GUIDELINES FOR THE MANAGEMENT OF ALLERGIC RHINITIS

Introduction
Patients with allergic rhinitis should have received optimal treatment for a full season prior to being referred to our allergy clinic.

Aetiology
Allergic rhinitis can be triggered by aeroallergens. The most common allergic causes for seasonal rhinitis are grass or tree pollens while the most common cause for perennial rhinitis is house dust mite or pets such as cats or dogs.

Tests
Specific IgE testing to all the above aeroallergens is available through your local laboratory. Please send a clotted blood specifying exactly which allergens you suspect as a trigger.

Management
For pet allergies, the animal triggering the symptoms must be avoided where possible. It is especially important that animals do not go into bedrooms of individuals who are allergic to them.
The recommended treatment is a regular nasal corticosteroid spray starting two weeks prior to the normal onset of summer symptoms. The nasal spray should be administered appropriately (with head bent forward and using the spray in the opposite hand to the nostril being sprayed). If one brand of nasal spray does not result in symptomatic benefit it is worth trying an alternative preparation as different patients find different brands more effective. The options include Beclometasone Dipropionate (Beconase), Mometasone Furoate (Nasonex), and Fluticasone furoate (Avamys).

In addition to regular nasal sprays it is recommended that patient takes a regular oral non sedating antihistamine such as cetirizine, fexofenadine or loratadine. All of these are licensed for once daily dosage but twice a day can be beneficial in rhinitis and there is a safely data for all of these to be used up to four times a day. Use of regular eye drops (antihistamine or sodium cromoglycate) is also recommended.

Improvement of symptom control in future years is often achieved if the above treatments are started 2 weeks before the usual onset of symptoms and continued throughout the pollen season.

If these measures fail to control your patient’s symptoms a short course of oral corticosteroids can be appropriate (10-15mg for 3-5 days). Corticosteroids should not be used regularly in the management of seasonal allergic rhinitis and depo-corticosteroids should be avoided. Desensitisation may be indicated particularly for patients with diagnosed grass pollen allergy who have failed optimal treatment.
We have found that with support and encouragement using these conventional treatments many of the patients we have seen recently in our clinics have had significant symptomatic improvement. If your patient continues to have problems despite this for treatment regime it may well be appropriate for them to be reviewed in the allergy clinic for consideration of desensitisation.