Allergic rhinitis management
1. In adults ≥12y (pregnancy/children on p2)

BSACI 2017 (Clin Exp Allergy 2017;47:856), International consensus statement: Allergic Rhinitis 2023 (ICAR 2023;13(4):293-859)

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The ARIA classification looks at severity and frequency of symptoms. Severity is used to guide which treatment to start. In practice, most who present to primary care will have moderate/severe symptoms:

Severity guides the starting treatment

MILD
- No 'troublesome' symptoms
- No impact on sleep
- No impact on daily activities
- Normal work/school

MODERATE/ SEVERE
- Troublesome symptoms
- Abnormal sleep
- Impaired daily activities
- Problems at school or work

If MILD symptoms: START TREATMENT HERE

ICAR guidance recommends intranasal saline alongside other treatments: improves QOL/nasal symptoms; reduces antihistamine use; is safe

If MODERATE OR SEVERE symptoms: START TREATMENT HERE

Antihistamine (oral or nasal)
or
Nasal corticosteroid spray
More effective, but daily use required

Treatment failure →

← *Step down or reduce nasal steroid dose if well controlled*

Nasal corticosteroid spray
Dose can be stepped down as symptoms resolve (see BNF)

Treatment failure ↓

Correct use of nasal corticosteroid spray IS ESSENTIAL:
- Gently blow nose. Shake container and look down
- Squeeze once (or twice, depending on dose, in different directions); using L hand for R nostril and vice versa helps avoid nasal septum, reducing nosebleeds
- Don't close opposite nostril
- Breath gently through nose – DO NOT sniff *(this keeps the active drug on the nasal mucosa and stops it being swallowed, reducing systemic absorption)*
- Keep going – full benefits can take a few weeks!

Check use, concordance and dose

Nasal corticosteroid spray AND antihistamine
(inhaled better than oral)

When monotherapy has failed, evidence favours **intranasal steroids WITH intranasal antihistamines**: more rapid onset of action, more effective symptom relief than other options. See main article for details. Usually more cost-effective as separate inhalers than combined in a single device

Treatment failure ↓

Check use, concordance and dose. Depending on symptoms, **consider** following:

Persistent watery rhinorrhoea
Add nasal ipratropium spray

Eye symptoms
Add topical mast cell stabiliser, e.g. sodium cromoglicate or topical antihistamine drops

Nasal blockage
Add brief nasal decongestant (<7d)

Persistent itch/ sneeze/rash
Switch to oral antihistamine with nasal ICS

Catarrh AND asthmatic
Add leukotriene receptor antagonist

Treatment failure ↓

- Is the diagnosis correct? Could this be something else (see table at end of main article)?
- Refer for ENT opinion if structural issue suspected
- Still suspect allergic rhinitis? Consider referral for consideration of immunotherapy (effective only if one allergen is responsible for most symptoms)

What about oral steroids? Most symptoms can be managed without oral steroids, and the risks of adverse events can outweigh the benefits. ICAR recommends NOT to use oral steroids. BSACI says short-term oral steroids can be considered for very severe or intractable symptoms. The DTB suggests 0.5mg/kg for 5–10 days (DTB 2020;58(4):57).
What about intramuscular steroids? No! Intramuscular corticosteroid injections are effective, but can be associated with systemic side-effects and muscular and subcutaneous necrosis, and are not advised by BSACI 2017 or ICAR 2023.

Allergic rhinitis management
2. Pregnancy or children (<12y)

BSACI 2017 (Clin Exp Allergy 2017;47:856), International consensus statement: Allergic Rhinitis 2023 (ICAR 2023;13(4):293-859)

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Management options in pregnancy and breastfeeding

Rhinitis affects at least 20% of pregnancies and falls into two groups:

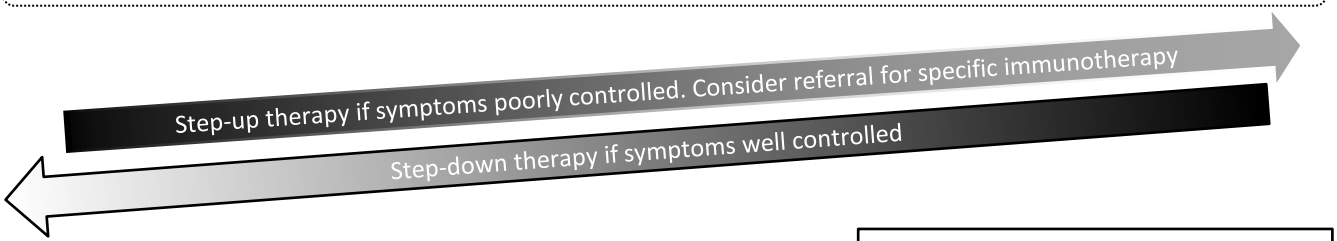
- Women with a history of allergic rhinitis that continues in pregnancy.
- Women who develop pregnancy-induced rhinitis (this is self-limiting).

BSACI guidance (2017) advises that most medications cross the placenta, and recommends that they should only be prescribed if the benefits outweigh the risks.

- **Nasal lavage with saline** is safe and reduces the need for antihistamines.
- In the first trimester, nasal chromones such as sodium cromoglycate are the drug of choice as they have not shown teratogenic effects in animals – *but this is no longer available in the UK.*
- **Nasal steroids:** the safety of nasal steroids has not been established in clinical trials, BUT beclometasone, fluticasone propionate and budesonide have "good safety records" and are used widely in asthma in pregnancy. As a nasal spray, fluticasone propionate has the lowest bioavailability.
- **Antihistamines:** there is considerable clinical experience using chlorphenamine, loratadine and cetirizine in pregnancy, and these can be used in addition to the above measures if necessary. **When breastfeeding**, avoid chlorphenamine as this may cause infant drowsiness or poor feeding.
- **Decongestants should NOT be used.**
- **Immunotherapy:** women can continue immunotherapy if they have reached maintenance phase, but it should not be initiated or up-titrated during pregnancy (*this would be a secondary care decision).*

Management options in children <12y

Note: different drugs are licensed at different ages – see BNFc



Antihistamine (oral or nasal)

Nasal inhaled corticosteroid
Choose one with low bioavailability (e.g. mometasone or fluticasone propionate), use lowest effective dose and monitor growth if long-term use (particularly if on multiple steroids)

Trial of **nasal inhaled corticosteroid AND antihistamine (oral or nasal)**
And, ONLY if asthmatic, can consider leukotriene receptor antagonist (off-licence)