RHINITIS/RHINOCONJUNCTIVITIS
Referral and Management Pathway for Primary Care

Symptoms/signs suggestive of allergic rhinitis/conjunctivitis?

- watery/mucous rhinorrhoea
- sneezing
- itchy nose/eyes/throat
- associated red/watery eyes
- nasal blockage/congestion
- post-nasal drip

Any red flag symptoms/signs?

- nasal crusting
- nasal bleeding / blood-stained rhinorrhoea
- nasal deformity, perforations, ulceration or collapse
- unilateral symptoms and signs (e.g. obstruction, rhinorrhoea, persistent unilateral epistaxis)
- cervical lymphadenopathy
- pain

Any signs/symptoms of non allergic pathology (infection or nasal polyps)?

- thick, mucopurulent (green) secretions; recurrent infection
- orbital cellulitis (refer urgently)
- facial pain/pressure
- visible nasal polyps
- anosmia

Refer to ENT
(urgent if any red flag symptoms/signs)

yes / no

Mild/intermittent symptoms *with no* impact on QoL, sleep and/or **work/school performance**

Medical management

- **allergen avoidance advice** *only if* culprit allergen(s) suspected (e.g. pets) and practicable
- **oral or non-sedating antihistamine**[1] only, **or nasal anti-histamine spray** (if oral antihistamines not tolerated)[4]
- ***Please consider the possibility of co-existing asthma in all patients (~50%)***

Moderate/severe and/or **persistent symptoms *with* impact on QoL, sleep** and/or **work/school performance**

Medical management

- **allergen avoidance advice *only if* culprit allergen(s) suspected (e.g. pets) and practicable**
- **regular nasal corticosteroid with low systemic bioavailability**[2]
- **oral non-sedating antihistamine**[1] **or nasal antihistamine spray** (the latter may be combined with nasal corticosteroid)[4]
- **consider antihistamine eye drops**[3]
- **consider nasal douching with saline and other add-on treatment in special circumstances**[4]
- ***Please consider the possibility of co-existing asthma in all patients (~50%)***

Review in 4 weeks

Improved?

Continue management as above

Not Improved?

Request total and specific IgE to relevant inhalant allergens[5]
(also review compliance and technique)

Positive → **Refer to Allergy/ Immunology**

Negative → **Refer to ENT**

NOTES

Note 1 — Oral non-sedating antihistamines

- **Cetirizine 10 mg od** - cost-effective 1st line; available OTC
- **Loratadine 10 mg od** - cost-effective alternative; available OTC
- **Fexofenadine 180 mg od** - suitable alternative if above do not lead to symptom relief
- Loratadine is the preferred choice during pregnancy and lactation
- DO NOT use sedating antihistamines (such as chlorphenamine)

Note 2 — Nasal corticosteroid sprays

- **Fluticasone furoate** 27.5 µg/spray, 2 sprays into each nostril once daily (when control achieved, reduce to minimum effective dose, 1 spray into each nostril once daily may be sufficient)
- **Fluticasone propionate** 50 µg/spray or **mometasone furoate** 50 µg/spray are other cost-effective options
- If on both a steroid and antihistamine nasal spray, consider combination product: **fluticasone propionate** 50 µg/spray **and azelastine** 125 µg/spray, 1 spray into each nostril twice daily
- Give **education** regarding nasal spray technique (see BSACI information sheet, available at : http://www.bsaci.org/Guidelines/SOPs (accessed Mar 2016)
- Advise the **need for regular treatment** (clinical improvement may not be apparent for a few days and maximal effect may not be apparent until after 2 weeks). Starting treatment 2 weeks before a known allergen season improves efficacy
- DO NOT use nasal steroids with moderate (beclomethasone) or high systemic bioavailability (betamethasone, dexamethasone); the latter two can be considered if associated chronic rhinosinusitis and nasal polyposis

Note 3 — Antihistamine eye drops

- **Antihistamine eye drops** (with additional mast cell stabilising properties), e.g. ketotifen, olopatadine, azelastine, are useful choices with convenient dosing regimen (twice daily)
- Lodoxamide, sodium cromoglycate and nedocromil eye drops are mast cell stabilisers only - would not be as effective as options above.

Note 4 — Add-on treatment in special circumstances

- *Significant watery rhinorrhoea* → **ipratropium bromide** nasal spray, 21 µg/spray, 2 sprays into each nostril 2 to 3 times per day
- *Concomitant asthma* → **montelukast**, 10 mg once daily
- *If topical antihistamine preferred* (e.g. drowsiness on oral antihistamines) → **azelastine nasal spray** 0.56 mg/spray, 1 spray into each nostril twice daily, or **in combination with nasal steroid** → fluticasone propionate and azelastine (*see Note 2)*
- Patients requiring rapid resolution of severe symptoms → consider add-on 5- to 10-day course of prednisolone, 20–40 mg a day
- Nasal douching with saline may also be a useful add-on, particularly for patients with moderate/severe symptoms
- Sympathomimetic decongestants should be avoided as long term use can cause rebound congestion (*rhinitis medicamentosa*); they may have a role when used occasionally and for less than 7-10 days

Note 5 — Specific IgE to common inhalant allergens

- house dust mites
- relevant animal dander (e.g. cat, dog, other animals)
- grass pollen
- birch pollen

Please note: these tests are required in order to decide the appropriate specialty to refer to (if Allergy → specific immunotherapy with relevant allergens will be considered)

Additional Information on Rhinitis

- Rhinitis is defined as having two or more of a) nasal blockage, b) anterior/posterior rhinorrhoea and c) sneezing/nasal itch, for ≥ 1h/day for ≥2 weeks
- Allergic rhinitis (with or without conjunctivitis) is common and affects >20% of the UK population
- Non-allergic rhinitis has a multifactorial aetiology; usually responds to treatment with steroids; may be a presenting complaint of systemic disorders (e.g. Churg-Strauss syndrome, Wegener's granulomatosis, sarcoidosis)
- **Asthma and rhinitis frequently co-exist**, with symptoms of rhinitis found in ~75-80% of patients with asthma, and asthma found in ~50% of patients with rhinitis
- See also BSACI primary care guideline on rhinitis: http://www.guiidelines.co.uk/bsaci/rhinitis

Based on:

1. BSACI guideline for the diagnosis and management of allergic and non-allergic rhinitis (revised edition 2017). Clin Exp Allergy. 2017;47:856-889
2. BSACI Primary Care Guideline—Management of allergic and non allergic rhinitis: www.guidelines.co.uk/bsaci/rhinitis
3. Allergic Rhinitis and its Impact on Asthma (ARIA) guidelines – 2010 revision. J Allergy Clin Immunol. 2010 Sep;126(3):466-76
4. Clinical Practice Guideline: Allergic Rhinitis Executive Summary – American Academy of Otolaryngology – Head And Neck Surgery Otolaryngology – Head and Neck Surgery 2015;152(2); 197-206
5. BSACI Nasal spray SOP, available at www.bsaci.org/Guidelines/SOPs, accessed Oct 2017