Allergic Rhinitis

Allergic rhinitis is caused by IgE-mediated inflammation usually to inhalant allergens. It is clinically defined by symptoms of nasal discharge, itching, nasal blockage or congestion. Rhinosinusitis occurs when both the nasal and sinus lining are inflamed. Allergic rhinitis is often associated with allergic conjunctivitis (rhinoconjunctivitis). Some patients may present with comorbidity; recurrent sinusitis, otitis media, poorly controlled asthma.

Immediate symptoms include sneezing, rhinorrhoea, itch and nasal blockage. Late symptoms include chronic obstruction, post-nasal discharge, hyposomia and nasal hyper-reactivity.

Rhinorrhoea is typically clear. Eye symptoms particularly occur with seasonal allergic rhinitis and include itching, hyperaemia, watering, chemosis and periorbital oedema. Allergic rhinitis is uncommon in infants and toddlers.

The allergen may be identified from the history:

- Seasonal
  - Spring: Tree pollen
  - Summer: Grass Pollen
  - Autumn: Moulds
- Perennial
  - House dust mite (the most common indoor allergen)
  - Animal dander

Management in primary care:

Mild to Moderate symptoms may be managed in primary care

- Intermittent: <4days per week or <4weeks of symptoms.
- Mild: Normal sleep, normal daily activities, Normal work or school, no troublesome symptoms

Avoidance of the allergen should be attempted for all causes. The website Allergy.Uk is a useful resource. Saline douching (washing the nose with isotonic or slight hypertonic saline) may reduce symptoms for some patients.

Mild intermittent symptoms may respond to oral anti-histamine. Mild persistent or moderate intermittent symptoms may respond to an oral anti-histamine and/or intra-nasal steroid

Medications:

Oral H1-antihistamines:

Loratidine

Fexofenadine

The greatest therapeutic effect is on rhinorrhoea. Little effect on nasal blockage

Intranasal steroids:

Types and appropriate ages

Both oral anti-histamines and intra nasal steroids have a better effect when taken regularly during symptomatic periods.

Nasal decongestants: Prolonged use is associated with rebound congestion. Should be avoided in primary care for use in children

Eye drops (sodium cromoglycate or anti-histamine) may be appropriate in patients with significant eyes symptoms.

Referral to Secondary care:

Distressing and or persistent symptoms may warrant investigations (skin prick tests or specific IgE) to confirm the allergen.

Failure of anti-histamines and intra-nasal steroids to control symptoms

Sleep associated breathing disorders

Eye symptoms not responding to anti-histamine

Associated frequent headaches or recurrent rhinosinusitis