

AAO 23: Percentage of patients with allergic rhinitis who are offered intranasal corticosteroids or oral antihistamines

This measure is intended to decrease variability in management of allergic rhinitis by clinicians and encouraging the use of intranasal steroids or oral antihistamines for treatment of allergic rhinitis as first line treatment.

Quality Domain: Effective Clinical Care

Intranasal steroids are very effective for the treatment of AR. With potent anti-inflammatory properties, INS directly modulate the pathophysiology of AR. In nasal allergen challenge models, pretreatment with INS results in significant reduction in mediator and cytokine release along with a significant inhibition in the recruitment of basophils, eosinophils, neutrophils, and mononuclear cells to nasal secretions. INS also reduce the antigen-induced hyperresponsiveness of the nasal mucosa to subsequent challenge by antigen and histamine release. There are multiple classes of effective therapy with differing risks, adverse effects, costs, and benefits. The clinician should use his or her expertise in assisting patients to evaluate the best treatment and to ensure patient compliance. Different preparations of INS are comparable in efficacy, making sensory attributes an important factor in patient preference and adherence to therapy. Along with diminished nasal symptoms, INS have beneficial effects on allergic eye symptoms including itching, tearing, redness, and puffiness. As far as duration of therapy before INS are considered ineffective, onset of action starts at time points ranging from 3-5 hours to 36 hours after the first dose, as mentioned above. Hypertrophic adenoids can also be reduced in size with INS use. There were some differences of opinion regarding the best therapy for mild or intermittent symptoms and oral or nasal antihistamines may be adequate therapy for those patients. Patients may not be able to tolerate INS or oral antihistamines. Patients allergic to both classes of medications are excluded from the measure. Patients with either an allergy to one class or a condition that would likely modify tolerability of one class of medications are excepted from the measure.

Oral antihistamines, which block the action of histamine on the H receptor, have numerous anti-inflammatory effects. While these agents may not be as effective as INS, they are adequate for many patients with mild to moderate disease and have the advantage of lower cost, rapid onset of action, and effectiveness for intermittent symptoms. Shared decision making in considering the benefits, harms, costs, and evaluation of the best treatment options. Clinicians should offer a comparison of evidence for the effectiveness of oral versus nasal administration of antihistamines and nasal steroids that will provide good patient adherence and treatment efficacy. Oral antihistamines usually produce no further improvement when added to treatment with INS, although the addition of as-needed INS to a regularly taken oral antihistamine is a viable strategy.

Goal: Avoidance of sedating antihistamine use and promotion of use of effective symptom-directed therapy

Denominator: Patients with allergic rhinitis seen for an ambulatory visit with a diagnosis of allergic rhinitis.

Denominator Exclusions:

Patients with an allergy to oral antihistamines AND intranasal corticosteroids.

Denominator Exceptions: Patients with an allergy to oral antihistamines OR intranasal corticosteroids.

Patients with prostate cancer or benign prostatic hypertrophy as these patients may be intolerant of medications.

Patients with a history of epistaxis (due to INS use).

Numerator: Patients who are taking intranasal steroids or oral antihistamines. A prescription for or medication reconciliation of over the counter medications can be used to identify patients taking medications

Empowering otolaryngologist–head and neck surgeons to deliver the best patient care

Measure Type: Process, Traditional, Proportional, High Priority

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