The Relationship of Cortisol Levels to Allergies

For many of us, the increased sunshine, longer daylight hours, birds chirping, bees buzzing and flowers blooming that come with onset of spring are most welcome after cold, gray winter days. However, for the allergy sufferer, these can be the signal of just another season of frustrating runny noses and itchy, watery eyes. While most of us remember to test cortisol in our fatigued or chronically stressed patients, it can also be quite useful to test cortisol levels in those suffering from chronic allergies.

Conventional approaches to treating allergic symptoms have often involved the use of a topical or inhaled corticosteroid. The corticosteroid, while effective at reducing the inflammation, does not address the underlying question of "Why can't this patient tolerate seemingly benign environmental factors such as grass or pollen?"

What we know about the role of the hypothalamic-pituitary-adrenal axis (HPA) and allergies is complex. Research shows that even in early life, infants who have an atopic disposition have an aberrant cortisol response. Initially, in infancy, when a stressor is incurred, the infant with an atopic disposition produces a higher level of cortisol than his or her non-atopic counterparts. However, in atopic adults, we see an attenuated response of the HPA to a stressor. What is unclear is whether this reduced responsiveness represents a genetically determined predisposition or whether a hyporeactive HPA is a consequence of chronic inflammatory markers increasing negative feedback effects on the HPA over time.

Another interesting study shows that the hyporeactivity of the HPA in adult atopy may be related to disease severity. This suggests that adults with increased allergic or atopic symptoms may have increased hyporeactivity of their HPA than other atopic adults. Also, increased stress, in the form of anxiety, has been shown to heighten the magnitude of allergic symptoms. For clinicians, this makes sense as we often see an increase in atopic and allergic symptoms in our patients who are undergoing stressful life events.

Ultimately what this information gives us is an understanding that cortisol production in the atopic patient is irregular. In the very young infant or child, it can be quite elevated before the onset of disease or clinical manifestations. In the toddler, child or adult who has atopic symptoms, we can see depressed cortisol levels indicating hyporesponsiveness of the HPA and, often, the severity of the depression of cortisol levels can be correlated with the severity of symptoms. This information gives us great incentive for monitoring our atopic

patients more closely with salivary cortisol levels in order to support their compromised HPA and help to holistically manage their symptoms.

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