Allergic Rhinitis Protocol

Avoiding allergens will reduce symptoms in all patients, but this may be difficult to achieve without restricting lifestyle. Allergen sensitivity is diagnosed with a skin prick test. The choice of treatment depends on which symptoms predominate.

NASAL SPRAYS - WHICH ONES?

Nasal Steroids

Nasal steroids need to be initiated before the pollen season starts. The range includes Beclomethasone (Beconase®), Budesonide (Rhinocort®), Flunisolide (Syntaris®), Fluticasone (Flixonase®) and Momethasone (NasoneX®).

Fluticasone and Momethasone have little systemic absorption and this may be worth remembering in those patients receiving oral steroids for other conditions.

Nasal steroids are not recommended in children except for short courses as they can alter growth. Children on long term steroids should have height and weight monitored. Beconase
Allergy is available for over the counter purchase at a retail price of £5.99. The other preparations have to be prescribed.

**Non-steroid Nasal Sprays**

Multimediator inhibitor, Azelastine (Rhinolast®) is an aqueous preparation which is effective against itching, rhinorrhoea, sneezing and nasal block. In addition to being a potent H1 blocker, it also inhibits leukotriene and PAF. It has virtually none of the side effects often associated with oral antihistamines and with its fast onset of action it provides a good alternative to a steroid spray.

Sodium Cromoglycate 4% (Rynacrom®) is more effective in the acute or early stages of rhinitis, but, less effective long term, than corticosteroids, has to be used several times a day and is expensive to buy (£19.10).

Anticholinergics such as Ipratropium (RinateC®) may be used for profuse rhinorrhoea but do not relieve itching, sneezing or nasal blockage.

Topical decongestants have a very limited role in hay fever sufferers. Their continual use can result in rebound nasal congestion.

**Antihistamines - sedating or non-sedating?**

The older antihistamines such as Chlorpheniramine are effective against sneezing, itching and rhinorrhoea symptoms or hay fever and still have a role to play where sedative effects are not troublesome. They should not be used for patients who need to be alert, drive or operate machinery.

**Which non-sedating antihistamine?**

It is important to remember that sedation has been reported with all the newer antihistamines, Acrivastine, Cetirizine and Loratidine. Astemizole is very long acting and therefore may take several days to act.

Astemizole has been reported to have potential cardiotoxic effects such as prolongation of OT interval and ventricular arrhythmias when used in doses higher than those recommended, and in patients with liver disease or those receiving drugs which inhibit the metabolism of Astemizole. Small packs of antihistamines are available without prescription from pharmacies.

**Which drug should not be given with Astemizole?**

a) Erythromycin and other macrolide antibiotics

b) Ketoconazole and other imidazole antifungals

c) Drugs which may pre-dispose to arrhythmias e.g. tricyclic antidepressants, neuroleptics and anti-arrhythmics

d) Drugs which may produce an electrolyte imbalance such as diuretics

**Eye Drops**

Azelastine eye drops (Optilast®) is a multimediator inhibitor effective against allergic conjunctivitis. It is a twice-daily application with a fast onset of action.

Sodium cromoglycate eye drops (e.g. Opticrom®, Hay-crom®) have been shown to be effective against allergic conjunctivitis. These can be purchased from pharmacies without prescription for less than the cost of an NHS prescription (£3.75 or £3.99).

**Systemic Corticosteroids**
A short course of oral Prednisolone (or as a last resort i.m. Kenalog® 40 to 100mg) may help those patients who experience multiple symptoms not controlled by other agents. Patients should be counselled carefully about the risks and benefits, and should carry a steroid card.

Prices as quoted in Chemist & Druggist Monthly Price List (June 2000).

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