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A practical guide to improve rhinitis management in primary care

Allergic rhinitis (AR) is a common condition affecting between 15-25% of the general population; its symptoms significantly reduce quality of life and pose a high economic burden, including indirect costs related to lost school and workdays.[1,2] Studies of people consulting general practitioners for AR found that 18–48% had symptoms uncontrolled by pharmacotherapy.[3-5] Despite the bothersome nature of symptoms, AR is often trivialised by those with AR – only 45% seek medical advice or treatment, which results in under-treatment and poor symptom control.[6] AR is strongly associated with an increased risk of developing asthma – approximately 20–30% of people with AR also have asthma.[7,8] These persons tend to be sensitised to multiple allergens.[9] Anybody with confirmed AR should be screened for asthma. Those with AR are more likely to have frequent asthma exacerbations and poorer symptom control than those with only asthma.[6] People with both asthma and AR also frequently have more persistent and severe AR symptoms and therefore experience a greater loss of school and work productivity.[10-12]

Introduction

Accurate diagnosis of rhinitis is crucial as underdiagnosis and misclassification lead to ineffective treatment, unnecessary costs and impaired quality of life (see Desktop Helper No.19 pg 14-17). Rhinitis is broadly classified into allergic (AR): IgE-mediated, triggered by allergens such as pollen/dust mites; non-allergic (NAR): not triggered by allergens, e.g., vasomotor, drug-induced, or infectious; and mixed phenotypes.[13] The Allergic Rhinitis and its Impact on Asthma (ARIA) guidelines emphasise the unified airway link between AR and asthma, advocating for:

1. Phenotype-driven management (intermittent or persistent; mild or moderate-severe)
2. Combined pharmacotherapy (for moderate-severe cases)
3. Allergen immunotherapy for refractory cases.

This desktop helper translates these principles into actionable steps for primary care.

Perceptions and concerns of persons with rhinitis

1. An under-recognised condition: rhinitis – whether AR or NAR – is often viewed as an everyday part of life. People generally see nasal symptoms like sneezing, congestion, a runny nose, and itching as temporary and harmless, often linked to weather changes, dietary triggers, or dust exposure. Rhinitis is frequently accompanied by disregarded ocular symptoms such as itching, tearing (or lacrimation) and injected conjunctivae (bloodshot eyes). AR is often mistaken for a common cold that does not go away, or as a "summer" cold, especially during seasonal changes. NAR, such as irritant-induced symptoms from pollution or strong odours, is often viewed as unavoidable. Infectious rhinitis, typically viral, is commonly self-treated with over-the-counter medications without seeking care. Although increasingly relevant in urban and industrial settings, occupational rhinitis is rarely recognised or linked to workplace exposure.

2. People with rhinitis tend to seek rapid symptom relief, often resorting to OTC self-medication and stop treatment once they feel better. They don't necessarily expect a structured diagnosis or management plan and only tend to seek help when symptoms are no longer tolerable.[14] Therefore a considered diagnosis, preventive care, allergen identification, and long-term medication use are uncommon.

However, many express concerns about the side effects of corticosteroid nasal sprays, which, when used properly are negligible, whereas topical nasal decongestants may cause dependence. A Visual Analogue Scale (VAS) of 0 (no symptoms) to 10 (very severe symptoms) is the simplest validated way to assess symptoms and the impact of treatment (see Desktop Helper No.19 pg 14-17).

3. Overlooked links between rhinitis, asthma, and sinusitis: There is limited awareness of the chronic nature of certain types of rhinitis and their effects on daily life, sleep, productivity (absenteeism and presenteeism), and mental health. Additionally, the potential overlap of rhinitis or chronic rhinosinusitis with asthma or COPD is often overlooked, leading to missed opportunities for early intervention: NSAID exacerbated respiratory disease (N-ERD) is such an example.[15]

4. Reframing rhinitis as a manageable condition: addressing these perceptions requires targeted education. Healthcare providers should explain the different forms of rhinitis, their underlying causes, and the importance of appropriate care according

to the underlying type of rhinitis. Just as public awareness of oral health has improved over time, a similar shift is needed for nasal health: moving public belief from rhinitis being considered as an unavoidable "nuisance" to a "manageable condition" is essential for improving outcomes.

Rhinitis is not trivial, harmless, or unmanageable. Primary care clinicians can support people suffering from rhinitis by helping them understand that attention to triggers, symptoms, and effective treatment can significantly reduce discomfort and improve quality of life.

Patient education and self-management - see Box 1.

Management of rhinitis where self-care is insufficient (see Figure 1)

Allergic rhinitis

In the majority of the cases, people with AR symptoms self-manage and stop treatment once they feel better (particularly in mild intermittent AR), without consulting a primary care clinician.[14] However, it is important to identify those with uncontrolled rhinitis who require further care. Pharmacists could play a key role in recognising such patients and referring those with moderate/severe symptoms to primary care. Once identified, and after evaluating the person's symptoms, commence baseline treatment (see Figure 1). Reassess after 14 days and discuss with the person (or the caregiver) whether the treatment plan needs adjusting.

Medications for the treatment of rhinitis are listed in Annex 1 at: https://www.ipcrg.org/DTH20_Annex. They may be available as OTC or by

Box 1 Patient education and self-management

Consider discussing with persons struggling with rhinitis:
Rhinitis is a common condition that affects the nose (and frequently the eyes) and can make daily life uncomfortable. Learning about it and how to manage it can help you feel better and live more comfortably.

What does the nose do? Your nose is not just for smelling! It works as a gatekeeper and air conditioner for your lungs. It:

- Filters out dust and particulate matter
- Warms the air you breathe in
- Adds moisture so the air is not too dry.

When your nose is not working correctly, it can affect your breathing and overall health.

What is rhinitis? Rhinitis means inflammation (swelling) inside the nose, affecting how your nose works.

Common symptoms include:

- Sneezing
- Itchy nose
- Stuffy nose (nasal congestion)
- Runny nose or postnasal drip (a sensation of mucus at the back of the throat, causing you to clear your throat)
- Itchy eyes (present in at least 50% of the patients with AR).

Types of rhinitis

- Allergic rhinitis: triggered by pollens, dust mites, pet dander, moulds, etc.
- Non-allergic rhinitis: caused by irritants such as smoke, strong smells, cold air, or spicy food
- Infectious rhinitis: usually from viruses like the common cold
- Occupational rhinitis: caused by exposures at work, such as exposure to chemicals or dust.

How can you prevent rhinitis?

- If possible, avoid your triggers (like dust, pollen, smoke, etc.)
- Keep your nose clean: practise good nasal hygiene (see below)
- Take the correct medications for your type of rhinitis
- Learn how to manage your symptoms at home
- Ensure good indoor air quality, if possible.

Self-management tips: how to take control of your rhinitis

- Know and follow your treatment plan
- Take medications as prescribed
- Keep a diary of your moderate to severe symptoms, as this can also help you identify your triggers
- Clean your nose regularly (see below)
- Do not overuse decongestants (in nasal sprays or drops), which should not be used for more than 5 continuous days
- Go back to your doctor if things do not improve or change

Nasal hygiene is a key preventive measure. Just as brushing teeth (oral hygiene) prevents gum disease, regular nasal cleaning helps prevent rhinitis.

Daily nasal hygiene checklist

- Rinse your nose daily, gently, with normal saline; during exacerbations, you can also use a nasal douching or a squirt bottle (after being shown how).
- Clean your nose after exposure to dust or smoke.

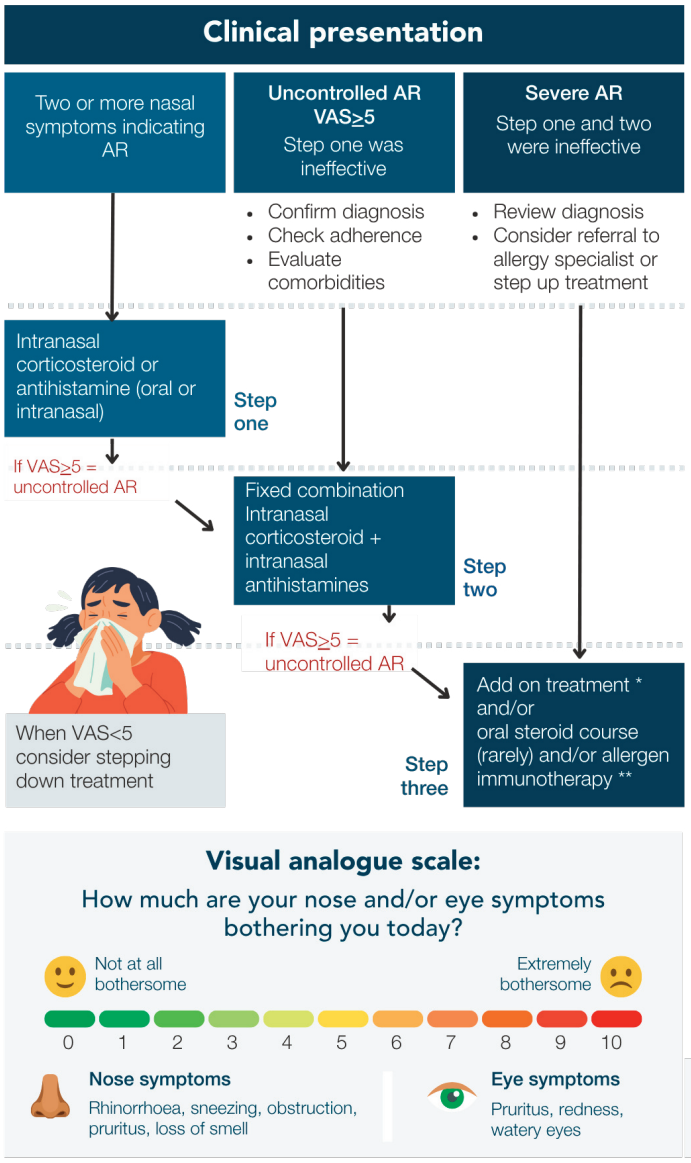
Make it a habit, just like brushing your teeth!

- Sinus Rinse Animation
  https://www.youtube.com/watch?v=IpTVVwEny30
- How to Wash your Nose
  https://www.youtube.com/watch?v=ivAQPYXaRNk

When should I see a doctor?

- Your nasal and/or eye symptoms last more than 2–4 weeks
- Medications are not helping
- You also have asthma that is getting worse
- Your sleep or daily activities are affected
- You are not sure what is causing your symptoms
- You have 2 or more of: nasal blockage and/or discharge, fever, facial pain, partial loss of smell lasting more than 10 days, or, importantly, deteriorating after 5 days.
- You are having trouble breathing (other than that caused by a blocked nose).

Figure 1. Allergic rhinitis (AR) treatment ladder when self-care is insufficient (adults)



*Possible add on treatments depending on symptom profile/diagnosis: (monotherapy often leads to greater satisfaction than combined therapy)

Runny nose: ipratropium

Rhinoconjunctivitis and asthma: leukotriene antagonist

Itchy eyes/skin: non-sedating oral antihistamines

Itchy, red, watery eyes: eye drops (antihistamines or cromones) for immediate relief; longer term use adds no benefit beyond oral AH

Nasal congestion: topical decongestants for 5 days maximum (to avoid rhinitis medicamentosa)

At step three, a short course of oral steroids may also (rarely) be considered (prednisolone 10 mg x 1 for 2-3-4 days). In such cases, follow-up is important to evaluate the need for allergen immunotherapy

For children and adolescents, dosing and medication should be adjusted according to age and weight

**If you cannot provide allergen immunotherapy, refer to a specialist

Patient education

- Involve patients in their treatment plan
- Ask which symptoms are their priority (all, nose, eyes)
- Advise them to avoid irritants and allergens, and practice regular nasal hygiene
- Costs vary globally, and should be discussed
- Consider locally produced medicine to reduce environmental impact
- Never use injectable steroids

Adapted from Sousa-Pinto B, et al. Validity, reliability, and responsiveness of daily monitoring visual analogue scales in MASK air(R). Clin Transl Allergy. 2021 Sept 19;11 (7):e 12062. doi: 10.1002/clt2. 12062.

prescription only, depending on local regulations and availability. Not all medicines are accessible in every country.

The pharmacotherapy should be adapted to the severity and frequency of symptoms:

- As-needed therapy may be sufficient for patients with mild intermittent symptoms, including those with predictable allergen exposure (e.g. pets).
- Daily therapy is most effective for intermittent bouts that typically last about 2 weeks

Intranasal corticosteroids (INCS) have been shown to be more effective than anti-histamines (oral and intranasal) for most symptoms.[16] INCS demonstrate incremental benefit over successive days. The onset of action of topical intranasal antihistamines (INAH) is more rapid than oral antihistamines (OAH). In patients with moderate/severe rhinitis, a combined formulation (e.g., azelastine-fluticasone, olapatadine-mometasone) is the preferred treatment for both speed of onset of action and greater efficacy.[16]

Oral leukotriene receptor antagonists (LTRA) are not advised as initial treatment for allergic rhinitis in adults or children, as they are less effective than INCS, INAH, and/ or OAH, and due to safety concerns, particularly neuropsychiatric side effects.[17] Their use should only be considered in patients with asthma, or if other therapies fail, or if the patient strongly prefers oral medication, especially when asthma is present.

The use of intranasal cromones is not recommended for

nasal symptoms but may be used for ocular symptoms if no other treatment is successful.

Correct administration technique is key for all topical treatments.

- **How to use a nasal spray**
  https://www.youtube.com/watch?v=S31maomo1xQ
- **Teaching patients to use nasal sprays**
  https://www.youtube.com/watch?v=_ytYj1TLojM

Local allergic rhinitis (LAR) is a nasal allergy condition where allergy symptoms are present but all specific IgE determinations or skin prick tests are negative and should be treated preferentially with nasal sprays, but oral antihistamines and allergen immunotherapy (AIT) have also proven to be effective (Annex 1 at: https://www.ipcrg.org/DTH20_Annex).[18]

Non-allergic rhinitis

One of the key parts of treatment is avoiding identified triggers, which may include tobacco smoke, certain medications, or dietary components (see Desktop Helper No.19 pg 14-17).[19] Some factors, such as a runny nose in cold or windy weather, are often unavoidable and usually cause only short-lived symptoms that do not require treatment.

Non-allergic rhinitis especially due to viral infections, can be temporarily treated (for a maximum of 5 continuous days) with decongestant nasal sprays (phenylephrine, oxymetazoline, xylometazoline, naphazoline) but are NOT recommended for regular treatment of allergic rhinitis. Longer use (>5 days) can cause rhinitis medicamentosa![20]

Not all persons with rhinitis have asthma, but approximately 80% of those with asthma have rhinitis; the more severe the rhinitis, the greater the impact on asthma control and exacerbations.[21-23]

Providing education to persons with rhinitis on how regular/daily use of medication allows maximal benefit to be achieved is important. However, similar to asthma, rhinitis is a variable disease so reducing medication when control is achieved seems a logical step and aligns with the maintenance and reliever therapy (MART) approach for asthma of varying medication according to symptoms. If patients or caregivers ask for guidance on environmentally friendly treatment options, and there is no direct evidence available, the most appropriate option is to recommend a locally produced product to minimise the environmental impact of transportation.[24]

Non-pharmacological treatment of AR, NAR, and mixed rhinitis

1. Saline irrigation: Nasal irrigation thins and removes mucus, clears proteins that induce inflammation, and flushes out irritants and bacteria from the nasal and sinus cavities. Nasal saline irrigation can be used for persons with AR, NAR, or mixed rhinitis, and is a crucial component of treatment for individuals with chronic rhinosinusitis. In patients with AR, saline irrigation reduces patient-reported disease severity compared with no irrigation.[25-27]

2. Other non-pharmacological approaches: environmental measures for managing rhinitis symptoms primarily aim to reduce exposure to allergens and irritants.

- Car filters efficiently trap airborne particles, including pollen, enhancing air quality inside vehicles.[28]
- Sunglasses protect the eyes from allergens, helping to reduce symptoms such as itching and tearing.[28]
- Air purifiers equipped with HEPA filters remove allergens from indoor air, creating a cleaner living environment.[28]
- Well-fitting masks, particularly those designed to filter allergens, help reduce pollen and irritant particles / dust inhalation when outdoors.[28]
- Pollen screens installed on windows and doors serve as fine mesh barriers that prevent allergens from entering homes and workplaces, while still allowing air circulation.
- Pollen forecasts provide valuable information on expected allergen levels, enabling individuals to plan activities and adopt preventive measures accordingly.

These cost-effective environmental interventions decrease allergen exposure and alleviate rhinitis symptoms.[29] By combining these strategies, individuals create a more allergen-controlled environment in their homes, vehicles, and outdoor settings, potentially reducing reliance on pharmacological treatments.[29]

Role of pharmacists and nurses

Nurses and community pharmacists are uniquely positioned to support people living with rhinitis and improve their quality of life by educating them on symptom management, advising on medication use, and promoting strategies to reduce allergen exposure. Through structured assessments and tailored advice, they help these persons distinguish between AR and NAR, manage their symptoms effectively, and recognise warning signs that require referral. Nurse/community pharmacist communication with GPs and specialists helps ensure continuity of care, while their role in empowering those with rhinitis supports self-management and reduces unnecessary healthcare visits.

Pharmacist-led interventions enhance adherence and clinical outcomes. Pharmacists can ensure the correct use of intranasal inhalers/sprays, which is key to achieving therapeutic efficacy and symptom relief, and support patients to manage their condition more effectively. This role becomes even more important in the context of switching from prescription to over-the-counter (OTC) therapies, where pharmacist-led guidance is likely to be the only professional support persons with rhinitis receive. Viral acute rhinosinusitis, in particular, can often be effectively managed at the pharmacy level through symptom relief and the promotion of self-care.[30-33]

Review: Monitoring and follow-up

How often should persons with rhinitis be reviewed?

In essence, this should depend on response. Full response

suggests no need to review, partial response suggests review of adherence, technique,[34] and address any non-allergic factors such as smoking or occupational aspects.[35] Non-response, especially when adherence and technique are good, suggests the need for diagnostic review and/or referral Increasingly, digital tools are likely to have a role in assisting both the patient and clinician to optimise outcomes.[36,37] The MASK-Air app (https://www.mask-air.com/) is well established. The use of a structured review improves outcomes,[38,39] as does shared decision-making.[40]

What should be reviewed?

Disease severity, as measured by the rhinitis VAS, treatment adherence and technique, the search for other factors such as NAR, change in occupation, or environmental exposure, and the shared decision-making plan.

When to consider allergen immunotherapy

Consider allergen immunotherapy (AIT), including sublingual immunotherapy (SLIT), for people with moderate to severe AR whose symptoms remain uncontrolled despite optimal pharmacological therapy. This includes regular use of INCS and INAH, OAH, and appropriate ocular treatments. Strong indications for AIT include symptoms that significantly impair daily functioning, sleep quality, school or work performance, or that persist even with low to moderate allergen exposure. A VAS score of 5 or higher typically indicates inadequate symptom control. A confirmed diagnosis of IgE-mediated allergy is essential, based on clinical history and supported by positive skin-prick testing or specific IgE to relevant allergens.

Access to AIT varies from country to country depending on the organisational model of health care and available resources.

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Rhinitis diagnosis and management

BREATHS
AN IPCRG INITIATIVE

Breaths is an International Primary Care Respiratory Group (IPCRG) initiative designed to enhance primary care providers' capability, confidence, and motivation in delivering high-quality respiratory care. It leverages structured microlearning strategies tailored to the time constraints of primary healthcare professionals.

Rhinitis Diagnosis

Learn how to recognise the clinical features of rhinitis, apply the Allergic Rhinitis and its Impact on Asthma (ARIA) classification of severity, and identify when and if further testing or referral is needed.

Rhinitis Management in Primary Care

Master using a Visual Analogue Scale to assess symptom severity and a stepwise treatment ladder to manage rhinitis, including deciding when to step up, step down, and refer.

Start learning with Breaths

Scan the QR code to access via IPCRG website.

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