NHS
North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

<table>
<tr><td>Condition or Treatment:</td><td>Rhinitis (Adult)</td></tr>
<tr><td>Background:</td><td>
Definition
Inflammation of the lining of the nose causing: blockage, rhinorrhoea (anterior or posterior), sneezing or itch.
Classification
• Infective
• Irritant
  Temperature, Chemicals
• Allergic
  Seasonal, Perennial, Occupational
• Non-allergic
  Drug induced (B-blockers, Topical decongestants, NSAIDs, ACEI)
  Hormones (Pregnancy, OCP, Hypothyroidism)
  Eosinophilic
  Systemic disorders (Cystic fibrosis, Granulomatous disease)
  Structural

Primary care management
Not greatly affected by diagnostic classification
Regular prophylactic medication (even when asymptomatic) is more effective
Starting treatment two weeks before known allergen improves efficacy
For Detailed Management Refer to CKS guidelines:
https://cks.nice.org.uk/topics/allergic-rhinitis/management/
General Principles Include:
1. Trigger avoidance
2. Smoking cessation
3. Nasal douching with high volume saline rinses see Appendix 1 for additional advice.
4. Pharmacotherapy – See (see Appendix 1 for additional advice)
  o Mild Rhinitis
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	Intranasal or Oral Antihistamines ○ Moderate Rhinitis Intranasal Steroids ○ Severe Rhinitis Intranasal or Oral Antihistamines and Intranasal Steroids ○ Watery Rhinorrhoea (eg Senile Rhinitis) Intranasal Steroids or Ipratropium Bromide ○ Asthmatic patients Consider adding Oral Leukotriene Receptor Antagonist ○ In the case of treatment failure with nasal steroid sprays consider using nasal steroid drops instead. ○ In the case of very severe symptoms or symptoms not responding to maximal treatment refer to CKS and consider oral steroids and short term nasal decongestents. (Correct use of Nasal Drops and Sprays – see Appendix 2)
Referral Guidance:	**2WW** • Unexplained nasal obstruction **Routine** • Recurrent unexplained epistaxis • Nasal perforation, ulceration or collapse • Inadequate control of symptoms despite three months of compliant treatment. For management of Sinusitis please see CKS and the EBI2 statement https://cks.nice.org.uk/topics/sinusitis/management/chronic-sinusitis/ https://www.aomrc.org.uk/search/?archive_search=evidence+based+interventions
Effective From:	1 July 2021
Summary of evidence/ rationale:	"BSACI guideline for the diagnosis and management of allergic and non-allergic rhinitis (Revised Edition 2017; First edition 2007)" https://www.bsaci.org/wp-content/uploads/2020/01/Scadding_et_al-2017-Clinical_amp_Experimental_Allergy.pdf https://cks.nice.org.uk/topics/allergic-rhinitis/ www.evidence.nhs.uk/formulary/bnf/current

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	www.nhs.uk/Conditions/Rhinitis---non-allergic/Pages/Treatment.aspx
Date:	February 2021
Review Date:	July 2023
Contact:	Dr C Ives, Governing Body GP

Appendix 1.

Regimens

Saline douching

- 1 pint of boiled, cooled water
- 1 tablespoon of rock salt
- 1 teaspoon of bicarbonate of soda

Sniff the solution up into each nostril in turn from the palm of the hand although a 20ml syringe provides a higher volume. Best treatment is obtained with a sinus rinse bottle such as “NeilMed” or “Netipot”.

Antihistamines – See CKS

Steroids – See CKS

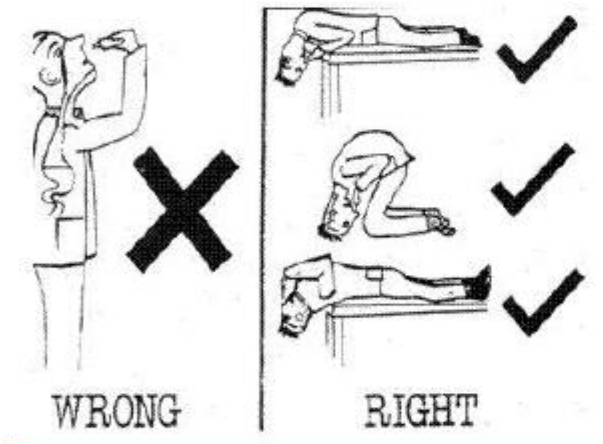
Intranasal Decongestants

Maximum 7/7 due to risk of rebound congestion (rhinitis medicamentosa), ephedrine nasal drops have the least risk.

Appendix 2.

Correct way to use nasal drops and sprays

Nasal Drops should be inserted in the head down position and patient should remain in that position for 2 minutes



Nasal sprays should be directed away from the nasal septum and should be followed by a gentle sniff in with the other nostril held closed