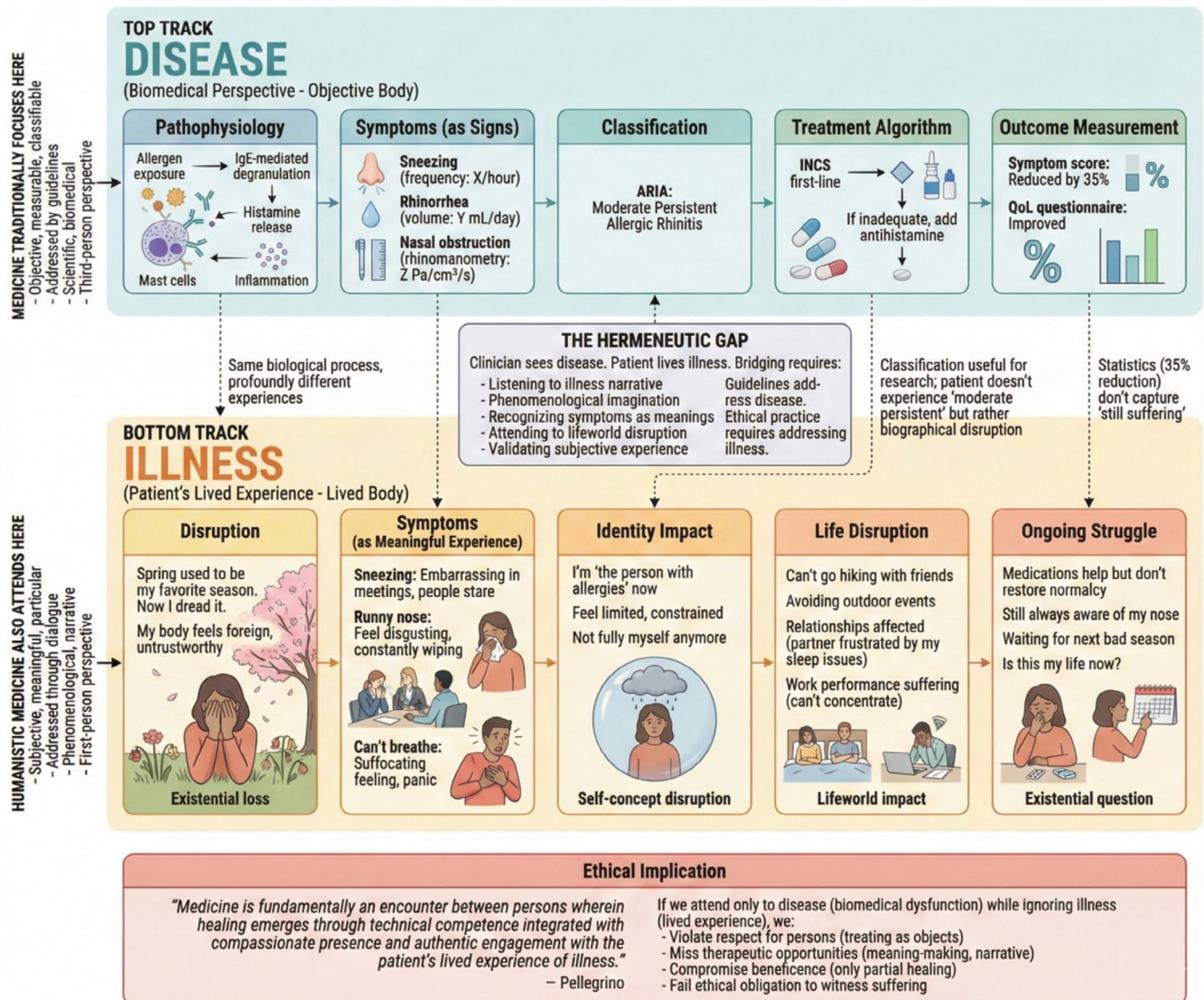
### 3 | From Disease to Illness

The distinction between disease (the biomedical entity) and illness (the lived experience of being unwell) is particularly relevant in allergic rhinitis (Figure 1). While disease-focused approaches emphasise pathophysiology, classification, treatment algorithms and measurable outcomes, the illness perspective captures the patient's subjective experience: the meaning of symptoms, the impact on identity, the disruption of daily life [4]. A patient may report a 35% reduction in symptom score—a success according to clinical trial metrics—yet continue to suffer significantly because spring remains a dreaded season, outdoor activities are still limited and sleep quality remains compromised. Recent work in this journal has emphasised the importance of integrating patients into programmes to bridge the knowledge-practice gap in allergy care, highlighting that

effective implementation requires patient and carer involvement at every stage [5]. Encouragingly, Core Outcome Sets are now being developed with extensive patient involvement through initiatives such as the COMET programme, ensuring that outcomes meaningful to patients—not only to researchers—are captured in both clinical trials and routine practice. As Edmund Pellegrino emphasised, medicine is not simply the technical application of scientific knowledge to biological problems, but fundamentally an encounter between persons, in which technical competence is inseparably intertwined with relational, existential and hermeneutic dimensions [6].

### 4 | Variability in Therapeutic Response

Second-generation antihistamines are recommended as first-line therapy for mild-to-moderate allergic rhinitis, and meta-analyses clearly demonstrate their superiority over placebo. However, this average efficacy conceals substantial interindividual variability: only 40%–60% of patients achieve complete



**FIGURE 1** | From disease to illness in allergic rhinitis. This figure contrasts the biomedical concept of disease with the patient's lived experience of illness. Bridging these perspectives requires interpretive and relational competencies that complement guideline-based management.

symptom control with antihistamine monotherapy. Similarly, intranasal corticosteroids show insufficient response rates in approximately 15%–30% of patients. When a patient reports poor efficacy of antihistamines, the clinician must consider multiple possible explanations: inadequate adherence, an obstruction-dominant phenotype in which antihistamines have limited impact, unrealistic expectations, incomplete diagnosis with an unrecognised non-allergic component, or comorbidities such as chronic rhinosinusitis. This complex decision-making process does not lend itself easily to linear algorithms.

## 5 | Allergen Immunotherapy: From Efficacy to Effectiveness

Allergen immunotherapy (AIT) represents the only disease-modifying treatment for allergic rhinitis, with 30%–40% reductions in symptom scores and sustained clinical benefits after treatment discontinuation [7]. However, a substantial gap exists between efficacy observed in clinical trials and effectiveness in real-world practice. The principal determinant of this discrepancy is treatment persistence: only 40%–60% of patients complete the recommended 3-year course of AIT. Strategies to improve persistence—careful patient selection, structured pre-treatment counselling, realistic expectation setting, shared decision-making and scheduled follow-up—are supported by evidence but difficult to codify in guidelines because they depend on communication skills, sensitivity to patient motivation and availability of time for counselling.

## 6 | Integrating Evidence and Experience

Michael Polanyi distinguished between *knowing what* (explicit, codifiable knowledge) and *knowing how* (practical, experiential knowledge) [8]. Clinical guidelines belong to the former domain: they translate available scientific evidence into explicit recommendations. Real-world medicine, however, also requires the latter—clinical judgement, pattern recognition beyond codified categories, tolerance of diagnostic uncertainty and intuitive reasoning that develops only through direct experience with thousands of patients. As Sackett and colleagues originally defined it, evidence-based medicine requires ‘the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients’, integrating clinical expertise with external evidence and patient values—a vision that transcends algorithmic application of guidelines [9]. The metaphor of guidelines as maps captures this relationship well. Maps are indispensable for orientation, but they are not the territory. The territory—the individual patient—is invariably richer, more complex and more ambiguous than any representation can fully convey.

## 7 | Conclusions

Clinical excellence does not arise from choosing between evidence and judgement, between standardisation and personalisation, or between science and humanity, but from their deliberate synthesis. Guidelines must be consulted, respected and applied, but also contextualised and, when necessary, thoughtfully

adapted to the individual patient. The challenge for clinicians—and for the educational systems that train them—is to cultivate this integrative capacity: to form professionals who are technically competent, scientifically rigorous and at the same time reflective, relationally attentive and capable of navigating uncertainty. In allergic rhinitis, as in much of clinical medicine, it is precisely in this space between map and territory, between rule and judgement, that the essence of excellent medical practice resides.

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### Data Availability Statement

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