

Madigan Army Medical Center

Referral Guidelines

Allergic Rhinoconjunctivitis

Diagnosis/Definition

- The presence of ocular itching, tearing, or redness and/or the presence of nasal itching, persistent rhinorrhea, nasal obstruction, or sneezing. There may be an identifiable season of the year or a particular exposure which will elicit symptoms. Symptoms should exceed 6 weeks or be present in a particular season at least 2 years in a row.

Initial Diagnosis and Management

- History should include identification of at least one of the symptoms indicated above, should be of sufficient duration or have recurred often enough to exclude transitory processes such as viral or irritant rhinitis.
- Examination should indicate the presence of inflammation or edema of nasal mucosa and/or conjunctivae.
- Mild or intermittent symptoms should be managed with a trial of a non-sedating antihistamine (Fexofenadine (Allegra), Cefatrizine (Zyrtec), or Loratadine (Claritin) with or without an oral decongestant.
- Persistent or more severe symptoms should be managed with daily use of a nasal corticosteroid spray, such as fluticasone (Flonase) or mometasone (Nasonex), combined with as needed oral antihistamine use. A more sedating antihistamine (hydroxyzine, diphenhydramine, or chlorpheniramine) can be added at bedtime, however, studies have shown significant daytime somnolence and decreased attention even with nighttime only use for some patients. Nasal cromolyn may be an effective alternative for some patients, although it is less effective than corticosteroids and requires frequent dosing to be effective.
- Serum specific IgE by Immucap (or RAST) testing can be ordered to help with identification of allergic triggers for avoidance education, to help confirm or rule out the diagnosis, and before more costly interventions such as pet removal or purchase or dust mite covers are being considered. The correct test to order in CHCS is Northwest RAST (MAMC).
- In patients with perennial rhinitis, the diagnosis of chronic sinusitis should be considered.

Ongoing Management and Objectives

- Patients should be symptom-free or have minimal symptoms with good functional capacity, good quality of life, and lack of side effects from medications.

Indications for Specialty Care Referral

- Refer to Allergy/Immunology Clinic after failure to get adequate relief of symptoms with regular use of medications after one month of continuous treatment with combined nasal corticosteroid spray and oral antihistamine use.
- Inability to tolerate medications.
- Complications of allergy such as asthma or sinusitis.

- Consideration for allergen immunotherapy: Allergen Immunotherapy can be highly effective in controlling allergic rhinitis symptoms and even provide lasting benefit after immunotherapy is discontinued. It has also been shown to reduce development of new sensitizations and improve control of allergic asthma. Allergen immunotherapy does require a significant time commitment to be worthwhile. There is also risk of anaphylaxis with immunotherapy and therefore it is not recommended for patients with cardiac disease, take beta-blockers, or who have poor lung function.
- Consider ENT referral for patients with suspicion of sinusitis or anatomical causes for symptoms and when allergy tests are negative.

Criteria for Return to Primary Care

- Allergy testing is negative
- Immunotherapy is not recommended
- Completion of immunotherapy

Last Review for this Guideline: **September 2009**
Referral Guidelines require review every three years.

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Clinical Practice and Referral Guidelines Administrator