EDITORIAL

Allergic rhinitis and rhinosinusitis in primary care: record-keeping, guidelines and implementation

See linked articles by Hoffmans *et al.* on pg 64 and Hammersley *et al.* on pg 71

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Rhinitis may be allergic (seasonal or non-seasonal), non-allergic, or infective. It may also involve the sinuses, and this is referred to as rhinosinusitis. Rhinosinusitis in turn may be acute or chronic.¹⁻⁵ Allergic rhinitis has been classified by ARIA (Allergic Rhinitis and its Impact on Asthma – www.whiar.org) according to symptom duration (intermittent vs. persistent) and severity (mild vs. moderate/severe), and this has recently been validated in children.^{4,6}

Rhinitis and rhinosinusitis are both managed largely in primary care. Both conditions may impact significantly on the lives of our patients – for example, the detrimental effect on children's examination performance due to allergic rhinitis.⁷ As well as the known links between allergic rhinitis and asthma,⁸ accurate diagnosis and evidence-based management are of prime importance for general practitioners (GPs). Two papers in this issue of the *PCRJ*^{9,10} address issues relevant to these conditions in the primary care setting.

The paper by Hammersley *et al.*⁹ is focused on the computerised record-keeping system in the UK, the way in which patients with seasonal allergic rhinitis (SAR) are coded, and what search methods are available for identifying these patients. They demonstrate very elegantly – through different search strategies – three alternative approaches to identifying these patients, with specificity and sensitivity ranging from 100%-86% and 85%-17%, respectively. Clearly the solution to the problem of identifying patients through computer searches lies in more rigorous attention to coding detail – ideally through the use of templates which can be used by clinicians when they enter data onto their computer systems. Allergic rhinitis was one of the topics highlighted in the Research Needs Statement from the International Primary Care Respiratory Group (IPCRG) published last year,¹¹ and perhaps this matter should be addressed in that context...

The other paper, by Hoffmans *et al.*,¹⁰ raises further questions – in particular, the implementation of guidelines, and strategies for improving care. In this survey of a Dutch population of GPs regarding the management of rhinosinusitis, the vast majority reported that when consulted by patients presenting with rhinosinusitis they do differentiate into acute and chronic rhinosinusitis. However, the Dutch College of General Practitioners' guideline for this condition does not distinguish between the two in its management advice, perhaps providing evidence of poor adherence to the local strategy?

The term 'evidence-based medicine' has become widely used in practice, and for many its practice has become synonymous with adherence to, or implementation of, guidelines in clinical practice. Of course, some guidelines, position papers, and clinical strategy documents are not truly evidence-based and are unsupported by clinical research findings. However, more recently, guidelines are developed on a firm foundation of scientific evidence. Therefore, the "million dollar question" is whether clinicians are aware of – or indeed, whether they consult and adhere to – guidelines, when managing their patients. As Haines and Jones pointed out years ago, unacceptable delay in the implementation of research findings results in suboptimal care for patients – as exemplified by the 150-year delay in introducing citrus into the diet of sailors to prevent scurvy despite clear and longstanding evidence of its efficacy.¹²

In the European position paper,^{1,5} management of rhinosinusitis is to an extent determined by whether patients present with acute or chronic rhinosinusitis – a classification based on whether or not symptoms have persisted for less than (acute) or more than (chronic) 12 weeks. Treatment for both types is determined by the severity of the illness (mild, moderate or severe). Acute rhinosinusitis is one of the commonest reasons for patients consulting their GP, and in most cases antibiotic prescription is not justifiable.^{1,5} The fact that the GPs in the study by Hoffman *et al.* differentiated this condition into acute and chronic suggests that perhaps they were aware of the European position paper on the subject. However, 1 in 5 still prescribed antibiotics for mild acute rhinosinusitis, thus indicating that they were not following the position paper advice.^{1,5}

For many years, we have known about the importance of guideline implementation,^{13,14} but many guideline developers fail to include clear strategies for implementation in their guideline statements. Perhaps this is exemplified in the Dutch survey.¹⁰ To further emphasise the point, the word “implementation” occurs in only one place in the European position paper document (in the Introduction), never to be referred to again in the whole document.⁵ On a more positive note, the Global Initiative for Asthma (GINA – www.ginasthma.org) is one of the organisations that is actively developing an implementation strategy. To this end, on World Asthma Day in 2010, the group launched a campaign to reduce asthma hospitalisations worldwide by 50% over the next five years. This will be achieved through active promotion of implementation strategies to facilitate improved knowledge of the GINA asthma strategy through the use of tools designed specifically for this purpose.

Conflict of interest declaration

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