Managing Seasonal Allergies

Nonpharmacologic management of seasonal allergies include **nasal irrigation** and **allergen avoidance** (e.g., keeping windows closed, using window screen filters and air conditioning, limiting outdoor time during peak allergen season, showering after outdoor exposure).[3] Choose a medication based on severity of symptoms, patient age, other medical conditions, and preferences.[2] Immunotherapy (subcutaneous or sublingual) can be considered if other management is not adequate or if the patient has seasonal allergies in combination with asthma.[1,2] Alternative therapies (e.g., supplements, homeopathy, acupuncture, honey) have been used and promoted for seasonal allergies; however, there are insufficient data to recommend these therapies.[3,4]

Drug/Class	Consider for…	Avoid or use particular caution…

Nasal corticosteroids
 	
See our chart, Nasal Sprays for Allergic Rhinitis.
	• first-line for moderate to severe, persistent symptoms.[3,5]
	• nasal congestion.[3,5]
	• itchy, irritated, or watery eyes.[3]
		• in children:[9,14]
		  • under six years (budesonide).
		  • under four years (fluticasone propionate).
		  • under two years (triamcinolone, mometasone [three years in Canada], fluticasone furoate).

Oral antihistamines See our comparison of first- and second-generation antihistamines later in this document.	• first-line for mild or intermittent symptoms (second generation).[3,5] • itching, sneezing, rhinorrhea (second generation).[5]	• under two years (most second generation).[9,22] • under 12 years (fexofenadine [Canada only]).[12] • in older adults, risk of excessive sedation (first generation, cetirizine).[9] • due to risk for decreased cognition or motor skills (first generation).[9] • with glaucoma (first generation).[9] • if severe liver impairment.[9] • if moderate to severe kidney impairment.[9,13] • with moderate or strong CYP3A4 inhibitors, grapefruit juice.[9,13] • with orange or apple juice; other OATP inhibitors (fexofenadine).[9] • if prolonged QT interval (Canada: bilastine, rupatadine).[7,13]

Nasal antihistamines
 	
See our chart, Nasal Sprays for Allergic Rhinitis.
	• add-on therapy with nasal steroids, if needed (especially for nasal congestion, rhinorrhea).[1,3,8]	• in children:
		  • under two years (azelastine 0.1% by prescription only [US]).[9]
		  • under six years (azelastine 0.15% [US], olopatadine [US]).[9]
		  • under five years (azelastine 0.1% [US]).[9]
		• (note: not available as single-ingredient nasal sprays in Canada).

Ophthalmic antihistamines	• add-on therapy for eye symptoms with nasal steroids, if needed.[1]	• under three years (ketotifen, olopatadine [Canada]).[9,15,16] • under two years (olopatadine [US]).[9]

Drug/Class	Consider for…	Avoid or use particular caution…
Decongestants (intranasal, oral)	• inadequate response from a nasal steroid for nasal congestion.[2] • use intranasal in combination with an oral antihistamine.[3] • intermittent nasal congestion.[2]	• if hypertension, arrhythmia, coronary heart disease, hyperthyroidism, glaucoma, diabetes, and benign prostatic hypertrophy (oral).[2] • prolonged use of intranasal (more than three to five days).[2,3] • with monoamine oxidase inhibitors.[6] • as monotherapy (intranasal).[6] • oral phenylephrine due to lack of efficacy.[23]
Cromolyn (intranasal [US]) See our chart, Nasal Sprays for Allergic Rhinitis.	• prevention. • inadequate response with other treatments. • children when parents have safety concerns with other therapy.[6]	• under two years.[9]
Leukotriene receptor antagonists (montelukast)	• use as a last resort.[6,10] • use if coexisting asthma.[1]	• for seasonal allergic rhinitis: under two years (US), under 15 years (Canada).[17,18] • if anxiety, depression, and psychiatric disorders.[6]
Oral corticosteroids	• use as a last resort for severe symptoms.[6,20,21]	• prolonged use (more than a few days).[6,20,21]

Comparison of First- and Second-Generation Antihistamines. Second-generation antihistamines are often recommended over first-generation antihistamines as they are as effective for seasonal allergies and have less sedation or other adverse effects.[11,19]

First-Generation Antihistamines[11,19]	Second-Generation Antihistamines[11,19]
• Some examples of first-generation antihistamines include: brompheniramine, chlorpheniramine, diphenhydramine, doxylamine, hydroxyzine • **Non-selective** (target histamine-1 receptors, but also cholinergic, alpha-adrenergic, and serotonergic receptors). • Can have **substantial adverse effects**, especially in older patients (not recommended in patients >65 years old). • Most common adverse effect is sedation. May decrease cognitive and motor skills, use with caution. • Some (especially children) may have stimulating effects (e.g., insomnia, anxiety, hallucinations). • Can cause anticholinergic effects (e.g., dry mouth, dry eyes, constipation, tachycardia).	• Some examples of second-generation antihistamines include: o bilastine (Canada only) o cetirizine o desloratadine o fexofenadine o loratadine o rupatadine (Canada only) • **Selective** (more specific to peripheral histamine-1 receptors; don't cross the blood-brain barrier). • Generally well tolerated. • Generally not sedating (note that cetirizine may be slightly more sedating than other second generation antihistamines). • Can be more expensive than first-generation antihistamines.

Users of this resource are cautioned to use their own professional judgment and consult any other necessary or appropriate sources prior to making clinical judgments based on the content of this document. Our editors have researched the information with input from experts, government agencies, and national organizations. Information and internet links in this article were current as of the date of publication.

Levels of Evidence

In accordance with our goal of providing Evidence-Based information, we are citing the **LEVEL OF EVIDENCE** for the clinical recommendations we publish.

Level	Definition	Study Quality
A	Good-quality patient-oriented evidence.*	1. High-quality randomized controlled trial (RCT) 2. Systematic review (SR)/Meta-analysis of RCTs with consistent findings 3. All-or-none study
B	Inconsistent or limited-quality patient-oriented evidence.*	1. Lower-quality RCT 2. SR/Meta-analysis with low-quality clinical trials or of studies with inconsistent findings 3. Cohort study 4. Case control study
C	Consensus; usual practice; expert opinion; disease-oriented evidence (e.g., physiologic or surrogate endpoints); case series for studies of diagnosis, treatment, prevention, or screening.	

***Outcomes that matter to patients** (e.g., morbidity, mortality, symptom improvement, quality of life).

[Adapted from Ebell MH, Siwek J, Weiss BD, et al. Strength of Recommendation Taxonomy (SORT): a patient-centered approach to grading evidence in the medical literature. Am Fam Physician 2004;69:548-56. https://www.aafp.org/pubs/afp/issues/2004/0201/p548.html.]

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