Government of **Western Australia**
Department of **Health**

Enhanced Access Community Pharmacy Pilot

Allergic and non-allergic rhinitis

Clinical practice guideline

Ineligibility for treatment as part of a prescribing service does not preclude a patient from accessing services provided as part of usual pharmacy care.

The information and content in this clinical practice guideline do not constitute medical advice, diagnosis, or treatment recommendations for individual patients. Pharmacists must exercise professional discretion and judgement consistent with their qualifications and legislative authority. This guideline does not override the responsibility of the pharmacist to undertake clinical assessments and to make decisions appropriate to the circumstances of the individual and the relevant standards of care, in consultation with the patient and/or their parent/caregiver. This clinical practice guideline may only be used by pharmacists who have been approved by the Department of Health to participate in the Enhanced Access Community Pharmacy Pilot (EACPP) and are authorised to prescribe under the *Medicines and Poisons Regulations 2016* (WA). This document alone does not provide an authorisation for a pharmacist to prescribe.

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- Unclear diagnosis
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- Signs or symptoms of undiagnosed or uncontrolled asthma
- Asthma in patients under the age of 16 years (does not preclude a patient from accessing usual pharmacy care)
- Inadequate response to optimal treatment.

Treat and concurrently refer

- Using a medicine that can cause or exacerbate rhinitis
- Quality of life is significantly affected.

Key points

- Rhinitis has a broad aetiology and can be classified as allergic, non-allergic (vasomotor), infectious, drug-induced and occupational. Allergic rhinitis (which may co-occur with non-allergic rhinitis) is the most common type[1]. Accurate differentiation of the type of rhinitis is important to inform effective treatment[2–4].
- Rhinitis can have significant impact on quality of life including sleep, cognitive and psychomotor function, social activities, and learning impairment in children[4, 5].
- Emerging evidence suggests that allergic rhinitis may be part of a systemic airway disease, as opposed to a localised disorder of the nose and nasal passages[6].
- Rhinitis and asthma commonly co-exist (sometimes referred to as United Airway Disease)[7]. Effective management of allergic rhinitis is important for the management of asthma; all asthma symptoms should be investigated and/or the patient provided with a referral to an appropriate healthcare provider[1, 6].
- Allergic rhinitis can be seasonal (e.g. pollens) or perennial (e.g. animal dander). This should be taken into consideration when deciding treatment duration and follow-up care[1].

Refer when

Refer the patient to an appropriate healthcare provider (including emergency services, if required) in the following situations:

- unclear diagnosis
- systemic symptoms, including fever, or generally unwell
- signs or symptoms of infection or infectious rhinosinusitis (e.g. facial pain, fever, purulent nasal discharge)
- nasal polyps or other structural abnormalities
- signs or symptoms of undiagnosed or uncontrolled asthma
- asthma in patients under the age of 16 years (does not preclude a patient from accessing usual pharmacy care)
- inadequate response to optimal treatment.

Treat (if clinically appropriate) and concurrently refer

Provide initial treatment and concurrently refer to an appropriate healthcare provider in the following situations:

- using a medicine that can cause or exacerbate rhinitis
- quality of life is significantly affected.

Patient history and assessment

Patient history

Obtain sufficient information from the patient to assess the safety and appropriateness of any recommendations and medicines.

The patient history should consider:

- age
- pregnancy and lactation status (if applicable)
- onset, nature, duration, frequency, severity and pattern of respiratory symptoms
- other signs and symptoms suggestive of infection including fever, purulent nasal discharge, or facial pain
- respiratory virus testing (PCR or RAT) and results
- presence of asthma symptoms
- co-existing and underlying medical conditions including asthma, nasal polyps, or other allergic diseases (e.g. atopic dermatitis)
- family history of nasal polyps or allergic disease (including rhinitis)
- triggering, aggravating and relieving factors (e.g. occupational exposure to cleaning chemicals, foods, pollen, cigarette smoke)
- emotional and social impacts of the condition
- current and recently ceased treatments (including prescribed medicines, vitamins, herbs, other supplements, and over-the-counter medicines)
- pharmacological and non-pharmacological strategies tried to treat current symptoms and response, including use of nasal decongestants
- drug allergies/adverse drug reactions
- smoking status.

The symptoms of allergic and non-allergic rhinitis are included in Table 1.

Table 1: Symptoms and clinical signs of rhinitis[1,2,5,8,9]

Allergic rhinitis	Non-allergic rhinitis
Symptoms after exposure to animals, pollen, dust, or other environmental factors/ allergens: • sneezing • nasal congestion • clear rhinorrhoea • upper airway cough syndrome (post-nasal drip) • mucosal itching of the nose, eyes, ears, and palate. Non-specific symptoms: • fuzzy head/brain fog • tiredness and daytime sleepiness • constant colds. Allergic conjunctivitis frequently co-occurs (eye redness, watering, and itching). In children, additional symptoms may include sniffing, blinking and eye rubbing, speech problems, snoring, mouth breathing, and dark undereye circles. Reported symptom improvement with second generation antihistamines is strongly suggestive of allergic rhinitis, as is a previous response to intranasal corticosteroids[6].	Symptoms without an identifiable infectious or allergic cause: • nasal blockage and/or congestion • clear rhinorrhoea • post-nasal drip. May or may not be present: • sneezing • itchy nose, ears, or throat. Symptoms may present sporadically at any time of the year, although they may be exacerbated by environmental factors such as barometric pressure or temperature changes, bright lights, or physical irritants.

Reminder

Pharmacists can access a range of clinical information in a patient's My Health Record, including details about current and past medication history, allergies, and current medical conditions.

Examination

- Physical examination of nose, throat, eyes, and ears is generally required[5].
- Where appropriate, palpate the neck for lymphadenopathy (more relevant when throat symptoms present).
- Where appropriate, conduct an assessment of vital signs.
- Outward signs of rhinitis upon examination may include:
  - enlarged/swelled, pale, boggy nasal mucosa with thin secretions
  - nasal polyps
  - dark undereye area due to venous congestion (particularly in children)
  - cobblestone throat due to irritation of post-nasal drip
  - mouth breathing[6].

Patients with symptoms of asthma or lower respiratory disease should have a chest examination in accordance with the clinical protocol for the Enhanced Access Community Pharmacy Pilot Improved Asthma Symptom Control Program.

Develop management plan

Pharmacists must ensure that they are prescribing medicines according to the specified sections of the current online version of the Therapeutic Guidelines.

Allergic rhinitis

Pharmacist management of allergic rhinitis involves:

- **developing a treatment plan:**
  - based on the Australasian Society of Clinical Immunology and Allergy: Allergic Rhinitis Treatment Plan[10]
- **non-pharmacological measures:**
  - education regarding allergen avoidance and minimising exposure to known/clinically obvious allergens and irritants if possible, as per the Australian Society of Clinical Immunology and Allergy: Allergic Rhinitis Clinical Update 2024[4]
  - nasal irrigation with saline to soothe nasal passages, and clear mucous and irritants[11]
  - advice to patients that oral and intranasal decongestants have no role in the management of allergic rhinitis. Use of intranasal decongestants for more than 3 to 5 days causes rebound congestion (rhinitis medicamentosa). Prolonged use of oral decongestants can increase blood pressure and the risk of arrythmias in people with cardiovascular disease[1]
- **pharmacotherapy** [NB1, NB2]:
  - a medicine mentioned in the Therapeutic Guidelines: Respiratory (Rhinitis and rhinosinusitis – Allergic rhinitis) for use under specialist advice only and are not authorised for use by pharmacists; these are not indicated for the initial management of allergic conjunctivitis. Vasoconstrictor eye drops (e.g. naphazoline and tetryzoline) are also not indicated for allergic conjunctivitis.

NB1: Anti-inflammatory eye drops (e.g. ketorolac and corticosteroids) are mentioned within the Therapeutic Guidelines: Respiratory (Rhinitis and rhinosinusitis – Allergic rhinitis) for use under specialist advice only and are not authorised for use by pharmacists; these are not indicated for the initial management of allergic conjunctivitis. Vasoconstrictor eye drops (e.g. naphazoline and tetryzoline) are also not indicated for allergic conjunctivitis.

NB2: The use of montelukast in the treatment of allergic rhinitis has limited evidence and potential for serious neuropsychiatric side effects and is not authorised for use by pharmacists. For further information, refer to the Australian Therapeutic Goods Administration (TGA) Safety Alert.

Non-allergic rhinitis

Pharmacist management of non-allergic rhinitis involves:

- **non-pharmacological measures:**
  - education regarding avoidance and minimisation of exposure to known/clinically obvious irritants where possible
  - nasal irrigation with saline to soothe dry nasal passages, and clear out mucous[12]
- **pharmacotherapy:**
  - a medicine mentioned in Therapeutic Guidelines: Respiratory (Rhinitis and rhinosinusitis – Nonallergic rhinitis)[9]. Intranasal corticosteroids are the mainstay of treatment for non-allergic rhinitis[9].

Confirm management is appropriate

Pharmacists must consult the *Therapeutic Guidelines, Australian Medicines Handbook* and other resources to confirm that management is appropriate, including for:

- contraindications and precautions
- drug interactions
- pregnancy and lactation.

Communicate agreed management plan

Comprehensive advice and counselling (including supporting written information when required) should be provided to the patient regarding:

- individual product and medicine use e.g. dosing and correct intranasal spray technique
- non-pharmacological measures
- how to manage adverse effects
- when to seek further care and/or treatment
- when to return for follow-up.

It is the pharmacist's responsibility to ensure the suitability and accuracy of any resources provided to patients (and/or parents/caregivers), and to ensure these comply with all copyright conditions.

The agreed management plan should be shared with members of the patient's multidisciplinary healthcare team, with the patient's consent.

Patient resources

- Therapeutic Guidelines: Allergic Rhinitis (Instructions for using a nasal spray)
- National Asthma Council Australia: How-to videos (Using your nasal spray and irrigation)
- Nasal irrigation – is it safe?

General advice

At the time of initial consultation, patients (and/or parents/caregivers) should be advised to see an appropriate healthcare provider if:

- the condition does not improve within 4 weeks of starting treatment
- the patient's condition worsens, including developing systemic signs and symptoms
- the patient develops new signs or symptoms (e.g. infection)
- the patient develops new or worsening asthma symptoms
- quality of life is significantly affected
- adverse effects of treatment cannot be managed in the pharmacy setting.

Clinical review

Clinical review with the pharmacist (or the patient's chosen healthcare provider) should occur in line with recommendations in the *Therapeutic Guidelines*.

- Patients should return for a follow-up consultation 4 weeks after initiation of intranasal corticosteroids to assess for:
  - response to treatment and if changes to the treatment plan are required (continue, modify, stop and/or refer)
  - intranasal spray administration technique.
- If the patient's symptoms are mild and adequately managed with an oral or intranasal antihistamine after trialling a new treatment for 4 weeks, clinical review will generally not be required, and the patient may be advised to remain on the minimum effective dose.

For patients continuing therapy, follow-up should be individualised to the patient's clinical presentation, response to treatment, and therapeutic goals.

Pharmacists should prescribe a quantity of medicine (including repeats), that aligns with the expected duration of therapy, ensuring sufficient supply until the patient's next review. The total quantity prescribed should be dependent on clinical need (e.g. seasonal vs perennial) and should not exceed 12 months' supply (including repeats).

Patients who require routine treatment over periods of > 12 months to feel well, may benefit from referral to a medical practitioner for consideration of immunotherapy.

Pharmacist resources

- Therapeutic Guidelines:
  - Allergic rhinitis
  - Non-allergic rhinitis
  - Asthma
- Australian Medicines Handbook:
  - Drugs for rhinitis and rhinosinusitis
  - Drugs for allergic and inflammatory eye conditions
  - Antihistamines
- Clinician Assist WA:
  - Allergic Rhinitis
  - Rhinosinusitis
- Australian Pharmaceutical Formulary and Handbook (APF): Treatment guideline for pharmacists (Allergic rhinitis (hay fever))
- Australian Society of Clinical Immunology and Allergy: Allergic Rhinitis Clinical Update
- Australian Family Physician (RACGP): Allergic rhinitis Practical management strategies
- The Royal Children's Hospital Melbourne: Allergic rhinitis hay fever.

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Feedback

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