

TABLE II. Grading the strength of the Consensus Based Statements (CBSs)**Strong CBS**

The work group and JTFPP are confident that the desirable effects of adherence to the statement outweigh the undesirable effects. This CBS may be appropriate to be used as a practice standard indicator. When making a strong CBS, the wording is “We recommend,” implying that the clinician “should” follow the recommendation.

The implications of a strong CBS are

- For patients—most people in your situation would want the recommended course of action and only a small proportion would not; request discussion if the intervention is not offered.
- For clinicians—most patients should receive the recommended course of action.
- For policy makers—the recommendation can be adopted as a policy in most situations.

Conditional CBS

The work group and JTFPP reach a decision that the desirable effects of adherence to a CBS probably outweigh the undesirable effect. When making a conditional CBS, the wording is “We suggest,” implying that the clinician “may” follow the recommendation.

The implications of a conditional CBS are

- For patients—most people in your situation would want the recommended course of action, but many would not.
- For clinicians—you should recognize that different choices will be appropriate for different patients and that you must help each patient to arrive at a management decision consistent with her or his values and preferences. It is likely that shared decision making will play a major role in arriving at the management decision.
- For policy makers—policy making will require substantial debate and involvement of many stakeholders.

TABLE III. Grading the certainty of evidence for each CBS

High = Further research is very unlikely to change our confidence in the estimate of effect. The recommendation is based on high-quality evidence, such as multiple highly rated randomized controlled trials, systematic reviews, or meta-analyses.

Moderate = Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate. The recommendation would likely be based on somewhat limited evidence, such as reduced number or quality of randomized controlled trials or controlled trials without randomization.

Low = Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate. The recommendation would likely be based on very weak evidence, such as nonexperimental studies, registries, or comparative studies.

Very low = Any estimate of effect is very uncertain. The recommendation is based largely on very low quality studies and/or on expert opinion.

CBS without determination of certainty:

When there are either no published studies, or very limited and/or very weak evidence, a consensus statement without any category of certainty of evidence was developed. The degree of agreement by all JTFPP and work group members is indicated, with voting details provided if there were dissenting votes.

Clinical history and physical examination

Recommendation 1. CBS: We recommend that the clinician complete a detailed history and a physical examination in a patient presenting with symptoms of rhinitis.

Strength of recommendation: Strong

Certainty of evidence: Low

Recommendation 2. CBS: We recommend that for patients presenting with rhinitis symptoms, a review of all current medications should be completed to assess whether drug-induced rhinitis may be present.

Strength of recommendation: Strong

Certainty of evidence: Ungraded due to lack of studies addressing this specific issue.

Note: Unanimous vote in favor by work group and JTFPP.

Clinical history in patients with rhinitis. The most important single element for establishing the diagnosis of rhinitis, allergic or nonallergic, and differentiating it from other conditions with overlapping symptoms, is the clinical history.^{1,20,175} The age of onset, duration, frequency, severity, timing during the year, suspected triggers, pattern of presentation, and progression of each patient-specific symptom should be obtained and recorded. The history should include the success or failure of past therapeutic interventions, including self-prescribed over-the-counter medications, homeopathic agents, or physician-prescribed treatments. The family history and personal history of comorbid respiratory conditions (eg, asthma and chronic rhinitis with or without

CRS) should be discussed. Because patients may not recognize symptoms of asthma, a history of symptoms suggestive of asthma (eg, wheezing, shortness of breath, chest tightness, and cough) should be sought, and if appropriate from symptoms, spirometry obtained. As noted earlier, AR coexists in about 75% to 80% of all patients with asthma, in nearly 100% of those with allergic asthma, and is a marker for more difficult-to-control or severe asthma. The overall medical, social, and psychiatric history; medication history (current and past); environmental exposures in the home or workplace; and family views on disease state and health care should be included in the patient history. As the final therapeutic decisions will involve shared decision making, the history should explore the wishes and desires of both the patient and family in selecting diagnostic procedures and therapeutic interventions, including their willingness to adhere to these therapies.

In clinical practice, especially in primary care, the diagnosis of AR is often made solely by history.¹⁷⁶ The use of validated questionnaires is more beneficial for excluding than for confirming AR. The use of a validated 4-question screening tool has been shown to have a high negative predictive value for positive skin prick tests to common aeroallergens.¹⁷⁷ Furthermore, if a patient has a late onset of symptoms (age >45 years); no family history of allergies; no seasonality of symptoms or symptoms around cats, dogs, or other furry pets; and has trouble with nonallergic triggers such as deodorants/fragrances, the likelihood of having a