

Allergic rhinitis

Dear [Dr _____],

Advice and guidance response pertaining to [Patient name]

[See Tables 1 & 2 following this template for age indications and dose]

Allergic rhinoconjunctivitis is a common condition which can have a severe impact on the quality of life of children and young people. This condition can be present all year round (perennial) and/or may be restricted to certain months (seasonal). Symptoms include sneezing, itchy nose, clear nasal secretions, nasal congestion, eye swelling, conjunctival injection, itchy eyes and watery eyes.

Mild allergic rhinoconjunctivitis where there is no impact on quality of life can be managed by over-the-counter non-sedating antihistamines and higher doses can be recommended if symptoms remain poorly controlled (Table 1). Antihistamine dose can be increased stepwise to the lowest effective dose, up to four times the normal BNFC daily dose for age (note that this represents an unlicensed dosage but is in line with national guidance

https://www.bsaci.org/wp-content/uploads/2020/01/Urticaria_Angioedema2015-1.pdf

Nasal douching (Howtoperformnasaldouching.pdf) and eye drops (sodium cromoglicate, nedocromil, azelastine, olopatadine) may also be helpful.

Moderate or severe allergic rhinitis where there is a significant impact on quality of life should be prescribed an age-appropriate steroid nasal spray with low systemic bioavailability (Table 2). Individuals should also be advised to take a daily non-sedative antihistamine (with a double dose if necessary), undertake nasal douching and use eye drops regularly if appropriate. If there has been a poor response to treatment after 4 weeks then consider adding in a leukotriene receptor antagonist such as Montelukast with appropriate counselling beforehand. If over 12 years of age, then a combination nasal spray can be considered e.g. Dymista (Azelastine/Fluticasone) or Ryaltris (Olopatadine/Mometasone). If there are ongoing symptoms affecting quality of life despite maximal treatment and compliance is assured then refer to the local paediatric allergy clinic which offers allergen immunotherapy.

Refer to paediatric allergy (or general paediatrics) if:

taking maximal treatment regularly and continues to have symptoms and a reduced quality of life; or

unable to tolerate therapy due to significant side-effects (e.g. recurrent epistaxis from nasal spray)

Refer to ENT if:

Unilateral nasal blockage/bloodstained discharge (urgent)

Nasal polyps (urgent): commence treatment with an intranasal steroid while waiting. (Inferior turbinates are normal nasal structures and care should be taken not to mistake these as abnormal nasal masses)

Primary symptom is nasal obstruction/ OSA

Refer for urgent eye assessment if allergic eye symptoms are severe and/or do not improve with treatment.

Refer urgently if there are symptoms suggestive of acute severe rhinosinusitis:

Sudden onset of two or more symptoms, including one of either nasal

blockage/obstruction/congestion or thick nasal discharge; plus: facial pain or pressure; reduction or loss of smell and/or headache.

If there is high fever, unilateral symptoms or displaced eyeball/eye movements, emergency referral for same day assessment is indicated.

For profuse watery nasal secretions, an ipratropium bromide nasal spray may be useful.

Short courses of oral steroids for 3 - 10 days can be considered for rescue medication for severe rhinitis symptoms, as short term relief for rare circumstances e.g. to cover exam period.

Injectable steroids, such as Kenalog are not recommended for the treatment of rhinitis due to the risk of severe side effects including avascular necrosis of the femoral head.

Avoid the chronic use of nasal decongestant medications for > 10 days as these are associated with rhinitis medicamentosa (worsening nasal symptoms).

Allergen avoidance advice (house dust mite and/or pet avoidance for perennial symptoms and pollen avoidance for seasonal symptoms) can be beneficial in certain patients where the culprit allergen can be clearly identified. These can be found on the Allergy UK website.

Patient and professional advice:

Allergy UK: <https://www.allergyuk.org/types-of-allergies/hayfever/>

ENT UK: https://www.entuk.org/patients/conditions/71/rhinitis_and_hayfever/

If referring back, please state that the referral has already been through Advice and Guidance and include a copy of the previous correspondence, to ensure we don't duplicate advice.

With kind regards,

[Clinician name and role]

Table 1. First-line doses of non-sedating antihistamines in allergic rhinoconjunctivitis

Antihistamine	Age	Dose and Frequency
Cetirizine	2 – 5 years 6 – 11 years 12 – 17 years	2.5 mg twice daily 5 mg twice daily 10 mg once daily
Loratadine	2 – 11 years (weight < 30 kg) 2 – 11 years (> 31 kg) 12 – 17 years	5 mg once daily 10 mg once daily 10 mg once daily
Desloratadine	1 – 5 years 6 – 11 years 12 – 17 years	1.25 mg once daily 2.5 mg once daily 5 mg once daily
Fexofenadine	6 – 11 years 12 – 17 years	30 mg twice daily 120 mg once daily

Table 2. Steroid nasal spray for allergic rhinoconjunctivitis. These are most efficacious when started at least 7 days before the expected start of the pollen season using the appropriate nasal spray technique ([How-to-use-a-Nasal-spray-PIL.pdf](#))

Steroid nasal spray	Age indications	Dose
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Mometasone furoate	3 - 11 years of age 12 years and older	One actuation (50 micrograms) once daily Two actuations (100 micrograms) once daily
Fluticasone furoate	6 - 11 years of age 12 years and older	One actuation (27.5 micrograms) once daily Two actuations (55 micrograms) once daily
Fluticasone propionate/azelastine hydrochloride	12 - 17 years of age	One actuation twice daily
Mometasone furoate/olopatadine	12 - 17 years of age	Two actuations twice daily