

Outpatient Primary Care Management and Referral Guidelines
San Antonio Military Medical Center and Wilford Hall Ambulatory Surgical Center
Allergy and Immunology Service

Allergic Rhinitis

Definition:

The presence of nasal itching, persistent rhinorrhea, nasal obstruction, or sneezing during an identifiable season or with a particular exposure, lasting >6 weeks, or be present in a particular season at least 2 years in a row. Objective testing with serum or skin testing identifies positive allergen sensitivities.

History

- Identification of at least one of the above symptoms
- Symptoms of sufficient duration to exclude transitory process (virus, irritant) or indicating a pattern of recurrence (lack of identifiable pattern often indicates more irritant or non-allergic process)

Examination/Evaluation

- Indication of inflammation or edema of nasal mucosa
- Consider obtaining sinus CT scan to rule out chronic sinusitis
- Consider obtaining screening allergy panel

Management

- Mild or intermittent symptoms should be managed with a trial of non-sedating antihistamines (loratadine, fexofenadine, cetirizine)
- Persistent or more severe symptoms should be managed with daily use of nasal corticosteroid (fluticasone) in combination with non-sedating antihistamine
- Additional control measures:
 - o Sinus Rinse prior to nasal sprays
 - o Nasal antihistamine (azelastine)
 - o Nasal cholinergic (ipratropium) for rhinorrhea component
 - o Increased dose of non-sedating antihistamine (double dose or twice daily dosing)
 - o Leukotriene modifier (montelukast) – best used in patients to co-existing asthma
 - o Evening dose of sedating antihistamine (hydroxyzine, diphenhydramine)

Indications for referral

- Patients must have failed at least **a 4 week consistent trial of combined daily oral non-sedating antihistamine and nasal corticosteroid**
- Any prior skin or serum **testing for allergies must indicate at least 1 sensitivity** (positive result); if all results were negative, than provider should refer to the non-allergic rhinitis algorithm for treatment options
- Patients who have moved to the area already on immunotherapy

Considerations before referring patients for Immunotherapy (“Allergy shots”)

- Immunotherapy is **very time consuming** and is **not a quick fix**. It requires weekly injections for 6 months before a maintenance dose is achieved. This dose is a monthly injection and should be maintained for 3-5 years for best long term efficacy. Symptoms typically do not improve until the maintenance dose is reached.
- Immunotherapy is not an option for patients who are unable to maintain this rigorous schedule (frequent travel, upcoming deployment or move).
- This is an **elective procedure** and carries a **significant risk of anaphylaxis** following each allergy shot.
- Immunotherapy is not an option for patients whose age or mental capacity makes them unable to communicate effectively (children under 6 years old, mental disabilities) since the patient is relied upon to provide initial signs/symptoms of anaphylaxis after an allergy shot.
- Immunotherapy is not an option for patients with significant comorbidities (including pregnancy, **uncontrolled** asthma, heart disease, cancer, etc)
- Immunotherapy is not an option for patients on a **beta blocker**, which can interfere with efficacy of epinephrine, the treatment for anaphylaxis.

There are very few consults that warrant ASAP or Urgent status. If this is entered by the referring provider, it will be downgraded to Routine unless that provider calls and directly speaks with an allergist either at SAMMC or WHASC and it is confirmed as an urgent consult.