NORTHERN IRELAND MEDICINES MANAGEMENT

Hayfever Supplement

May 2024

£4.5 million was spent on preparations for the management and treatment of hayfever in NI 22/23

The aim of this newsletter supplement is to provide information to support the appropriate management of allergic rhinitis in primary care.
NICE CKS recently updated advice for the management of allergic rhinitis. It covers background to the condition, diagnosis, management and prescribing information. The NI Formulary Respiratory Chapter has recently been reviewed and will be published later in May '24. This bulletin reflects the information from the updated Respiratory Chapter .
Allergic rhinitis may be seasonal (more commonly known as hayfever where symptoms occur at the same time each year) or perennial (symptoms occur throughout the year).

Non–pharmacological management

It is useful to signpost to sources of information including Allergy UK and NI Direct websites.
Patients should be advised on allergen avoidance measures, such as keeping car and building windows shut, wearing sunglasses and using nasal barriers when the pollen count is high. Pollen count can be monitored using a website such as the Met Office. NICE CKS provide advice on avoidance for specific allergens.
Nasal irrigation with saline could also be considered to rinse the nasal cavity using a spray, pump, or squirt bottle and this can be purchased over the counter (OTC).

Pharmacological management

Mild and / or intermittent symptoms
are defined as symptoms which do not disturb sleep or activities of daily living. They occur less than four days per week, or for fewer than four weeks.

In line with Department of Health NI and SPPG policy, patients are encouraged to self–care and seek advice from their local community pharmacist to help manage minor conditions and self-limiting illnesses such as in seasonal allergic rhinitis. Patients do not normally need to seek medical advice and should be able to manage mild and intermittent allergic rhinitis symptoms by purchasing OTC medication directly from pharmacy or retail outlets. Any first line treatment may be suggested depending on patient preference and symptoms.

NICE CKS first line OTC treatment options include:

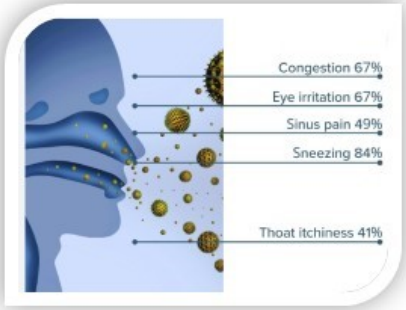
- Oral non-sedating antihistamine or
- Intranasal corticosteroid (INCS) or
- A combination of both

Provide the patient with information on how to use a nasal spray as poor technique will lead to treatment failure. SPPG has also developed a poster for practices and a leaflet for patients, found in the Patient Area of the Northern Ireland Formulary.

Pharmacological management (cont.)

Moderate to severe, or persistent symptoms
are defined as symptoms which are troublesome and affect sleep and / or activities of daily living. They occur more than four days per week, and for longer than four weeks.

Generally, when the condition is long-term (such as perennial rhinitis), treatments may be prescribed in primary care. However, the patient may wish to purchase products OTC and should be supported to do so if they wish. Advise or prescribe INCS as first line treatment. Patient preference may be for an oral antihistamine. If so, prescribe or advise an oral antihistamine.



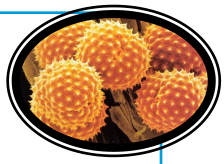
1. **INCS**: Intranasal corticosteroids are the most effective treatment for allergic rhinitis, but patients may prefer oral medication. They may take several hours to several days to become effective and maximal effect may not be seen for two weeks. Once symptoms are well controlled the patient should reduce to the lowest effective maintenance dose. If prescribing, choose a product in line with the updated NI Formulary:

First choice	**Mometasone** furoate 50mcg /dose nasal spray (140 dose) or **Beclometasone** dipropionate 50mcg /dose nasal spray (200 dose) **NB - Ensure the 200 dose container is selected as other pack sizes are more expensive**	Once daily dosing - see SPC for more details Twice daily dosing - see SPC for more details
Second choice	**Fluticasone furoate** 27.5 micrograms/ dose nasal spray	Maintenance once daily dosing - see SPC for more details

2. **Non-sedating oral antihistamine**: Prescribe or advise **cetirizine** or **loratadine tablets** as per NI Formulary.
3. Combination nasal sprays such as Dymista® (azelastine and fluticasone propionate) or Ryaltris® (olopatadine and mometasone) **should not be used as a first line treatment choice**. If a person has refractory symptoms while using a regular INCS preparation, compliance and technique should be checked. After other causes for treatment failure have been considered, treatment may be stepped up to manage the predominate symptom(s) in line with NICE CKS.

Combined use of oral and intranasal antihistamine is not recommended.

Management of refractory symptoms



After checking treatment compliance and technique for using a nasal spray**, consider stepping up treatment** if a person has refractory symptoms while using a regular intranasal corticosteroid preparation.

Refractory symptom	Treatment choice (see individual product SPCs for further details)
Additional eye symptoms: red, watery, itchy, swollen eyes	Prevention and treatment: Mast cell stabilizers can be used if symptoms are recurrent or persistent, e.g. **sodium cromoglicate** eye drops
	Short-term treatment of redness and itching: Topical antihistamine, e.g. **antazoline** eye drops
Nasal congestion (sudden/severe)	Short-term intranasal decongestant, e.g. **xylometazoline** nasal spray or drops
Persistent nasal itching and sneezing	Add in a non-sedating oral antihistamine taken regularly rather than 'as needed' for 8-12 weeks, then review, e.g. **cetirizine 10mg tablets** or **loratadine 10mg tablets** or a combination preparation containing an intranasal antihistamine and an INCS spray, if monotherapy with either an antihistamine or intranasal corticosteroid is ineffective. **Note: combined use of oral and intranasal antihistamine is not recommended.**
Persistent watery rhinorrhoea, despite use of oral antihistamine and / or INCS	Add in an intranasal anticholinergic, e.g. **ipratropium bromide** nasal spray

Continuing or stepping down treatment

If symptoms are intermittent and there is no ongoing allergen exposure, step down treatment and stop.
If drug treatment provides adequate symptom control, advise the person to continue treatment until they are no longer likely to be exposed to the suspected allergen.

- With recurrent episodes advise the person to restart treatment two weeks before re-exposure to causative allergens.
- If the time of re-exposure is uncertain, such as the start of the pollination season, advise the person to start treatment several weeks before the most likely time of re-exposure**.**

Referral for specialist assessment

Consider arranging referral for specialist assessment and management to an allergy or ear, nose, and throat (ENT) specialist if:

- There are **red flag** features such as unilateral symptoms, blood-stained nasal discharge, recurrent epistaxis, or nasal pain — arrange an urgent two week-wait referral to ENT.
- There is predominant nasal obstruction and/or a structural abnormality such as deviated nasal septum which makes intranasal drug treatment difficult — arrange referral to ENT.
- There are persistent symptoms despite optimal management in primary care — consider referral to an allergy specialist for allergy testing and possible immunotherapy treatment, depending on local referral pathways and availability.
- Allergen avoidance techniques such as house dust mite or animal dander avoidance are being considered — skin prick allergy testing to confirm the responsible allergen may be needed.
- The diagnosis is uncertain — consider referral to an allergy or ENT specialist, depending on clinical judgement.