

Allergic Rhinitis - Primary Care Clinical Pathway for Children Aged 2-16 Years Old

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.

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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 10% of 6 and 7 year olds and 15-19% of 13 to 14 year olds. Some 80-90% of children with continue to have symptoms in adulthood.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 Children with allergic rhinitis are at greater risk of developing asthma and treatment of rhinitis in children with co-existing allergic rhinitis and asthma improves asthma control. 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 lost productivity. This policy has been derived from the guidance in BMJ 2014; 348: 25-31 and in consultation with hospital specialists.

Diagnosis

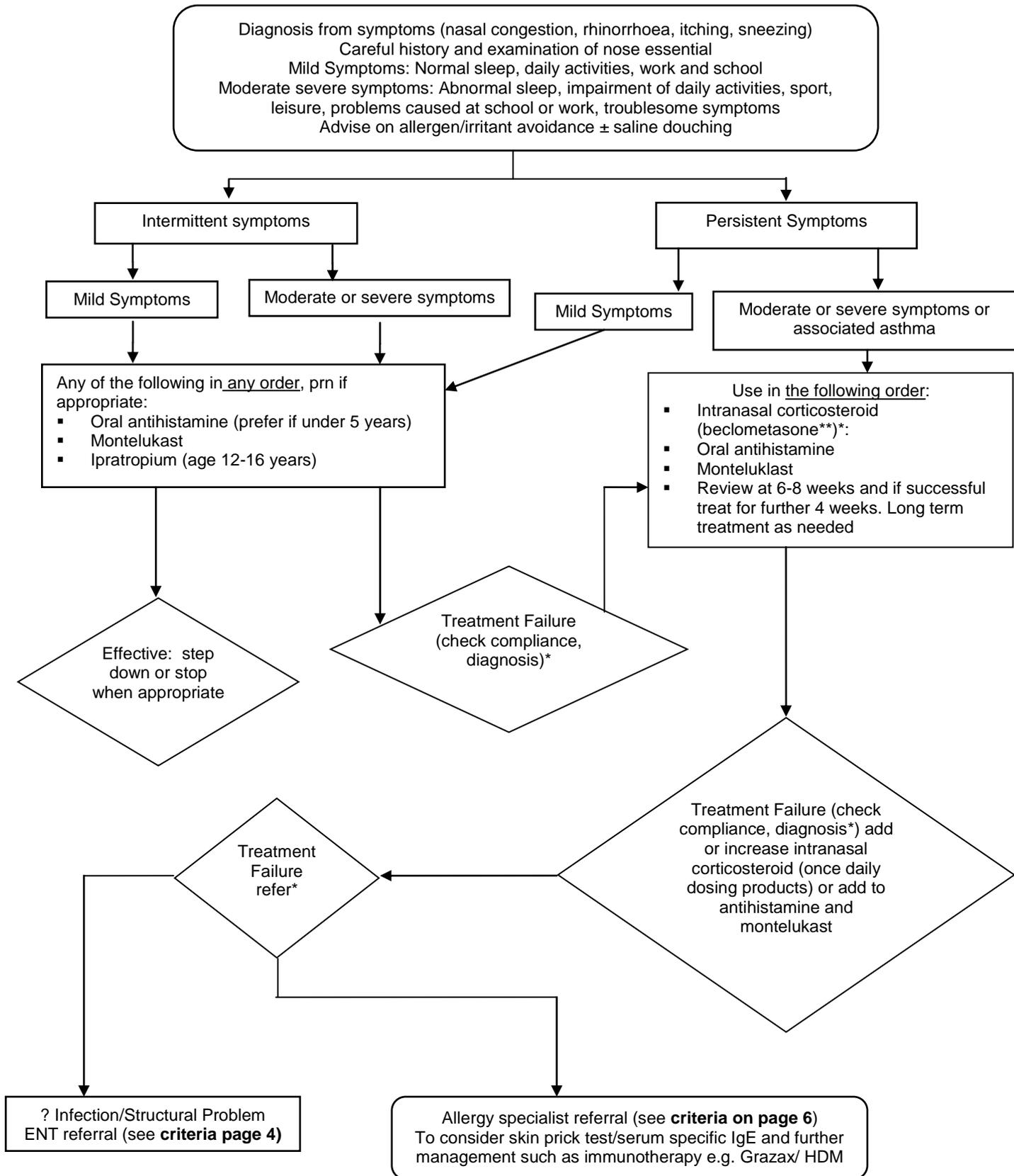
- Correct diagnosis from history is key to effective management.
- Careful clinical history may point to an allergic trigger.
- Examine the nose to rule out any structural problems.
- There is need to differentiate allergic from non allergic and other types of rhinitis.
- Rhinitis symptoms for less than 4 days per week or less than 4 consecutive weeks is defined as intermittent. Symptoms in excess of this are considered persistent allergic rhinitis.⁶

Treatment

Review of treatment and definition of treatment failure

- In cases of persistent rhinitis, review after 6-8 weeks as the onset of action of nasal steroid may be slow.
- If symptoms improve, follow up:
 - continue therapy for one month in intermittent or mild cases;
 - consider stepping down treatment;
 - continue for more than one month in moderate/severe persistent cases.
- If Seasonal Allergic Rhinitis, start treatment before the season (late March) and step down/ stop at the end (October). Stop or change management if no response within 6 weeks of using first line treatment.

Pathway for Primary Care Management



*See page 2 for definition on treatment failure.

- Main causes of treatment failure are: lack of compliance, nasal obstruction; incorrect nasal spray/ inhaler technique; or severe disease. Consider once daily nasal steroid (mometasone furoate 50 micrograms/spray) to improve compliance if twice daily intranasal beclometasone 50 micrograms/spray is ineffective.
- Intranasal douches/ saline washes are not recommended for prescription as evidence is based on a small population with no clear guidance as to dosing or dose frequency.

Duration of treatment

- Duration of treatment varies with the clinical condition being considered.
- Nasal steroids can be for as long as symptoms expected; for example, may be seasonal (pollen), perennial (house dust), or intermittent (animal allergen).
- Nasal steroids can take 4 – 6 weeks to see significant benefit.
- Nasal passages should be clear of secretions before using inhaled steroids.
- If possible stop antihistamines 5 days before being seen in an allergy clinic.
- Decongestants such as xylometazoline are not recommended.

Top Tips

- Children with asthma are a **high priority** for effective treatment of allergic rhinitis.
- ** In children being treated for asthma with inhaled steroids, or for eczema using moderate or high potency steroid creams, the first line nasal steroid should be mometasone due to potential concerns about growth suppression with beclometasone **.
- Allergen avoidance is particularly helpful for animal dander and mould spore proven 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.
- Avoid: sedating antihistamines; depot corticosteroids; and chronic use of decongestants or systemically
- Systemic glucocorticosteroids: Rarely indicated in the management of rhinitis, except for:
 - severe nasal obstruction;
 - short-term (5-7 days as 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 and should be under consultant level care.

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.**

Correct Techniques (continued)

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 (CCG formulary)

- Antihistamines: cetirizine and loratadine (both first line). Consider hydroxyzine when sedation is required (second line) or fexofenadine (non-formulary, licensed for patients over 12 years old only) when other treatments have been optimised and failed.
- Intranasal sprays: beclometasone spray (first line but see cautions above) and mometasone furoate spray or sodium cromoglicate (second line).
- Combination intranasal antihistamines and steroids are not recommended.
- Levocetirizine and desloratadine (licensed for patients over 12 years old only) are not recommended for use by Cambridgeshire and Peterborough Clinical Commissioning Group.

Referral Criteria

Allergy clinic referral may be considered where there has been failure of treatment despite following pathway (see checklist):

- Inadequate control of allergic rhinitis.
- Recurrent nasal polyps.
- Multisystem allergy, eg when associated with asthma.
- **STOP antihistamines 5 days before being seen in allergy clinic as may affect blood tests.**

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. Ghouri et al J Roy Soc Med 2008; 101: 466-72.
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 Walker S, Sheikh A. (2005) Self reported rhinitis is a significant problem for patients with asthma. Primary Care Respiratory Journal 14: 83-87.
3. 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.
4. Kiyohara C, Tanaka K, Miyake Y (2008). Genetic susceptibility to atopic dermatitis. Allergol International 57; (1): 39-56
5. Bousquet J, Allergy 2008; 63(Suppl 86): 8-160.

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.
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.
Grazax (Standardised allergen extract of grass pollen from Timothy (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.

