NHS
Kent and Medway

Allergic Rhinoconjunctivitis Treatment Pathway for Children (<16 years of age)

- **The guidance is aimed at clinicians involved in the management of rhinitis for children who can be successfully managed in a primary care setting.**

- **Where indicated as Over the Counter (OTC) patients/carers should be advised to purchase as per Kent & Medway guidance on OTC prescribing.**

- **Pinpointing which allergens are causing a person's symptoms can help their quality of life. Avoidance measures, such as minimising exposure to triggers, can help alleviate symptoms, allowing individuals to lead more comfortable and productive lives. Allergen avoidance advice can be beneficial in certain patients when the culprit allergen can be clearly identified (e.g. pet or horse allergy). Other air allergens are difficult to avoid. Other interventions which may help to reduce pollen related rhinitis symptoms include wrap-around sunglasses and ointments applied to the nose.**
  Link to "Common triggers for hay fever and allergic rhinitis": Hay Fever and Allergic Rhinitis | Allergy UK | National Charity

Drug cautions:

- **Injectable steroids are not recommended for the treatment of rhinitis due to the risk of severe side effects (including avascular necrosis of the femoral head).**

- **Short courses of oral steroids (e.g. prednisolone 20mg for 5 to 10 days) can be considered for rescue therapy for severe rhinitis symptoms.**

- **Avoid chronic use of nasal decongestant medications for more than 10 days as these are associated with rhinitis medicamentosa (worsening nasal congestion).**

- **Montelukast: Reminder of the risk of neuropsychiatric reactions. The Medicines and Healthcare products Regulatory Agency (MHRA) has published a drug safety update to remind healthcare professionals to be alert to the of the risk of neuropsychiatric reactions in people prescribed montelukast. Reactions can occur in adults, children and adolescents. These reactions include sleep disorders, hallucinations, anxiety and depression, as well as changes in behaviour and mood. Healthcare professionals should advise patients and their caregivers to be alert to these risks and seek medical advice as soon as possible if neuropsychiatric reactions occur.**

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Suspected Allergic Rhinitis with no red flag signs[1, 2] (see "Notes" below)

Mild rhinitis with no impact on quality of life (e.g. sleep, school attendance, studying)

Moderate or severe rhinitis impacting on quality of life

- **Start an age-appropriate daily non-sedating antihistamine[3] (OTC)**
- **Double the antihistamine dose if symptoms are not controlled [4]**
- **Consider nasal saline douching [5] (OTC)**

Improved?

Poor response after 2 weeks of treatment?

- **Start a regular, daily steroid nasal spray with a low systemic absorption. [6,7]**
- **Ensure correct nasal spray technique and treatment compliance. [8] If use of one nasal spray device is difficult or problematic, consider starting an alternative nasal spray device.**
- **Advise nasal saline douching. [5]**
- **Continue a daily non-sedative antihistamine (with a double dose if necessary).**
- **Ensure optimal asthma control (if applicable).**
- **See the supplementary text box for the management of allergic conjunctivitis.**

Improved?

Poor response after a further 4 weeks of treatment? Add an anti-leukotriene receptor antagonist (e.g. montelukast at night [9]) to the treatment regime

Poor response after a further 4 weeks of treatment

If over 12 years of age, start an alternative, second line steroid & antihistamine combination nasal spray (e.g. fluticasone propionate/azelastine nasal spray). Continue high dose antihistamine and montelukast.

Continue treatment regime

Improved?

Poor response after a further 4 weeks of treatment

Consider referral to ENT for further investigation and diagnosis (e.g. nasal endoscopy) if under 6 years of age with significant sleep disordered breathing or with nasal polyps

Allergic Rhinitis and poor response to treatment with maximal medical allergic rhinitis therapy

Consider referral to Paediatric Allergy for further investigations and possible allergen desensitisation.

Kent and Medway Allergic Rhinoconjunctivitis Treatment Pathway for Children (<16 years of age)
Approved by: Kent and Medway Integrated Care Board (KMICB) Integrated Medicines Optimisation Committee
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Notes

1. **RED flag symptoms** would be unilateral symptoms, persistent purulent discharge or blood staining, or symptoms suggestive of acute severe rhinosinusitis. This condition that can be life threatening and is characterised by the sudden onset of two or more symptoms, one of which should be either nasal blockage/obstruction/congestion or thick nasal discharge. Additional symptoms include facial pain or pressure, reduction or loss of smell and/or headache. If high fever and displaced eyeball are present urgent referral to the acute admissions unit is warranted.

2. **Allergic rhinitis triggers** include seasonal allergens (grass, tree and weed) pollens and moulds as well as perennial allergens (house dust mites, animal dander). Allergy testing does not change the initial management and would not be required at this stage. However consider allergen avoidance measures if a culprit allergen is suspected (e.g. for example house dust mite reduction measures, pet or pollen avoidance).

3. **Start an age-appropriate, cost-effective non-sedating antihistamine:**

Antihistamine	Age	Dose and Frequency
Cetirizine*	**2 – 5 years** **6 – 11 years** **12 – 17 years**	**2.5mg twice daily** **5mg twice daily** **10mg once daily**
Loratadine*	**2 – 11 years (weight < 30 kg)** **2 – 11 years (> 31 kg)** **12 – 17 years**	**5mg once daily** **10mg once daily** **10mg once daily**
Acrivastine*	**12 years plus**	**8mg three times a day**
Desloratadine	**1 – 5 years** **6 – 11 years** **12 – 17 years**	**1.25mg once daily** **2.5mg once daily** **5mg once daily**
Fexofenadine	**6 – 11 years** **12 – 17 years**	**30mg twice daily** **120mg once daily**

***Over the Counter preparations are available (OTC) to purchase**

Avoid the use of 1st generation sedating antihistamines (e.g. chlorphenamine)

4. **Off-licence dose of antihistamines** it is well recognised that antihistamines are sometimes given at higher than licensed doses by the Paediatric Allergy clinic (e.g. cetirizine twice daily, loratadine twice daily or fexofenadine twice daily).

5. **Saline nasal rinse kits are not available on the NHS – patient will need to purchase.** Further information on nasal douching, including how to make an isotonic douching solution can be found at: **https://www.bsaci.org/wp-content/uploads/2019/12/Howtoperformnasaldouching.pdf**

6. **Intranasal steroids** have similar clinical efficacy but variable bioavailability**. First line steroid nasal sprays** with negligible systemic absorption include fluticasone furoate, fluticasone propionate or mometasone furoate. Intranasal corticosteroid systemic absorption is modest with beclometasone dipropionate and high with betamethasone (which should be used short-term only). Onset of action is 6-8 hours after the first dose and maximal effect may not be apparent until after two weeks. Starting treatment two weeks prior to known allergen season improves efficacy. When symptoms are controlled, reduce the nasal spray dose to one spray to each nostril once daily to maintain rhinitis control.
   Please ensure there are no contraindications to the use of a steroid nasal spray (for example glaucoma).

7. **For seasonal pollen related rhinitis -** start the steroid nasal spray two weeks before the rhinitis symptoms are expected to begin.

8. **Ensure the patient uses their steroid nasal spray on a daily basis and with the correct technique to maximise its effectiveness and to reduce the risk of nasal crusting, bleeding and pain which can be caused by misapplication of the steroid spray.** A BSACI Standard Operating Procedure demonstrating correct nasal spray technique can be found via the following link: https://www.bsaci.org/wp-content/uploads/2019/12/Howtouseanasalspray.pdf

9. **Montelukast:** Parents/children should be counselled regarding potential side effects – See MHRA advice above.

Treatment of Allergic Conjunctivitis

- **Where indicated as Over the Counter (OTC) patients/carers should be advised to purchase as per Kent & Medway guidance on OTC prescribing.**

- **Use eye drops daily and regularly.**

- **Refer to current Kent & Medway formularies below for advice on:**
  - **Mast cell stabilising eye drops**
  - **Mast cell stabilising eye drops with antihistamine properties**
  - **Antihistamine eye drops**

  Dartford, Gravesham & Swanley - Formulary (dgsdvhformulary.nhs.uk)
  East Kent - East Kent Prescribing Formulary (eastkentformulary.nhs.uk)
  Medway/Swale - Formulary (medwayswaleformulary.co.uk)
  West Kent - Formulary (formularywkccgmtw.co.uk)

- **If allergic eye symptoms are severe and/or do not improve with treatment, consider referring the patient to Ophthalmology for further assessment.**