Allergic rhino-conjunctivitis symptoms (characterised by sneezing, nasal congestion, itch +/- ocular symptoms) occur following exposure to a known causative allergen, such as:

- Tree pollens — symptoms occur from early to late spring.
- Grass pollens — symptoms occur from late spring to summer.
- Weed pollens — symptoms may occur from early spring to early autumn.
- House dust mites — symptoms often worse on waking and are present all year-round, but may maybe exacerbated by exposure to a dusty environment.
- Animal dander — symptoms follow exposure to animal dander, and may be all year-round if related to pet exposure.

Further Testing

Allergy testing in the form of Specific IgE to above allergens can be sent in a yellow bottle in brown immunology form to aid diagnosis in conjunction with history from the patient.

Treatment options

Most people with rhinitis symptoms will benefit from nasal irrigation with saline and allergen avoidance (where possible).

Mild symptoms

- Non-sedating oral antihistamine (such as cetirizine) as required, or regularly

Moderate symptoms

- Non-sedating oral antihistamine (such as cetirizine) as required, or regularly
- Regular intranasal corticosteroid spray
    - Advise that the onset of action occurs 6-8 hours after first dose and maximum effect may not be seen for up to two weeks.
    - Please ensure correct technique with nasal spray is being used and advice on this can be found at BSACI standard operating procedures section on the BSACI website (www.bsaci.org)
    - Intranasal corticosteroids can be taken regularly for perennial symptoms or seasonally (restarted two weeks prior to the suspected allergen season).

Severe / Refractory symptoms

- Check compliance with prescribed medications and nasal spray technique.
- Combination nasal spray such as azelastine hydrochloride and fluticasone propionate (*Dymista*).

- Non-sedating oral antihistamine (such as cetirizine) regularly. In some patients up to four times the recommended dose may be required; e.g. cetirizine 10 mg four times daily, or Fexofenadine 180 mg four times daily. Incremental up dosing of antihistamines is recommended depending on clinical response.
- Consider adding in leukotriene receptor antagonist such as montelukast particularly if there is a history of asthma.
- Ensure optimal asthma control

Referral Options

- To immunology for severe / treatment refractory allergic rhino-conjunctivitis only. Sensitisation should be confirmed by specific IgE tests before referral.

  Desensitisation can be offered for grass pollen, tree pollen and house dust mite only.

- To ENT if persistent symptom/ structural component is suspected.

References

Scadding G, et al. BSACI guideline for the diagnosis and management of allergic and non-allergic rhinitis (Revised Edition 2017; First edition 2007). Clin Exp Allergy. 2017; 47: 856-889.