HERPC

Hull & East Riding Prescribing Committee

Rhinitis Guidelines

Classification and Differential Diagnosis

1. Rhinitis is defined as having two of the listed symptoms for ≥1 hour/day for ≥2 weeks
    a. blockage
    b. running (including postnasal drip)
    c. sneezing (including nasal itch)

2. Classification of rhinitis

Allergic	**Infective**	**Other**	**As part of systemic disorder**
• Seasonal • Perennial • Occupational	• Acute • Chronic	• Idiopathic • NARES (non-allergic rhinitis with eosinophilia) • Drug induced: ▪ beta-blockers ▪ oral contraceptives ▪ aspirin ▪ NSAIDS ▪ local decongestants • Autonomic (responds to anticholinergics) • Atrophic • Neoplastic	• Primary defect in mucus ▪ cystic fibrosis ▪ Young's syndrome • Primary ciliary dyskinesia (Kartagener's syndrome) • Immunological ▪ systemic lupus erythematosus ▪ rheumatoid arthritis • AIDS • Antibody deficiency • Granulomatous disease ▪ Wegener's ▪ sarcoidosis • Hormonal ▪ hypothyroidism ▪ pregnancy ▪ "old man's drip"
Severity		**Mild** • normal sleep *and* • no impairment of daily activities, sport, leisure *and* • no impairment of work and school *and* • no troublesome symptoms **Moderate-Severe** • abnormal sleep *or* • impairment of daily activities, sport, leisure *or* • impaired work and school *or* • troublesome symptoms	

Nasal problems are often multi-factorial and this needs to be taken into account when using the above classification or considering treatment.

Diagnosis

1. Take a history

2. Nasal examination
    a. external and internal appearance
    b. secretions (clear, discoloured or blood stained)
    c. airflow
    d. palpation

3. Consider:
    a. specific IgE
    b. other blood tests, e.g. FBC, thyroid function

Treatment (see Figure 1)

1. Education
    a. provide advice on allergen avoidance and drug therapy, including safety and side effects
    b. poor compliance or poor technique in the use of nasal sprays and drops will result in treatment failure, therefore appropriate training is imperative

2. Antihistamines (AH)
    a. available as oral (OAH) or intranasal (INAH) preparations
    b. **first-line** therapy for **mild allergic rhinitis**
    c. **addition** to intranasal steroids for **moderate/severe allergic rhinitis** uncontrolled on topical intranasal steroids (INS) alone
    d. OAH – effective predominantly on "wet" symptoms such as itch, sneeze and rhinorrhoea; regular therapy is more effective than 'as-needed' use. Hull and East Riding Joint Formulary: First line choice – Cetirizine; Second line choices – Loratadine or Fexofenadine
    e. INAH (Azelastine) – useful as rescue therapy due to fast onset of action within 15 minute

3. Topical intranasal corticosteroids (INS)
    a. **first-line therapy** for **moderate to severe allergic rhinitis persistent** symptoms. Hull and East Riding Joint Formulary: First line choice – Beclometasone nasal spray; Second line choices - Budesonide nasal spray or Mometasone nasal spray or Fluticasone nasal spray
    b. **addition** to OAH or INAH in **uncontrolled mild allergic rhinitis**
    c. topical steroid drops should be used initially in nasal polyposis and severe obstruction. These are for short term use only.
    d. systemic absorption negligible with Mometasone and Fluticasone, modest for the remainder and high for Betamethasone nasal drops and Fluticasone nasal drops which are for short term use only

4. Topical combination of antihistamine and intranasal corticosteroids (IHAH + INS)

a. For **treatment failure** a combination of azelastine and fluticasone is available.
b. Check use, dose and compliance before prescribing.

5. Systemic corticosteroids:
    a. rarely indicated in the management of rhinitis, except for
        i. severe nasal obstruction
        ii. short-term Prednisolone (0.5 mg/kg for 5 to 10 days) rescue medication for uncontrolled symptoms on conventional pharmacotherapy
        iii. important social or work-related events, e.g. examinations, weddings
    b. oral corticosteroids should be used briefly and always in combination with a topical nasal corticosteroid
    c. Injectable corticosteroids are not recommended as the risk-benefit profile is poor

6. Anti-leukotrienes (LTRA)
    a. Montelukast is licensed in the UK for those with **seasonal allergic rhinitis** who also have concomitant asthma since the age of 6 months

7. Topical anti-cholinergic (e.g. Ipratropium bromide)
    a. **watery rhinorrhoea in allergic rhinitis** despite compliance with INS or INS with OAH or INAH
    b. **autonomic rhinitis** when the dominant symptom is profuse watery rhinorrhoea in response to irritant triggers or changes in temperature

8. Chromones (e.g. Sodium cromoglicate)
    a. children and adults with mild symptoms only and **sporadic problems in season** or on **limited allergen exposure**
    b. Cromoglicate and Nedocromil eye drops are useful in **allergic conjunctivitis** as topical therapy

9. Allergen immunotherapy (desensitisation)
    a. for pollen-allergic patients who fail to respond sufficiently to maximum conventional treatment (combination of INS and OAH or INAH)

NB. Treatment failure should always provoke a review of compliance.

Rhinitis in pregnancy and during breastfeeding

- rhinitis affects at least 20% of pregnancies and can start during any gestational week
- regular nasal douching may be helpful
- most medications cross the placenta and should only be prescribed when the apparent benefit is greater than the risk to the foetus
- it is a good practice to start treatment with 'tried and tested' drugs
    - intranasal Beclomethasone, Fluticasone and Budesonide appear to have good safety records as they are widely used in pregnant asthmatic women
    - intanasal and ocular Cromoglicate may be helpful
    - oral Chlorphenamine, Loratidine or Cetirizine may be added cautiously if additional treatment is needed but decongestants should be avoided

Referral (see Figure 1)

1. ENT referral
    a. unilateral nasal problems
    b. nasal perforations, ulceration or collapse
    c. blood-stained discharge
    d. crusting high in the nasal cavity
    e. periorbital cellulitis (refer urgently call HUTH switchboard on 01482 875875 and ask to talk to ENT first oncall)

2. Allergy referral
    a. inadequate control of symptoms
    b. allergen/trigger identification
    c. to consider desensitisation
    d. recurrent nasal polyps
    e. recurrent infective rhinitis and sinusitis requiring antibiotics to exclude allergy or immunodeficiency
    f. multisystem allergy (e.g. rhinitis with asthma, eczema or food allergy)
    g. occupational rhinitis

References

1. BSACI guideline for the diagnosis and management of allergic and non-allergic rhinitis (Revised edition 2017, 1st edition 2007) https://www.bsaci.org/Guidelines/rhinitis-2nd-edition-guideline Accessed 28/5/2020
2. NICE Clinical Knowledge Summaries – allergic rhinitis https://cks.nice.org.uk/allergic-rhinitis

APPROVAL PROCESS

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Figure 1. Management or rhinitis