

London Regional guideline and pathway for the management of Rhinitis

Introduction

This guideline has been created as a pan London guideline for the diagnosis and treatment of Rhinitis.

Rhinitis key facts:

- Rhinitis is common in children and adults and is a significant cause of morbidity. Symptoms can affect quality of life, sleep, school and work performance.
- Rhinitis is subdivided into allergic rhinitis (AR) and non-allergic rhinitis (NAR). This distinction can be made based on the history, and/or on the results of allergy tests to common aeroallergens if needed.
- Allergic rhinitis can be seasonal (i.e. hayfever) or perennial (e.g. dust allergy). Non-allergic rhinitis is usually perennial.
- All patients with rhinitis must be evaluated for asthma symptoms, and both upper and lower-airway conditions should be treated together when present. 75% of children with asthma suffer from AR, and AR increases the risk of hospitalisation in children with asthma.
- Most patients with moderate-severe rhinitis symptoms require long-term administration of a nasal steroid spray. Patients must be educated about the importance of good nasal spray technique and compliance, and adherence to therapy should be established before stepping up therapy.
- Nasal steroid sprays take around 6 weeks to reach their maximum effect. Short-term prescription (e.g. 4-6 weeks) of nasal steroid sprays for rhinitis is therefore not appropriate. An initial 2-3 month trial of a recurring prescription should be started before evaluating response.
- Rhinitis is a long-term condition. If the patient responds well to a spray it should usually be continued in the long term, although the dose can be halved if this still controls their symptoms. Mometasone and fluticasone-based nasal sprays have an excellent safety profile for long-term use.



Diagnosis:

- **Symptoms:** Nasal congestion (usually bilateral/alternating), clear rhinorrhoea, itchy nose or eyes, sneezing.
- *Timing:* Ask about seasonality and exacerbation from contact with dust/pets.
- **PMH:** Ask about atopic diseases and any symptoms of asthma.
- **DHx**: Combined OCP, nasal decongestant sprays, beta-blockers, NSAIDs can cause/exacerbate rhinitis.
- SHx: Smoking, cocaine, occupational exposures.
- **NB:** Predominant sneezing/itching/clear rhinorrhoea suggests AR and possible response to oral antihistamine monotherapy. Predominant nasal blockage without sneezing/itching suggests NAR, usually requiring regular nasal steroid spray.

Examination:

- Look for bulky, moist inferior turbinates (the relative size will alternate with the nasal cycle).
- Septal deviations are less likely to be significant if patient has bilateral/alternating blockage.

Investigations:

- Allergy testing is not required in all cases:
 - Mild or seasonal symptoms that respond to oral antihistamines can be assumed to be allergic in origin.
 - Most moderate-severe rhinitis patients respond to a regular, long-term nasal steroid spray, regardless of aetiology.
 - Therefore, complete response to Step 1 + 2 therapies largely negates the need to distinguish between AR and NAR.
- Consider allergy testing in:
 - Severe allergic-type symptoms (sneezing, itching, rhinorrhoea)
 - o Symptoms resistant to long-term use of first-line steroid spray
 - Considering long-term Dymista or Ryaltris, or referral for immunotherapy (now NICE approved).
- Specific IgE (RAST) testing Send serum sample and request 'specific IgE to aeroallergens' (includes grass pollen mix, tree pollen mix, house dust mite, cat, dog and mould mix) and any other suspected allergens e.g. other animals. Skin prick testing where available, gives information on reactivity to common aeroallergens within 10-15 mins. Not suitable in dermographia or if antihistamines taken in last 72 hours

Document History

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(now NICE approved)

NHS Pan London guideline for the management of Rhinitis

Full history, nasal examination and RAST testing Further investigation needed if RED FLAGS present	Review every 2-3 months at each step Step up if symptoms uncontrolled Maintain therapy when patient gains control				
INITIAL TREATMENT SELECTION:	STEP 1: Saline Rinse	STEP 2: Antihistamine*	STEP 3: Corticosteroid	STEP 4: Combinations**	STEP 5: Investigations and Referral
MILD AND INTERMITTENT OR PERSISTENT SYMPTOMS • Completes normal daily activities • Sleep not affected • Seasonal Commence step 1 and 2 MODERATE-SEVERE OR PERSISTENT • Troublesome symptoms • Impaired daily activities • Abnormal sleep, sleep disturbance • Perennial Commence step 1,2 and 3 If congestion is only symptom, commence step 1 and 3 only	 Self-Management Strategy Nasal Douche: Saline preparations (OTC) Video Demonstration: https://youtu.be/GW2PiOFhF tY Allergen Avoidance Techniques 	 Step 2- PRN Antihistamine Intranasal Antihistamine Preparations: Azelastine (POM) Or Non-sedating Oral Antihistamines: Cetirizine (OTC), Loratadine (OTC) and Fexofenadine 120mg (OTC) Combined use of an intranasal and oral antihistamine is not recommended. For those in which antihistamines are contraindicated or not tolerated: Intranasal Chromone: 	 Step 3: Regular Intranasal Corticosteroid Intranasal Corticosteroids Sprays: fluticasone propionate (OTC), mometasone furoate (POM), fluticasone furoate (POM) For Severe Nasal Obstruction: Fluticasone proprionate nasules 	 Step 4a: Regular Combination Intranasal Corticosteroid and Antihistamine azelastine hydrochloride and fluticasone propionate (POM) olopatadine hydrochloride and mometasone furoate monohydrate Step 4b: OR Regular Oral Antihistamine Regular Non-sedating Oral Antihistamines: Cetirizine, Loratadine, Fexofenadine (120mg) Step 4c: OR Combination Nasal Douche and corticosteroid Nasal Douche: Saline preparations (OTC) with addition of Fluticasone propionate (POM) +/- Intranasal Antihistamine Preparations: Azelastine (POM) 	 Step 5a: Investigations for persistent Symptom For ongoing symptoms despite treatment, consider investigations, where available: Inhaled Allergen Blood Tests (RAST) Skin prick testing CT paranasal sinuses Step 5b: Treatment Not Adequately Managing Symptoms Review the cause of treatment failure Consider compliance to both self-management strategies and treatment Consider alternative diagnosis Step 5c: Refer to secondary care If structural problem or patient choice for surgical intervention, consider referral to ENT If symptoms primarily due to single allergen, consider

RED FLAGS – Urgent referral to ENT Specialist

- Unilateral symptoms including new/progressive unilateral blockage
- Unilateral facial/orbital pain
- Progressive headache, raised ICP signs, visual or neurological signs
- Unilateral rhinorrhoea, especially if serosanguinous
- New anosmia associated with unilateral nasal symptoms

Severe, Uncontrolled Symptoms that are significantly affecting Quality of Life

Consider prescribing a short course of oral corticosteroids to provide rapid symptom relief, such as:

- For adults: prednisolone 0.5mg/kg in the morning for 5 to 10 days.
- For children: prednisolone 10 to 15 mg in the morning for 3 to 7 days.

Advise the person to continue using an intranasal corticosteroid preparation, to allow improved intranasal drug penetration.



* Sodium Cromoglicate not referenced in Step 2 as the product is no longer available

** Further detail on the specifics within Step 4 can be seen in the table below:

Symptom	Pharmacotherapy
Nasal Congestion	Intranasal Decongestant:
	Ephedrine (OTC) or Xylometazoline (OTC)
	NB short-term use only for up to 5–7 days
	Intranasal Corticosteroid:
	Fluticasone proprionate nasules (POM)
Persistent Watery	If combined use of an intranasal corticosteroid and
Rhinorrhoea	oral antihistamine is ineffective consider an
	Intranasal Anticholinergic:
	Ipratropium bromide (POM)
	NB avoid in glaucoma
Nasal Itching and	If monotherapy with either an antihistamine (taken regularly) or
Sneezing	intranasal corticosteroid is ineffective consider an
	Antihistamine and Corticosteroid Intranasal Combination Spray:
	Azelastine/Fluticasone (POM)
	NB combined use of an intranasal and oral antihistamine is not
	recommended
Patients with	Consider leukotriene receptor antagonist e.g. [montelukast
ongoing	(POM)] in addition to an oral or intranasal antihistamine.
symptoms and a	
history or asthma	



Appendix 1: Nasal spray technique guidance for patients

How to use nasal sprays

A step-by-step guide

- 1. Wash your hands and gently blow your nose.
- 2. Gently shake the nasal spray. Twist the cap anti-clockwise to remove it.
- 3. Keep your head upright. Insert the nozzle tip into one nostril. Keep your other nostril open.
- 4. Hold the bottle with your index and middle finger at the top, and your thumb at the bottom (Figure 1a).
- 5. Try to direct the spray away from the septum (the middle part inside the nose). You may find it easier using your right hand for spraying your left nostril and vice versa (Figure 1b).
- 6. Breathe in gently as you spray. Do not sniff hard as the spray then travels past the nose into the throat.
- 7. After spraying both nostrils, clean the nozzle and replace the cap.





Appendix 2: Saline nasal irrigation guidance for patients

Guidance for patients

Saline nasal irrigation



Procedure

- 1. Lean forward over a sink
- 2. Fill a mug/cup with the solution and bring it up to the nose.
- 3. Close one nostril with your finger.

4. Sniff a small amount of the solution into the nose for 2-3 seconds. Keep the head bent forward to avoid choking on the water. A syringe, squeezy bottle, <u>neti</u> pot or powered device can be used to squirt water into the nose.

5. Move the cup away from the nose, stop sniffing, and allow the solution to flow out of the nose into the sink

6. Repeat this technique, alternating which nostril is held closed, until all the solution has been used up

7. After douching, blow the nose gently, and wait 20 minutes before administering any steroid spray or drops.



Appendix 3: Advice for patients on avoiding allergens

Advice for patients

Avoiding allergens

For people with pollen allergy

- Avoiding walking in grassy or wooded open spaces, particularly during the early morning, evening, and night, when pollen counts are at their highest.
- Keeping windows shut in cars and buildings.
- Changing car pollen filters with each service, if these are fitted.
- Avoid hanging clothes outside to dry during pollen season.
- Consider changing clothes when re-entering the home after walking outside.

For people with confirmed house dust mite allergy inadequately controlled by drug treatment

- Fitting mattresses and pillows with house dust mite impermeable covers.
- Using synthetic pillows and acrylic duvets, and keeping furry toys off the bed.
- Washing all bedding and furry toys at least once a week at high temperatures.
- Choosing wooden or hard floor surfaces instead of carpets, if possible.
- Fitting blinds that can be wiped clean instead of curtains. Surfaces should be wiped regularly with a clean, damp cloth.

For people with confirmed animal allergy

- Advise that ideally the animal should not be allowed in the house.
- When this is not acceptable, advise restricting their presence to the kitchen.

For people with occupational allergy

• Advise eliminating or reducing exposure to allergens, for example by using latex free gloves, using a dust mask, and ensuring that their environment is adequately ventilated.

Ref: https://cks.nice.org.uk/allergic-rhinitis#!scenario:1



Appendix 4: Useful Links

- Nasal spray technique video
 - o http://www.itchysneezywheezy.co.uk/RhinitisVideos.html
- Four Seasons Booklet from Allergy UK about managing asthma and allergic rhinitis
 - o Layout 1 (allergyuk.org)
- NHS Choices Allergic Rhinitis
 - o <u>Allergic rhinitis NHS (www.nhs.uk)</u>
- NICE Clinical Knowledge Summary
 - o <u>Allergic rhinitis | Health topics A to Z | CKS | NICE</u>
- BSACI Rhinitis Guidelines 2017
 - https://www.bsaci.org/wp-content/uploads/2020/01/Scadding_et_al-2017
 <u>Clinical_amp_Experimental_Allergy.pd</u>
- Improving air quality
 - o <u>At Home | Allergy UK | National Charity</u>