

Allergic Rhinitis

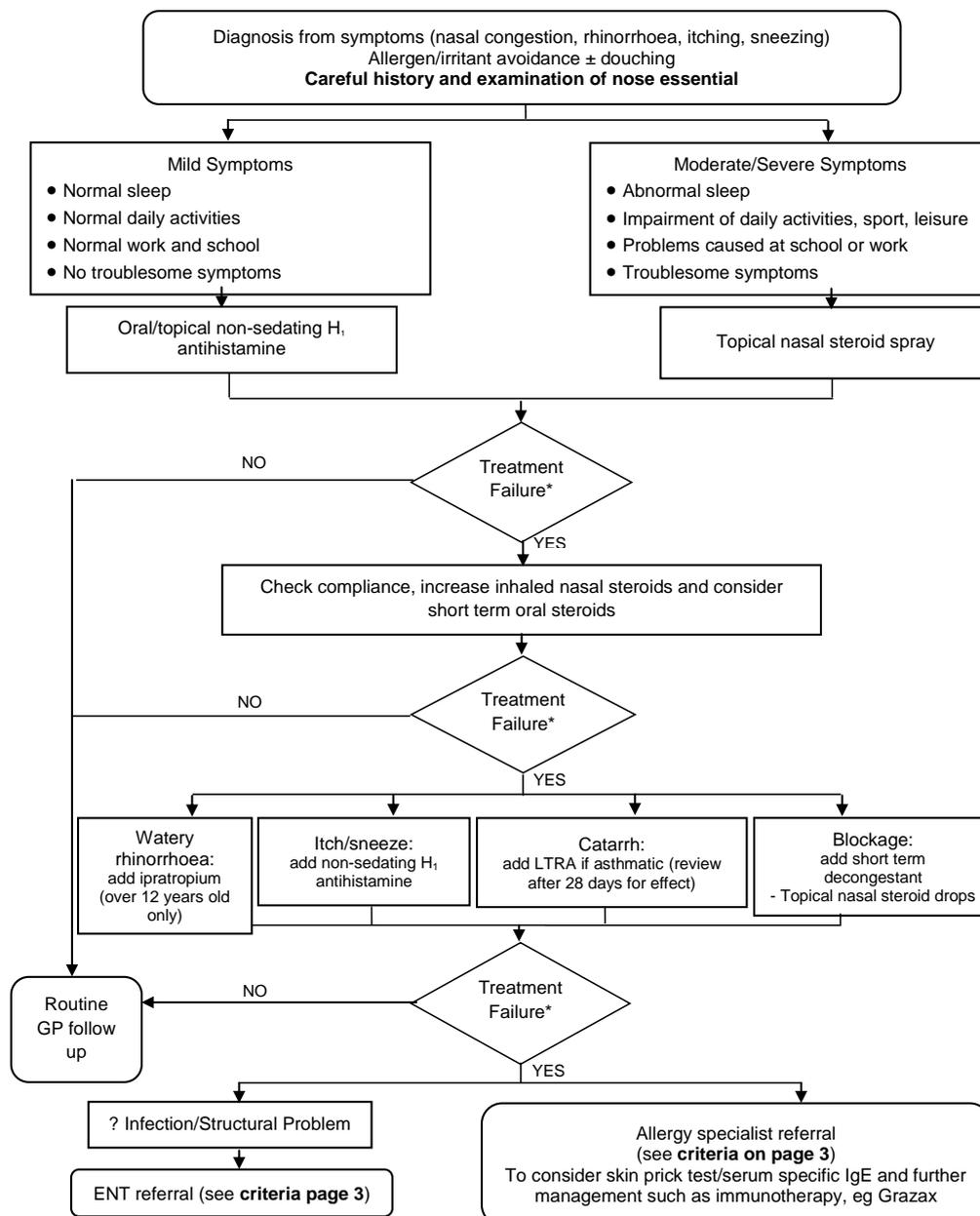
Primary Care Policy

Allergic Rhinitis is a common condition that can be effectively managed in primary care in the majority of patients. The CCG has agreed that management of rhinitis in primary care will be in line with the outlined pathway. Please check age restrictions for all licensed products stated in this clinical pathway.

It is the responsibility of referring and treating clinicians to ensure compliance with this policy.

If treatment for a patient deviates from this pathway clinicians can apply for funding to the Exceptional Cases Panel <http://www.cambsphn.nhs.uk/CCPF/ExcptnalandIFR.aspx>.

Pathway for primary care management ^{1, 2}



*See page 2 for definition on treatment failure.

LTRA: leukotriene receptor antagonist

Background and Rationale

Rhinitis is defined as *symptoms of nasal irritation/itching, sneezing, rhinorrhoea and nasal blockage which are reversible spontaneously or with treatment*. Some definitions mention having these symptoms more than two hours per day for longer than two weeks.

Allergic Rhinitis is common in the UK affecting over 20% of the general population.¹ In addition, 80% of asthmatics suffer from some degree of allergic rhinitis,^{3,4} and 50% of people with atopic eczema have allergic rhinitis.⁵ Although not perhaps obviously a serious condition in itself rhinitis can be highly debilitating. The effects of rhinitis include: impaired quality of life; impaired academic performance; and high economic costs due to lost productivity in 30% of the workforce. Rhinitis is associated with other co-morbid conditions including asthma, sinusitis, pharyngitis, otitis media with effusion, and lower respiratory tract infections.

Diagnosis

- Correct diagnosis from history is key to effective management.
- Careful clinical history may point to an allergic trigger.
- Examine the nose to rule out any structural problems.
- There is need to differentiate allergic from non allergic and other types of rhinitis.

Treatment

Review of treatment and definition of treatment failure

- In cases of persistent rhinitis, review after 2-4 weeks:
 - If symptoms improve, follow up:
 - continue therapy for one month in intermittent or mild cases;
 - consider stepping down treatment and continuing for more than one month in moderate/severe persistent cases.
 - If symptoms do not improve, change management.
- If Seasonal Allergic Rhinitis, change management if no response within 4 weeks of using inhaled nasal steroids.
- Main causes of treatment failure are: nasal obstruction; lack of compliance; incorrect nasal spray/inhaler technique; or severe disease.

Duration of treatment

- Duration of treatment varies with the clinical condition being considered.
- Nasal steroids can be long term for as long as symptoms expected; for example, may be seasonal (pollen), perennial (house dust), or intermittent (animal allergen).
 - Nasal steroids can take 2 weeks to see benefit.
 - Nasal passages should be clear of secretions before using inhaled steroids.
- Decongestants such as Xylometazoline should be very short courses, ie up to 5 days to allow access for longer term nasal corticosteroid.

Top Tips

- Allergen avoidance is particularly helpful for animal allergy, but may not always be possible (eg pollen allergy).
- It is important to remember when treating allergic rhinitis that individual patients vary considerably in their response to particular therapeutic agents. Thus, when one agent does not appear to bring relief, changing to, or adding, a different agent or type of agent should be tried.
- When treating pollen-related seasonal allergic rhinitis, it is best to start the nasal spray one to two weeks before the onset of the appropriate pollen season. Generally, significant benefit is seen within the first seven days.
- Nasal steroid sprays are unlikely to work in cases with blockage due to nasal secretions, and it is worth trying nasal steroid drops in these cases or pre-dosing with topical decongestant for up to 5 days..
- Ipratropium is only for a specific subset with profuse watery rhinorrhoea.
- Avoid: sedating antihistamines; depot corticosteroids; and chronic use of decongestants or systemically bioavailable intranasal steroids (INS), eg dexamethasone, betamethasone.
- Systemic glucocorticosteroids:
 - Rarely indicated in the management of rhinitis, except for:

- severe nasal obstruction;
- short-term (eg 25mg/day for 7 days, for adults) rescue medication for uncontrolled symptoms on conventional pharmacotherapy;
- social or work-related events, eg examinations, weddings.
- Oral corticosteroids should be used briefly and always in combination with a topical nasal corticosteroid.

Correct Techniques

Always demonstrate to the patient how to use the nasal spray or nose drops.

Nasal spray:

1. Blow nose
2. Shake bottle well.
3. Look down.
4. Using RIGHT hand for LEFT nostril, put nozzle just inside nose aiming towards outside wall.
5. Squirt once or twice (two different directions).
6. Change hands and repeat for other side.
7. **DO NOT SNIFF HARD.**

Nose drops:

1. Blow nose.
2. Remove cap from bottle.
3. Lie down on a bed on your back with your head back over the end of the bed, looking up to the ceiling.
4. Put the required number of drops into each nostril - and if possible stay there for **at least a minute** before.
5. For comfort, rolling over into the 'head down and forward' position illustrated below.
6. Stay in this position for **two minutes**. (This is the preferred position for children).
7. Replace cap on bottle.

Note: Standing up with your head back may cause the drops to run down the back of your throat and into your stomach. This is an incorrect technique.

Drugs (PCT formulary)

- Antihistamines: Cetirizine (first line); and Loratadine or Hydroxyzine (second line).
- Intranasal sprays: Beclometasone spray (first line) and Mometasone furoate spray or Sodium cromoglicate (second line).
- Topical nasal decongestants are considered to be of limited clinical value and less suitable for prescribing.
- Levocetirizine and Desloratidine (licensed for patients over 12 years old only) are “not recommended” which means they are not funded for routine prescribing in primary care by the CCG.

Referral criteria

Allergy clinic referral may be considered where there has been severity of symptoms and failure of treatment despite following the pathway (see checklist on page 5):

- Inadequate control of allergic rhinitis.
- Recurrent nasal polyps.
- Multisystem allergy, eg when associated with asthma.
- Occupational rhinitis suspected.

ENT referral - considered for:

- Unilateral nasal problems (symptoms and signs).
- Nasal perforations, ulceration or collapse.
- New onset unilateral polyps.
- Blood-stained discharge.
- Crusting high in the nasal cavity.
- Recurrent infection.
- Periorbital cellulitis (**refer urgently**).

References

1. Scadding S, et al. (2008). BSACI guidelines for the management of allergic and non-allergic rhinitis. *Clinical and Experimental Allergy*, 38, 19–42. doi: 10.1111/j.1365-2222.2007.02888.x URL: <http://www3.interscience.wiley.com/cgi-bin/fulltext/119410075/PDFSTART>.
2. The British Society for Allergy and Clinical Immunology (2008). Rhinitis management guidelines. URL: http://www.eguidelines.co.uk/eguidelinesmain/guidelines/summaries/eye_ear_nose_throat/bsaci_rhinitis.php.
3. Walker S, Sheikh A.(2005) Self reported rhinitis is a significant problem for patients with asthma. *Primary Care Respiratory Journal* **14**: 83-87.
4. Bourdin A, Gras D , Vachier I, Chanez P (2009). Upper airway 1: Allergic rhinitis and asthma: united disease through epithelial cells. A review *Thorax* **64**; 999-1004.
5. Kiyohara C, Tanaka K, Miyake Y (2008). Genetic susceptibility to atopic dermatitis. *Allergol International* **57**; (1): 39-56.

Glossary

Antihistamines:	These are a class of drugs that inhibits the release or action of histamine and are commonly used for treatment of allergy.
Corticosteroids nasal spray:	These are a class of topically acting sprays containing steroidal hormones.
Grazax (Standardised allergen extract of grass pollen from Timothy Grass [Phleum pratense] 75,000 SQ-T* per oral lyophilisate):	Indicated as a disease-modifying treatment of grass pollen induced rhinitis and conjunctivitis in adults and children (5 years or older), with clinically relevant symptoms and diagnosed with a positive skin prick test and/or specific IgE test to grass pollen. This should be initiated by a Consultant Physician with a month supply and the prescribing responsibility then transferred to GPs with a standard letter indicating monitoring and stopping criteria.
Rhinorrhoea:	Is commonly referred to as runny nose and consists of an unusually significant amount of nasal fluid.
Rhinitis:	Is commonly known as a runny nose, is the medical term describing irritation and inflammation of some internal areas of the nose.
Skin prick test (SPT):	Is a method for medical diagnosis of allergies that attempts to provoke a small, controlled, allergic response by pricking the skin with a needle or pin containing a small amount of the allergen.

