NHS
Harrogate and Rural District
Clinical Commissioning Group

General Commissioning Statement

Condition or Treatment	**Rhinitis (Adult)**
Background	Phase I of the CCG's RSS project indicated that patients with rhinitis were often referred to secondary care without management options in primary care being exhausted.
Referral guidance	**Referral guidance only**
Commissioning statement	**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 Serum IgE tests for allergies if not clear from history 1. **Allergen avoidance** 2. **Smoking cessation** 3. **Nasal douching with high volume saline rinses** 4. **Pharmacotherapy:** ▪ ***Mild Rhinitis*** ***Intranasal or Oral Antihistamines***

Notes

1.This Statement will be reviewed in the light of new evidence, or guidance from NICE

	▪ ***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*** ▪ ***Nasal Blockage*** ***Oral Steroids (if inflammatory cause or severe nasal polyps) or Intranasal Decongestant, followed by Intranasal Steroids*** **(Correct use of Nasal Drops and Sprays)** **Referral to secondary care** **2WW** ○ Unilateral nasal obstruction with purulent discharge, epistaxis, cranial nerve palsies or epiphoria. **Routine** ○ Unilateral symptoms ○ Recurrent unexplained epistaxis ○ Nasal perforation, ulceration or collapse ○ Inadequate control of symptoms despite **three months of compliant treatment**
Effective from	2/11/15
Summary of evidence / rationale	**References** BSACI guidelines for the management of allergic and non-allergic rhinitis *Clinical and Experimental Allergy, 38(1), 19-42* www.cks.nice.org.uk/allergic-rhinitis www.evidence.nhs.uk/formulary/bnf/current www.nhs.uk/Conditions/Rhinitis---non-allergic/Pages/Treatment.aspx
Date	October 2015
Review Date	October 2016
Contact for this policy	Dr Bruce Willoughby GP/Governing Member Brucewilloughby@nhs.net

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

- Intranasal
  - Azelastine Nasal Spray
- Oral
  - Cetirizine or Loratadine (1st line)
  - Fexofenadine (2nd line)

Steroids

- Intranasal
  - Beclomethasone Nasal Spray but Mometasone or Fluticasone for lowest systemic absorption and compliance
  - Betamethasone Nasal Drops for up to 6 weeks in severe cases
- Oral
  - Prednisolone 30mg daily for 7 days

Ipratropium

- Ipratropium Nasal Spray (Rinatec)

Leukotriene Receptor Antagonists

- Montelucast (1st line)

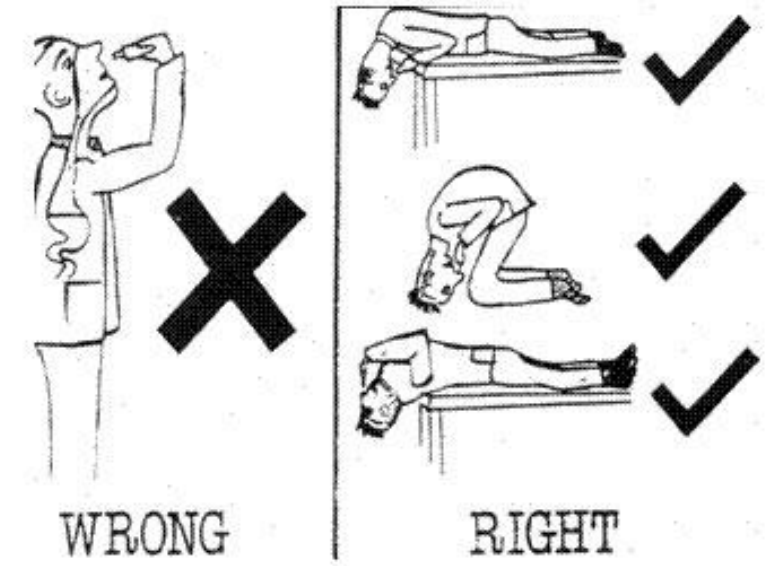
Intranasal Decongestants

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