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General Information on Treatment of Allergic Rhinitis in Adults:

If possible, avoidance of the allergen is recommended. This may be possible with allergies to animals and may also be possible to some extent with allergies to house dust mites, but it is very difficult with allergies to tree/grass pollen and to moulds.

The first level of treatment is an as required antihistamine such as Cetirizine or Loratadine (10mg daily) or alternatively a nasal anti-histamine (e.g., Rhinolast (Azelastine) 140mcg into each nostril twice daily). If this fails to gain adequate control, then this should be taken regularly.

If this fails to adequately control symptoms, then the addition of a nasal corticosteroid is recommended. Nasal corticosteroids take around 10-14 days to take full effect. Beclomethasone or Fluticasone are over the counter medications that are suitable for this purpose given as one to two puffs in each nostril, once or twice daily. Alternative nasal corticosteroid formulations may be obtained with a prescription such as Nasonex (Mometasone) or Avamys (Fluticasone). Advice on the appropriate method of administration of a nasal corticosteroid can be obtained here or as a video at on the asthma UK website. If there is significant nasal blockage then short courses of steroid nasal drops (e.g., Fluticasone 200mcg (approximately 6 drops) into each nostril once or twice daily for 4 weeks, Betnesol (Betamethasone) 0.1% 2-3 drops once or twice daily into each nostril for 2 weeks) or oral steroids (e.g., Prednisolone 20-30mg for 5 days taken at 9am) may be helpful. Nasal drops should be given in the head 'upside down' position with the nostrils pointing upwards.

If avoidance measures, regular antihistamines (nasal or oral) and the nasal corticosteroid fail to adequately control symptoms then consider the combination nasal spray Dymista, which contains both Fluticasone (a steroid) and Azelastine (an antihistamine). Dymista is given as 1 spray twice daily to each nostril. If control of symptoms is an ongoing issue, then an additional one puff into each nostril of a nasal steroid spray (options above) should also be given (i.e., a total of 4 sprays to each nostril per day).

Short courses (i.e., <10 days) of nasal decongestants (e.g., Xylometazoline, Oxymetazoline or Ephidrine) can help to get topical steroids to the appropriate area by opening up the nose. They should be used along with nasal corticosteroids (either drops or a spray). Long term use of nasal decongestants should be avoided as this can cause inflammation in the nose (termed 'rhinitis medicamentosa').

Nasal douching may be helpful and the equipment to do this can be bought over the counter. It can safely be performed multiple times per day if beneficial. It is suggested that nasal douching is best performed just prior to the administration of nasal medications. Here is some advice on how to perform nasal douching. Options for nasal douching include making your own or buying them from a reputable supplier.

If nasal drip is a significant issue, then Rinatec (Ipratropium Bromide) nasal spray may be considered. It is given as two sprays two or three times daily. Consideration may also be given to a trial of Montelukast 10mg daily, particularly if the patient has asthma.

For eye symptoms both nasal and oral treatments as above may be helpful. However, topical eye treatments such as artificial tears may be needed. Eye drops containing anti-histamines (e.g., Azelastine drops 2-4 times per day), Sodium Cromoglycate (4 times daily) or Nedocromil (2-4 times per day) may be more effective in relieving symptoms.

If these medicines fail to adequately control symptoms, then immunotherapy may be considered where incremental doses of the allergen are given to reduce the reactiveness of the immune system to the allergen. However, this treatment often involves multiple trips to hospital, and does have some risk (particularly in provoking an allergic reaction). Immunotherapy is either given as injections in hospital or taken under the tongue daily at home. It is reserved for patients in whom the medical treatments above (e.g., a nasal corticosteroid + oral/topical antihistamine as a minimum) have failed to achieve adequate control, where the allergic trigger is only a single or a small number of allergens (e.g., isolated grass pollen allergy). Decisions on immunotherapy are taken by specialists in allergy, and administration of immunotherapy is performed in specialist hospital clinics. Immunotherapy treatment is usually given over a period of 3 years, so it is quite a commitment. It is moderately effective with grass and tree allergies, and of limited effectiveness with a house dust mite allergy. Desensitisation for allergies to cats/dogs/horses are generally limited to those with occupational exposure (e.g., Vets).