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Please note, this is promotional material. A link to prescribing information and details on how to report adverse events can be found on page 4.

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QUICK GUIDE

Allergic rhinitis: A guide for General Practitioners

Allergic rhinitis (AR) is an IgE-mediated atopic cause of inflammation of the nasal mucosa.[1] It presents with sneezing, nasal congestion/pruritus and rhinorrhoea.[1] AR affects 10-15% of children and up to a quarter of all adults in the UK.[1] The effect on quality of life can be significant, with evidence for impacts on sleep, concentration, daytime functioning and exam performance.[2-4] The pathophysiology of AR is of an immune response to allergens such as pollen – specific IgE (sIgE) binds to receptors on mast cells and basophils, causing release of histamine and cytokines.

Classification

AR can be seasonal (usually caused by pollen), perennial (due to year-round allergens such as house dust mites [HDM] and pets) or occupational (caused by workplace-specific allergens).[1] It is further sub-divided into intermittent and persistent AR; persistent AR occurs for ≥4 consecutive days per week and ≥4 consecutive weeks per year.[5]

Co-morbidities

AR is associated with other atopic conditions such as asthma, allergic conjunctivitis, food allergies and eczema.[1] Asthma control is often worse in those who also have AR,[1] because the upper and lower respiratory tracts are one airway, lined by the same epithelium and subject to the same inflammatory mediators.

Assessment in primary care

History is key in the diagnosis of AR; investigations are not always needed.[1] History should include the following:

- Symptoms.
- Seasonality, triggers or a link to work (reliable improvement on annual leave suggests an occupational cause).
- Atopic co-morbidities.
- Previous treatments tried, including lifestyle change, prescribed or over-the-counter (OTC) medication, and adherence to these and their effectiveness.
- Severity and effect of symptoms on sleep, work or school performance – management may be particularly urgent for an adolescent with impending public exams, or an adult with an important life event such as an upcoming wedding.

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- Possible iatrogenic cause – long-term use of nasal decongestants causing rhinitis medicamentosa and other medication such as non-steroidal anti-inflammatories, angiotensin-converting enzyme inhibitors and oral contraceptive pills. This list is not exhaustive.

Examination may be normal, particularly if being seen after a period of time away from triggers, but there may be an allergic crease[6] when AR is longstanding: a horizontal indentation in the skin of the nose, caused by regularly rubbing the nose in an upward direction to try to stop the itch of AR. If seen when symptoms are present, there may be nasal mucosa swelling or crusting, conjunctivitis, dark circles under the eyes due to eye-rubbing,[7] or wheeze. The patient may breathe through their mouth when being seen, or they may report doing this at night.[1]

Not every blocked nose is AR; other differential diagnoses would particularly be considered if there are unilateral symptoms, blood-tinged nasal discharge or symptoms suggestive of acute infection.[1]

If the diagnosis is unclear, or initial treatment does not help, sIgE tests for suspected allergens can be requested in primary care, or skin prick testing (SPT) can be accessed by allergy clinic referral. A raised eosinophil count is supportive of an atopic diagnosis, and is now first-line in the diagnosis of asthma in adults, but not required to confirm a diagnosis of AR.

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Self-management

Allergen avoidance is key, but not always easy. Pollens are ubiquitous during spring and summer (and likely to increase further with climate change), HDM can never be fully eradicated from a home[8] and removing a trigger such as a family pet from a child who is emotionally attached to it can be difficult. Some possible actions are listed in Box 1, although evidence is often limited.

BOX 1: Strategies for allergen avoidance

Pollen:[1,9]

- Check pollen forecasts – stay indoors when they are high, as well as in the early morning and evening and during/after thunderstorms.
- Wear wraparound sunglasses and a hat with a peak, use a barrier balm under each nostril.
- Shower and wash hair on arrival home.
- Keep windows closed in the house/car.
- Avoid drying clothes outside.

HDM:[8]

- Use allergen-proof covers on pillows, mattresses and duvets.
- Wash bedding, soft toys and clothes at 60°C or put in freezer for 12 hours.
- Increase ventilation.
- Increase hard flooring and reduce carpets or vacuum carpets regularly with a high filtration vacuum cleaner.

Pets:[10]

- Do not allow pets to sleep in bedrooms or go on the furniture.
- Wash pet-bedding regularly at 60°C.
- Wash dogs twice a week – one study suggests that this reduces allergens in their hair;[11] there is no evidence on this for cats (presumably due to impracticality).

Occupational:

- For the individual – seek an occupational health opinion and risk assessment, use protective equipment and/or change working patterns to avoid the allergen.
- For the employer – consider changes to the workplace which avoid initial sensitisation.

Other self-management possibilities include use of a saline nasal wash and good adherence to any therapies bought OTC.

Pharmacological management in primary care

There is no NICE guidance on AR, but the British Society for Allergy and Clinical Immunology (BSACI) has a guideline,[1] and many areas have local guidelines. Initial therapy may be chosen depending on severity, details of symptoms and patient preference. Prescribing for AR is restricted on the NHS, with an expectation that most medication will be bought OTC. Clinical judgment should be used, recognising that not all appropriate therapies are available OTC and that prescribing may be appropriate, particularly with severe symptoms; NHS England[12] advises OTC use for 'mild to moderate hay fever'. Categories of medication commonly used in primary care are given in Box 2 – many patients will need a combination of medication for full control.

BOX 2: Summary of BSACI guidelines for pharmacological management of AR (2017)[1]

Please refer to the SmPCs of all medicines mentioned in this Quick Guide before making prescribing decisions.

Antihistamines:

- Available as oral and topical (intranasal) preparations.[1]
- Oral antihistamines reduce itch, sneeze and rhinorrhoea, with modest effect on nasal congestion.[1] Nasal antihistamines attenuate rhinitis symptoms and decrease nasal obstruction.[1]
- First-generation antihistamines are not recommended due to their association with sedation and cognitive impairment.[1]

Nasal corticosteroids:

- Include mometasone furoate, fluticasone furoate, fluticasone propionate, budesonide and triamcinolone; choice should take into account systemic bioavailability, safety and cost.[1]
- Reduce nasal congestion.[1] Effect builds up over days/weeks so regular use is crucial. Treatment with nasal spray may need to be initiated some days before the expected start of the pollen season in patients who have a history of moderate to severe symptoms of seasonal allergic rhinitis.[13]
- Good technique is important.

Other options:

- Nasal cromoglycate or nedocromil can be used for mild, sporadic symptoms.[1] Useful in individuals unable to take other medications, such as pregnant females.[1] Need to be used several times per day.[1]
- Antihistamine or mast cell stabiliser eye drops for ocular symptoms.[1]
- Short course of oral corticosteroids may be used for severe nasal obstruction.[1]
- Montelukast is licensed for symptomatic relief of seasonal AR in patients who also have asthma.[14]

Treatments to avoid:

- Injectable depot corticosteroids are not licensed for the treatment of AR in the UK[15] and no longer used on the NHS due to an unacceptable increased risk of adverse effects including osteoporosis, avascular necrosis of the femoral head and increased vulnerability to infection.[15,16]
- Nasal decongestants are available OTC but only short-term use (generally fewer than 10 days) recommended, due to potential paradoxical increase in nasal congestion (rhinitis medicamentosa).[1]
- There is no evidence for complementary therapies such as acupuncture, herbal medicine, phototherapy and homoeopathy.[1]

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Particular consideration is needed for the management of pregnant women; the UK teratology information service (UKTIS)[17] advises non-pharmacological measures first-line, then intranasal/ocular mast cell stabilisers and intranasal corticosteroids. Antihistamines can be used after that, with a preference for those where data is available (e.g., loratadine and cetirizine) over newer varieties (e.g., acrivastine and fexofenadine). Neonatal sedation is possible if chlorphenamine is used in the third trimester. Decongestants should be completely avoided, with a theoretical risk of placental vasoconstriction.

Referral and secondary care management

Referral to an allergy clinic is indicated if the diagnosis is unclear, or optimal primary care management doesn't control symptoms and there is an ongoing effect on quality of life. Occupational health referral should be done (by the employer) if there is a possible occupational cause.

Key points

- AR is common and can impact on sleep, daytime functioning and performance at work and in exams.
- A good history is important, to make a positive diagnosis of AR and exclude other differentials.
- There is much that patients can do in terms of allergen avoidance and self-management; the mainstay of primary care treatment is antihistamines and nasal corticosteroids, with nasal corticosteroids that have less systemic absorption being more suitable for children.
- Referral should be considered if there is diagnostic doubt or symptoms cannot be controlled with optimal management in primary care.

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Nasonex®

(mometasone furoate aqueous nasal spray)

Nasonex® 50mcg actuation nasal spray, suspension

Nasonex is a intranasal corticosteroid indicated for use in adults and children 3 years of age and older to treat the symptoms of seasonal allergic or perennial rhinitis.[1]

The British Society for Allergy and Clinical Immunology (BSACI) guidelines states an intranasal corticosteroid for the first-line treatment of SAR if the patient is experiencing moderate-to-severe persistent symptoms vs placebo[3]

NASONEX: Demonstrated efficacy in the relief of seasonal allergic rhinitis (SAR) symptoms vs placebo[2]

In 2007 a US-based, multicentre, phase III randomised, 15 day, double blind clinical study, patients ≥12 years old (n=429) with moderate-to-severe baseline symptoms of SAR rated the severity of their symptoms daily before using Nasonex or a placebo.[2]

Subjects were scheduled to receive Nasonex with 200ug once daily (two 50ug sprays per nostril at approximately the same time each morning) or matching vehicle placebo spray for 15 days.[2]

Co-primary endpoints were reduction from baseline in instantaneous TOSS and instantaneous TNSS. Symptoms scored included rhinorrhoea, nasal congestion, nasal itching, sneezing, redness of eyes, itching/ burning eyes and tearing/ watering eyes.[2]

Nasonex showed a greater reduction from baseline in total nasal and ocular symptom scores over days 2 to 15 versus placebo[2]

Instantaneous TOSS reduction: Nasonex: -1.71 (-25.1%); placebo: -1.37 (-20.1%); treatment difference: -0.34 (95% CI: -0.65 to -0.04); p=0.026 Instantaneous TNSS reduction: Nasonex: -2.54 (-26.4%); placebo: -1.66 (-16.9%); treatment difference: -0.88 (95% CI: -1.27 to -0.51); p<0.001. TNSS: total nasal symptom score; TOSS: total ocular symptom score.[2]

MFNS was generally well tolerated, with treatment-emergent adverse events (AEs) reported in 14.5% of patients, compared with 12.0% in the placebo group. Headache was the only AE reported by more than 2% of participants in either group (2.3% in both MFNS and placebo). Treatment-related AEs occurred in 5.0% of MFNS patients (13 events) versus 3.3% with placebo (7 events). The most common treatment-related side effects were epistaxis (1.8% MFNS vs 0.5% placebo) and nasal discomfort (1.8% MFNS vs 0% placebo). No serious adverse events were reported in either group.[2]

Safety information

Do not use Nasonex if:[1]

- the patient is allergic (hypersensitive) to mometasone furoate or any other ingredients of this medicine
- the patient has an untreated infection in their nose. Use of Nasonex during an untreated infection in your nose, such as herpes, can worsen the infection. The patient should be advised to wait until the infection is resolved before starting to use the nasal spray
- the patient has recently had an operation on their nose or has injured their nose. The patient should be advised to wait until their nose has healed

The safety and efficacy of Nasonex nasal spray in children under 3 years of age have not been established.[1]

Adverse effects of Nasonex commonly reported in clinical trials in adult and adolescent patients include headache, epistaxis, pharyngitis, upper respiratory tract infection,† nasal burning, nasal irritation, nasal ulceration and throat irritation.[1],‡

For full prescribing information, safety information and adverse events - please see the Summary of product characteristics[1]

Adverse events should be reported. Reporting forms and information can be found at https://yellowcard.mhra.gov.uk/ or search for MHRA Yellow Card in the Google Play or Apple App Store. Adverse events should also be reported to Organon Pharma (UK) Limited. (Tel: 02081 593593). By clicking the above link you will be taken to the MHRA website.

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SAR = Seasonal Allergic Rhinitis
† Recorded at uncommon frequency for twice-daily dosing for nasal polyposis.
‡ Recorded for twice-daily dosing for nasal polyposis.

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