

# Practice Guidelines

## Treatment of Seasonal Allergic Rhinitis: A Guideline from the AAAAI/ACAAI Joint Task Force on Practice Parameters

### Key Points for Practice

- Patients 12 years and older should be treated with intranasal corticosteroid monotherapy over combined intranasal corticosteroid and oral antihistamine therapy to treat seasonal allergic rhinitis.
- Combined intranasal corticosteroid and intranasal antihistamine therapy can be considered for allergic nasal symptoms for patients 12 years and older.
- For patients 15 years and older, an intranasal corticosteroid is preferred over a leukotriene receptor antagonist.

From the AFP Editors

and oral leukotriene receptor antagonists. However, the three questions addressed in the updated guideline focused on only certain medications based on clinical importance, new data, and the opportunity to support improved care or better cost effectiveness. Because combination therapy with oral antihistamines and intranasal corticosteroids is commonly used in patients with seasonal allergic rhinitis that does not respond to intranasal corticosteroids alone, the first question aimed to determine if there was any clinical benefit of using combination therapy over intranasal corticosteroid monotherapy. Because previous recommendations indicate that intranasal antihistamines can be used as first-line treatment despite being less effective than intranasal corticosteroids, the second question outlined the clinical benefit of using combined intranasal corticosteroids and intranasal antihistamines compared with either medication alone. Finally, because multiple monotherapies for treatment of seasonal allergic rhinitis exist, such as montelukast (Singulair) or intranasal corticosteroids, the third question discussed the effects of montelukast vs. intranasal corticosteroids in patients 15 years and older.

### Recommendations

For patients at least 12 years of age presenting with seasonal allergic rhinitis, intranasal corticosteroid therapy should initially be prescribed over combined intranasal corticosteroid and oral antihistamine therapy to treat nasal symptoms, because moderate-quality data did not show a benefit associated with adding the antihistamine. With this regimen, adherence and convenience were shown to be improved and adverse effects reduced (e.g., sedation with oral antihistamines). By supporting monotherapy, physicians can reduce variations in care and improve quality of life, including performance at work or school and sleep. In addition, there is no increased risk of harm of monotherapy vs. combination

**Seasonal allergic rhinitis**, which has a prevalence of 14% among U.S. adults, can be mild (i.e., symptoms do not affect quality of life) to severe (i.e., symptoms do affect quality of life). Although treatment options include environmental controls and allergen immunotherapy, it is often treated with pharmacologic therapy, which is the focus of this guideline. However, there is no consensus about whether one medication is superior to another, or if using at least two medications in combination is beneficial. To outline quality improvement opportunities for the treatment of seasonal allergic rhinitis, the Joint Task Force on Practice Parameters, consisting of experts from the American Academy of Allergy, Asthma, and Immunology (AAAAI) and the American College of Allergy, Asthma, and Immunology (ACAAI), created a guideline to outline initial pharmacologic treatment in persons at least 12 years of age with moderate to severe seasonal allergic rhinitis.

### Questions

Pharmacologic therapy includes intranasal and oral formulations of antihistamines, decongestants, and corticosteroids, and intranasal cromolyn, intranasal anticholinergics,

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**This series** is coordinated by Sumi Sexton, MD, Editor-in-Chief.

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therapy. Although intranasal corticosteroid monotherapy may not be effective in some patients, the data were inadequate to determine if additional therapy with oral antihistamines is beneficial to treat persistent symptoms.

For patients 12 years and older, combined intranasal corticosteroid and intranasal antihistamine therapy may be considered for nasal symptoms, because they can be better controlled with combination therapy than with either therapy alone. High-quality evidence indicated that the combination was beneficial, with combined fluticasone propionate and azelastine (Dymista) having greatest effect on symptoms compared with either agent alone. It should be noted that although using a single spray may be more convenient, it has a greater cost and possibly no benefit over separate sprays. Adverse effects of combination treatment include sedation, unpleasant taste, and nosebleeds.

For patients 15 years and older, an intranasal corticosteroid is preferred over a leukotriene receptor antagonist, such as montelukast. High-quality evidence indicated intranasal corticosteroids were more effective, increased benefits, and decreased treatment variation. In addition, there is no significant difference in adverse effect rates among them.

Intranasal corticosteroids are associated with nasal irritation, bleeding, and long-term effects such as cataracts, increased intraocular pressure, and glaucoma. Montelukast is associated with headaches and rare neuropsychiatric events. Some patients may prefer oral montelukast or another leukotriene receptor antagonist, even though these therapies are less effective than intranasal corticosteroids. These alternatives may be beneficial in some patients, particularly those who also have mild persistent asthma.

**Guideline source:** Joint Task Force on Practice Parameters

**Evidence rating system used?** Yes

**Systematic literature search described?** Yes

**Guideline developed by participants without relevant financial ties to industry?** No

**Recommendations based on patient-oriented outcomes?** Yes

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