# Why are views on the management of patients with vasomotor rhinitis changing?

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**BACKGROUND.** Vasomotor rhinitis represents a significant global health burden, with prevalence rates ranging from 5 to 25 %. It is a subtype of non-allergic rhinitis, a heterogeneous group of disorders characterized by rhinitis symptoms not caused by atopy or infection, which are sometimes grouped with other phenotypes such as gustatory, hormonal, or drug-induced rhinitis. In contrast to allergic rhinitis, which involves IgE-mediated immune responses, vasomotor rhinitis is driven by neurogenic and autonomic dysfunction. Previously, several authors proposed using the terms "vasomotor rhinitis" and "non-allergic rhinopathy" concurrently, or even classifying allergic rhinitis under vasomotor rhinitis. This creates discrepancies in interpreting the concepts of "vasomotor rhinitis", "non-allergic rhinopathy", and "allergic rhinitis", hindering a clear understanding of management approaches for the respective patient categories.

**OBJECTIVE.** To analyze available data on the etiology, pathogenesis, clinical manifestations, diagnosis, treatment, and prevention of vasomotor rhinitis.

**MATERIALS AND METHODS.** A search for available information sources, analytical processing, and discussion of the obtained results.

**RESULTS AND DISCUSSION.** Vasomotor rhinitis is a common, yet poorly studied, type of chronic rhinitis that is currently believed to be neurogenic in origin. Several authors use the term "non-allergic rhinopathy" instead of "vasomotor rhinitis", which complicates the understanding of this issue. Currently, there are no unified international diagnostic criteria for vasomotor rhinitis. In real clinical practice, physicians should perform differential diagnosis between vasomotor and allergic rhinitis (using specific allergodiagnostic methods), as well as exclude infectious rhinitis, drug-induced rhinitis, and chronic rhinosinusitis (using history taking, endoscopy, and other supplementary investigation methods). The majority of patients with vasomotor rhinitis respond adequately to treatment with topical saline solutions, topical antihistamines, corticosteroids, and ipratropium sprays, all of which alleviate rhinitis symptoms. Individuals who are refractory to traditional treatment may undergo therapy with capsaicin, botulinum toxin, and posterior nasal nerve ablation using radiofrequency ablation or cryotherapy. Currently, biological agents and neuromodulatory treatments are at various stages of investigation, focusing on the effect of such targeted therapy on type 2 inflammation, specifically the blockade of interleukin-4 and -13. Despite the encouraging nature of this data for other rhinitis subtypes, their role in vasomotor rhinitis remains unclear. Standardized and highly agreed-upon diagnostic criteria for vasomotor rhinitis must be developed to allow for more precise patient classification through phenotyping, enable targeted therapeutic selection, and establish a reliable evidence base regarding the efficacy and safety of treatment methods for this patient category.

**CONCLUSIONS.** Patients with vasomotor rhinitis often seek medical attention from allergists, otolaryngologists, and physicians of other specialties. Currently, there is no standardized approach to the management of such patients among various specialists. The issue of vasomotor rhinitis remains relevant and poorly understood, but the approaches to managing these patients must be unified.

**KEY WORDS:** vasomotor rhinitis, nonallergic rhinopathy, idiopathic rhinitis, pathophysiology, clinical manifestations, diagnosis, treatment.