Hayfever — practical management issues

In this month’s Journal Owen et al\(^\text{I}\) compare the effectiveness of topical treatments, namely mast cell stabilisers (cromoglycate, nedocromil and lodoxamide) with topical antihistamines (azelastine, emedastine, antazoline and levocabastine) for the treatment of seasonal allergic conjunctivitis. They conclude that both are effective groups, but that there is insufficient evidence as to whether the benefits of potentially faster treatment with topical antihistamines are worthwhile. The importance of patient preference in deciding on treatment options is noted.

Patients with allergic conjunctivitis or rhinitis present at varying times. Some sufferers experience symptoms in April, when tree pollen levels are abundant. For others, symptoms start with the onset of the grass pollen season,
usually in May. Grass pollen is the chief allergen, some weed pollens also cause problems and fungal spores may be a factor at the end of the summer. The start of the pollen season varies with weather conditions and is generally later with northward progression. In some years, hay fever is particularly troublesome, for example in 1992. This is chiefly because the somewhat fickle weather in the United Kingdom (UK) profoundly affects the level of airborne pollen and smaller fragments of allergenic material, known as paucimicronic particles. The latter have been implicated in exacerbations of asthma around the time of thunderstorms. This editorial was written at the end of a very wet April and, so far, hay fever rates are low in the North and average in the South. Peak incidence is in school age children and declines with age. A recent publication suggests that hay fever is declining in severity, a finding in keeping with reduced asthma attacks resulting in hospital admissions or presentation to general practitioners.

Typical hay fever symptoms include sneezing, rhinorhoea and irritating, watery eyes. A third of patients presenting with hay fever also report wheezeiness. Peaks of asthma incidence have been described that are synchronous with hay fever and these are particularly obvious in children and young adults. For the vast majority of sufferers, hay fever is relatively mild and very few patients are referred to secondary care. Hay fever is a huge pyramid of disease, those at the base experiencing relatively mild symptoms, whereas a smaller group at the top are considerably incapacitated, with disruption of education, especially at exam time, and of work. It is estimated that as many as one in five people suffer from hay fever, but only 1–2% consult a general practitioner each year. The rate of consultations with general practitioners increased during the 1970s and 1980s, but there is evidence of a downward trend over the last 10 years.

In the UK many patients self medicate, particularly adults who pay for their prescriptions. Unless relatively large quantities of medication are required, the cost of a prescription and the inconvenience of a trip to the doctor further encourage patients to seek advice from a pharmacist. Additionally, prescriptions are often authorised without consultation where patients have consulted in previous years. Most patients consult having already experienced symptoms, rather than in anticipation of the forthcoming hay fever season.

The challenge for the patient and the general practitioner is to pitch treatment at an appropriate level for their anticipated disease severity, without risking side effects more serious than the disease. PRODIGY guidance includes a classification of the severity of allergic rhinitis, but it is difficult to attach much therapeutic relevance to this. For example, mild allergic rhinitis is defined as ‘symptoms are not troublesome and normal activities, such as sleep, sport, leisure, work and school, are unaffected’. It is difficult to imagine a patient in this category requesting treatment.

Management should be tailored to each individual patient, based on their previous experience of the condition, the effectiveness of treatments tried previously, the severity of current symptoms and the timing in relation to the hay fever season. The tendency of many patients to grow out of their hay fever, or at least to have periods of remission, should be put into the equation. Awareness of likely prevailing pollen levels and simple advice on minimising exposure to pollen is potentially useful (see Box 1), but some of these suggestions may be excessive for all but the most severe sufferers.

Those with a history of severe symptoms and a history of concurrent asthma exacerbations should be treated with regular medication for both conditions and have a clear plan of action to deal with a worsening of their asthma.

It has been advocated that prophylactic treatment (topical nasal corticosteroids and sodium cromoglycate eye drops) should be started 2–3 weeks before the pollen season to prevent priming by allergen. However, regular use of two preparations and the probable addition of oral antihistamines over several months should be restricted to those likely to have severe symptoms. For most patients with relatively minor symptoms medication is used as necessary and more regularly during the peak periods. Conventional treatments for hay fever are well tolerated by most people. Antihistamines and intranasal corticosteroids such as beclometasone and fluticasone are the usual treatment options; the latter are particularly useful in reducing nasal congestion. There is little evidence that the newer third generation antihistamines, such as desloratadine or levocetirizine, confer benefit over second generation versions such as loratadine and cetirizine. Antihistamines in current use have a good safety profile, but drowsiness may occur, particularly with some of the older products such as chlorpheniramine. Topical nasal or eye treatments have relatively few reported side effects, but there are potential problems with long-term usage of corticosteroid nasal sprays, especially in children.

Recent examples of serious problems with treatments should not be forgotten; terfenadine and astemizole were withdrawn because of concerns regarding cardiac arrhythmia, in particular torsade de points, which is potentially fatal. Desensitising injections are now only given in centres where full cardiorespiratory resuscitation facilities are available because of a number of reported deaths in the early 1980s. Depot corticosteroid injections are less frequently used because their effects cannot be reversed and skin atrophy or abscess formation may occur. Short courses of oral corticosteroids may be very useful in severe exacerbations of hay fever, but their significant side effect profile must be borne in mind. Prolonged use of oral corticosteroids should be avoided if at all possible; immune system suppression may occur, which is a particular concern in relation to chick-
en pox in younger persons. The herbal treatment ‘butterbur’ attracted attention recently, when it was found to be as effective as cetirizine for the short-term treatment of pollen-related rhinitis.14 However, ‘more data on safety are required because hepatotoxic alkaloids had been removed from the butterbur extract used in the trial’.10

Age, seasonal variation and weather conditions all influence hay fever. Thus, a dynamic and flexible approach to management is required, particularly for those with mild symptoms. These concepts can be discussed at a consultation to establish an appropriate management plan to cover different eventualities. This is likely to be time well spent.

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References

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