Vale of York Clinical Commissioning Group

Referral Support Service

ENT

ENT15
Rhinitis

Definition

Inflammation of the lining of the nose, which can be allergic, non-allergic (includes variety of environmental, hormonal, drug-induced and idiopathic agents; vaso-motor rhinitis) or infective. Distinguish acute / chronic / perennial rhinitis.

Exclude Red Flag Symptoms

- Recurrent unexplained blood stained discharge, especially if unilateral
  History of preceeding significant head or facial injury (previous CSF leak)
  Severe associated headaches, any systemic upset or weight loss;
- Lymphadenopathy; swallowing problems, persistent cough.

General Points

- Rhinitis is a common problem and can often be managed effectively in primary care with the aim to control symptoms (but not to cure the condition). A lot of patients notice seasonal variation of rhinitis symptoms and may respond to intermittent treatment, to start a few weeks before the expected onset of symptoms.
- The main symptom of rhinitis, nasal blockage +/- discharge, can present with additional symptoms, such as post-nasal drip and reduced sense of smell or taste.

Management

- Discuss possible triggers (inhaled, ingested or applied, e.g. foods or spices, perfumes and make-up etc) and situations when seemingly better (e.g. on holiday).

- Establish occupation and exposure to possible mechanical (dust) or chemical irritants. Examine external nose for apparent deformity. Examine inside of nose to determine level of inflammation and exclude possible foreign body. Test degree of nasal obstruction. Taking swabs of any discharge is usually of no value. Ask about altered or reduced sense of smell or taste.

- Nasal sprays: the intranasal corticosteroids that are available in the UK are equally effective and therefore choice should be based on cost-effectiveness (first line: **beclometasone 50mcg spray**, second line: **budesonide 64mcg spray**, third line: **fluticasone furoate 27.5mcg spray**). Ensure correct application (ask a pharmacist; get a leaflet)

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Clinical Research & Effectiveness approved: Sep 2016
Date published: Sep 2016
Next Review: Sep 2024

- Advise patients who are paying for prescriptions that several steroid nasal sprays are available over the counter e.g. **beclometasone as Beconase®** and **fluticasone as Flixonase®**

- Advise patient that topical steroids can take several weeks to take effect.

- Antihistamines – **loratadine and cetirizine** are first-line choices. See medal ranking for hayfever and allergic rhinitis for full information of prescribing (same choices)

- Consider **sodium cromoglycate 4% aqueous nasal spray**

- Short term decongestants may be of some benefit, but long-term use can lead to re-bound rhinitis

- Nasal douching can be very helpful for symptom relief. Advise that the solution can be easily and cheaply made up by patients by mixing some **sodium bicarbonate** and salt into moderately warm water (more specific measurements can be found online). Ready-made sachets are available e.g. Neilmed (how to nasal douche). Nasal douching will only work as long as it is done.

- Advise that commercial "allergy testing kits" can be expensive and unreliable.

Outcome

In many cases the patient can expect improved symptom control, but not a cure.

Referral Information

Indications for referral

- Persistent disabling functional symptoms for more than 8 weeks on combination treatment
- Complications such as septum perforation, ulceration or collapse, significant crusting, or cellulitis
- Need for formal skin-prick allergy testing (e.g. for occupational reasons)

Information to include in referral letter

- Time line
- Known triggers or situations of relief (e.g. on holiday).
- Smoking and occupational history.
- Allergy history
- Attempted treatments so far (medical/non-medical, prescribed and over the counter).
- Relevant past medical history (asthma)

Investigations prior to referral

- Consider screening blood test for “common aero-allergens”, although this is not necessarily as specific as skin-prick testing

Patient information leaflets/ PDAs

http://www.patient.co.uk/health/persistent-rhinitis

References

Quillen David, Feller David B. Diagnosing Rhinitis: Allergic vs. Nonallergic. AAFP 2006; 73(9)
http://bestpractice.bmj.com/best-practice/monograph/231/diagnosis/step-by-step.html