Optimal management of hayfever in primary care

The UK is “the most allergic nation on earth,” according to a speaker at this year’s event. “If it was a competition we would be winning,” warned Dr David Fox, consultant paediatric allergist and joint clinical lead at Guy’s & St Thomas’ Hospitals, in his presentation on the UK’s approach to hayfever management.

In the last 200 years, there has been a dramatic shift in the number of people with hayfever, who are often seen in primary care. The increase is especially pronounced in children, with a recent worldwide study showing that 10.1% of children aged six to seven years were estimated to have symptoms of hayfever (allergic rhinitis), while 15.3% of adolescents aged 13 to 14 years were found to be suffering the same condition.1 “For most of these kids it is not that big a deal and is something that they can manage with over-the-counter antihistamines, but for a proportion of children and adults it can be a very significant problem”, said Dr Fox.

The most noticeable impact of hayfever is on sleep and tiredness, with 46% of patients suffering from hayfever feeling tired in the daytime and 77% have trouble falling asleep.2 Hayfever also impacts on mood, work and school productivity, learning and cognitive function, with a 50% increased risk in children with hayfever dropping a grade in the space between mock exams around Christmas and the formal exam in the summer months.3 In adults, the effect of hayfever on reflexes and driving can equate to being on the border of the drink-drive limit (0.05% blood alcohol).4

In contrast to food allergy, allergen avoidance is not a feasible option for respiratory allergies. The common treatment option for hayfever is a long-acting non-sedating antihistamine, although “it is important to make sure you get the right one, as it is still really common that people are taking chlorphenamine regularly for their hayfever,” warned Dr Fox. As chlorphenamine is a sedating, short-acting antihistamine, it is more suited to treating allergic food reactions, and a study on exam performance showed children taking chlorphenamine for their hayfever actually had a 70% risk of dropping an exam grade between their mock and final exam.3

Other treatment options include nasal steroids, which are effective in treating nasal congestion and mucus but
“extra care needs to be taken to reassure parents that nasal steroids do not inhibit their child’s growth,” said Dr Fox. Nasal sprays can be used before the pollen season begins to prevent inflammation, while antihistamines can be taken as soon as symptoms of hay fever develop. Leukotriene-receptor antagonists should be considered in children who develop seasonal asthma with rhinitis as they treat both conditions. If treatment with antihistamines and nasal steroids is unsuccessful, which occurs in about 15% of all patients, then doses can temporarily be doubled.

In patients with chronic significant rhinitis, depot steroids are no longer recommended due to concerns over their long-term side-effects. Desensitisation is now the preferred alternative, with a three-year desensitisation course resulting in a long-term reduction in symptoms as you “actually change the underlying immune response”, explained Dr Fox. Patient selection for desensitisation is currently strict, any patient with uncontrolled asthma is ineligible for treatment and patients are observed for much longer (up to an hour) after an injection to control any adverse reactions. Treatment is usually one injection per week for three years, but it can also be offered as tablets, spray or drops administered at home, either as a daily dose for three years, or in the two to three months prior to the pollen season and then continued for the season’s duration.

In spite of its efficacy, in the UK desensitisation is considered a last resort, and “if you compare us to the rest of Europe we are an absolute mile behind, as for every child that is desensitised in the UK, there are about 250 being desensitised in France,” said Dr Fox. The common adverse reaction associated with desensitisation is short-term and localised – usually minor itching or irritation at the area of administration – and one billion sublingual immunotherapy courses given worldwide have resulted in no fatal reactions. However, even with desensitisation, “it is all about managing patients’ expectations,” cautioned Dr Fox, because although it can have profound effects “desensitisation is not a cure, it just attenuates your immune response.”

**Inflammatory bowel disease treatment in 2017**

GP systems are seeing growing numbers of patients with inflammatory bowel disease (IBD) and need to ensure careful management, delegates heard from Dr Charlie Murray, clinical director for gastroenterology at the Royal Free Hospital.

“Generally speaking IBD refers to Crohn’s disease and ulcerative colitis and it is a condition we used to talk about being seen relatively infrequently by general practice, but it is increasing in prevalence,” said Dr Murray. At present, in the UK around one in every 650 people will develop Crohn’s disease and one in 420 will develop ulcerative colitis, and although either condition can develop at any age there has been a recent increase in the number of children diagnosed.

“IBD management has become more successful, but it has also become more complex,” Dr Murray explained, with the management of IBD increasingly carried out in secondary and tertiary care and requiring a multidisciplinary approach. However, early intervention in primary care is vital as remission is always higher in patients when the duration of disease has been shorter. “We need to get on with our therapy as early as we can,” said Dr Murray. Late presentation is the main reason for a delayed diagnosis, with one in three patients with Crohn’s disease waiting more than a year for diagnosis after onset of symptoms. Patients also see numerous health professionals before an IBD diagnosis is confirmed, which means “doctors are also missing opportunities,” warned Dr Murray.

IBD is difficult to diagnose. Crohn’s disease, for example, has numerous different phenotypes that can affect anywhere in the gastrointestinal tract from the anus to the mouth, and “frustratingly, for patients and us, around 15% of all people we diagnose with IBD also remain unclassified,” said Dr Murray. Red flags that clinicians should be aware of are: a family history of IBD, diarrhoea with blood, incontinence, low albumin levels and a high platelet count in patients that seem otherwise healthy. A faecal calprotectin test is useful to check for underlying inflammation, as patients can sometimes have severe inflammation without exhibiting major symptoms.

In diagnosing Crohn’s disease, mucosal visualisation using either an MRI scan, an ultrasound of the small and/or endoscopic imaging, is useful. Colonoscopy is also an important diagnostic tool to help differentiate Crohn’s disease from ulcerative colitis in around 85% of cases. A capsule endoscopy can detect Crohn’s disease and bleeding in the bowels, although there is a risk that the capsules can get stuck in strictures. Ulcerative colitis only affects the colon and it is typically confluent – so it can be recognised by a continuous inflammation in the bowel that then has a clear cut-off.

If untreated, IBD is progressive and aggressive and can develop from an inflammatory phenotype to strictures, which, in the case of Crohn’s disease, can lead to penetration through the bowel wall. “Surgery can be very helpful, but it often leads to more surgery,” said Dr Murray, adding that current emphasis is directed to achieve mucosal healing and to reduce hospitalisations. “Steroids are evil,” cautioned Dr Murray, as in the short-term they work very well, and are sometimes overused by doctors and patients, but they do not alter the disease course and can have short-term and long-term side-effects such as thinning of the skin, osteoporosis, weight gain and psychosis.

Drug treatment for IBD should not be stopped during pregnancy. Treatment options such as azathioprine, mercaptopurine, mesalazine, topical and systemic steroids (only when necessary) and TNF inhibitors appear to be comparatively safe during pregnancy and breastfeeding. “It is much more important that mothers stay well than it is to stop treatment out of fear,” said Dr Murray. Methotrexate, however, is not safe to prescribe during pregnancy.

In recent years, “anti-TNF medication has revolutionised our treatment of Crohn’s disease and, to a certain degree, ulcerative colitis, to the stage now where multiple biological targets are being hit”, said Dr Murray. “We have more biological treatments available [for IBD] and even more coming to market,” he concluded, citing TNF inhibitors (infliximab and adalimumab), anti-integrin drugs...
(vedolizumab), and janus kinase (JAK) inhibitors (tofacitinib, filgotinib and upadacitinib), which are either currently available or in development for IBD.

**Alcohol and drug treatment in primary care**

Jeff Fernandez, nurse consultant for Islington Drug and Alcohol Services, described how the shared care programme was struggling with previously unseen challenges presented by an ageing population that was housebound and had long-term conditions and multiple co-morbidities.

The Islington shared care services, or Primary Care Alcohol and Drug Services (PCADS), began as a pilot scheme in 2004 to help patients with alcohol issues who had low attendance in specialised care, which was centralised and often far from a patient’s home. The PCADS model instead operates under a nurse-led system, which is intended to free-up GP time and treat patients locally. “This seems to work on a whole lot of levels,” said Mr Fernandez. “We have a GP to rubber stamp our clinical ethos and the nurses are able to prescribe within their area of expertise, which means that patients can come in, see one nurse or non-medical prescriber, or someone from PCADS, and get the whole service from motivational interviewing to prescribing.”

In PCADS, the main drugs used for alcohol and substance misuse are: buprenorphine, methadone, chlor Diazepoxide, naltrexone, disulfiram, and nalinefene. At present, methadone is the main drug used to treat substance misuse in patients who are opioid dependent, while buprenorphine is used in later stages of the detox as it has a shorter half-life than methadone. Chlor Diazepoxide is used for alcohol detoxification as it is a short-acting benzodiazepine that does not require much supervision, while naltrexone, which is usually used in patients detoxing off opioids or buprenorphine, “is increasingly being used to also keep people off alcohol, for which it seems to work really well,” said Mr Fernandez.

An ageing population with long-term conditions and multiple co-morbidities is presenting new challenges. “Before, we never saw patients with COPD or heart failure or diabetes, and this changes certain concepts of how we prescribe... COPD is a particular problem as people can smoke their drugs, be it crack cocaine or heroin,” Mr Fernandez pointed out. More patients with alcohol and substance addictions are also housebound and require home visits, which “is a new problem that hasn’t been seen in PCADS before and is an aspect of our care that I think will get more and more intensive,” said Mr Fernandez.

A number of patients seen in primary care have been on diazepam since the 1970s. Others are dependent on pregabalin, gabapentin, tramadol and over-the-counter drugs such as codeine and other opioid medications. “You have to be quite flexible in how you structure care and how you shape your service,” explained Mr Fernandez. “If you are focused on recovery then some patients will not fit in to services, and they are the ones that end up on the overdose statistics.”

The success rates are impressive. “We are getting to treat more patients in PCADS that had not been seen by specialised drug and alcohol services before” said Mr Fernandez. Research has shown that prescribing outcomes for alcohol and drug misuse disorders are just as effective in primary care as in specialised services, while prescribing methadone in primary care can reduce heroin use from 78% to 2%.

**References:**