

OTOLARYNGOLOGY WAIVERS

CONDITION: ALLERGIC / NONALLERGIC RHINITIS
(ICD9 477 / 477.9)

Revised January 2002

AEROMEDICAL CONCERNS: Allergic rhinitis is a common upper respiratory condition with a potential for causing significant medical incapacitation in flight personnel. Rhinitis is not usually disabling but is a distraction possibly causing significant periods of down time and, thus, reduced operational effectiveness. The reduced sense of smell could be hazardous in the cockpit. Congestion and swelling of the nasal passages in addition to rhinorrhea could interfere with the movement of air and result in difficulty breathing, distraction, discomfort, the use of medications with unacceptable side effects (i.e., drowsiness), or ear and sinus barotrauma with the potential for in-flight incapacitation.

WAIVER:

Initial Applicants:

Class 1A/1W: Mild SAR with symptoms less than 30 days a year and treated with short acting decongestants, antihistamines or intranasal steroids will be recorded as information only. Exception to policy must be requested for initial flight applicants who have been treated for greater than 30 days per year, or used systemic or topical steroids, prolonged antihistamine use, mast cell stabilizer therapy, immunotherapy, or have a history of sinus surgery to include polyp removal.

Classes 2, 3 & 4: Uncomplicated perennial or seasonal allergic rhinitis is not disqualifying and will be recorded as information only. Uncomplicated means treatment less than 30 days a year.

Rated Aviation Personnel (All Classes): Rated aircrew members will require a waiver if the condition is controlled by immunotherapy; or chronic (>30 days per year) use of a non-sedating antihistamine, as long as there are no significant adverse effects. (See Medications APL) Rated aircrew whose condition is controlled by intranasal steroids alone do not require a waiver and will be classified as Information Only.

INFORMATION REQUIRED: All requests for waiver or exception to policy should include:

- Brief AMS – to include major symptoms, duration and frequency of symptoms, medications or treatments used in the past, environmental triggers (e.g. animals, pollens, cold, altitude changes, etc.), and any smoking history.
- Allergy skin testing,
- ENT and allergy evaluations in cases of prolonged or moderate-to-severe symptoms should be included if consultation was requested.

FOLLOW-UP: None required unless symptoms worsen with significant impact on aircrew readiness.

TREATMENT:

Antihistamines – Fexofenadine (Allegra), and Loratadine (Claritin), (all other antihistamines are Class 4 [non-waiverable] this includes Cetirizine (Zyrtec)). This is the recommended first line treatment for mild disease.

Cromolyn sodium (Nasalcrom)- This is effective, but requires frequent (qid) dosing.

Intranasal Steroids – Dexamethasone (Dexacort), Flunisolide (Nasarel or Nasalide), Beclomethasone (Beconase, Beconase AQ, Vancenase, Vancenase AQ DS), Budesonide (Rhinocort), and Triamcinolone (Nasacort or Nasacort AQ), Fluticasone (Flonase), and Mometasone (Nasonex). This is the recommended first line treatment for moderate disease. (See Medications APL)

Intranasal Anticholinergics - Ipratropium bromide (Atrovent) 0.03% nasal spray is effective when rhinorrhea is the predominant symptom. It is not very helpful for relieving congestion, itchy watery eyes or sneezing.

Immunotherapy may be used while the aviator remains on flight status provided he (or she) remains relatively asymptomatic without the use of antihistamines. Occasional sudafed or use of an intranasal steroid is permitted. Aviation personnel should be grounded 12 hours following immunotherapy injection or for the duration of local or systemic reaction. (AR 40-8, Temporary Flying Restrictions due to Exogenous Factors, paragraph 4 b, August 1976) The accelerated method of reaching maintenance immunotherapy (Rush technique) can be used and should be considered to minimize grounding time.

DISCUSSION: Rhinitis is an inflammation of the nasal passages which can be subdivided into two major categories: Allergic and Nonallergic. Allergic rhinitis can be either seasonal or year round and can be characterized by any or all of the following symptoms: rhinorrhea, nasal congestion, sneezing, nasal or ocular pruritus and lacrimation. Seasonal allergic rhinitis is caused by an IgE mediated reaction to seasonal aeroallergens, typically tree, grass and /or weed pollens as well as molds. Perennial allergic rhinitis is a year round condition also due to an IgE mediated reaction to aeroallergens which primarily include dust mites, animal allergens and molds. Intranasal steroids and cromolyn have minimal side effects and are approved for use in aviation personnel. Nonallergic rhinitis may consist of nasal congestion, sneezing, and rhinorrhea. The congestion is often seen as alternating, with sometimes severe nasal obstruction. Inciting factors include temperature and humidity changes, odors, irritants, recumbency, and emotion. Treatment of nonallergic rhinitis with inhaled nasal steroids can be effective; and if symptoms are not disabling, no waiver is required. Daily antihistamine use is not recommended for treatment of nonallergic rhinitis.

The diagnosis rests primarily on history (time of day, seasonal variation of symptoms, frequency and duration of episodes, environmental factors such as home or work exposures, whether symptoms improve with altitude or humidity and if there are any triggers such as MSG, pollen, smoke, cold weather, physical exertion). Further evaluation is indicated if symptoms are severe and do not respond to medical therapy. Sinus CT scans or rhinoscopy would be part of a more in-depth evaluation. Allergy skin prick testing is the most sensitive test for identifying specific allergies. It is simple and inexpensive. Total IgE or eosinophil counts are not good screening tests and therefore are not recommended. Nasal smears are also dependent on good technique in obtaining, staining, and interpretation and are not recommended for diagnosis.

REFERENCES:

Dykewicz, MS, Fineman, S, et al. *Diagnosis and Management of Rhinitis: Parameter Documents of the Joint Task Force on Practice Parameters in Allergy, Asthma, and Immunology*. Annals of Allergy, Asthma, Immunology 1998; 81: 463-518.