Clinical Sub-Group to support the delivery of an Expanded Role for Community Pharmacy

Common Conditions Service Protocol

Allergic Rhinitis & Allergic Conjunctivitis (Final)

V1.5 26/09/2025

This protocol does not impede the sale and supply of medicines 'over the counter' where this legal route of supply is relevant

Table of Contents

1. Critical Elements

1.1 Protocol Version
Version 1.5
1.2 Protocol Authors
Clinical Sub-Group to support the delivery of an Expanded Role for Community Pharmacy (See Appendix A for membership)
• Pharmacists wishing to deliver this service must: 1. Complete the mandatory Common Conditions Service training. Training can be accessed on the Irish Institute of Pharmacy website. 2. Adhere to the information and recommendations included in the Clinical Protocol for this common condition, and always ensure that they are following the current version of the protocol. Current versions of the Clinical Protocols can be accessed on the HSE website. 3. Comply with legislation in place that relates to delivery of the service and any associated guidance from the PSI. • NOTE: Locum pharmacists employed on a temporary basis who have successfully completed the training may be authorised to provide the service. They must be able to produce a record of their training upon request.

2. Clinical Criteria

2.1 Clinical condition for use of the protocol and differential diagnosis

Allergic Rhinitis and/or Allergic Conjunctivitis

Background

Symptoms usually start soon after an individual is exposed to an allergen which triggers an immunoglobulin E (IgE)-mediated inflammatory condition of the nasal mucosa and/or conjunctiva of the eye. Continuous or repeated exposure to the allergen may cause sensitisation, even at lower levels.

Signs and Symptoms

Allergic Rhinitis

Allergic rhinitis symptoms include sneezing, watery rhinorrhoea and nasal obstruction often associated with itchy eyes, nose or palate. Not all individuals with Allergic Rhinitis will experience eye symptoms. It can also cause irritability or fatigue, particularly in young children. Most people with allergic rhinitis have mild symptoms, but for some people, symptoms can be severe and persistent. They can cause sleep problems and interfere with everyday life. In children, there may be the presence of a transverse nasal crease (allergic salute) caused by rubbing of the nose. The symptoms of allergic rhinitis can improve with time (this can take many years), however it is unlikely that the condition will disappear completely. Allergic rhinitis is also commonly associated with asthma, atopic dermatitis, and allergic conjunctivitis.

Allergic Conjunctivitis

Signs and symptoms of allergic conjunctivitis may include:

- Irritated red eye with dilated/injected vessels (red inflamed blood vessels) on the conjunctival lining of the white of the eye (sclera) across the entire white of the eye
- Pink mild swelling in the eyelid (puffy eyes)
- Profuse watery or mucoserous, stringy discharge
- Feeling of an itchy eye i.e. needing to rub the eye
- Sensation of grittiness, burning, or irritation
- Crusting on lid margin in morning
- Rhinorrhoea or hay fever-like symptoms

The signs can be unilateral or bilateral but are more often bilateral in allergic conjunctivitis. Blurred vision or pain is not associated with allergic conjunctivitis. Causes of allergic conjunctivitis include seasonal allergens (most common in spring to summer – e.g. high pollen counts, often with rhinitis), irritants (e.g. new cream, cleanser, applying makeup on or close to eyelids), unknown allergens, use of topical drops e.g. glaucoma drops, or long term use of preserved eye drops of any kind due to exposure to benzalkonium chloride (the most commonly used preservative in bottled drops).

Note: Photophobia, dry eyes and unilateral symptoms are unlikely to be associated with allergic conjunctivitis. Pharmacists should consider other causes of red eye/eyelid (see protocol on *Acute Infective Conjunctivitis*) for individuals presenting with these symptoms and refer to a medical practitioner where appropriate.

Conjunctivitis caused by allergies like hay fever makes eyes red and watery but is not contagious. Credit: DR P. MARAZZI/SCIENCE PHOTO LIBRARY (HSE A-Z)

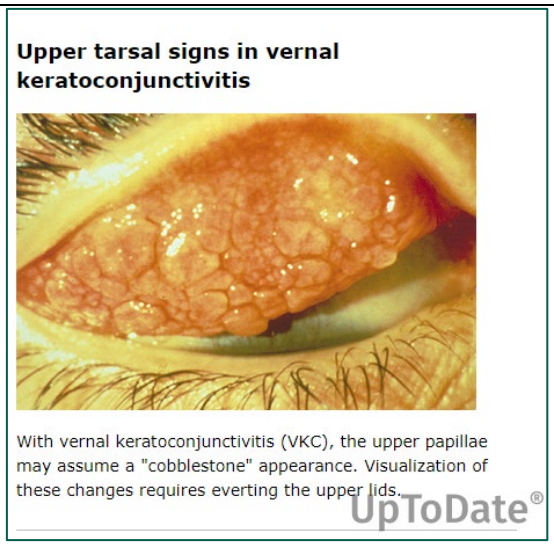
Acute seasonal conjunctivitis (UpToDate®)

Vernal/Atopic Keratoconjunctivitis
This is a chronic condition caused by an allergic inflammation of the eye. Presentation can be seen at any age – although it more commonly presents early with initial episodes, as opposed to allergic conjunctivitis without atopy that can start at any age. Presentation may occur later if there was a failure to obtain diagnosis and treatment for a previous episode of vernal conjunctivitis.

It is characterised by a lack of response to a topical antihistamine or a mast cell stabiliser. Symptoms include thick swollen lids (papillae – see image below), secondary corneal changes, or blurred vision. Intense eye rubbing is often a feature.

Blurred vision may be an indicator of secondary corneal changes, which may have long term consequences for vision including the risk of corneal scarring and vision loss. As part of the assessment for blurred vision, individuals should be advised to wear any necessary prescription eyewear and evaluate if the blurring continues to be present. The presence of blurred vision is always an indication for referral to a medical practitioner for further assessment.

If signs and symptoms of allergic conjunctivitis are severe or not settling within 14 days of topical antihistamine or a mast cell stabiliser treatment, then referral to a GP is warranted as it may indicate the presence of Vernal/Atopic Keratoconjunctivitis. A subsequent ophthalmological opinion may be required as treatment may include the use of steroids.



Upper tarsal signs in vernal keratoconjunctivitis (UpToDate®)

Types of Allergens:

- Seasonal allergens may include tree, grass or weed pollen and can last for months particularly during the Spring and Summer periods.
- Perennial allergens are year-round such as house dust mites, mould and animal dander (flakes of skin from some animals or droplets of urine or saliva from some animals).

Allergic rhinitis may also be episodic with specific or identified allergen exposure e.g. exposure to animal dander at a neighbour's house or dust mite exposure at a location outside the home.

2.2 Clinical Features

Classification of allergic rhinitis:
Allergic rhinitis is classified[1] as:

- Intermittent – when symptoms are present less than 4 days per week or less than 4 weeks per episode.
- Persistent – when symptoms are present more than 4 days per week or for longer than 4 weeks.

Symptoms may be:

- Mild – when there are no troublesome symptoms, and symptoms do not impact on quality of life such as school, work, sleep, leisure.
- Moderate – when symptoms are more troublesome but little impact on day-to-day activities.
- Severe – when symptoms are very troublesome or daily functioning is impacted e.g. impaired school, work or leisure, sleep disturbances.

Assessment of allergic rhinitis and allergic conjunctivitis in the Community Pharmacy setting
The expert group Allergic Rhinitis and Impact on Asthma (ARIA) have developed guidelines to provide an evidence based and integrated care approach to the management of allergic rhinitis (AR) and common AR related comorbidities in the community pharmacy[2]. The ARIA guidelines provide a list of questions to help identify allergic rhinitis and/or allergic conjunctivitis, which have been adapted for the Irish context.

These may be used in conjunction with a Visual Analogue Scale (VAS), if appropriate, for individuals who find it difficult to categorise or communicate the severity of symptoms (See Appendix B for further details).

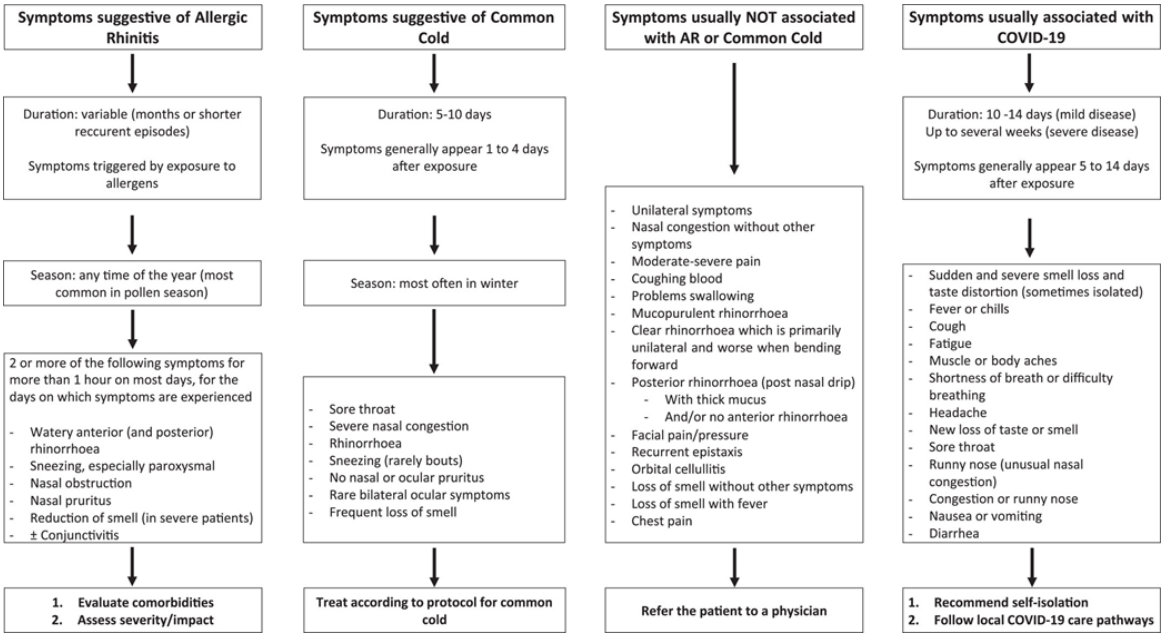
Questions to help identify allergic rhinitis in the Pharmacy[3]

What is your main symptom? (Check for rhinorrhoea, sneezing, itchy nose, nasal congestion, watery or itchy eyes.)
How long have you had these symptoms?
Do you have the symptoms all the time or do they come and go?
Are you aware of anything that seems to bring the symptoms on, such as being outdoors, pollen seasons, contact with animals, something you handle at work or at home?
Has a doctor ever diagnosed you with hay fever, allergic rhinitis, or asthma? (see Appendix C for further screening of asthma in individuals presenting with allergic rhinitis in the pharmacy)
Is your nasal discharge clear and watery? (Purulent discharge suggests infection)
Are you experiencing any wheezing or shortness of breath? ("Yes" may indicate asthma - see Appendix C for further screening of asthma in rhinitis patients in the pharmacy)
Do you have an earache or any pain in your face? ("Yes" may indicate otitis media or sinusitis.)

[1] UpToDate Pharmacotherapy of allergic rhinitis https://www.uptodate.com/contents/pharmacotherapy-of-allergic-rhinitis
[2] Lourenço O, Cvetkovski B, Kritikos V, House R, Scheire S, Costa EM, Fonseca JA, Menditto E, Bedbrook A, Bialek S, Briedis V, Boussery K, Canonica GW, Haahtela T, Kuna P, Mullol J, Orlando V, Samolinski B, Wallace D, Duggan C, Paulino E, Pinto GS, Söderlund LÅ, Bousquet J, Bosnic-Anticevich S. Management of allergic rhinitis symptoms in the pharmacy Pocket guide 2022. Clin Transl Allergy. 2022 Oct 5;12(10):e12183. doi: 10.1002/clt2.12183. PMID: 36225265; PMCID: PMC9533218.
[3] *Ibid*

The following table provides a useful summary of symptoms which may typically present for allergic rhinitis, and those symptoms which may indicate an alternative diagnosis or require a referral to a medical practitioner.

Recognising allergic rhinitis in the pharmacy and common different diagnosis[4]



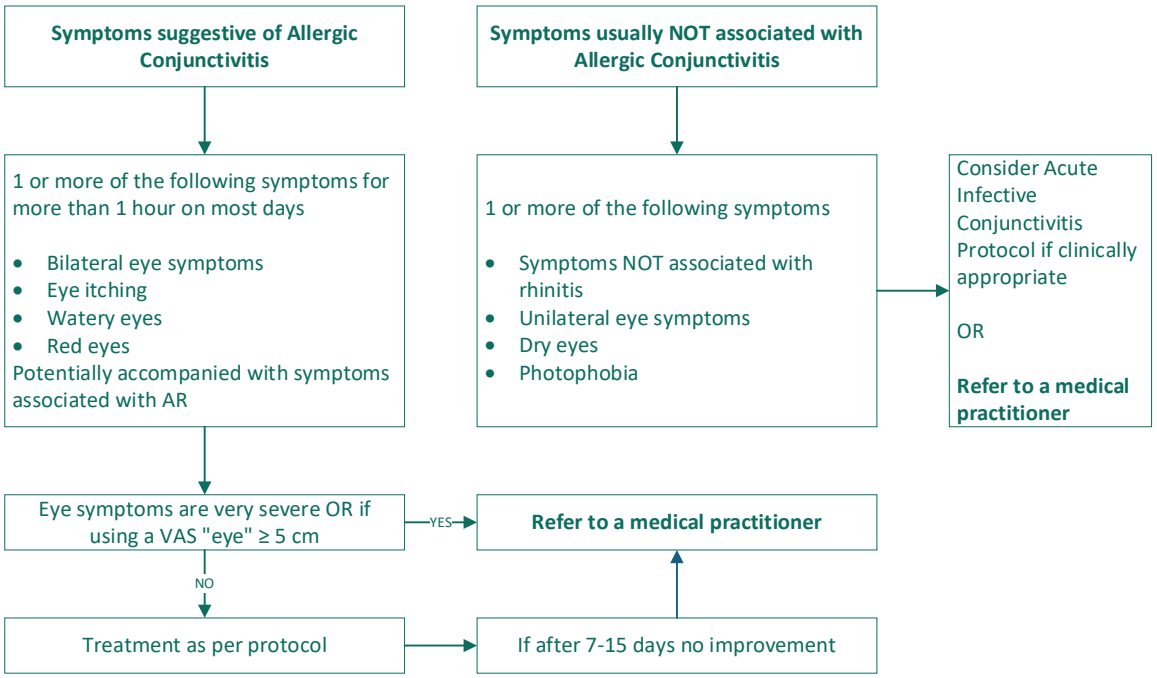
Questions to help identify allergic conjunctivitis in the Pharmacy[5]

What is your main symptom? (Check for bilateral eye symptoms, eye itching, watery eyes, red eyes)
Do you have allergic rhinitis or hay fever?
Do they have other eye conditions or symptoms which may indicate an alternative diagnosis? (See *Acute Infective Conjunctivitis* protocol for consideration of other red eye/red eyelid conditions) Note: the use of preservatives in eye drops may trigger an allergic reaction with prolonged use due to benzalkonium chloride. Eye conditions which causes tearing may result in some non-irritating nasal congestion and should not be mistaken for allergic rhinitis.
Do you have sensitivity with light/bright light e.g. looking at screen phone/ need to sit in a dark room? ("Yes" – Mild sensitivity to light may occur with allergic conjunctivitis due to very inflamed, bloodshot, itchy allergic eyes. Photophobia which is more severe or where symptoms are less suggestive of allergic conjunctivitis should prompt referral to a medical practitioner.)
Do you have an earache or any pain in your face? ("Yes" may indicate otitis media or sinusitis.)

[4] Lourenço O, Cvetkovski B, Kritikos V, House R, Scheire S, Costa EM, Fonseca JA, Menditto E, Bedbrook A, Bialek S, Briedis V, Boussery K, Canonica GW, Haahtela T, Kuna P, Mullol J, Orlando V, Samolinski B, Wallace D, Duggan C, Paulino E, Pinto GS, Söderlund LÅ, Bousquet J, Bosnic-Anticevich S. Management of allergic rhinitis symptoms in the pharmacy Pocket guide 2022. Clin Transl Allergy. 2022 Oct 5;12(10):e12183. doi: 10.1002/clt2.12183. PMID: 36225265; PMCID: PMC9533218.
[5] Lourenço O, Cvetkovski B, Kritikos V, House R, Scheire S, Costa EM, Fonseca JA, Menditto E, Bedbrook A, Bialek S, Briedis V, Boussery K, Canonica GW, Haahtela T, Kuna P, Mullol J, Orlando V, Samolinski B, Wallace D, Duggan C, Paulino E, Pinto GS, Söderlund LÅ, Bousquet J, Bosnic-Anticevich S. Management of allergic rhinitis symptoms in the pharmacy Pocket guide 2022. Clin Transl Allergy. 2022 Oct 5;12(10):e12183. doi: 10.1002/clt2.12183. PMID: 36225265; PMCID: PMC9533218.

Recognising allergic conjunctivitis symptoms in the pharmacy and common differential diagnoses

The following table provides a useful summary of symptoms which may typically present for allergic conjunctivitis, and those symptoms which may indicate an alternative diagnosis or require a referral to a medical practitioner[6].



[6] Lourenço O, Cvetkovski B, Kritikos V, House R, Scheire S, Costa EM, Fonseca JA, Menditto E, Bedbrook A, Bialek S, Briedis V, Boussery K, Canonica GW, Haahtela T, Kuna P, Mullol J, Orlando V, Samolinski B, Wallace D, Duggan C, Paulino E, Pinto GS, Söderlund LÅ, Bousquet J, Bosnic-Anticevich S. Management of allergic rhinitis symptoms in the pharmacy Pocket guide 2022. Clin Transl Allergy. 2022 Oct 5;12(10):e12183. doi: 10.1002/clt2.12183. PMID: 36225265; PMCID: PMC9533218.

2.3 Inclusion criteria

2.3.1 CRITERIA FOR INCLUSION

- Informed consent given by an individual or parent/legal guardian for a child aged under 16 years.
- Individuals aged 2 years and over.
- Symptoms consistent with allergic rhinitis and/or allergic conjunctivitis.
- Pharmacists can **consider prescribing an initial supply of treatment if clinically appropriate**, while referring individuals who meet the criteria set out in **Section 2.4.3**.

2.4 Exclusion criteria and Referral Pathways

2.4.1 CRITERIA REQUIRING EMERGENCY REFERRAL TO HOSPITAL EMERGENCY DEPARTMENT/CONTACTING EMERGENCY SERVICES

- Symptoms of anaphylaxis including swollen tongue, breathing difficulties, tight chest, trouble swallowing or speaking, feeling dizzy or faint, and collapse*
- Symptoms of severe asthma attack*

***Pharmacists who have undergone the requisite training should consider use of emergency medicines if clinically appropriate, in addition to calling an ambulance (Medicinal Products (Prescription and Control of Supply) (Amendment) (No. 2) Regulations 2015 (SI 449/2015))**

2.4.2 CRITERIA REQUIRING REFERRAL TO GENERAL PRACTITIONER or OTHER RELEVANT MEDICAL PRACTITIONER WHERE PRESCRIBING NOT PERMITTED

Note: Pharmacist prescribing not permitted

- Individuals under 2 years of age.
- Contraindications as specified in the medication Summary of Product Characteristics.
- Pregnancy or suspected pregnancy (refer to GP/treating obstetrician/gynaecologist).
- Known hypersensitivity or adverse reaction to medication treatment options as included in Section 3.1, or any of the components within the formulation.
- Suspected sinusitis infection or continuous mucopurulent discharge.
- Suspected ear infections e.g. otitis media.
- Suspected drug induced rhinitis.
- Persistent headache, eye or facial pain.
- Nasal symptoms present primarily in only one nostril.
- Children under 18 years of age on systemic steroid and/or medium to high dose inhaled corticosteroids and/or continuous use of potent topical steroids for eczema or other skin conditions due to the risk of effects on growth.
- Blurred vision
- Intranasal corticosteroid treatment already used continuously for 8 weeks in children under 18 years of age.

2.4.3 CRITERIA REQUIRING REFERRAL TO GENERAL PRACTITIONER or OTHER RELEVANT MEDICAL PRACTITIONER – INITIAL LIMITED SUPPLY*

***Pharmacists can consider prescribing an initial limited supply of treatment if clinically appropriate to mitigate the risk of delay in access to treatment. Treatment should be limited to the dose or time necessary for an individual to access the referral pathway.**

- Symptoms not sufficiently controlled under this protocol.
- Dyspnoea, wheezing or uncontrolled asthma.
- Recent nasal surgery or trauma.
- Suspected vernal conjunctivitis.

2.5 Action to be taken where individual meets exclusion criteria, or treatment is not indicated, or if the individual/parent/legal guardian declines treatment

- If individual meets exclusion criteria, they should be referred or signposted as per the protocol (see Section 2.4).
- Advise individual/parent/legal guardian to seek medical advice if symptoms deteriorate.
- Signpost to available resources on HSE A-Z and the HSE app if appropriate.
- Consider documenting advice given.

3. Details of medication

3.1 Name of medication, dose, and duration

The treatment of allergic rhinitis and allergic conjunctivitis requires guidance to be provided to individuals on the:

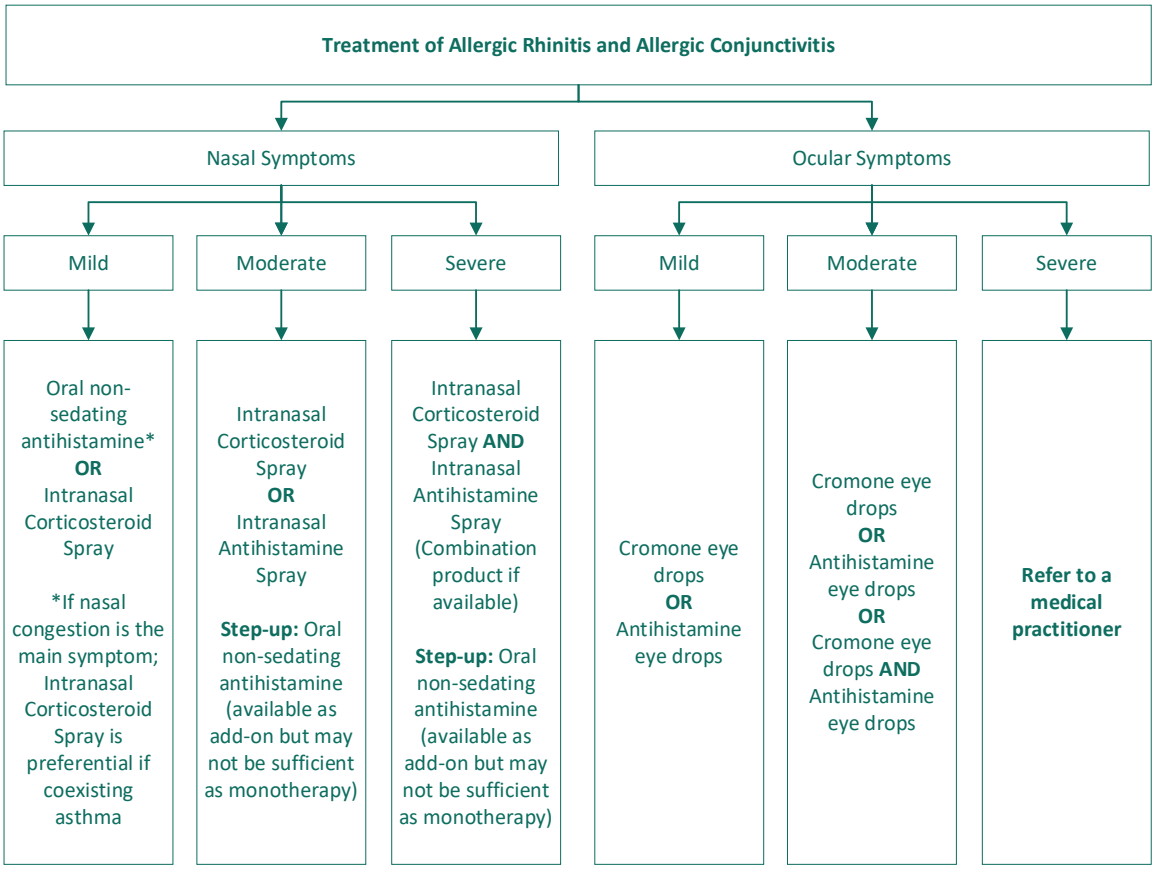
- Avoidance of allergen exposure (see Section 4).
- Medication recommendations including correct use of medication e.g. nasal spray technique.
- The importance of adherence to a treatment regime.

Treatment selection should include consideration of pricing and the individual's needs and preference.

A medicines reconciliation and drug-drug interaction assessment should be completed before treatment selection.

Treatment Options & Formulary

The ARIA guidelines base treatment recommendations on the impact of symptoms on day-to-day living. Symptoms may be intermittent or persistent, which may impact on the duration of treatment but not on the treatment recommended.



Oral Antihistamines (AH)
Many individuals with allergic rhinitis tend to utilise older sedating antihistamines and underutilise the more effective intranasal corticosteroids. The newer minimally sedating antihistamines may be beneficial in individuals who have mild allergic rhinitis or those who prefer an oral therapy. In addition, oral antihistamines may have a role as a step-up treatment in individuals who do not respond adequately or tolerate intranasal corticosteroids and/or intranasal antihistamines. They may also be preferable in children in which the use of a topical spray may not be practicable.

Regular daily use is recommended, however as needed use may be sufficient for mild symptoms or predictable allergen exposure e.g. visiting a household with a pet. All second-generation antihistamines appear to be similarly effective. It is important to note that there is a risk of some minimal sedation with these newer oral antihistamines. There may also be degrees of anticholinergic effects, for example dry eyes.

Chlorphenamine is a sedating antihistamine with anticholinergic properties. It is short-acting, requiring 6 hourly dosing. It is not recommended in general, however there may be circumstances where it may be effective, e.g. for acute, moderate-severe episodes of allergic conditions, while awaiting the full onset of action of corticosteroid sprays or to take at night-time if allergic rhinitis is interfering with sleep. Use should be short-term. People taking chlorphenamine long-term at home should be advised about tapering and withdrawal and consideration of alternative therapy if required.

Antihistamines should be used with caution in individuals with a previous history or current cardiac arrhythmia. There is an increased risk of QT prolongation/Torsade de points with some antihistamines. Refer to medication Summary of Product Characteristics for further information.

Intranasal Corticosteroid Sprays (INCS)
Intranasal corticosteroid sprays (INCS) are the most effective treatment for allergic rhinitis, especially in patients with asthma. All available INCS are effective in controlling symptoms. When considering suitability of INCS, the total systemic burden of corticosteroids should be considered e.g. concurrent use of other forms of corticosteroid treatment. Second-generation sprays such as fluticasone furoate, fluticasone propionate and mometasone furoate are generally preferred due to negligible bioavailability and less potential to cause side effects.

INCS therapy (with or without antihistamine) is generally very safe. While there are some risks of long-term INCS use, these are small due to the relatively low doses involved and limited glucocorticoid steroid absorption (particularly with second-generation formulations).

Growth in children should be monitored when any glucocorticoid-containing medication is prescribed, especially if additional glucocorticoid-based medications are given, such as inhaled agents for asthma or topical corticosteroids for atopic dermatitis. The formulations that are once-daily second-generation sprays are preferred in growing children since they may be less likely to impact the hypothalamic-pituitary axis (HPA) and growth[7]. Short term use is unlikely to be significant.

Due to the increased bioavailability and risk of adverse reactions, the use of first-generation INCS in individuals under 18 years of age is outside the scope of this protocol (Beclometasone Dipropionate and Triamcinolone acetonide). Children who are prescribed second-generation INCS treatment must be reviewed after 4-6

[7] UpToDate Pharmacotherapy of allergic rhinitis https://www.uptodate.com/contents/pharmacotherapy-of-allergic-rhinitis

weeks of treatment to assess symptom response and establish if there is a benefit to continuing treatment. The maximum duration of second-generation INCS treatment which can be prescribed by a pharmacist for individuals under 18 years of age is 8 weeks. Children who require INCS longer than 8 weeks duration should be referred to their medical practitioner.

Visual disturbances have been associated with the use of INCS. If an individual presents with symptoms such as blurred vision or other visual disturbances, they should be signposted to their medical practitioner and may require ophthalmological review.

Formulations containing alcohol or propylene glycol are more irritating than aqueous preparations and may lead to irritation of the nasal mucosa including drying, burning, and/or discomfort. Bleeding due to mucosal irritation is common (epistaxis). If affected, the individual's administration technique should be reviewed as per product SPC (also see Section 4 "Optimal Nasal Spray Technique"). It may be necessary to stop treatment on the affected side of the nose before restarting therapy. Recurrent or chronic epistaxis should prompt further evaluation by a medical practitioner for chronic nasal inflammation.

INCS can sometimes cause adrenal suppression. Drug interactions between intranasal fluticasone and strong inhibitors of CYP3A4 enzymes can effectively raise the dose of glucocorticoid and result in clinically significant adrenal suppression[8]. **A medicines reconciliation and drug-drug interaction assessment should be completed before prescribing any INCS.** The total systemic burden of corticosteroids should be considered whenever other forms of corticosteroid treatment are prescribed concurrently (e.g. creams, nasal sprays, eye drops, inhalers). The individual should also be advised when accessing other health services to inform the healthcare professional that they are taking this medication. Treatment with higher than recommended doses of nasal corticosteroids may result in clinically significant adrenal suppression. Individuals who requiring continuous INCS use may benefit from allergen specific immunotherapy (see Section 4.2).

Individuals with a predisposition to high intraocular pressure (glaucoma) should be advised to inform their treating ophthalmologist that they are using INCS (if long term or repeated courses).

INCS of any type should be tapered to the lowest effective dose in all patients once symptoms are controlled. When used as needed, INCS should be started two days prior to the exposure and continued for two days afterward. For seasonal symptoms, regular treatment is initiated at least one week prior to pollen season, rather than after symptoms have begun. The use of INCS should be stopped once exposure to the allergen has ended.

Intranasal Antihistamines (INAH)
Intranasal Antihistamines (INAH) e.g. azelastine, without INCS, are an option for patients who prefer to avoid glucocorticoids. These agents appear to have some anti-inflammatory effect and can improve nasal congestion. They may also be used in combination with INCS for individuals who do not improve with INCS alone.

They have a rapid onset of action (less than 15 minutes) and can be administered "on demand" treatment where the individual is aware of risk of exposure to an allergen e.g. animal dander from a companion animal while visiting a neighbour's house.

[8] UpToDate Pharmacotherapy of allergic rhinitis https://www.uptodate.com/contents/pharmacotherapy-of-allergic-rhinitis

Systemic absorption may cause somnolence (drowsiness). Some INAH preparations containing azelastine may have a bitter taste. Local irritation may occur as a result of INAH use including stinging, itching, sneezing, and epistaxis. Individual's spray technique should be reviewed as per product SPC to minimise the risk of adverse effects (also see Section 4 "Optimal Nasal Spray Technique").

Other

Nasal Saline Rinses

Individuals should be advised that cleaning nasal passages often with a saline/salt water (Sodium Chloride 0.9% w/v) solution can provide symptomatic relief for mild cases of allergic rhinitis. This is called nasal douching or irrigation and helps keep the nose free of allergens/irritants. For individuals with more severe symptoms, the use of saline prior to administration of other nasal preparations used in allergic rhinitis can help improve their efficacy.

Decongestants

For individuals who are so obstructed that the INCS spray will not penetrate into the nasal space, the use of a decongestant spray is advised 10 minutes before treatment. This should only be done for five or fewer days to avoid the complications relating to prolonged use of decongestant sprays. After that, the INCS should be continued alone. If the nasal decongestant spray is not effective in relieving the obstruction, referral to a medical practitioner is required. Prolonged use of nasal decongestant sprays may lead to rhinitis medicamentosa (drug-induced non-allergic rhinitis). Oral decongestants should be used with caution due to possible side-effects such as insomnia, elevated blood pressure, and tachycardia.

Eye Drops

The use of eye drops without preservatives is preferable, particularly if longer than a month is required, to minimise the risk of eye irritation.

Cromone Eye Drops

Cromone eye drops such as sodium cromoglicate are mast cell stabilising agents[9]. These are preventative therapies with full efficacy reached 5 to 14 days after therapy has been initiated. Therefore, these medicines are not useful for acute symptoms. In addition, dosing of mast cell stabilizers is four times daily compared with twice daily for most agents with combined actions e.g. intraocular antihistamines with mast cell stabilising properties.

Because of these limitations, mast cell stabilizers are often impractical, but they may provide an option for patients with seasonal allergic conjunctivitis (SAC) who do not tolerate other therapies and can anticipate when their symptoms will start. Such patients should begin treatment two to four weeks before the pollen season. However, for most patients, antihistamines with mast cell-stabilizing properties are more convenient and effective.

Antihistamine Eye Drops

Some antihistamines eye drops have mast cell-stabilising properties e.g. olopatadine and ketotifen. These agents have two main actions[10]:

- As antihistamines, they competitively and reversibly block histamine receptors in the conjunctiva and eyelids, thus inhibiting the actions of the primary mast cell-derived mediator. This also helps reduce the late phase of the allergic response.

[9] UpToDate Allergic conjunctivitis: Management https://www.uptodate.com/contents/allergic-conjunctivitis-management
[10] *Ibid*

- As mast cell stabilizers, they inhibit mast cell degranulation, limiting the release of histamine, tryptase, and prostaglandin D2 (PGD2). Release of these proinflammatory mast cell mediators is the first step in the allergic cascade. These drugs also inhibit leukocyte activity and dampen mediator release from basophils, eosinophils, and neutrophils.

Onset of action is within minutes for most drugs. It may take up to two weeks for inflammation to be controlled and symptoms to subside completely. Common side effects include stinging and burning upon instillation. Other adverse effects include headache and increased ocular dryness. It may be beneficial to use topical lubricant drops to provide symptomatic relief.

Review of initial treatment of Allergic Rhinitis and Allergic Conjunctivitis
If an individual presents to the pharmacy following 7-10 days of treatment, the pharmacist can consider:

- Checking adherence to treatment and nasal spray technique (where appropriate)
- Suitability of alternative therapies under this protocol
  OR
  Suitability of add-on therapies to step up treatment under this protocol
- The requirement to refer the individual to their medical practitioner for more severe symptoms

Allergic Rhinitis – Nasal Sprays			
Class	**Drug**	**Dose**	**Notes**
INCS – Second Generation Glucocorticoid (systemic bioavailability <1% or undetectable)	Fluticasone furoate 27.5 micrograms per spray, nasal spray, suspension	See summary of product characteristics for directions of use in adults and children (where licensed for use in a paediatric population)	Available without prescription: No Prescription medication: Check individual product SPC with some licensed for use in children 6 years and older
	Fluticasone propionate 50 micrograms per spray, nasal spray, suspension	See summary of product characteristics for directions of use in adults and children (where licensed for use in a paediatric population)	Available without prescription: Yes, some OTC products available OTC: Licensed for use in individuals 18 years and older. Prescription medication: Check individual product SPC with some licensed for use in children 4 years and older

	Mometasone Furoate 50 micrograms per spray, nasal spray, suspension	See summary of product characteristics for directions of use in adults and children (where licensed for use in a paediatric population)	Available without prescription: Yes, some OTC products available OTC: Licensed for use in individuals 18 years and older. Prescription medication: Check individual product SPC with some licensed for use in children 3 years and older
INCS + INAH – Second Generation Glucocorticoid in combination with an antihistamine (glucocorticoid systemic bioavailability <1% or undetectable)	Azelastine Hydrochloride - Fluticasone Propionate 137 micrograms/50 micrograms per actuation, nasal spray, suspension	See summary of product characteristics for directions of use in adults and children (where licensed for use in a paediatric population)	Available without prescription: No Prescription medication: check individual product SPC with some licensed for use in children 12 years and older
	Mometasone Furoate - Olopatadine 25 micrograms/600 micrograms per actuation, nasal spray, suspension	See summary of product characteristics for directions of use in adults and children (where licensed for use in a paediatric population)	Available without prescription: No Prescription medication: Check individual product SPC with some licensed for use in children 12 years and older
INCS – First Generation Glucocorticoid (systemic bioavailability 10 to 50%) **Due to the increased bioavailability and risk of adverse reactions, the use of first-generation INCS in individuals under**	Beclometasone Dipropionate 50 micrograms per spray, nasal spray, suspension	See summary of product characteristics for directions of use in adults.	Available without prescription: Yes, some OTC products available OTC: Licensed for use in individuals 18 years and older. Prescription medication: check individual product SPC

18 years of age is outside the scope of this protocol.	Triamcinolone acetonide 55 micrograms per dose, nasal spray, suspension	See summary of product characteristics for directions of use in adults.	Available without prescription: Yes, some OTC products available OTC: Licensed for use in individuals 18 years and older. Prescription medication: check individual product SPC
INAH – Antihistamine Nasal Spray	Azelastine Hydrochloride 140 micrograms per spray, nasal spray, solution	See summary of product characteristics for directions of use in adults and children (where licensed for use in a paediatric population)	Available without prescription: No Prescription medication: Check individual product SPC with some licensed for use in children 5 years and older

Allergic Rhinitis – Minimally sedating oral antihistamines			
Class	**Drug**	**Dose**	**Notes**
Second Generation Antihistamines (minimally sedating antihistamines) *Cetirizine may be more sedating that others listed and may be taken in the evening time if clinically appropriate	Cetirizine dihydrochloride* 10 mg tablets OR Cetirizine dihydrochloride 1 mg/ml oral solution	See summary of product characteristics for directions of use in adults and children (where licensed for use in a paediatric population)	Available without prescription: Yes, some OTC products available OTC: check individual product SPC with some licensed for use in children 2 years and older. Prescription medication: check individual product SPC with some licensed for use in children 2 years and older
	Loratadine 10mg tablets	See summary of product characteristics for directions of use in adults and children (where licensed for use in a paediatric population)	Available without prescription: Yes, some OTC products available OTC: check individual product SPC with some licensed for use in

			children 6 years and older. Prescription medication: check individual product SPC with some licensed for use in children 6 years and older
	Bilastine 10 mg orodispersible tablets OR 20 mg tablets OR 2.5 mg/ml oral solution	See summary of product characteristics for directions of use in adults and children (where licensed for use in a paediatric population)	Available without prescription: No Prescription medication: check individual product SPC with some licensed for use in children 2 years (with a body weight of at least 15 kg) and older (Note: scope of protocol is: Treatment in accordance with licensed use of an individual product, of children two years and older)
Third Generation Antihistamines *Levocetirizine may be more sedating that others listed and may be taken in the evening time if clinically appropriate	Desloratadine 5 mg tablets OR 0.5 mg/ml oral solution	See summary of product characteristics for directions of use in adults and children (where licensed for use in a paediatric population)	Prescription medication: check individual product SPC with some licensed for use in children 1 years and older (Note: scope of protocol is: Treatment in accordance with licensed use of an individual product, of children two years and older)
	Fexofenadine Hydrochloride 120mg tablets	See summary of product characteristics for directions of use in adults and children (where licensed for use in a paediatric population)	Available without prescription: Yes, some OTC products available OTC: check individual product SPC with some licensed for use in children 12 years and older. Prescription medication: check individual product

			SPC with some licensed for use in children 12 years and older
	Levocetirizine Dihydrochloride* 5mg tablets OR 0.5mg/ml oral solution	See summary of product characteristics for directions of use in adults and children (where licensed for use in a paediatric population)	Available without prescription: No Prescription medication: check individual product SPC with some licensed for use in children 2 years and older

Allergic Conjunctivitis (only affecting the eye OR not responding to oral antihistamine (non-sedative))

Class	Drug	Dose	Notes
IOC – Intraocular Cromone (Mast cell stabiliser)	Sodium cromoglicate 2% w/v eye drops, solution	See summary of product characteristics for directions of use in adults and children (where licensed for use in a paediatric population)	Available without prescription: Yes Should be used regularly to ensure optimal control of symptoms. It is recommended that treatment is continued during the period of exposure to allergen.
IOAH – Intraocular antihistamine	Ketotifen 0.25mg/ml, eye drops, solution	See summary of product characteristics for directions of use in adults and children (where licensed for use in a paediatric population)	Available without prescription: No Antihistamine and mast cell stabilizer If symptoms are not improving/worsening after 2 weeks refer to GP/eye services
	Olopatadine 1mg/ml, eye drops, solution	See summary of product characteristics for directions of use in adults and children (where licensed for use in a paediatric population)	Available without prescription: No Antihistamine and mast cell stabilizer If symptoms are not improving/worsening after 2 weeks refer to GP/eye services

3.2 Summary of Product Characteristics including warnings, cautions, contraindications, interactions and side effects.
Visit the Health Products Regulatory Authority (HPRA) website for detailed drug information (summary of product characteristics and patient information leaflets). Dosing details, contraindications and drug interactions can also be found in the Irish Medicines Formulary (IMF) or other reference sources such as British National Formulary (BNF) / BNF for children (BNFC).
3.3 Reporting of suspected adverse reactions
Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via HPRA Pharmacovigilance, website: www.hpra.ie
3.4 Procedure for the reporting and documentation of errors and near misses involving the medication including open disclosure.
PSI Advice on Medication Error Management: https://www.psi.ie/practice-supports/practice-updates-and-learnings/advice-medication-error-management PSI Open Disclosure: Open Disclosure | PSI
3.5 Resources and equipment necessary for care under the protocol to be specified. This is dependent on the assessment requirements and best practice guidelines identified for the clinical condition.
• HSE National Consent Policy • Chaperone Policy • Patient Consultation Area • Infection Prevention Control Measures • Protecting Staff – Occupational Health

4. Patient/service-user care information

4.1 General Advice for Self-Care and Safety Netting

Allergen Avoidance

Allergen avoidance should be recommended for individuals who have an obvious allergy based on clinical history. This approach may be only feasible where allergens have been identified, and exposure can be reduced effectively. It may be difficult for polysensitised patients and patients with pollen allergies during pollen season to minimise exposure. The following measures may be effective in avoiding the most common allergens.

- **House dust mites**
  Dust mites are one of the biggest causes of allergies. They're microscopic insects that breed in household dust. To help limit the number of mites in the house, individuals should be advised to:
  - Consider buying allergy-proof covers for mattresses, duvets and pillows.
  - Choose wood or hard vinyl floor coverings instead of carpet.
  - Fit roller blinds that are easy to wipe clean.
  - Clean cushions, soft toys, curtains and upholstered furniture often by washing or vacuuming them.
  - Use synthetic pillows and acrylic duvets instead of woollen blankets or feather bedding.
  - Use a vacuum cleaner fitted with a high-efficiency particulate air (HEPA) filter to remove more dust.
  - Use a clean damp cloth to wipe surfaces – dry dusting can spread allergens further.
  - Concentrate efforts on the areas of the home where they spend the most time, such as the bedroom and living room.
- **Pets**
  Pet fur does not cause an allergic reaction, however exposure to flakes of their dead skin, saliva and dried urine may cause an allergic reaction. If the pet cannot be removed from the house, individuals should be advised to:
  - Keep pets outside as much as possible or limit them to 1 room, preferably one without carpet.
  - Keep pets out of the bedroom.
  - Wash pets at least once a fortnight.
  - Groom dogs outside and often.
  - Wash bedding and soft furnishings the pet has been on often.

  If they are visiting a friend or relative that has a pet, ask them not to dust or vacuum on the day of the visit as this moves the allergens into the air. Taking an antihistamine medicine 1 hour before entering a house that has a pet can help reduce symptoms.
- **Pollen**
  Different plants and trees pollinate at different times of the year. The time of year an individual gets allergic rhinitis depends on what sort of pollens they are allergic to. Most people are affected during the spring and summer months as this is when most trees and plants pollinate. To avoid exposure to pollen, individuals should be advised to:
  - Check weather reports or pollen apps for the pollen count and stay indoors when it's high.
  - Avoid line-drying clothes and bedding when the pollen count is high.
  - Wear wraparound sunglasses to protect their eyes from pollen.
  - Keep doors and windows shut during the mid-morning and early evening. This is when there's most pollen in the air.

- Shower, wash their hair and change their clothes after being outside.
- Avoid grassy areas, such as parks and fields, when possible.
- Consider asking someone else to cut the grass for them if they have a lawn.

- **Mould spores**
  Moulds can grow on any decaying matter. Moulds are not allergens, but the spores they release are. Moulds release spores when there's a sudden rise in temperature in a moist environment. For example, when central heating is turned on in a damp house or wet clothes are dried next to a fireplace. To help prevent mould spores, individuals should be advised to:
  - Keep the home dry and well ventilated.
  - When showering or cooking, use extractor fans or open windows but keep internal doors closed. This stops damp air spreading through the house.
  - Avoid drying clothes indoors, storing clothes in damp cupboards and packing clothes too tightly in wardrobes.
  - Deal with any damp and condensation in their home.

Optimal Nasal Spray Technique
Optimal nasal spray technique includes proper positioning of the head to prevent the spray from draining down the throat. Specific guidance depends on the type of spray. It is important that individuals are counselled on appropriate administration technique for intranasal medication, especially in avoiding the nasal septum. By avoiding the nasal septum, medication efficacy is increased and the likelihood of local adverse effects such as nasal irritation are reduced. There are rare reports of nasal septal perforation with INCS.

Use of multiple eye drops
For patients using multiple types of eye drops, such as a topical medication and artificial tears, it is advisable to space drops five minutes apart if possible, so that instillation of a second drop does not wash out the first. In addition, closure of the eyelids for a few seconds after drug instillation helps absorption into ocular tissues. Repetitive blinking should be avoided as much as possible as it causes topical medications to wash out of the ocular surface more quickly.

Allergen specific immunotherapy
Allergen specific immunotherapy is a treatment that alters the disease course by exposing the individual to an allergen in a controlled manner over a period of time. This results in desensitisation to the allergen. It may be beneficial in individuals with moderate to severe symptoms who are unresponsive or inadequately controlled by other treatment regimes. It may require referral to medical practitioners who specialise in allergies.

4.2 Medication information to be provided to the individual/parent/legal guardian using the authorised patient information leaflet if one is available.

- Signpost to available resources on HSE A-Z and the HSE app.
- Medication Patient Information Leaflets (PILs).

Key References

- HPRA https://www.hpra.ie/
- HSE A-Z https://www2.hse.ie/conditions/
- HSE Clinical Design and Innovation – Allergic Rhinoconjunctivitis https://www.hse.ie/eng/about/who/cspd/ncps/paediatrics-neonatology/resources/allergic-rhinitis.pdf
- UpToDate Allergen avoidance in the treatment of asthma and allergic rhinitis https://www.uptodate.com/contents/allergen-avoidance-in-the-treatment-of-asthma-and-allergic-rhinitis
- UpToDate Pharmacotherapy of allergic rhinitis https://www.uptodate.com/contents/pharmacotherapy-of-allergic-rhinitis
- UpToDate Allergic conjunctivitis: Management https://www.uptodate.com/contents/allergic-conjunctivitis-management
- Lourenço O, Bosnic-Anticevich S, Costa E, Fonseca JA, Menditto E, Cvetkovski B, Kritikos V, Tan R, Bedbrook A, Scheire S, Bachert C, Białek S, Briedis V, Boussery K, Canonica GW, Haahtela T, Kuna P, Novellino E, Samoliński B, Schünemann HJ, Wallace D, Bousquet J. Managing Allergic Rhinitis in the Pharmacy: An ARIA Guide for Implementation in Practice. Pharmacy (Basel). 2020 May 16;8(2):85. doi: 10.3390/pharmacy8020085. PMID: 32429362; PMCID: PMC7355936.
- Lourenço O, Cvetkovski B, Kritikos V, House R, Scheire S, Costa EM, Fonseca JA, Menditto E, Bedbrook A, Bialek S, Briedis V, Boussery K, Canonica GW, Haahtela T, Kuna P, Mullol J, Orlando V, Samolinski B, Wallace D, Duggan C, Paulino E, Pinto GS, Söderlund LÅ, Bousquet J, Bosnic-Anticevich S. Management of allergic rhinitis symptoms in the pharmacy Pocket guide 2022. Clin Transl Allergy. 2022 Oct 5;12(10):e12183. doi: 10.1002/clt2.12183. PMID: 36225265; PMCID: PMC9533218.

Appendix A – Clinical Sub-Group Membership

Core Membership

- Dr. Siobhán Ní Bhriain - HSE National Clinical Director Integrated Care (Chair)
- Dr. David Hanlon - HSE National Clinical Advisor Primary Care (Vice Chair)
- Ms. Ciara Kirke - HSE Clinical Lead National Medication Safety Programme
- Ms. Linda Fitzharris - HSE PCRS Head of Pharmacy
- Dr. Diarmuid Quinlan - Medical Director ICGP & GP
- Ms. Elaine Dobell - HSE General Manager, Office of National Clinical Director Integrated Care
- Ms. Marie Philbin - AMRIC Chief Pharmacist
- Mr. Jonathon Morrissey - Community Pharmacist
- Ms. Áine McCabe - Community Pharmacist
- Dr. Clíona Murphy – National Women and Infants Health Programme
- Ms. Sarah Clarke - Medicines Management Programme

General Membership as needed

- Ms. Aoife Doyle - HSE National Clinical Lead for Ophthalmology
- Prof. Anne Marie Tobin - HSE National Clinical Lead for Dermatology
- Dr. Eavan Muldoon - HSE National Clinical Lead for Infectious Diseases
- Dr. Seán O'Dowd - HSE National Clinical Lead for National Dementia Office representing National Clinical Programme for Neurology on behalf of Prof. Sinéad Murphy
- Ms. Ruth Hoban - HSE West Assistant Director of Nursing and Midwifery for Nurse Prescribing on behalf of Dr. Geraldine Shaw
- Prof. Fiona Lyons - HSE National Clinical Lead for Sexual Health
- Ms. Caoimhe Gleeson - HSE National Office for Human Rights and Equality Policy
- Dr. Andrew Bolas - Assistant National Oral Health Lead
- Dr. Myra Herlihy - Assistant National Oral Health Lead Special Care and Training
- Prof. Basil Elnazir – Consultant in Paediatric Respiratory Medicine

Allergic Rhinitis CSG Working Group

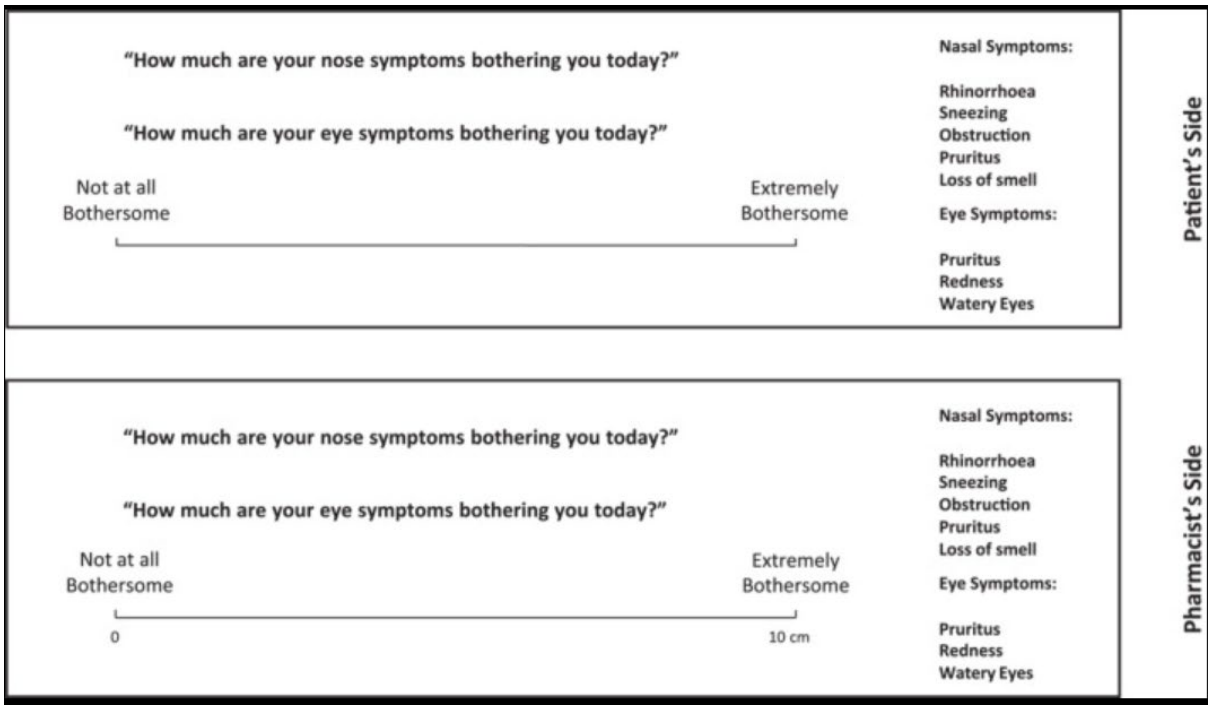
- Dr. David Hanlon - HSE National Clinical Advisor Primary Care (Vice Chair)
- Prof. Basil Elnazir – Consultant in Paediatric Respiratory Medicine
- Ms. Ciara Kirke - HSE Clinical Lead National Medication Safety Programme
- Ms. Marie Philbin - AMRIC Chief Pharmacist
- Mr. Jonathon Morrissey - Community Pharmacist
- Ms. Áine McCabe - Community Pharmacist

Appendix B Determining the impact of Allergic Rhinitis and/or Allergic Conjunctivitis using a Visual Analogue Scale (VAS)[11]

For individuals who find it difficult to categorise severity of symptoms a visual analogue scale (VAS), may be beneficial.

Assessed by the pharmacist:

- less than 2cm on the scale are “mild”
- between 2cm and 5cm are “moderate”
- greater than 5cm are “severe”



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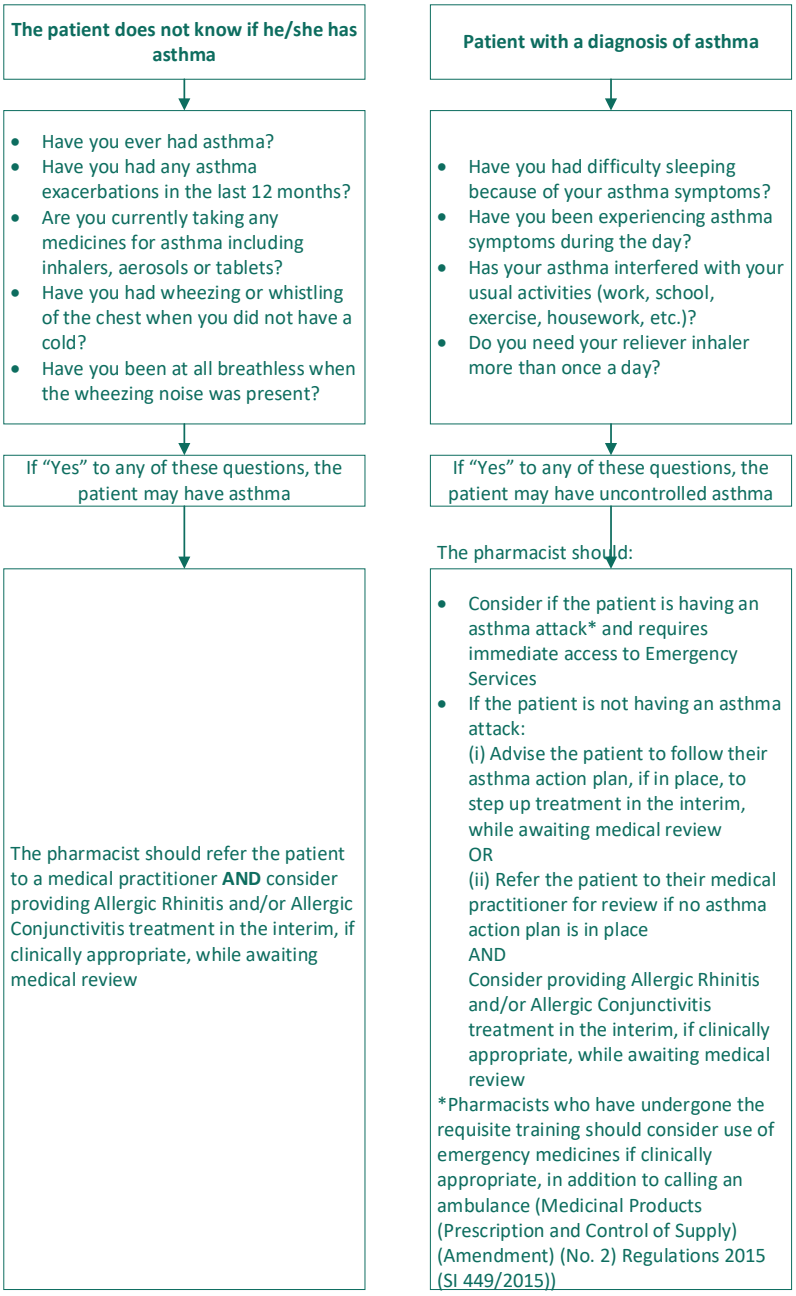
Appendix C Screening for Asthma in Allergic Rhinitis (AR) patients in the Pharmacy[12]

Allergic Rhinitis and Asthma often co-exist, and presence of asthma should always be evaluated in a patient presenting with AR symptoms. Allergic Rhinitis is also a risk for the development of asthma. In patients with asthma, AR may be associated with a poor control of the disease. The following questions will support pharmacists in screening patients for asthma:



[12] Lourenço O, Cvetkovski B, Kritikos V, House R, Scheire S, Costa EM, Fonseca JA, Menditto E, Bedbrook A, Bialek S, Briedis V, Boussery K, Canonica GW, Haahtela T, Kuna P, Mullol J, Orlando V, Samolinski B, Wallace D, Duggan C, Paulino E, Pinto GS, Söderlund LÅ, Bousquet J, Bosnic-Anticevich S. Management of allergic rhinitis symptoms in the pharmacy Pocket guide 2022. Clin Transl Allergy. 2022 Oct 5;12(10):e12183. doi: 10.1002/clt2.12183. PMID: 36225265; PMCID: PMC9533218.