



CSACI: Management of Allergic Rhinitis during COVID-19 Pandemic

INTRODUCTION

Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) has caused a global pandemic, necessitating major changes in how healthcare providers deliver care across the world. As it pertains to the practice of allergy and immunology, the outbreak of COVID-19 has led to a number of questions regarding the management of allergic diseases. An ad-hoc expert panel of allergists and immunologists across Canada and the US recently convened to make recommendations on managing allergic conditions during this unanticipated and highly unusual time; this review article is currently in press. ^[1] We feel that it provides a thorough and pragmatic approach to the most common problems encountered in allergy practice.

However, questions still exist around whether standard management of allergic rhinitis continues to be appropriate during this time of outbreak. The approach to managing allergic rhinitis has been reviewed extensively and outlined for Canadian physicians in our society's recent supplements published in 2018. ^[2] The recommendations in this paper set a standard for management of allergic rhinitis in Canada and are supported by the Canadian Society of Allergy & Clinical Immunology. The mainstays of treatment include allergen avoidance, second-generation oral antihistamines, intranasal corticosteroids, and allergen immunotherapy. The purpose of this letter is to clarify our recommendations regarding management of allergic rhinitis during the COVID-19 pandemic. The target audience is any Canadian physician managing allergic conditions.

INTRANASAL STEROIDS

Recently, some physicians have suggested that intranasal corticosteroids may make patients more susceptible to viral infections, including COVID-19. ^[3] However, as far as we are aware, there is no clinical data to suggest that intranasal corticosteroids increase the risk of contracting SARS-CoV-2 or the risk of more severe outcomes. Therefore, with the current data available, we recommend continuing to follow the accepted clinical approach to treating allergic rhinitis: if allergen avoidance and second-generation antihistamines are not clinically effective, then intranasal corticosteroids should be considered as the next step in treatment. This approach is supported by the review article by Shaker et al ^[1], and by other professional allergy societies. ^[4]

ALLERGEN IMMUNOTHERAPY

During this time of pandemic, many health authorities and professional organizations have recommended that non-essential medical services be temporarily suspended. Aeroallergen immunotherapy, offered either via sublingual or subcutaneous routes, is one such service that may be considered nonessential.

In Canada, sublingual immunotherapy (SLIT) tablets are currently available for grass, ragweed, and house dust mite. Grass and ragweed SLIT are typically initiated prior to their respective aeroallergen seasons and continued daily until the end of the season. As such, ragweed immunotherapy is typically initiated in May (approximately 12 weeks prior to ragweed season). In Canada, the standard of practice is that a physician (typically an allergist) supervises the first dose of sublingual immunotherapy for the season annually at the start of the course. That said, we have received communications from ALK Canada and Stallergenes Greer Canada that there have not been any reported cases of systemic reactions or anaphylaxis in North America with the initial dose on second or subsequent years of treatment with sublingual grass and ragweed immunotherapy. Also, there is supportive data that suggests that resuming sublingual immunotherapy with house dust mite after interruption is likely safe.^[5] Therefore, we suggest that if the patient has previously taken and tolerated ragweed sublingual immunotherapy, they are likely safe to resume treatment this year from home without a physician observing the first dose. In future, a similar approach could be used for resuming house dust mite immunotherapy after interruption, or patients resuming grass sublingual immunotherapy. The physician and patient should also discuss whether an epinephrine auto-injector should be prescribed and made available. These should be a shared decision between the prescribing physician and the patient. We do not recommend initiating the first season of sublingual immunotherapy at this time.

In contrast, given that non-essential services are currently being suspended, physicians should consider suspending or stopping aeroallergen subcutaneous immunotherapy (SCIT), especially in high risk groups for COVID-19. During this time, SCIT should not be initiated. For patients who are already receiving regular SCIT, if SCIT is interrupted for an extended length of time, the dosing will have to be decreased upon re-initiation or the immunotherapy protocol may have to be restarted. We understand that many patients will find it a great inconvenience to restart their SCIT if treatment is interrupted for an extended period. The decision for how to proceed should be a shared decision between the prescribing physician and the patient.^[1] Further, local standards set during the pandemic must be taken into consideration.

CONCLUSION

In summary, regardless of the current state of the pandemic, current evidence supports our recommendation to continue to manage patients with allergic rhinitis per the published guidelines and the standard of care. This includes the appropriate use of

intranasal corticosteroids. In order to decrease non-essential clinic visits, we suggest that in second and subsequent years, sublingual immunotherapy may be reinitiated at home instead of in the clinic, using shared decision making between the patient and physician. Subcutaneous immunotherapy should not be initiated during this pandemic and consideration should be made to suspend ongoing subcutaneous immunotherapy, especially in high risk patients. Any interruption of subcutaneous immunotherapy will require dosing adjustments when treatment is resumed.

We understand that the COVID-19 pandemic has caused major disruptions in all of our clinical allergy/immunology practices across Canada. We have all had to make many difficult decisions and we understand that there remains great uncertainty surrounding the next weeks and months.

Thank you for your dedication to the expert and compassionate care for patients with allergic conditions.

Dr. Harold Kim, President
Dr. Tim Vander Leek, Vice President
Dr. Anne Ellis, Treasurer

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3. Holland P. Coronavirus: Asthma and hay fever pills could “make fighting of COVID-19 harder” [Internet]. The Daily Mirror; 2020 Apr 16 [cited 2020 Apr 19] Available from: <https://www.mirror.co.uk/news/uk-news/coronavirus-asthma-hay-fever-pills-21875999>
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