



## **DR IAN HAY LTD CONSULTING PAEDIATRICIANS**

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### **PATIENT INFORMATION SHEET: ALLERGIC RHINITIS**

Springtime heralds misery for many children suffering from seasonal allergies so it is opportune to consider some important aspects of hayfever.

The British Society for Allergy and Clinical Immunology has issued guidelines (Google: BSACI Guidelines. BSACI Guideline 7 Management of allergic and non-allergic rhinitis) that contain a summary of the best scientific evidence for diagnosis and management.

The Executive summary and recommendations state that Allergic rhinitis:

- \* Is common and affects 20% of the UK population
- \* Affects quality of life, school attendance and performance
- \* Is diagnosed by history and examination and backed by specific allergy tests
- \* Is a risk factor for development of asthma
- \* Topical nasal corticosteroids are the treatments of choice for moderate to severe disease
- \* Treatment failure may be related to poor technique in the use of sprays and drops.
- \* Education in medicine administration technique is imperative
- \* Immunotherapy is highly effective in selected cases
- \* Treatment of rhinitis is associated with benefits for asthma

Nasal itching, sneezing and nasal blockage and congestion are the classical signs. These early and immediate reactions are due to chemicals released following exposure to the allergen. Late phase reactions involve inflammation and are characterised by obstruction, loss of sense of smell, and post nasal discharge. Nose rubbing, the "allergic salute" and a horizontal crease across the tip of the nose are typical clinical signs.

A clinical classification of seasonal and perennial rhinitis is useful. House dust mite allergy is the most important cause of perennial rhinitis whereas pollens from trees, grass, shrubs and weeds are the most important causes of seasonal rhinitis. Many other allergens are potential triggers and a careful history may help to identify them.

Skin prick test should be carried out routinely in all cases to determine whether the rhinitis is allergic or non-allergic. Specific immunoglobulin E (RAST) test are useful when skin prick tests, together with the clinical history, give equivocal results.

Treatment is based on understanding the nature of the problem, allergen avoidance and carefully selected medication.

H1-antihistamines, topical intranasal corticosteroids, anti-leukotrienes, topical anticholinergics, chromones and allergen immunotherapy (sublingual or injected) all have a place in carefully tailored treatment. Decongestants have a very limited role in treatment and oral steroids are occasionally needed for severe episodes.

Antihistamines and nasal steroids are the first line treatments in children.

In our practice we normally work in conjunction with Paediatric Allergy specialists who help us diagnose and plan treatment for this complex condition. Successful treatment has a huge benefit in terms of quality of life for affected children.