Table 13A. Rhinitis

Referral Guideline	Rationale	Evidence Type
Patients with prolonged or severe manifestations of rhinitis, with co-morbid conditions e.g. asthma, recurrent sinusitis, with symptoms interfering with quality of life and/or ability to function, or who have found medications to be ineffective or have had adverse reactions to medications. [1-3]	Allergist/immunologist care for rhinitis is associated with improved quality of life, compliance, and satisfaction with care.[4- 4,5]	Direct outcome
	Allergy cannot be diagnosed on the basis of history alone.[6,7] Allergist/immunologists are highly trained to interpret the clinical history and allergy diagnostic tests in both upper and lower airway conditions.[8]	Diagnostic
	Treatment for co-morbid rhinitis may improve asthma outcomes.[9]	Indirect outcome (pharmacologic therapy)
	Allergist/immunologists have familiarity with the wide variety of both indoor and outdoor aeroallergen exposures that have been shown to impact on the upper respiratory tree and have the expertise to provide avoidance education.[8]	Indirect outcome (avoidance)
	Allergen immunotherapy may be highly effective in controlling the symptoms of allergic rhinitis.[10] Allergen immunotherapy may provide lasting benefits after immunotherapy is discontinued. [11]	Indirect outcome (immunotherapy)
Patients with nasal polyps	Allergist/immunologists are specifically trained and experienced in the medical management of nasal polyps, including intranasal steroids, oral steroids, and treatment of complicating sinusitis [1,8]	Indirect outcome (pharmacologic therapy)
In addition to above guidelines, consider referral of the child with allergic rhinitis because of the potential preventive role of allergen immunotherapy in progression of allergic disease.	Allergen immunotherapy has been shown to reduce development of new sensitizations and asthma in children with allergic rhinitis compared to children with allergic rhinitis treated with medication alone.[12]	Indirect outcome (immunotherapy)

References:

1. Diagnosis and management of rhinitis: parameter documents. Joint Task Force on Practice Parameters representing the American Academy of Allergy, Asthma & Immunology, the American College of Allergy, Asthma and Immunology, and the Joint Council on Allergy, Asthma and Immunology. Ann Allergy Asthma Immunol. 1998; 81(5 pt 2):478-518. Evidence Grade: IV

2. Practice parameters for allergen immunotherapy. Joint Task Force on Practice Parameters representing the American Academy of Allergy, Asthma & Immunology, the American College of Allergy, Asthma and Immunology and the Joint Council on Allergy, Asthma and Immunology. Ann Allergy Asthma Immunol. 2003; 90(1):Supplement 1-40. Evidence Grade: IV

3. Bousquet J, van Cauwenberge P, Khaltaev N. Allergic rhinitis and its impact on asthma. J Allergy Clin Immunol 2001; 108:147-334. Evidence Grade: IV

4. Demoly P, Allaert FA, Lecasble M, PRAGMA. ERASM, a pharmacoepidemiologic survey on management of intermittent allergic rhinitis in every day general medical practice in France. Allergy 2002; 57:546-54. Evidence Grade: III

5. Bagenstose SF, Bernstein JA. Treatment of chronic rhinitis by an allergy specialist improves quality of life outcomes. Ann Allergy Asthma Immunol 1999; 83:524-8. Evidence Grade: III

6. Smith HE, Hogger C, Lallemant C et al. Is structured allergy history sufficient when assessing patients with asthma and rhinitis in general practice? J Allergy Clin Immunol 2009;123:646-50. Evidence grade: III

7. Williams PB, Ahlstedt S, Barnes JH, Soderstrom L, Portnoy J. Are our impressions of allergy test performances correct? Ann Allergy Asthma Immunol 2003; 91:26-33. Evidence Grade: III

8. Allergy and Immunology Core Curriculum Outline 1996. Core Curriculum Subcommittee of the Training Program Directors. American Academy of Allergy, Asthma and Immunology. J Allergy Clin Immunol 1996; 98(6pt.1):1012-5, updated in 2002 (http://www.aaaai.org/professionals/careers/training_programs.stm). Evidence Grade: IV

9. Expert Panel Report 3 (EPR3): Guidelines for the Diagnosis and Management of Asthma – Summary Report 2007. J Allergy Clin Immunol 2007;120:s94-s138. Evidence grade: IV

10. Bousquet J, Lockey R, Malling HJ. Allergen immunotherapy: therapeutic vaccines for allergic diseases. A WHO position paper. J Allergy Clin Immunol 1998; 102(4 pt 1):558-62. Evidence Grade: IV

11. Durham SR, Walker SM, Varga EM, et al. Long-term clinical efficacy of grass-pollen immunotherapy. N Engl J Med 1999; 341(7):468-75. Evidence Grade: Ib

12. Moller C, Dreborg S, Ferdousi HA, et al. Pollen immunotherapy reduces the development of asthma in children with seasonal rhinoconjunctivitis (the PAT study). J Allergy Clin Immunol 2002; 109:251-6. Evidence Grade: Ib