Allergic Rhinoconjunctivitis Treatment Pathway - ADULTS

NHS Kent and Medway

- **This guidance is aimed at clinicians involved in the management of rhinitis for adults who can be successfully managed in a primary care setting.**

- **Where indicated as Over the Counter (OTC) patients/carers should be advised to purchase as per Kent & Medway guidance on OTC prescribing.**

- **Refer to the KM formularies for information regarding formulary choices:**
  Dartford, Gravesham & Swanley - Formulary (dgsdvhformulary.nhs.uk)
  East Kent - East Kent Prescribing Formulary (eastkentformulary.nhs.uk)
  Medway/Swale - Formulary (medwayswaleformulary.co.uk)
  West Kent - Formulary (formularywkccgmtw.co.uk)

- **Pinpointing which allergens are causing a person's symptoms can help plan and put in place avoidance measures, such as minimising exposure to triggers. This in turn can help alleviate symptoms, allowing individuals to lead more comfortable and productive lives. Allergen avoidance advice can be especially beneficial in certain patients when the culprit allergen can be clearly identified (e.g. pet or horse allergy). Other air allergens can be difficult to avoid. Some interventions which may help to reduce pollen-related rhinitis symptoms include wrap-around sunglasses and ointments applied to the nose.**

- **Link to "Common triggers for hay fever and allergic rhinitis":** Hay Fever and Allergic Rhinitis | Allergy UK | National Charity

Drug cautions:

- **Anti-epileptics interaction especially with cetirizine**

- **Injectable steroids are not recommended for the treatment of rhinitis due to the risk of severe side effects (including avascular necrosis of the femoral head).**

- **Short courses of oral steroids (e.g. prednisolone 20mg for 5 to 10 days) can be considered for rescue therapy for severe rhinitis symptoms.**

- **Avoid chronic use of nasal decongestant medications for more than 10 days as these are associated with rhinitis medicamentosa (worsening nasal congestion).**

- **Montelukast: Reminder of the risk of neuropsychiatric reactions. The Medicines and Healthcare products Regulatory Agency (MHRA) has published a drug safety update to remind healthcare professionals to be alert to the of the risk of neuropsychiatric reactions in people prescribed montelukast. Reactions can occur in adults, children and adolescents. These reactions include sleep disorders, hallucinations, anxiety and depression, as well as changes in behaviour and mood. Healthcare professionals should advise patients and their caregivers to be alert to these risks and seek medical advice as soon as possible.**

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Full patient history and nasal examination

Further investigation needed if **RED FLAGS**[1,2] present, e.g. blood-stained nasal discharge, facial pain, swelling.

If asthma present: Treat seasonal asthma and escalate treatment if needed (consider montelukast)

If patient is pregnant see SPS guidance on Hay fever or allergic rhinitis: treatment during pregnancy.

MILD AND INTERMITTENT

- No troublesome symptoms
- Completes normal daily activities
- Sleep not affected
- Normal work and school

MODERATE–SEVERE OR PERSISTENT

- Impaired daily activities
- Abnormal sleep, sleep disturbance
- Troublesome symptoms
- Problems caused at school/work

STEP 1 – Self management and oral antihistamine[3]

1. Advise **purchase of over-the-counter oral antihistamine**: **Cetirizine** 10mg once daily **or loratadine** 10mg once daily.
2. Consider **nasal douching** (Appendix 1)
3. Advise **purchase of OTC eye drops** if needed: e.g. sodium cromoglicate or antihistamine eye drops (not with soft contact lenses, for other contact lenses - remove before application and wait at least 15 mins before reinsertion).

IF Moderate-Severe or Persistent

In addition to STEP 1 self- management and oral antihistamine, ADD an

1. **Intranasal corticosteroid** as listed in **Step 2** (**purchase a suitable product over the counter first line**).
2. Consider **higher dose**[4] **cetirizine up to a max. dose of 20mg** twice a day (off licence) if standard dose ineffective. Titrate according to sedative side effects and patient tolerance – advise patient not to drive if they do feel drowsy (drowsiness can occur at higher doses even if licensed doses were tolerated).

STEP 2 – ADD an Intranasal Corticosteroid[5,6,7], trial for 1 month

Advise correct **nasal spray technique** – see https://www.asthmaandlung.org.uk/living-with/inhaler-videos/nasal-spray

If ineffective after 1 month (using correct technique), trial a second before moving to next step

- **1st line – Patients should be advised to purchase a suitable product over the counter first line.** e.g. Beclometasone dipropionate 50microgram/dose nasal spray. 2 sprays each nostril twice daily. Remind patient to reduce dose to 1 spray each nostril twice daily once symptoms controlled.
- **2nd line** - Mometasone Furoate 50microgram/dose Nasal Spray POM ***Perennial rhinitis/nasal polyps*** 2 sprays each nostril once daily, reduce to 1 spray each nostril once daily once symptoms controlled
- **3rd line** - Fluticasone Furoate 27.5microgram/dose Nasal Spray **(Avamys®)** POM ***Allergic rhinitis with accompanying ocular symptoms*** 2 sprays each nostril once daily, reduce to 1 spray each nostril once daily once symptoms controlled.

If effective, advise that in future, start corticosteroid spray 2 weeks prior to season starting[6]

If at least two choices from **STEP 2 NOT TOLERATED or INEFFECTIVE**

STEP 3 – Alternative to Intranasal Corticosteroid

Azelastine nasal spray **(Rhinolast®)** POM - 1 spray each nostril twice daily

If **ineffective** after 1 month of compliant use

STEP 4 – Stop all other treatments (including oral antihistamines) and START:

Fluticasone Propionate/Azelastine nasal spray **(Dymista®)** POM – 1 spray each nostril twice daily

If effective, continue maintenance treatment with Fluticasone Propionate/Azelastine nasal spray Dymista® nasal spray during periods of allergen exposure.

If symptoms are severe, consider a short course of oral corticosteroids (in addition to nasal spray), e.g. prednisolone 30mg daily for 3 days or 5 days or 7 days duration, depending on patient response, then stop

After 2 months, if symptoms persist, refer to secondary care specialist[8]:

- **Refer to Allergy** – see Note 8 below
- **Refer to ENT** – see Note 8 below

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Notes (see flow chat above)

1. **RED flag symptoms** would be unilateral symptoms, persistent purulent discharge or blood staining, or symptoms suggestive of acute severe rhinosinusitis. This condition that can be life threatening and is characterised by the sudden onset of two or more symptoms, one of which should be either nasal blockage/obstruction/congestion or thick nasal discharge. Additional symptoms include facial pain or pressure, reduction or loss of smell and/or headache. If high fever and displaced eyeball are present urgent referral to the acute admissions unit is warranted.
2. **Allergic rhinitis triggers** include seasonal allergens (grass, tree and weed) pollens and moulds as well as perennial allergens (house dust mites, animal dander). Allergy testing does not change the initial management and would not be required at this stage. However consider allergen avoidance measures if a culprit allergen is suspected (e.g. for example house dust mite reduction measures, pet or pollen avoidance).
3. **STEP 1 – Self management and oral antihistamine**
   - Patient information on hay fever & allergic rhinitis: www.patient.info, www.allergyuk.org
   - If history suggests **pet allergy** advise avoidance measures (Allergy UK)
4. **Off-licence dose of antihistamines** it is well recognised that antihistamines are sometimes given at higher than licensed doses by Allergy clinics (e.g. cetirizine twice daily, loratadine twice daily or fexofenadine twice daily).
5. **Intranasal steroids** have similar clinical efficacy but variable bioavailability**. First line steroid nasal sprays** with negligible systemic absorption include fluticasone furoate, fluticasone propionate or mometasone furoate. Intranasal corticosteroid systemic absorption is modest with beclometasone dipropionate and high with betamethasone (which should be used short-term only). Onset of action is 6-8 hours after the first dose and maximal effect may not be apparent until after two weeks. Starting treatment two weeks prior to known allergen season improves efficacy. When symptoms are controlled, reduce the nasal spray dose to one spray to each nostril once daily to maintain rhinitis control.

   Please ensure there are no contraindications to the use of a steroid nasal spray (for example glaucoma).
6. **For seasonal pollen related rhinitis -** start the steroid nasal spray two weeks before the rhinitis symptoms are expected to begin.
7. **Ensure the patient uses their steroid nasal spray on a daily basis and with the correct technique to maximise its effectiveness and to reduce the risk of nasal crusting, bleeding and pain which can be caused by misapplication of the steroid spray.** A BSACI Standard Operating Procedure demonstrating correct nasal spray technique can be found via the following link: https://www.bsaci.org/wp-content/uploads/2019/12/Howtouseanasalspray.pdf
8. **After 2 months, if symptoms persist, refer to secondary care specialist:**
   Refer to Allergy for immunotherapy/desensitisation if pathway completed and demonstrated positive specific IgE and/or skin test (trees – spring/early summer, grass - June/July or perennial symptoms – house dust mite). Note that desensitisation is not offered for animal dander unless occupational allergy and is not available for weeds (late summer) or moulds (usually late summer and autumn). Consider occupational causes if symptoms improve away from work.
   OR
   Refer to ENT if main symptoms is blocked nose, there are polyps on examination and non-allergic rhinitis is suspected (specific IgE and/or skin testing negative).

Appendix 1 – Nasal Douching Summary (ref: BSACI Standard Operating Procedure)

Nasal douching or nasal irrigation, as it is sometimes called, is a safe and simple system of washing out the nose and can be performed in several different ways. The method shown below involves sniffing a homemade solution into the nose and allowing it to drain out. The solution is easy to make and costs very little. For other methods see the BSACI procedure.

Nasal douching can be carried out in the morning and / or evening, or more often if advised to do so by your clinician.

1. Wash your hands

2. Make the "douching solution" in a **clean** mug or jug:
Recipe: **240ml boiled water that has cooled down**
Equal parts: ¼ (quarter) teaspoon table salt
¼ teaspoon bicarbonate of soda (baking soda)

- Mix the salt and bicarbonate of soda in the clean mug or jug
- Add the boiled and cooled water
- Stir with a clean spoon until all the ingredients have dissolved
- The solution must be at room temperature before use
- If you are not going to use it straight away, cover and keep at room temperature (not in the fridge)
  Use within 24 hours and stir well before use

3. Lean over a sink and bring the mug or jug of solution to nose.
Or use cupped hands and pour a small amount of the solution into your hands and sniff from your hands.

4. Sniff a **small** amount of the fluid into the nose for approximately two to three seconds.
Do not sniff up large amounts of liquid and do not swallow it (don't worry if you accidentally swallow a small amount though).

To cleanse each side of the nasal cavity block one nostril with your finger as you sniff the solution, release and block the other nostril as you sniff the solution again.

5. Take your nose away from the mug and let the liquid run back out of the nose and into the sink.

6. Repeat steps 3 to 5 several times until you have used as much of the liquid in the mug / jug as possible.

7. After nasal douching blow your nose **gently** and let it rest for 10-20 minutes before applying any treatment spray.