MANAGEMENT OF ALLERGIC RHINITIS SYMPTOMS IN THE PHARMACY

POCKET GUIDE

ALLERGIC RHINITIS AND ITS IMPACT ON ASTHMA

A Pocket Guide for Pharmacists

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PREFACE

• Allergic rhinitis is **clinically defined** as a symptomatic disorder of the nose induced, after allergen exposure, by an IgE-mediated inflammation of the membranes lining the nose.

• Allergic rhinitis represents a **global health problem** affecting at least 10% to 40% of the population. Although it is not usually a severe disease, it alters the social life of patients and affects school performance and work productivity.

• **Asthma and rhinitis** are common co-morbidities suggesting the concept of "one airway, one disease."

• New knowledge on the mechanisms underlying allergic inflammation of the airways has resulted in better therapeutic strategies.

• The ARIA initiative has been developed in collaboration with WHO to be state-of-the-art for physicians and health-care workers. A special guide has been developed for the pharmacist.

• As trusted healthcare professionals, pharmacists are in an excellent position to identify symptoms of allergic rhinitis and recommend any appropriate treatment. This guide provides a practical, step-by-step approach to enable pharmacists to advise patients:
  • in recognising allergic rhinitis and assessing its severity,
  • in understanding the effect of treatment on rhinitis and co-morbidities,
  • in determining whether management in the pharmacy is appropriate,
  • on the initiation of an appropriate treatment and monitoring plan,
  • by proposing appropriate preventive measures.

• This guide should:
  • increase collaboration between pharmacists, physicians and other health-care professionals,
  • reduce the burden incurred by allergic rhinitis and its co-morbidities,
  • aid in the identification of undiagnosed or uncontrolled asthma,
  • improve cost-effectiveness in the management of allergic rhinitis.

This document is a guide. It is not intended to be a mandatory standard of care document for individual countries. It is provided as a basis for pharmacists and their staff to develop relevant local standards of care for their patients.
Recognising allergic rhinitis in the pharmacy

1- Recognising allergic rhinitis and differentiating allergy from other causes including infection

• Some patients who consult the pharmacist will have had allergic rhinitis previously diagnosed by a physician, others will have made an appropriate self-diagnosis, some will not have received any diagnosis of rhinitis or may even have an incorrect diagnosis (e.g. a viral infection or a cold).

• Allergic rhinitis has symptoms similar to those of a number of other conditions and may be confused with a viral infection such as the common cold or chronic sinusitis.

• The presence of nasal itching, rhinorrhea, sneezing and eye symptoms are usually consistent with allergic rhinitis.

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

Classify and assess severity

Symptoms usually NOT associated with allergic rhinitis

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

Refer the patient rapidly to a physician

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2- Assessing the severity of allergic rhinitis

A recent classification of allergic rhinitis (intermittent or persistent) has replaced the previous classification of seasonal and perennial forms.

<table>
<thead>
<tr>
<th>Intermittent</th>
<th>Persistent</th>
</tr>
</thead>
<tbody>
<tr>
<td>• ≤ 4 days per week</td>
<td>• &gt; 4 days per week</td>
</tr>
<tr>
<td>• or ≤ 4 weeks</td>
<td>• and &gt; 4 weeks</td>
</tr>
</tbody>
</table>

Mild
- normal sleep
- no impairment of daily activities, sport, leisure
- normal work and school
- no troublesome symptoms

Moderate-severe
- abnormal sleep
- impairment of daily activities, sport, leisure
- impairment of work and school activities
- troublesome symptoms

3- Management by pharmacists or referral to physician

• Referral to a physician should be considered in cases where:
  • persistent, moderate to severe symptoms of rhinitis are present (although initial treatment might be provided by a pharmacist whilst waiting to see a physician),
  • symptoms are suggestive of undiagnosed asthma or uncontrolled asthma in patients with a diagnosis of asthma (e.g. wheezing or shortness of breath),
  • symptoms of infection (mucopurulent discharge, sore throat, myalgia, asthenia, fever) are reported,
  • symptoms do not respond to initial pharmacy management within 2 to 4 weeks,
  • bothersome side effects are experienced.

• Referral to a physician is also advisable during pregnancy, because some medications should be administered with caution.

• Management by a physician is also appropriate for children under 12, taking into account the difficulties in establishing the diagnosis, in selecting the proper medications to avoid side effects and the frequent off-label use of medicines in this young age group.
4- Asthma co-morbidity

- Allergic rhinitis and asthma often coexist. Allergic rhinitis is regarded as a risk factor for the development of asthma.
- In patients with asthma, rhinitis may be associated with a poor control of the disease.
- Patients with persistent rhinitis should be questioned for symptoms of asthma.
- Patients with asthma should be questioned for symptoms of rhinitis.

5- Conjunctivitis

- Eye symptoms are common in patients suffering from allergic rhinitis. However, they do not exist in all patients with rhinitis.
- The presence of conjunctivitis should always be considered.
- On the other hand, conjunctivitis is not always induced by allergic triggers.
- Photophobia (light sensitivity) is an important symptom to be noted, and, if present, needs a physician evaluation. Eye itching is common in allergic conjunctivitis. In contrast, eye burning is rarely a sign of allergic conjunctivitis.

### Symptoms suggestive of allergic conjunctivitis

1 or more of the following symptoms for > 1 hr on most days:
- symptoms associated with rhinitis
- bilateral eye symptoms
- eye itching
- watery eyes
- red eyes
- NO photophobia

**Do the symptoms concern the patient or the pharmacist?**

- **Yes**: Refer the patient to a doctor
- **No**: oral H1-blocker* or ocular H1-blocker** or ocular chromone**

### Symptoms NOT suggestive of allergic conjunctivitis

1 or more of the following symptoms:
- symptoms NOT associated with rhinitis
- unilateral conjunctivitis
- NO eye itching
- BUT eye burning
- dry eyes
- photophobia

* depending on drug availability not in preferred order
** non-sedating H1-blockers are preferred
*** formulations without preservatives are better tolerated
Management of allergic rhinitis

The management of allergic rhinitis is evidence-based and includes:

• **Allergen avoidance:**
  - Most allergen avoidance studies have dealt with asthma symptoms and very few have studied rhinitis symptoms. A single intervention may be insufficient to control symptoms of rhinitis or asthma.
  - However, allergen avoidance, including house mites, should be an integral part of a management strategy.
  - More data are needed to fully appreciate the value of allergen avoidance.

• **Medications (pharmacological treatment):**
  - Pharmacological treatment should take into account the efficacy, safety and cost-effectiveness of medications, the patient’s preference as well as the objective of treatment, severity of the disease and the presence of co-morbidities.
  - Medications used for rhinitis are most commonly administered intranasally or orally.
  - The efficacy of medications may differ between patients.
  - Many medications used in the treatment of allergic rhinitis are available without a medical prescription although there is a large disparity between countries.
  - Non-sedating H₁ oral antihistamines are preferred to sedative ones because of their considerably lower incidence of side effects compared to sedating antihistamines. Patients may not always perceive sedation and mental impairment.
  - Intranasal corticosteroids are the most effective treatment of allergic rhinitis, in particular in severe disease or when nasal obstruction predominates. They are safe but some patients prefer oral drugs.
  - Common treatments currently available for allergic rhinitis (including prescription-only medicines) are listed below and pharmacists are able to advise patients on both prescribed and OTC medications.

• **Specific immunotherapy:**
  - Allergen specific vaccination is the practice of administering gradually increasing quantities of an allergen extract to an allergic subject to
ameliorate the symptoms associated with the subsequent exposure to the causative allergen. The efficacy of injection and sublingual immunotherapy using inhalant allergens to treat allergic rhinitis and asthma is evidence-based when optimally administered. Standardised therapeutic vaccines which are available for the most common allergens are favoured.

- **Education:**

  
  ![Diagram](image)

  - allergen avoidance indicated when possible
  - immunotherapy effectiveness; specialist prescription may alter the natural course of the disease
  - pharmacotherapy safety; effectiveness; easily administered
  - costs
  - patient’s education always indicated

**Responses to commonly asked questions**

- Medications are for the relief of symptoms and have no long-lasting effect when stopped. Therefore, in persistent disease, maintenance treatment is required.
- Tachyphylaxis does not usually occur with prolonged treatment except for intranasal decongestants. Continuous treatment with other medications is effective.
- Most medications recommended in this guideline do not have significant long-term side effects and can be administered for prolonged periods.

- **Alternative and complementary medicine** (e.g. homeopathy, herbal medicines, acupuncture) is increasingly used for the treatment of rhinitis, although the definite proof of their efficacy is not evidence-based. Herbal medicine can induce pharmacological interactions with medications used in the treatment of allergic rhinitis or other illnesses.
- **Surgery** may be used as an adjunctive intervention in a few highly selected patients.
- It is recommended to propose a strategy combining the treatment of both the upper and lower airway disease in terms of efficacy and safety.
- Follow-up is required in patients with persistent rhinitis and severe intermittent rhinitis.
TREAT IN A STEPWISE APPROACH
(adolescents and adults)

DIAGNOSIS OF ALLERGIC RHINITIS
(history ± skin prick tests or serum specific IgE)
Allergen avoidance

Intermittent symptoms

Persistent symptoms

mild

Not in preferred order
• oral H₁-blocker
• intranasal H₁-blocker
• and/or decongestant

mild

Not in preferred order
• oral H₁-blocker
• intranasal H₁-blocker
• and/or decongestant
• intranasal CS
• chromone

Moderate

Severe

intranasal CS

review the patient
after 2-4 weeks

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

Increased

RHINORRHEA

itch/sneeze
blockage

add H₁-blocker
add ipratropium
add decongestant
or oral CS (short term)

Failure

surgical referral

If conjunctivitis add:
• oral H₁-blocker
• or intra-ocular H₁-blocker
• or intra-ocular chromone
• (or saline)

consider specific immunotherapy
Medications available for the treatment of allergic rhinitis (including prescription-only medicines):

<table>
<thead>
<tr>
<th>Classification</th>
<th>Generic names</th>
<th>Mechanism of action</th>
<th>Side effects</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Oral H&lt;sub&gt;1&lt;/sub&gt; antihistamines</strong></td>
<td>2nd generation</td>
<td>- blockage of H&lt;sub&gt;1&lt;/sub&gt; receptor</td>
<td>2nd generation</td>
<td>- 2nd generation oral H&lt;sub&gt;1&lt;/sub&gt;-antihistamines are preferred for their favorale efficacy/ safety ratio and pharmacokinetics</td>
</tr>
<tr>
<td></td>
<td>Acrivastine</td>
<td>- some anti-allergic activity</td>
<td></td>
<td>- 2nd generation medications can be used once daily</td>
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<tr>
<td></td>
<td>Azelastine</td>
<td>- new generation medications can be used once daily</td>
<td></td>
<td>- no development of tachyphylaxis</td>
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<tr>
<td></td>
<td>Cetirizine</td>
<td>- no cardio toxicity</td>
<td></td>
<td>- oral azelastine may induce sedation and has a bitter taste</td>
</tr>
<tr>
<td></td>
<td>Desloratadine</td>
<td>- acrivastine has sedative effects</td>
<td></td>
<td>- anti-cholinergic effect may occur</td>
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<tr>
<td></td>
<td>Ebastine</td>
<td>- oral azelastine may induce sedation and has a bitter taste</td>
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<tr>
<td></td>
<td>Fexofenadine</td>
<td>- reduce nasal hyperreactivity</td>
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<td></td>
<td>Levocetrizine</td>
<td>- potentely reduce nasal inflammation</td>
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<td></td>
<td>Loratadine</td>
<td>- growth concerns raised by BDP in young children</td>
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<td></td>
<td>Mizolastine</td>
<td>- in young children, consider the combination of intranasal and inhaled medications</td>
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<tr>
<td></td>
<td>1st generation</td>
<td>- rapidly effective (&lt;30 mins) on nasal or ocular symptoms</td>
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<tr>
<td></td>
<td>Chlorpheniramine</td>
<td>- sedation is common and may not be perceived</td>
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<tr>
<td></td>
<td>Clemastine</td>
<td>- potentiation of impairment induced by alcohol</td>
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<tr>
<td></td>
<td>Diphenhydramine</td>
<td>- anti-cholinergic effect may occur</td>
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<td></td>
<td>Hydroxyzine</td>
<td>- minor local side effects</td>
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<tr>
<td></td>
<td>Ketotifen</td>
<td>- azelastine: bitter taste</td>
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<td></td>
<td>Mequitazine</td>
<td>- potent local side effects</td>
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<tr>
<td></td>
<td>Oxatomide</td>
<td>- orally effective on nasal congestion</td>
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<tr>
<td></td>
<td>Others</td>
<td>- the most effective pharmacological treatment of allergic rhinitis</td>
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<tr>
<td></td>
<td>Cardiotoxic</td>
<td>- effective on nasal congestion</td>
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<td></td>
<td>Astemizole</td>
<td>- effect on smell</td>
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<td></td>
<td>Terfenadine</td>
<td>- effect observed after 7-8 hrs but maximal effect up to 2 weeks</td>
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<tr>
<td><strong>Local H&lt;sub&gt;1&lt;/sub&gt; antihistamines</strong></td>
<td>Azelastine</td>
<td>- rapidly effective (&lt;30 mins) on nasal or ocular symptoms</td>
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<tr>
<td></td>
<td>Levocabastine</td>
<td>- blockage of H&lt;sub&gt;1&lt;/sub&gt; receptor</td>
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<tr>
<td></td>
<td>Olopatadine</td>
<td>- some anti-allergic activity for azelastine</td>
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<tr>
<td><strong>(intranasal, ocular)</strong></td>
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<tr>
<td><strong>Intranasal glucocorticosteroids</strong></td>
<td>Beclomethasone</td>
<td>- reduce nasal hyperreactivity</td>
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<tr>
<td></td>
<td>Budesonide</td>
<td>- potentely reduce nasal inflammation</td>
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<tr>
<td></td>
<td>Ciclesonide</td>
<td>- wide margin for systemic side effects</td>
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<tr>
<td></td>
<td>Fluticasone</td>
<td>- growth concerns raised by BDP in young children</td>
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<tr>
<td></td>
<td>Flunisolide</td>
<td>- in young children, consider the combination of intranasal and inhaled medications</td>
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<tr>
<td></td>
<td>Mometasone</td>
<td>- intraocular chromones are effective</td>
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<td></td>
<td>Triamcinolone</td>
<td>- intranasal chromones are effective</td>
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<tr>
<td><strong>Local chromones</strong> (intranasal, ocular)</td>
<td>Sodium cromoglicate</td>
<td>- poorly known</td>
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<tr>
<td></td>
<td>Nedocromil</td>
<td>- minor local side effects</td>
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<td></td>
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<tr>
<td><strong>(intranasal, ocular)</strong></td>
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<td></td>
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<tr>
<td><strong>Oral decongestants</strong></td>
<td>Ephedrine</td>
<td>- sympathomimetic medications</td>
<td></td>
<td>- use oral decongestants with caution in patients with other disease</td>
</tr>
<tr>
<td></td>
<td>Phenylephrine</td>
<td>- relieve symptoms of nasal congestion</td>
<td></td>
<td>- Oral H&lt;sub&gt;1&lt;/sub&gt; antihistamine/ decongestant combination products may be more effective than either product alone but side effects are combined</td>
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<tr>
<td></td>
<td>Phenylpropanolamine</td>
<td>- hypertension</td>
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<tr>
<td></td>
<td>pseudoephedrine</td>
<td>- palpitations</td>
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<tr>
<td></td>
<td>Others</td>
<td>- restlessness</td>
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<tr>
<td></td>
<td></td>
<td>- agitation</td>
<td></td>
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<td>- tremor</td>
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<td></td>
<td></td>
<td>- insomnia</td>
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<td></td>
<td>- headache</td>
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<td></td>
<td>- dry mucous membranes</td>
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<td>- urinary retention</td>
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<td></td>
<td></td>
<td>- exacerbation of glaucoma or thyrotoxicosis</td>
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</tbody>
</table>
A pharmacy protocol for treating allergic rhinitis

With recent changes in the regulatory status of some medications for allergic rhinitis symptoms, pharmacists may recommend more therapies which are available without prescription. The use of these medications is likely to result in cost savings for both the patient and health care professional. The involvement of the pharmacist in the overall management of the patient is also likely to reduce risks of overdosing and drug interactions.

Based on the above considerations, a recommended pharmacy protocol for managing allergic rhinitis is proposed.

<table>
<thead>
<tr>
<th>Symptoms of allergic rhinitis</th>
</tr>
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<tbody>
<tr>
<td>Mild intermittent</td>
</tr>
<tr>
<td>Oral H1-blocker* / $</td>
</tr>
<tr>
<td>or nasal H1-blocker*</td>
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<tr>
<td>or decongestant*</td>
</tr>
<tr>
<td>or nasal chromone*</td>
</tr>
<tr>
<td>or nasal saline</td>
</tr>
<tr>
<td>Oral H1-blocker* / $</td>
</tr>
<tr>
<td>or nasal H1-blocker*</td>
</tr>
<tr>
<td>and/or decongestant*</td>
</tr>
<tr>
<td>or nasal steroid* / £</td>
</tr>
<tr>
<td>or nasal chromone*</td>
</tr>
<tr>
<td>Refer to physician</td>
</tr>
<tr>
<td>If after 7-15 days</td>
</tr>
<tr>
<td>No improvement</td>
</tr>
</tbody>
</table>

*: depending on drug availability and not in preferred order
$: non-sedating H1-blockers should be preferred
£: if nasal obstruction predominates, intranasal steroids are the first line treatment
Allergic rhinitis, like other chronic diseases, requires monitoring for:
• improvement of symptoms and quality of life,
• assessment of safety of OTC and prescribed medications,
• need for referral to a physician,
• need to discontinue or reinstate medications.

A pharmacy protocol for treating **ocular symptoms**

• With the exception of nasal decongestants and anticholinergics, all the major treatments discussed above are effective against the ocular symptoms of allergic rhinitis. Sodium cromoglycate, nedocromil sodium, NAAGA and H1-antihistamines (azelastine, levocabastine, ketotifen, olopatadine) are also available as eye drops. Intranasal glucocorticosteroids have shown some effect in eye symptoms associated with allergic rhinitis.

• Intraocular glucocorticosteroids are effective, but because of known side effects should only be prescribed and monitored by eye-care professionals.

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**Symptoms suggestive of allergic conjunctivitis**

1 or more of the following symptoms for > 1 hr on most days
- symptoms associated with rhinitis
- bilateral eye symptoms
- eye itching
- watery eyes
- red eyes
- **NO** photophobia

**Do eye symptoms concern the patient or the pharmacist?**

- **yes**
  - Refer the patient to a physician

- **no**
  - **Oral H1-blocker**
  - or **ocular H1-blocker**
  - or **ocular chromone**

---

*: depending on drug availability
*: not in preferred order
$: formulations without preservatives are better tolerated
The management of allergic rhinitis and asthma in the pharmacy

- Asthma may be severe and even life-threatening.
- When pharmacists identify patients with undiagnosed or untreated asthma, or asthma which is not optimally controlled, they should encourage these individuals to obtain appropriate medical care.

The patient does not know if he (she) is asthmatic

4 simple questions:
- Have you had an attack or recurrent attack of wheezing?
- Do you have a troublesome cough, especially at night?
- Do you cough or wheeze after exercise?
- Does your chest feel tight?

If YES to any of these questions your patient may be asthmatic

Patient with a diagnosis of asthma

1 or more of the following:*:
- Have you had difficulty sleeping because of your asthma symptoms (including cough)?
- Have you had your usual asthma symptoms during the day?
- Has your asthma interfered with usual activities (e.g. housework, work/school)?
- Do you need your reliever inhaler (blue) more than once a day?

If YES to any of these questions your patient has uncontrolled asthmatic

Refer the patient to a physician

*from the National Asthma Campaign, "conquering asthma"

- The treatment of asthma should follow the recently published GINA guidelines (www.ginasthma.org).
- It is important to manage co-morbidity of allergic rhinitis and asthma. Treatment of allergic rhinitis has been associated with improved outcomes from asthma.