

Allergic Rhinitis in Adults by Dr Rashmi Jain

Allergic rhinoconjunctivitis is a common allergic condition affecting a large segment of the adult population. Its impact on quality of life is often underestimated by both physicians and general public. Symptoms can be there all the year round (perennial or persistent) or can be there during certain times of the year (seasonal or intermittent). Patients could be allergic to tree pollen which would tend to cause symptoms from February/March going on till May. Thereafter the grass pollen kicks in with symptoms from June all the way up to September. Weeds can cause symptoms towards the end of summer season. Moulds tend to cause symptoms in October-November. House dust mite allergy and allergy to pets can cause symptoms all the year round. Thus a patient can be allergic to house dust mite or to their pets and have symptoms all the year round or can be allergic to multiple allergens which can cause symptoms throughout the year. A good history helps in guiding towards the likely underlying causative allergen. Symptoms can vary in severity from mild to severe. Nose symptoms can include itchy, runny or blocked nose, with bouts of sneezing; eye symptoms could include watery, itchy, red, sore or swollen eyes. In some patients allergic rhinitis can trigger wheezing and often asthma and allergic rhinitis can co-exist. The symptoms can affect a persons' ability to go to school/work, sleep, and leisure activities.

Most patients with mild symptoms tend to self-medicate with over the counter anti-histamines. When they present to their GP practice it is crucial to take a good history of their symptoms, its severity and its impact on their work and leisure activities. A simple blood test looking for specific antibodies against the common aeroallergens (tree pollen, grass pollen, house dust mite, moulds, cats/dogs) can pick up most of the allergens causing symptoms. These tests can be done through the GP surgery.

Majority of the patients are managed in the GP setting. They should be given advice about simple allergen avoidance measures, for example sleeping with windows closed and driving with windows closed during tree or grass pollen season and using hypoallergenic mattress covers, duvets and pillows for house dust mite allergy. To avoid keeping pets to which they are allergic to, and if that is unavoidable to keep minimal contact with pets, washing hands after touching the pets, and not allowing pets to enter bedrooms.

As far as medical management is concerned, if patients' suffer from mild symptoms this can be treated with a long acting, non-sedating antihistamine like Cetirizine or Loratadine on an as and when needed basis or if more frequent symptoms a daily antihistamine. An extra tablet can be taken for breakthrough symptoms. It is quite safe to gradually increase the dose of long acting, non-sedating antihistamine to even up to four tablets a day if need be (it is prudent to choose one which does not make them drowsy). Patients' with moderate to severe symptoms should be started on steroid nasal spray. This should be started at least 2 weeks before the onset of symptoms; this prevents the development of chronicity of symptoms. It is critical that patients be taught the correct technique for using the nasal spray. Incorrect technique is one of the main reasons why steroid nasal sprays do not work. The patient should be advised to use the steroid nasal spray regularly for its true benefit. Patients may benefit from using antihistamine eye drops or sodium cromoglicate eye drops.

If patient fails maximal, optimal medical therapy (regular steroid nasal spray used with the correct technique and started before symptom onset and high dose antihistamines) then they should be referred to nearest Immunologist/Allergist for further evaluation. Skin prick tests and /or blood tests

to various aeroallergens can be done to ascertain the culprit allergen. Many Immunology/Allergy centres across UK can offer pollen or house dust mite immunotherapy (also called desensitisation) to induce tolerance to the culprit allergens. This usually involves a three year course, wherein patients are given either subcutaneous injections of the allergen or sublingual drops or sprays of the allergen. Desensitisation is offered in tertiary centres, with careful selection of patients to ensure there are no contraindications to desensitisation. A number of regimes and products are available, some licensed and some unlicensed. The treating Immunologist/Allergist will be able to give advice on which one would be best for the patient in conjunction with patient's choice.