Brighton and Sussex University Hospital Guideline for the Management of Allergic Rhinitis (AR)

Brighton and Sussex University Hospitals NHS Trust

√ Allergic rhinitis is common in children and adults and is a significant cause of morbidity.
√ Symptoms can affect quality of life (2), school performance (3) and impact on family life (4).
√ Patients must be evaluated for asthma symptoms. 75% of children with asthma suffer from AR (5) and AR increases the risk of hospitalisation in children with asthma (6)
√ Patients must be asked about eczema and pollen food syndrome.
√ Patients must demonstrate their nasal spray technique regularly and **adherence to therapy should be established *before* stepping up therapy**.

Diagnosis

1. **Classic symptoms:** Rhinorrhoea, pruritus (nose, throat, mouth), nasal congestion (mouth breathing, snoring), sneezing
2. **Careful history** (may identify allergic trigger)
3. **Examination of the nose to rule out any structural problems**

ARIA Classification of Allergic Rhinitis[7]

Intermittent Symptoms <4 days per week **or** <4 consecutive weeks	**Persistent** Symptoms >4 days per week **and** >4 consecutive weeks
Mild **all** of the following: 1) Normal sleep 2) No impairment of daily activities 3) No impairment of work/school 4) Symptoms present but not troublesome	**Moderate – Severe** **one or more** of: 1) Disturbed sleep 2) Impairment of daily activities 3) Impairment of work/school 4) Troublesome Symptoms

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(or sooner if evidence or practice changes)

BSUH Guideline for the Management of Allergic Rhinitis (AR)

Step up treatment if uncontrolled

Allow 8-12 weeks at each step before escalating treatment

Step down when patient gains control

Step 1

If moderate to severe symptoms (ARIA criteria) start Step 1 and Step 2 together

Allergen avoidance

Seasonal allergic rhinitis – please see Allergy UK guidance and BSACI guidance and NHS Choices
Perennial (House dust mite) – please see BSACI guidance

Nasal douching

Make your own saline solution see BSACI guidance

Step 2

Start with antihistamine if pruritus dominant or nasal corticosteroid if congestion dominant
For information for management in pregnancy and breastfeeding refer to CKS

Regular long acting non-sedating antihistamine

(see p3 for OTC options in adult patients)

See BNF and BNFC for current dosing for age group and formulations available

1st line:
Cetirizine
(from age 1 year. Use twice daily regimen in <12 years)
or
Loratadine
(from age 2 years)

2nd line:
(can consider if trial of above fails):
Fexofenadine
(from age 6 years)

Regular nasal corticosteroid spray*

(see p3 for OTC options in adult patients)

Demonstrate & check technique

See BNF and BNFC for current dosing for age

Mometasone furoate
(50micrograms per spray)
From age 6 years
or
Fluticasone *furoate* (Avamys®)
(27.5 micrograms per spray)
From age 6 years. Good effect on eye symptoms
or
Fluticasone *propionate*
(e.g. Flixonase®)
(50 micrograms per spray)
From age 4 years

For patients taking cobicistat or ritonavir use:
Beclometasone dipropionate
(50 micrograms per spray)
See MHRA advice Dec 2016

Step 3

Trial of oral antihistamine and nasal corticosteroid as per products in Step 2

Step 4

(Primary care or specialist initiation)

Regular nasal corticosteroid and oral antihistamine

Consider switching nasal steroid spray (especially if patient is already on fluticasone propionate nasal spray) **to:**

Fluticasone propionate with azelastine spray (Dymista®)
From age 12 years
Good effect on eye symptoms.

Continue oral antihistamine in combination with nasal spray

Consider referral to specialist. Steps 1-4 can be done in primary care

Step 5

Specialist allergy clinic

Specialist initiation only

Leukotriene receptor antagonist (e.g. montelukast)

Can be considered in asthmatic patients

See BNF and BNFC for current dosing for age

Specialist initiation and continued prescribing only

Allergen specific immunotherapy

BSUH within Brighton and Hove Clinical Commissioning Group
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BSUH Integrated Guideline for the Management of Allergic Rhinitis (AR)

Paediatrics

Top Tips

1. For seasonal rhinitis, start nasal spray 1-2 weeks before onset of appropriate pollen season
2. Nasal steroids unlikely to work if there is nasal blockage due to secretions. Try nasal steroid drops or pre-dosing with topical decongestant for 5 days
3. Avoid sedating antihistamines, and intranasal beclometasone (e.g. Beconase®) as it can have systemic effects due to a high bioavailability *(due to interactions beclomethasone is the preferred product in those taking cobicistat or ritonavir however. See MHRA advice Dec 2016)*
4. Avoid chronic use of decongestants
5. If eye symptoms present consider:
   - Olopatadine eye drops (from age 3)
   - Sodium cromoglicate eye drops

The following may be an indication for referral to Paediatric Allergy Specialist

1. Children with AR who are unresponsive and/or intolerant to conventional treatment
2. Children with diagnostic uncertainty and in whom further investigations (skin prick test +/- sIgE) would be helpful
4. Children who may be considered for desensitisation
5. Multisystem allergy (rhinitis with eczema, asthma or food allergy)

Adults

For seasonal rhinitis, start nasal spray 1-2 weeks before onset of appropriate pollen season

If eye symptoms present consider:

- Olopatadine eye drops
- Sodium cromoglicate eye drops

In severe cases of nasal obstruction thought to be due to allergic rhinitis a short course (e.g. 5 days) of prednisolone 0.5mg/kg could be considered (adults only, max 2 courses per year)

AVOID:

- Sedating antihistamines
- Depot corticosteroids
- Chronic use of decongestants or nasal beclometasone, as has high bioavailability

The following may be an indication for referral to Allergy Specialist

Inadequate control of symptoms on conventional treatment

1. Allergen/trigger identification
2. Consideration of desensitisation
3. Recurrent nasal polyps
4. Multisystem allergy (e.g. rhinitis with asthma, eczema or food allergy)
5. Occupational rhinitis

For adults, the following are available OTC without prescription, which patients could consider buying:

- Fluticasone propionate 50mcg nasal spray
- Beclometasone 50mcg nasal spray

(not preferred for routine prescribing, though may be cheaper than fluticasone OTC. Preferred product for patients on cobicistat or ritonavir, see MHRA advice Dec 2016)

- Loratadine tabs, liquid
- Cetirizine tabs, liquid
- Sodium cromoglicate eye drops
- Xylometazoline & antazoline eye drops (Otrivine Antistin®)

ENT Red Flags for urgent referral

- Unilateral symptoms including blockage, clear rhinorrhoea and facial pain
- Serosanguinous discharge
- Visual and neurological signs (considering sinonasal malignancy)
- Failure of 3 months maximum medical therapy, particularly where nasal blockage and anosmia remain significant symptoms

References

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