Queensland Community Pharmacy Scope of Practice Pilot

Allergic and Nonallergic Rhinitis - Clinical Practice Guideline

Guideline Overview

Pilot and professional obligations

- Initial patient eligibility and suitability for management within the scope of the pilot
- Patient informed consent
  - Pilot participation
  - Financial
  - Pharmacist communication with other health practitioners
- Professional standards
- Privacy
- Documentation and record keeping
- Interprofessional communication

Gather information and assess patient's needs

- Presenting signs and symptoms
- Patient history
- Examination

Management and treatment plan

- Allergic rhinitis
  - Treatment plan
  - General measures
  - Pharmacotherapy
- Nonallergic rhinitis
  - General measures
  - Pharmacotherapy

Confirm management is appropriate

- Contraindications and precautions
- Drug interactions
- Pregnancy and lactation

Communicate agreed treatment plan

- How to use
- Patient resources/ information
- Adverse effects
- Communication with other health practitioners

Refer when

Refer to a medical practitioner if:

- The patient has 'red flag' warning signs
- A clear diagnosis of allergic or nonallergic rhinitis cannot be made
- The patient has signs or symptoms of systemic infection or infectious rhinosinusitis including facial pain, fever or purulent nasal discharge
- The patient is aged under 6 years of age
- The patient has other underlying or co-existing medical conditions that complicate treatment for allergic or nonallergic rhinitis, and require management by a medical practitioner e.g., Severe asthma or asthma in patients under the age of 16, sinusitis, nasal polyps or other structural abnormalities
- The patient is taking a medicine prescribed by another health practitioner that can cause or exacerbate rhinitis
- The condition is having a marked negative emotional or social effect on the patient
- The condition does not respond to optimal treatment or worsens

Clinical review

- Response to treatment
- Adverse effects
- Continue, modify or stop treatment
- Communication with other health practitioners

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‘Red flag’ warning signs at patient presentation that necessitate referral to a medical practitioner:

- Signs and symptoms of lower respiratory disease including severe asthma or asthma in patients under the age of 16
- Signs and symptoms of systemic illness, fever, severe infection or is generally unwell.

Key points

- Rhinitis has a broad aetiology and can be classified as allergic, nonallergic (vasomotor), infectious, drug-induced and occupational. Allergic rhinitis (which may co-occur with nonallergic rhinitis) is the most common type [1]. Accurate differentiation of the type of Rhinitis is important to inform effective treatment [2-4].
- Rhinitis can have significant impact on quality of life including sleep, cognitive and psychomotor function, social activities and learning impairment in children [4, 5].
- Emerging evidence suggests that allergic rhinitis may be part of a systemic airway disease, as opposed to a localised disorder of the nose and nasal passages [6, 7].
- Rhinitis and asthma commonly co-exist (sometimes referred to as United Airway Disease) [7]. Effective management of allergic rhinitis is important for the management of asthma; all asthma symptoms should be investigated or the patient provided with a referral to a medical practitioner [1, 6].

When applying the information contained within this clinical practice guideline, pharmacists are advised to exercise professional discretion and judgement. The clinical practice guideline does not override the responsibility of the pharmacist to make decisions appropriate to the circumstances of the individual, in consultation with the patient and/or their carer.

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Gather information and assess patient’s needs

Presenting signs and symptoms

The symptoms of allergic and nonallergic rhinitis are included in Table 1.

Table 1 Symptoms and clinical signs of rhinitis

Table 1. Symptoms and clinical signs of rhinitis [2, 5, 8]	
Allergic rhinitis	**Non-allergic rhinitis**
Symptoms after exposure to animals, pollen, dust or other environmental factors/allergens: • sneezing • nasal congestion • clear rhinorrhoea • upper airway cough syndrome (post-nasal drip) • mucosal itching of the nose, eyes, ears and palate. Non-specific symptoms: • ‘fuzzy’ head • tiredness and daytime sleepiness • constant ‘colds’. Allergic conjunctivitis frequently co-occurs (eye redness, watering and itching). In children, additional symptoms may include sniffing, blinking and eye rubbing, speech problems, snoring, mouth breathing, and dark undereye circles.	Symptoms without an identifiable trigger or exposure to allergens: • nasal blockage and/or congestion • clear rhinorrhoea • post-nasal drip May or may not be present: • sneezing • itchy skin or watery eyes. Symptoms may present sporadically at any time of the year, although they may be exacerbated by environmental factors such as barometric pressure or temperature changes, bright lights or physical irritants.

Reported symptom improvement with second generation antihistamines is strongly suggestive of allergic rhinitis, as is a previous response to intranasal corticosteroids [6].	

Patient history

Sufficient information should be obtained from the patient to assess the safety and appropriateness of any recommendations and medicines.

The patient history should consider:

- age
- pregnancy and lactation status (if applicable)
- onset, nature, duration, frequency, severity and pattern of respiratory symptoms
- other signs and symptoms suggestive of infection including fever, purulent nasal discharge or facial pain
- presence of asthma symptoms
- co-existing and underlying medical conditions including asthma, nasal polyps or other allergic diseases (e.g., atopic dermatitis)
- family history of nasal polyps or allergic disease (including rhinitis)
- triggering, aggravating and relieving factors (e.g., occupational exposure to cleaning chemicals, foods, pollen, cigarette smoke)
- emotional and social impacts of the condition
- current medication use (all medications including prescribed medicines, vitamins, herbs, other supplements and over-the-counter medicines)
- medications used or trialled to treat symptoms, adherence and response, including use of nasal decongestants
- drug allergies/adverse drug effects
- smoking status.

Reminder

Pharmacists can access a range of clinical information in a patient's My Health Record, including details about current and past medication history, allergies and current medical conditions.

Examination

- Physical examination of nose, throat, eyes and ears is generally required [5].
- Where appropriate, conduct assessment of vital signs.
- Outward signs of rhinitis upon examination may include:
    - enlarged/swelled, pale, boggy nasal mucosa with thin secretions
    - nasal polyps
    - dark undereye area due to venous congestion (particularly in children)
    - cobblestone throat due to irritation of post-nasal drip

- mouth breathing [6].

- Patients with symptoms of asthma or lower respiratory disease should have a chest examination in accordance with the clinical protocol for the Improved Asthma Symptom Control Program.

Management and treatment plan

Allergic rhinitis

Pharmacist management of allergic rhinitis involves:

- **developing a treatment plan:**
  - Based on the Australasian Society of Clinical Immunology and Allergy Allergic Rhinitis Treatment Plan [9].
- **general measures:**
  - Education regarding allergen avoidance and minimising exposure to known/clinically obvious allergens and irritants if possible, as per the Australian Society of Clinical Immunology and Allergy: Allergic Rhinitis Clinical Update 2022 [4].
- **pharmacotherapy**:
  - As per the Therapeutic Guidelines: Allergic rhinitis, including eye drops for allergic conjunctivitis[1] [1].

NB1: Anti-inflammatory eye drops (e.g., ketorolac and corticosteroids) are mentioned within the Therapeutic Guidelines: Allergic rhinitis for use under specialist advice only and are not for use in the Pilot; these are not indicated for the initial management of allergic conjunctivitis. Vasoconstrictor eye drops (e.g., naphazoline and tetryzoline) are not indicated for allergic conjunctivitis.

Nonallergic rhinitis

Pharmacist management of nonallergic rhinitis involves:

- **general measures:**
  - Education regarding avoidance and minimisation of exposure to known/clinically obvious irritants where possible.
- **pharmacotherapy**:
  - Pharmacotherapy as per the Therapeutic Guidelines: Non-allergic rhinitis [10].

Confirm management is appropriate

Pharmacists must consult the Therapeutic Guidelines, Australian Medicines Handbook and other relevant references to confirm the management is appropriate, including for:

- contraindications and precautions
- drug interactions
- pregnancy and lactation.

Communicate agreed management plan

Comprehensive advice and counselling (including supporting written information when required) as per the Therapeutic Guidelines, Australian Medicines Handbook, and other relevant references, should be provided to the patient regarding:

- individual product and medicine use e.g., dosing and correct intranasal spray technique
- how to manage adverse effects
- when to seek further care and/or treatment
- when to return to the pharmacist for follow up.

It is the pharmacist's responsibility to ensure the suitability and accuracy of any resources provided to patients (and parents/caregivers if applicable), and to ensure these comply with all copyright conditions.

The agreed management plan should be shared with members of the patient's multidisciplinary healthcare team, with the patient's consent.

Patient resources

- Instructions for using a nasal spray (printable box) - Therapeutic Guidelines: Allergic Rhinitis.
- How-to videos (using your nasal spray and irrigation) – National Asthma Council Australia.

Clinical review

Clinical review with the pharmacist should occur in line with recommendations in the Therapeutic Guidelines and other relevant guidelines.

If the patient's symptoms are mild and adequately managed with an oral or intranasal antihistamine after trialling a new treatment for 4 weeks, clinical review will generally not be required, and the patient may be advised to remain on the minimum effective dose.

Clinical review is recommended **4 weeks** after initiation of intranasal corticosteroids to assess for:

- response to treatment and if changes to the treatment plan are required (continue, modify, stop and/or refer)
- intranasal spray administration technique
- adverse effects.

Pharmacists should generally only prescribe a sufficient quantity of medicine (including repeats) for the period until the patient's next review.

Pharmacist resources

- Therapeutic Guidelines:
  - Allergic rhinitis
  - Nonallergic rhinitis
  - Asthma
- Australian Medicines Handbook:
  - Drugs for rhinitis and rhinosinusitis
  - Drugs for allergic and inflammatory eye conditions
  - Antihistamines
  - Montelukast
  - Ipratropium
- Australian Society of Clinical Immunology and Allergy - Allergic Rhinitis Clinical Update 2022
- Australian Family Physician (RACGP) - Allergic rhinitis: Practical management strategies
- Royal Children's Hospital Melbourne - Allergic rhinitis hay fever.

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References

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