

key points

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Allergic rhinitis (AR) affects around one in four individuals

over their lifetime. A survey has shown that 10.1% of children aged six to seven and 15.3% of those aged 13-14 years report symptoms of allergic rhino-conjunctivitis in the past 12 months. Children with AR perform significantly worse in summer exams, relative to their mock results, when compared with their peers. Those individuals showing most symptoms are likely to be affected by other allergic diseases. Nasal blockage is the most common complaint associated with chronic AR, with acute exacerbations causing sneezing, clear nasal discharge and itchy eyes following exposure to the relevant airborne triggers.

Allergen avoidance measures should be instituted

according to seasonal or perennial symptomatology, guided by allergy testing, alongside nonsedating antihistamines such as cetirizine or loratadine. Continued symptoms should be treated with regular intranasal steroid spray. Anti-leukotrienes should be considered early in children presenting with multi-trigger wheeze.

Temporal patterns of exacerbation give clues as to the

most important aeroallergens implicated. In the UK, tree pollen allergy predominates throughout the spring, whereas those affected by grass pollen allergy may find their symptoms increasing over the summer months. In contrast, perennial AR symptoms are the result of exposure to house dust mites, animals and moulds. Children who are allergic to these often find the winter more troublesome as they spend more time indoors and the central heating regularly disperses these household allergens.

With dust mite allergy, a focused trial of dust allergen

reduction measures may demonstrate significant clinical improvement. Children with multiple system involvement often require a nasal steroid spray in addition to antihistamines. Long-term follow-up studies with recent nasal sprays such as once daily fluticasone furoate, mometasone, beclometasone and budesonide show no impact on growth. Decongestants are known to cause vasoconstriction of the nasal blood vessels thereby decreasing nasal congestion. However, their use should be limited to three to five days at a time because of the rebound congestion effect.

Where continuing deterioration presents a challenge

and allergic symptoms remain uncontrolled, patients should be referred to a specialist allergy service to be considered for immunotherapy. Subcutaneous immunotherapy became increasingly widespread over the course of the 20th century and various studies have demonstrated its efficacy in both adults and children. Sublingual immunotherapy is a relatively new development with proven efficacy and a good safety profile.