GUIDELINES ON ANTIHISTAMINES, INTRANASAL STEROID SPRAYS AND DROPS (NASULES)

Intranasal steroid sprays

- Antihistamines (e.g. cetirizine, loratidine) are the usual first line treatment for **mild** allergic rhinitis, but are usually started in primary care. Where feasible, patients should be encouraged to purchase these over the counter (OTC).
- Intranasal steroids are a first line treatment in **moderate and severe** allergic rhinitis, either alone or in combination with oral antihistamines. Beconase can also be bought OTC. They are also an essential arm of therapy in long term management of nasal polyps.
- A range of drugs is necessary as some patients find tolerability better with one than another. Common reasons to change preparations include effects on taste, stinging, etc.
- Initial treatment should use the maximum dosage.
- Each treatment choice should be tried for a minimum of 14 days.
- Maintenance therapy can be down-titrated depending on symptoms, with many patients finding they can step the dose down to one puff in each nostril: Twice daily for beclometasone or daily for mometasone or fluticasone.
- True seasonal rhinitis may only need therapy with inhaled steroids during seasonal months and so treatments can be used, as a course of therapy, during the season affected and then stopped. However, some patients with perennial rhinitis may require long term maintenance therapy.
- Children have appropriate lower doses (see BNFc):
  - Fluticasone propionate (Flixonase®) is licensed from 4 years. It should only be used in patients aged 4 and 5 within Berkshire.
  - Beclometasone (Beconase®), mometasone (Nasonex®) and fluticasone furoate (Avamys®) are licensed from 6 years.

  It is important to consider steroidal side effects in children especially in those concurrently on steroid inhalers. The CSM recommend monitoring the height of children receiving prolonged treatment with any nasal steroid.

Formulary choice of intranasal steroid spray

1st choice: First generation intranasal steroids, beclometasone or budesonide, have a long record of safe usage. Beclometasone is cheap and convenient and available to purchase over the counter (for adults only). It should be considered to be the usual first line choice.

2nd choice: Newer intranasal steroids, e.g. mometasone and fluticasone are given once a day. This advantage needs to be balanced against the greater cost of these agents, i.e. approximately 3 times the cost of beclomethasone. Mometasone (Nasonex®) spray is the usual second line choice.

3rd choice: Fluticasone furoate (Avamys®) is preferred locally over the fluticasone propionate salt (Flixonase®) for reasons of cost and mode of delivery. Fluticasone furoate gives a mist rather than a spray and in theory can be useful in patients who have problems with tolerating 1st and 2nd line choices.

Original authors: Mr Ian Bottrill, ENT Consultant, Mr John Capper, ENT Consultant, Mr Hamish Thompson, ENT Consultant, Sarah Crotty, Interface Pharmacist, NHS Buckinghamshire. January 2013

Fluticasone proprionate nasal drops (Flixonase® nasules)

Fluticasone propionate (Flixonase®) nasules are a potent topical corticosteroid preparation used on a once daily basis. They deliver a higher dose of the steroid to the nose. This preparation is not a first line agent and should only be used following a trial of all three standard topical nasal corticosteroid sprays at their maximum doses.

Note: Because they are a high dose treatment, long term use of fluticasone propionate (Flixonase®) nasules pose a higher risk of steroid related side effects. They are significantly more expensive than corticosteroid nasal sprays.

Guidelines for usage in patients with severe nasal polyposis

- Fluticasone propionate (Flixonase®) nasules are a useful addition pre-operatively if the patient presents with nasal polyps which have not responded to a trial of three nasal corticosteroid sprays at their maximum doses.
- Licensed dose = 200 micrograms (half a nasule) in each nostril once or twice a day.
- If the patient responds to the nasules after a one month trial, then the patient can be transferred back onto a corticosteroid nasal spray to see if their improvement will be maintained. If the polyps return, then the nasules can be re-administered and their use titrated against clinical improvement.
- If the polyps are particularly severe, half a nasule in each nostril may be given twice daily, although the usual dosage is half a nasule in each nostril is once daily.

Post-operative use of fluticasone propionate (Flixonase®) nasules

- If the patient has a successful response then the patient can titrate the dose according to symptomatic improvement.
- Following the removal of polyps, in many patients symptoms will be adequately controlled with a topical nasal corticosteroid spray.
- Fluticasone propionate nasules are generally prescribed for six weeks and then stepped down to fluticasone propionate spray. Every attempt should be made to step the patient down after the initial six week acute treatment period.
- If the polyps do return, or for patients who have had multiple surgical procedures, benefit may be gained from re-treatment with a course of fluticasone propionate nasules.
- A small number of patients will require long term maintenance therapy. This should only be commenced by an ENT Consultant. If a GP is requested to continue long term treatment, the GP should be contacted to ensure that their treatment is continued in the community.

Date taken to APC	6th May 2015, approved by APC 1st July 2015
Date ratified by GP MOC	18th August 2015

Original authors: Mr Ian Bottrill, ENT Consultant, Mr John Capper, ENT Consultant, Mr Hamish Thompson, ENT Consultant, Sarah Crotty, Interface Pharmacist, NHS Buckinghamshire. January 2013