MANAGEMENT OF ALLERGIC RHINITIS AND ITS IMPACT ON ASTHMA

POCKET GUIDE

GLOBAL PRIMARY CARE EDUCATION

BASED ON THE 2007 ARIA WORKSHOP REPORT AND THE IPAG HANDBOOK

In collaboration with WHO, GA²LEN, AllerGen, and Wonca
THE PURPOSE OF THIS GUIDE

This document was prepared by the Wonca Expert Panel, including Bousquet J, Reid J, Van Weel C, Baena Cagnani C, Demoly P, Denburg J, Fokkens WJ, Grouse L, Mullol K, Ohta K, Schermer T, Valovirta E and Zhong N. It was edited by Dmitry Nonikov. This material is based on the IPAG Handbook and the ARIA Workshop Report, in collaboration with the World Health Organization, GA²LEN (Global Allergy and Asthma European Network), AllerGen, International Primary Care Respiratory Group (IPCRG), European Federation of Allergy and Airways Diseases Patients Associations (EFA), and the World Organization of Family Doctors (Wonca).

Management that follows evidence-based practice guidelines yields better patient results. However, global evidence-based practice guidelines are often complicated and recommend the use of resources often not available in the primary care setting worldwide. The joint Wonca/GARD expert panel offers support to primary care physicians worldwide by distilling the existing evidence based recommendations into this brief reference guide. The guide lists diagnostic and therapeutic measures that can be carried out worldwide in the primary care environment and in this way provide the best possible care for patients with allergic rhinitis. The material presented in sections 1-5 will assist you in diagnosing and treating allergic rhinitis.

PRIMARY CARE CHALLENGE

Allergic rhinitis is a growing primary care challenge since most patients consult primary care physicians. General practitioners play a major role in the management of allergic rhinitis as they make the diagnosis, start the treatment, give the relevant information, and monitor most of the patients. In some countries, general practitioners perform skin prick tests. Studies in Holland and the UK found that common nasal allergies can be diagnosed with a high certainty using simple diagnostic criteria. Nurses may also play an important role in the identification of allergic diseases including allergic rhinitis in the primary care of developing countries and in schools. In addition, many patients with allergic rhinitis have concomitant asthma and this must be checked.

ALLERGIC RHINITIS RECOMMENDATIONS

1. Allergic rhinitis is a major chronic respiratory disease due to its:
   - Prevalence
   - Impact on quality-of-life
   - Impact on work/school performance and productivity
   - Economic burden
   - Links with asthma

2. In addition, allergic rhinitis is associated with co-morbidities such as conjunctivitis.

3. Allergic rhinitis should be considered as a risk factor for asthma along with other known risk factors.

4. A new subdivision of allergic rhinitis has been proposed:
   - Intermittent (IAR)
   - Persistent (PER)

5. The severity of allergic rhinitis has been classified as “mild” or “moderate/severe” depending on the severity of symptoms and quality-of-life outcomes.

6. Depending on the subdivision and severity of allergic rhinitis, a stepwise therapeutic approach has been proposed.

7. The treatment of allergic rhinitis combines:
   - Pharmacotherapy
   - Immunotherapy
   - Education

8. Patients with persistent allergic rhinitis should be evaluated for asthma by means of a medical history, chest examination, and, if possible and when necessary, the assessment of airflow obstruction before and after bronchodilator.

9. Patients with asthma should be appropriately evaluated (history and physical examination) for rhinitis.

10. Ideally, a combined strategy should be used to treat the upper and lower airway diseases to optimize efficacy and safety.
1- RECOGNIZE ALLERGIC RHINITIS

ALLERGIC RHINITIS QUESTIONNAIRE

Instructions: To evaluate the possibility of allergic rhinitis, start by asking the questions below to patients with nasal symptoms.

This questionnaire contains the questions related to allergic rhinitis symptoms that have been identified in peer-reviewed literature as having the greatest diagnostic value. It will not produce a definitive diagnosis, but may enable you to determine whether a diagnosis of allergic rhinitis should be further investigated or is unlikely.

Allergic Rhinitis Questionnaire

1. Do you have any of the following symptoms?
   - Symptoms on only one side of your nose
   - Thick, green or yellow discharge from your nose (see NOTE)
   - Postnasal drip (down the back of your throat) with thick mucus and/or runny nose (see NOTE)
   - Facial pain (see NOTE)
   - Recurrent nosebleeds
   - Loss of smell (see NOTE)

2. Do you have any of the following symptoms for at least one hour on most days (or on most days during the season if your symptoms are seasonal)?
   - Watery runny nose
   - Sneezing, especially violent and in bouts
   - Nasal obstruction
   - Nasal itching
   - Conjunctivitis (red, itchy eyes)

Evaluation:

The symptoms described in Question 1 are usually NOT found in allergic rhinitis. The presence of ANY ONE of them suggests that alternative diagnoses should be investigated. Consider alternative diagnoses and/or referral to a specialist.

- NOTE: Purulent discharge, postnasal drip, facial pain, and loss of smell are common symptoms of sinusitis. Because most patients with sinusitis also have rhinitis (though not always allergic in origin), in this situation the clinician should also evaluate the possibility of allergic rhinitis.
- The presence of watery runny nose with ONE OR MORE of the other symptoms listed in Question 2 suggests allergic rhinitis, and indicates that the patient should undergo further diagnostic assessment.
- The presence of watery runny nose ALONE suggests that the patient MAY have allergic rhinitis. (Additionally, some patients with allergic rhinitis have only nasal obstruction as a cardinal symptom.)
- If the patient has sneezing, nasal itching, and/or conjunctivitis, but NOT watery runny nose, consider alternative diagnoses and/or referral to a specialist.
- In adults with late-onset rhinitis, consider and query occupational causes. Occupational rhinitis frequently precedes or accompanies the development of occupational asthma. Patients in whom an occupational association is suspected should be referred to a specialist for further objective testing and assessment.

ALLERGIC RHINITIS DIAGNOSIS GUIDE

Instructions: In patients of all ages with lower nasal symptoms only, whose responses to the Allergic Rhinitis Questionnaire suggest that this diagnosis should be investigated, use this guide to help you evaluate the possibility of allergic rhinitis. All of the diagnostic investigations presented in this guide may not be available in all areas; in most cases, the combination of those diagnostic investigations that are available and the individual health care professional’s clinical judgement will lead to a robust clinical diagnosis. This guide is intended to supplement, not replace, a complete physical examination and thorough medical history.

Allergic Rhinitis Diagnosis Guide

<table>
<thead>
<tr>
<th>Diagnostic Tool</th>
<th>Findings that Support Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical exam</td>
<td>Transverse crease of nose, allergic shiners, allergic salute.</td>
</tr>
<tr>
<td>Neat anterior rhinitis:</td>
<td>Exclusion of other causes.</td>
</tr>
<tr>
<td>Speculum and mirror gives limited but still valuable information</td>
<td></td>
</tr>
<tr>
<td>Nasal endoscopy (usually performed by specialist) may be needed to exclude other causes of rhinitis, nasal polyps, and anatomical abnormalities</td>
<td></td>
</tr>
<tr>
<td>Trial of therapy</td>
<td>Improvement with antihistamines or intranasal glucocorticosteroid.</td>
</tr>
<tr>
<td>Allergy skin testing or measurement of allergen-specific IgE in serum (if symptoms are persistent and/or moderate/severe, or if quality of life is affected)</td>
<td>• Confirm presence of atopy. • Specific triggers identified.</td>
</tr>
<tr>
<td>Nasal challenge tests (if occupational rhinitis suspected)</td>
<td>Confirm sensitivity to specific triggers.</td>
</tr>
</tbody>
</table>

2- DIFFERENTIAL DIAGNOSIS OF ALLERGIC RHINITIS²

Symptoms suggestive of allergic rhinitis

2 or more of the following symptoms for > 1 hr on most days:
- watery anterior rhinorrhea
- sneezing, especially paroxysmal
- nasal obstruction
- nasal pruritis
± conjunctivitis

Symptoms usually NOT associated with allergic rhinitis

- unilateral symptoms
- nasal obstruction without other symptoms
- mucopurulent rhinorrhea
- posterior rhinorrhea (post nasal drip) – with thick mucous
- – and/or no anterior rhinorrhea
- pain
- recurrent epistaxis
- anosmia

Classify and assess severity (see section 4)

3- MAKE THE DIAGNOSIS OF ALLERGIC RHINITIS²

Symptoms suggestive of allergic rhinitis

- Anterior rhinorrhea
- Sneezing
- Nasal obstruction
(and possibly other nasal or ocular symptoms)

Primary care

- Phadiatop or Multi-allergen test

- Negative
  - Rhinitis is unlikely to be allergic

- Positive
  - Allergic rhinitis

- Refer the patient to specialist

Specialist

- Skin prick test

- Positive + correlated with symptoms
  - Allergic rhinitis

- Negative
  - Non allergic rhinitis


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4- CLASSIFY ALLERGIC RHINITIS

**Intermittent symptoms**
- <4 days per week
- or <4 consecutive weeks

**Persistent symptoms**
- >4 days/week
- and >4 consecutive weeks

**Mild**
- all of the following
  - normal sleep
  - no impairment of daily activities, sport, leisure
  - no impairment of work and school
  - symptoms present but not troublesome

**Moderate-Severe**
- one or more items
  - sleep disturbance
  - impairment of daily activities, sport, leisure
  - impairment of school or work
  - troublesome symptoms

5- TREAT ALLERGIC RHINITIS

**Treatment Goals**

Goals for the treatment of rhinitis assume accurate diagnosis and assessment of severity as well as any link with asthma in an individual patient. Goals include:

- Unimpaired sleep
- Ability to undertake normal daily activities, including work and school attendance, without limitation or impairment, and the ability to participate fully in sport and leisure activities
- No troublesome symptoms
- No or minimal side-effects of rhinitis treatment

STRENGTH OF EVIDENCE FOR EFFICACY OF RHINITIS TREATMENT

<table>
<thead>
<tr>
<th>Intervention</th>
<th>SAR - adults</th>
<th>SAR - children</th>
<th>PAR - adults</th>
<th>PAR - children</th>
<th>PER - adults</th>
<th>PER - children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral H1 Antihistamine</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Intranasal H1 Antihistamine</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A**</td>
<td></td>
</tr>
<tr>
<td>Intranasal CS</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A**</td>
<td></td>
</tr>
<tr>
<td>Intranasal cromone</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>LTRAs</td>
<td>A</td>
<td>A (&gt;6 yrs)</td>
<td>A</td>
<td>A</td>
<td>A**</td>
<td></td>
</tr>
<tr>
<td>Subcutaneous SIT</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A**</td>
<td></td>
</tr>
<tr>
<td>Sublingual / nasal SIT</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>B</td>
<td>A**</td>
<td></td>
</tr>
<tr>
<td>Allergen avoidance</td>
<td>D</td>
<td>D</td>
<td>A*</td>
<td>B</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SAR - Seasonal Allergic Rhinitis
PAR - Perennial Allergic Rhinitis
PER - Persistent Allergic Rhinitis
CS - Corticosteroids
LTRAs - Anti-Leukotrienes
SIT - Specific Immunotherapy

*not effective in the general population
**extrapolated from studies in SAR/PAR

**DIAGNOSIS AND SEVERITY ASSESSMENT OF ALLERGIC RHINITIS**

**Diagnosis of allergic rhinitis**

**Intermittent symptoms**

- **mild**
  - *Not in preferred order*
  - Oral H1-antihistamine
  - Intranasal H1-antihistamine
  - And/or decongestant or LTRA**

- **moderate-severe**
  - *Not in preferred order*
  - Oral H1-antihistamine
  - Intranasal H1-antihistamine
  - And/or decongestant or intranasal CS* or LTRA**
  - (or cromone)

  In persistent rhinitis, review the patient after 2-4 weeks

  - If failure: step-up
  - If improved: continue for 1 month

**Persistent symptoms**

- **moderate severe**

  - *In preferred order*
  - Intranasal CS
  - H1-antihistamine or LTRA**

  - Review the patient after 2-4 weeks

  - If improved: step-down and continue treatment for 1 month

  - If failure:
    - Increase intranasal CS dose
    - Add H1 antihistamine
    - Add decongestant
    - Blockage

  - Surgical referral

*Total dose of topical CS should be considered if inhaled steroids are used for concomitant asthma

**Allergen and irritant avoidance may be appropriate**

- **If conjunctivitis** add:
  - Oral H1-antihistamine
  - Intraocular H1-antihistamine
  - Or intraocular cromone
  - (or saline)

**Consider specific immunotherapy**

**PEDIATRIC ASPECTS**

Allergic rhinitis is part of the "allergic march" during childhood but intermittent allergic rhinitis is unusual before two years of age. Allergic rhinitis is most prevalent during school age years. In preschool children, the diagnosis of AR is difficult. In school children and adolescents, the principles of treatment are the same as for adults, but doses may be adapted, and special care should be taken to avoid the side effects of treatments typical in this age group.

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GLOSSARY OF RHINITIS MEDICATIONS

<table>
<thead>
<tr>
<th>Name and Also known as</th>
<th>Generic name</th>
<th>Mechanism of action</th>
<th>Side effects</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral H&lt;sub&gt;1&lt;/sub&gt; antihistamines H&lt;sub&gt;1&lt;/sub&gt;-blockers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd generation</td>
<td>Cetirizine, Ebastine, Fexofenadine, Loratadine, Mizolastine, Acrivastine, Azelastine, Mequitazine, New products Desloratadine, Levocetirizine, Rupatadine</td>
<td>- blockage of H&lt;sub&gt;1&lt;/sub&gt; receptor</td>
<td>- no development of tachyphylaxis</td>
<td>- First-line therapy except in Moderate/Severe Persistent Allergic Rhinitis - 2nd generation oral H&lt;sub&gt;1&lt;/sub&gt;-blockers are preferred for their favorable efficacy/safety ratio and pharmacokinetics; first generation molecules are no longer recommended because of their unfavorable safety/efficacy ratio - Rapidly effective (less than 1 hr) on nasal and ocular symptoms - Moderately effective on nasal congestion - Acrivastine has sedative effects - Oral azelastine may induce sedation and a bitter taste</td>
</tr>
<tr>
<td>Local H&lt;sub&gt;1&lt;/sub&gt; antihistamines (intranasal, intraocular)</td>
<td>Azelastine, Levocabastine, Olopatadine</td>
<td>- blockage of H&lt;sub&gt;1&lt;/sub&gt; receptor</td>
<td>- Minor local side effects - Azelastine: bitter taste in some patients</td>
<td>Rapidly effective (less than 30 min) on nasal or ocular symptoms</td>
</tr>
<tr>
<td>Intranasal glucocorticosteroids</td>
<td>Beclomethasone dipropionate, Budesonide, Ciclesonide, Fluticasone propionate, Fluticasone furoate, Mometasone furoate, Triamcinolone acetonide</td>
<td>- potently reduce nasal inflammation - reduce nasal hyperreactivity</td>
<td>- Minor local side effects - Wide margin for systemic side effects - Growth concerns with BDP only - In young children consider the combination of intranasal and inhaled drugs</td>
<td>- The most effective pharmacologic treatment of allergic rhinitis; first-line treatment for Moderate/Severe Persistent Allergic Rhinitis - Effective on nasal congestion - Effective on smell - Effect observed after 6–12 hrs but maximal effect after a few days - Patients should be advised on the proper method of administering intranasal glucocorticosteroids, including the importance of directing the spray laterally rather than medially (toward the septum) in the nose</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment Type</th>
<th>Drugs</th>
<th>Mechanism</th>
<th>Common Effects</th>
<th>Potential Complications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral decongestants</td>
<td>Ephedrine, Phenylephrine, Phenylpropanolamine, Pseudoephedrine</td>
<td>Sympathomimetic drug</td>
<td>Relieve symptoms of nasal congestion</td>
<td>Hypertension, Palpitations, Restlessness, Tachycardia, Insomnia, Headache, Tremor, Insomnia, Headache, Dry mucous membranes, Urinary retention, Exacerbation of glaucoma or thyrotoxicosis</td>
</tr>
<tr>
<td>Oral H1-antihistamine-decongestant combination</td>
<td></td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Intranasal decongestants</td>
<td>Oxymethazoline, Others</td>
<td>Sympathomimetic drugs</td>
<td>Relieve symptoms of nasal congestion</td>
<td>Same side effects as oral decongestants but less intense</td>
</tr>
<tr>
<td>Intranasal anti-cholinergics</td>
<td>Ipratropium</td>
<td>Anticholinergics block almost exclusively rhinorrhea</td>
<td>Minor local side effects</td>
<td>Effective in allergic and nonallergic patients with rhinorrhea</td>
</tr>
<tr>
<td>CysLT antagonists Antileukotrienes</td>
<td>Montelukast, Pranlukast, Zafirlukast</td>
<td>Block CysLT receptor</td>
<td>Excellent tolerance</td>
<td>Effective on rhinitis and asthma, Effective on all symptoms of rhinitis and ocular symptoms</td>
</tr>
<tr>
<td>Oral / IM glucocorticosteroids</td>
<td>Dexamethasone, Hydrocortisone, Methylprednisolone, Prednisolone, Prednisone, Triamcinolone, Betamethasone, Deflazacort</td>
<td>Potently reduce nasal inflammation, Reduce nasal hyperreactivity</td>
<td>Systemic side effects common in particular for IM drugs, Depot injections may cause local tissue atrophy</td>
<td>When possible, intranasal glucocorticosteroids should replace oral or IM drugs. However, a short course of oral glucocorticosteroids may be needed for moderate/severe symptoms</td>
</tr>
<tr>
<td>Local cromones (intranasal, intraocular)</td>
<td>Cromoglycate, Nedocromil, Naaga</td>
<td>Mechanism of action poorly known</td>
<td>Minor local side effects</td>
<td>Intraocular cromones are very effective. Intranasal cromones are less effective and their effect is short lasting. Overall excellent safety</td>
</tr>
<tr>
<td>Oral H1-antihistamine decongestant combination products</td>
<td></td>
<td></td>
<td></td>
<td>Use oral decongestants with caution in patients with heart disease. Oral H1-antihistamine decongestant combination products may be more effective than either product alone but side effects are combined</td>
</tr>
</tbody>
</table>

References: 1) International Primary Care Airways Group (IPAG) Handbook available at www.globalfamilydoctor.com. 2) Allergic Rhinitis and its impact on Asthma (ARIA) 2007. Full text ARIA documents and resources: www.whiar.org. GINA materials have been used with permission from the Global Initiative for Asthma (www.ginasthma.org). Material from the IPAG Handbook has been used with permission from the International Primary Care Airways Group.

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