**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

**Refer to ENT**

(urgent if any red flag symptoms/signs)

**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

**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
- oral or non-sedating antihistamine¹ only, or nasal antihistamine spray (if oral antihistamines not tolerated)⁴
  - Please consider the possibility of co-existing asthma in all patients (~50%)

**Review in 4 weeks**

**Improved?**

- Continue management as above

**Not Improved?**

- Refer to Allergy/Immunology

**Positve**

- Refer to ENT

**Negative**

- Request total and specific IgE to relevant inhalant allergens⁵ (also review compliance and technique)

**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
- regular nasal corticosteroid with low systemic bioavailability²
- oral non-sedating antihistamine¹ or nasal antihistamine spray (the latter may be combined with nasal corticosteroid)⁴
- consider antihistamine eye drops³
- consider nasal douching with saline and other add-on treatment in special circumstances⁴
  - Please consider the possibility of co-existing asthma in all patients (~50%)
**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
- 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

**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 rhinorrhea 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.guidelines.co.uk/bsaci/rhinitis

Based on:
2. BSACI Primary Care Guideline — Management of allergic and non allergic rhinitis: www.guidelines.co.uk/bsaci/rhinitis