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Treatment of Allergic Rhinitis in Pregnancy and Breastfeeding

Allergic rhinitis is an inflammation of the nasal mucosal membranes causing sneezing, rhinorrhea, itchy eyes and nose, and nasal congestion. People with seasonal rhinitis ("hay fever") exhibit symptoms at specific times during the year (usually spring and summer), while those with perennial rhinitis have symptoms all year. Tree, grass and weed pollens are the usual seasonal allergens. Perennial allergens include house dust mites, indoor moulds, animal hair and occupational allergens.

Allergic rhinitis affects approximately one-third of women of childbearing age. Drug treatment may be needed for symptoms during pregnancy and/or breastfeeding. Pre-existing rhinitis may worsen, improve, or remain unchanged during pregnancy. In addition, pregnancy-induced vasomotor changes may result in increased nasal congestion.

Ideally all drug therapy should be avoided during pregnancy and/or breastfeeding, especially in the first trimester. However, treatment can sometimes not be avoided. Treatment choice usually depends upon the predominant symptoms, with topical agents considered first-line as these minimise systemic exposure.

Important considerations regarding treatment:

- Avoid / minimise precipitating allergens, if known or possible.
- Assess risk and benefits of treatment. Avoid all unnecessary drug treatment especially in the first trimester of pregnancy.
- Any medication used during pregnancy or breastfeeding should be at the lowest effective dose for the shortest time necessary.
- Dose after a feed to minimise infant exposure in breastfeeding.

First-line therapy

Intranasal corticosteroids eg. beclomethasone, fluticasone, budesonide, triamcinolone

These are particularly useful for nasal congestion. While studies of intranasal use are limited, systemic use does not appear to pose significant risk. Topical use should be safer since absorption is less in comparison. Similarly, untoward effects on a breastfed infant are not expected. There is likely to be little difference in efficacy between the various intranasal corticosteroids. Beclomethasone has been in use longer, thus having a greater amount of evidence of safety, but use of fluticasone, budesonide or triamcinolone are also reasonable.

Oral first-generation antihistamines eg. promethazine, dexchlorpheniramine

These are considered safe to use in pregnancy and breastfeeding. However sedating effects may not be tolerated. Do not use after 36 weeks gestation of pregnancy due to risks of neonatal CNS & respiratory depression. Monitor breastfed infants for signs of sedation or irritability as a precaution, and dosing after a feed may help minimise exposure. Promethazine tends to be preferred as it is fully funded. Note: antihistamines are largely ineffective for nasal congestion.

Second-line therapy

Oral second generation antihistamines eg. loratadine, desloratadine, cetirizine, fexofenadine

These are generally considered safe in pregnancy and breastfeeding. They are only "second-line" due to greater amount of data with sedating agents. Use first-line is reasonable if sedative effects undesired. The safety data is most proven for loratadine.

Eye drops / intranasal sodium cromoglycate

Eyedrops may be useful in people with ocular symptoms not adequately treated by other means. Both the nasal spray and eye drops need to be given 2-4 times daily, so compliance may be an issue. Also, prolonged use (greater than one week) may result in rebound congestion on cessation, so intranasal corticosteroids tend to be preferred. These are considered safe for use in breastfeeding.

Lodoxamide is a mast cell stabiliser similar to sodium cromoglycate. However, data is lacking regarding the safety of use during pregnancy and breastfeeding, so sodium cromoglycate is preferred.

Intranasal ipratropium

Since inhaled ipratropium for asthma is considered safe in pregnancy and breastfeeding, the same can be assumed for intranasal use. Intranasal ipratropium may be of particular use where rhinorrhoea is the predominant complaint.

Eyedrops / intranasal sympathomimetic decongestants eg. phenylephrine, pseudoephedrine, oxymetazoline

These are not recommended for use in pregnancy (see below). Short-term use is unlikely to be problematic in breastfeeding. There is a theoretical risk of stimulation / irritability in the infant.

Intranasal antihistamines eg. azelastine, levocabastine

Data are limited regarding the safety of the available products in pregnancy. While systemic absorption from topical use may be small, alternative agents are generally preferred. There is a lack of specific safety data in breastfeeding, but transfer is unlikely to be clinically significant and use would be reasonable. However these are considered second-line after intranasal corticosteroids.

Not recommended

Oral sympathomimetic decongestants (and sympathomimetic eyedrops / intranasal use in pregnancy) eg. phenylephrine, pseudoephedrine, oxymetazoline

These are of limited use in the treatment of allergic rhinitis and rebound congestion tends to occur. Oral sympathomimetics have been associated with constriction of uterine blood vessels leading to foetal hypoxia. As safer alternatives are available, these agents are best avoided in pregnancy. Topical preparations are preferred due to lower systemic absorption.

Contact the Drug Information Service (ext. 80900) for more information or assistance with treatment options.