NORTHERN IRELAND MEDICINES MANAGEMENT

Allergic Rhinitis Supplement

April 2026

£4.9 million was spent on prescriptions for the management and treatment of hayfever in NI during 24/25

Key Points

- Patients should be encouraged to self-care and seek advice from their local community pharmacist to help manage milder symptoms
- Combination nasal sprays are NOT a first-line treatment choice; only prescribe after checking technique with first-line intranasal corticosteroid (INCS)
- If a combination nasal spray is required, prescribe generically. Fluticasone propionate 50micrograms/dose / Azelastine 137micrograms/dose nasal spray costs £5.60*; the brand Dymista® costs £14.80. *April 2026 Drug Tariff.

The aim of this newsletter is to provide information to support the appropriate management of allergic rhinitis in primary care.

NICE CKS has the most recent advice on the management of allergic rhinitis. It covers background to the condition, diagnosis, management and prescribing information. The NI Formulary Respiratory Chapter also contains information on managing the condition.

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). Whether season or perennial, treatment is the same.

Non-Pharmacological Management

Patients should be advised on allergen avoidance measures, such as:

- Keeping car and building windows shut
- Monitoring the pollen count using a website such as the Met Office
- Wearing sunglasses and using nasal barriers when pollen count high
- Drying clothes indoors when pollen count is high
- Specific allergen avoidance, advice can be found here

Nasal irrigation with saline could also be considered and this can be purchased over the counter (OTC).

It is useful to signpost to sources of information including Allergy UK and NI Direct websites.

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 4 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 community pharmacist to help manage minor and self-limiting conditions such as seasonal allergic rhinitis. Patients do not normally need to seek medical advice and should be able to manage symptoms by purchasing OTC medication. First-line treatment depends on patient preference and symptoms. NICE CKS first line options include:

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

SPPG has also developed a poster for practices and a leaflet for patients, found in the Patient Zone of the Northern Ireland Formulary.

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. A non-sedating oral antihistamine and / or INCS should be recommended or prescribed.

1. **Intranasal Corticosteroids (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.

Patients should be provided with information on how to use a nasal spray as poor technique will lead to treatment failure. Once symptoms are well controlled the patient should reduce to the lowest effective maintenance dose. Prescribing should be in line with the NI formulary:

First Choice	**Mometasone furoate** 50mcg/dose nasal spray (140 dose)	Once daily dosing- see SPC
Second choice	**Fluticasone furoate** 27.5 micrograms/ dose nasal spray (Avamys®)	Maintenance once daily dosing- see SPC

2. Non-sedating oral antihistamine

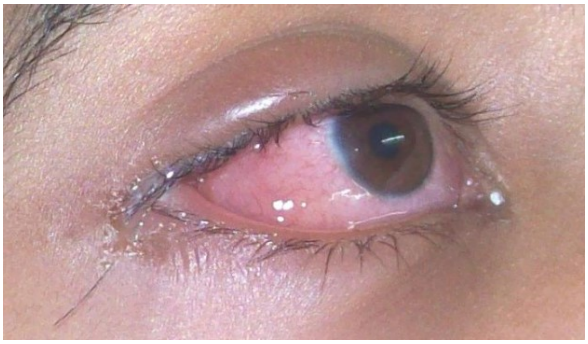
Prescribe or advise **cetirizine or loratadine tablets** as per NI formulary.

3. Combination nasal sprays

Combination nasal sprays such as fluticasone propionate and azelastine (Dymista®) or mometasone and olopatadine (Ryaltris®) **should not be used as first line treatment.**

£840,000 was spent on Dymista® in 24/25. If a combination nasal spray is required, select the generic fluticasone propionate and azelastine product.

Product	Cost
Fluticasone propionate 50micrograms/ dose / Azelastine 137micrograms/dose 120 dose nasal spray	**£5.60** (April 26 Drug Tariff)
Dymista® 120 dose nasal spray	£14.80



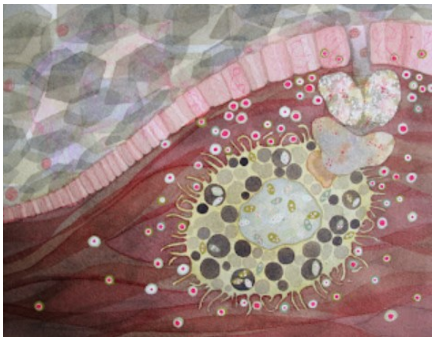
After checking treatment compliance and technique for using a nasal spray**, stepping up treatment** should be considered if a person has refractory symptoms whilst using a regular intranasal corticosteroid preparation. This is in line with NICE CKS.

Combined use of oral and intranasal antihistamine is not recommended.

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**
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, treatment should be stepped down and stopped.



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