Nasal Preparations
Use first line for persistent and/or moderate-to-severe symptoms, when nasal symptoms predominates, and when treatment is required in pregnancy or breastfeeding.

- **1st line:** Beclometasone 50 mcg aqueous nasal spray 200 dose
  Adults and children over 6 years: (2 sprays) into each nostril twice daily.
  When symptoms are controlled reduce to 50micrograms (1 spray) into each nostril twice daily.

- **2nd line in adults:** Budesonide 64mcg aqueous nasal spray.
  Adult and child over 12 years: 128mcg (2 sprays) in each nostril once daily or 64mcg into each nostril twice daily. When symptoms controlled reduce to 64mcg (1 spray) once daily. Maximum duration of therapy - 3 months.

- **2nd line in Children 6-12 Years:** Fluticasone furoate (Avamys®) nasal spray 27.5mcg (1 spray) in each nostril once daily.

- **Fluticasone propionate** is not recommended as evidence showing superiority is lacking and it is more expensive than the furoate.

- Intra-nasal decongestants can be used short term (7 days) to relieve congestion and can be useful when starting treatment. Not to be used in young children.

- Ipratropium nasal spray 0.03% can be added to oral therapy for watery rhinorrhea associated with persistent allergic rhinitis. Adults and children over 12 years: 2 sprays into each nostril 2 – 3 times daily.

- Sodium cromoglicate and the topical antihistamines azelastine are less effective than nasal corticosteroids. They are an option for young children or as an add-on if symptoms persist despite other treatments.

Nasal Preparation additional information
- Intra-nasal corticosteroids begin to take affect within 7-8 hours; for maximum efficacy begin therapy 2 weeks prior to exposure
- No difference in efficacy between the intra-nasal corticosteroid products. All available OTC (price/pack less than prescription)
- Correct use of nasal sprays may minimise local adverse effects, but if these are troublesome cease therapy for a period of time.
- When prescribing intra-nasal corticosteroids, take into account the use of other systemic and topical corticosteroids (for example creams, ointments, and inhalers). The effect of these drugs could be additive and therefore requires close monitoring.
- Differences in systemic bioavailability between intra-nasal corticosteroids are unlikely to be clinically relevant.
- Monitor height of children on long-term steroids.

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**Hayfever Guidance**

### Oral Antihistamines
First line treatment for young children and for adults with intermittent and/or mild symptoms.

- **1st line:** Cetirizine 10mg tablets.
- Adults and children over 6 years: Cetirizine 10mg daily or 5mg twice daily.
- Children 2-6 years: Cetirizine 5mg daily or 2.5mg twice daily.
- Oral solution 5mg/5ml is available.
- Alternative: Loratadine 10mg tablets.
- Adults and children over 6 years: Loratadine 10mg daily.
- Children 2-5 years: Loratadine 5mg daily. Oral solution 5mg/5ml is available.

### Oral Antihistamines additional information
- A difference in efficacy between once daily antihistamines has not been established.
- Desloratadine and levocetirizine are not recommended for routine prescribing as there is little evidence confirming additional benefit and they are significantly more expensive.
- Patients should be advised that drowsiness can occur with non-sedating antihistamines. Recent evidence suggests cetirizine may cause some sedation.
- Mizolastine, acrivastine and rupatidine are NOT recommended.
- Only use sedating antihistamines if symptoms disturb sleep.

### Eye Preparations
Both intra-nasal corticosteroid and oral antihistamines are usually effective for eye symptoms, but if additional treatment is required consider:
For prophylactic use and must be used regularly, Sodium cromoglicate eye drops 2% Adults and children: 1 drop into each eye four times daily
Or, for quick acting infrequent use, Otrivine-Antistin: Adults and children over 12 years: apply 2-3 times daily. Avoid in angle-closure glaucoma.

### Options when standard therapy fails
- Oral prednisolone as a short course (e.g. 20 mg prednisolone for 5 days) only as an adjunct for severe symptoms or on special occasions such as when sitting exams.
- Depot steroids (e.g. Kenalog) are NOT recommended.
- Montelukast has similar efficacy to oral antihistamines, but is less effective than intra-nasal corticosteroids and may not provide additional benefit when combined with antihistamine. A trial may be considered when standard treatments are not sufficiently effective in patients with asthma.
- Desensitisation (Grazax®) may have a limited role. Specialist management is required and should only be considered when other treatments have failed.

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### CCG Facts and Figures
In 2012, HAST CCG and South of Tees CCG together spent:
- £35,500 on desloratadine and levocetirizine tablets. If these had prescribed as loratadine and cetirizine, savings of £25,000 could have been realised
- £109,000 on fluticasone propionate nasal spray. If these had been prescribed as fluticasone furoate, savings of £63,000 could have been realised

### References:
NICE CKS  Allergic rhinitis (accessed 2.5.13) [http://cks.nice.org.uk/allergic-rhinitis/#topicsummary](http://cks.nice.org.uk/allergic-rhinitis/#topicsummary)

Guidance Approved By Tees Medicines Management Committee September 2013 – Review March 2014