key points

SELECTED BY

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Allergic rhinitis is defined clinically by the presence of symptoms caused by an IgE-mediated inflammation of the nasal mucosa on exposure to airborne allergens. Symptoms include sneezing, rhinorrhoea, nasal obstruction and pruritus. It typically develops in older children or early adulthood. Allergic rhinitis can affect a child's physical health, reduce their quality of life, sleep and concentration, and impact on school performance.

Common comorbidities include asthma; conjunctivitis; rhinosinusitis; middle ear effusion; eustachian dysfunction and adenoidal hypertrophy. It is important to ask about asthma symptoms in patients with allergic rhinitis and vice versa. Children with allergic rhinitis are at increased risk of developing asthma. Around 85% of those with asthma have allergic rhinitis, which can complicate diagnosis and management and also increase the risk of hospitalisation for asthma exacerbations. However, appropriate management of allergic rhinitis can improve asthma control.

There are two distinct groups of allergic rhinitis: perennial and seasonal. Perennial allergens include house dust mite, pet dander and mould spores, and seasonal allergens include grass and tree pollen. Some children may be affected by both groups of allergens and present with acute on chronic exacerbations during spring and summer.

The diagnosis of allergic rhinitis can usually be made on the basis of the patient's history and examination alone. A holistic approach is necessary to manage allergic rhinitis effectively. This involves education, preventative measures, accurate diagnosis, pharmacological treatment and, when appropriate, desensitisation which may require referral to an allergy centre.

Oral antihistamines are considered as first-line treatment. Long-acting, non-sedating antihistamines such as cetirizine and loratadine are preferable. Intranasal corticosteroids are effective and safe. Corticosteroids may take a couple of days to start having an effect, around two weeks to achieve optimum efficacy, and require appropriate administration and continuous use. To obtain maximum benefit in children with established seasonal symptoms it is important to commence intranasal steroids 2-4 weeks before the pollen season. No growth retardation has been observed in children treated with fluticasone or mometasone. Nasal saline douching can reduce symptoms if used daily and can be used alongside other medications. GPs should consider referral to an allergy clinic if symptoms continue to interfere with sleep or lifestyle activities, where a wider diagnosis or referral for immunotherapy can be duly considered.