COLDS & FLU

Patient assessment and symptomatic management • Infographic summary

From assessment to safe OTC care

Recognise symptoms → Identify red flags → Choose therapy → Counsel patients

Comprehensive patient assessment and evidence-informed OTC care.

1 | Common cold: essentials

Clinical overview

DEFINITION

Self-limiting viral infection of the upper respiratory tract.

TRANSMISSION

Mainly hand-to-nose contact. Contaminated surfaces (handles, phones) may carry viable viruses for hours.

Coughing/sneezing: secondary route.

PREVENTION

Wash hands frequently.

Use disposable tissues.

Avoid touching nose/eyes.

Children catch colds more often than adults.

2 | Patient assessment: AGE + ONSET

AGE / REFERRAL

Very young patients and frail older adults, especially with comorbidities (e.g., diabetes), require referral.

Age also determines treatment suitability.

ONSET + DURATION

COMMON COLD: gradual onset; typically 7–14 days. Cough may outlast other symptoms.

INFLUENZA: often abrupt onset and more debilitating.

FOLLOW-UP

See a doctor if cold symptoms have not improved within 14 days.

3 | Symptoms of the common cold

Progression and clinically important clues

THROAT + NOSE

Dry/sore throat may be the first symptom.

Rhinorrhea: clear watery discharge → thicker mucus.

Blocked nose, sneezing and coughing.

PAIN + SINUSES

Aches or headache may occur.

Persistent/worsening frontal headache, especially worse on bending forward or lying down → consider sinusitis and refer.

FEVER

Common cold: often low-grade fever; high fever is less typical.

Fever with systemic illness may indicate influenza or COVID-19; symptoms alone cannot reliably distinguish them.

4 | Cold vs flu: rapid comparison

COMMON COLD

Onset: gradual

Main symptoms: sore throat, rhinorrhea, nasal blockage, sneezing, cough

Duration: often 7–14 days

Occurs throughout the year

INFLUENZA

Onset: often abrupt

Typical features: fever, respiratory symptom(s), plus headache / malaise / myalgia / chills / sweats

Usually more debilitating

Peak season: winter

Important: Influenza and COVID-19 have overlapping symptoms; follow current local clinical/public-health guidance.

5 | Complications & special assessment

EARACHE / OTITIS MEDIA

Earache may follow a cold, especially in children; middle-ear fluid can cause acute otitis media.

Pain relief: paracetamol or ibuprofen. Many cases resolve within 2–3 days.

Refer if pain persists or child is unwell (e.g., fever >39°C).

MEDICAL / MEDICINE HISTORY

Asthma or COPD: viral illness may precipitate exacerbation.

Heart/lung disease, kidney disease, diabetes or immunocompromise increase concern.

Immunosuppressants (corticosteroid, ciclosporin) and failure of prior OTC remedies require referral.

6 | WHEN TO REFER

Pharmacy triage — red-flag summary

HIGH-RISK PATIENT

Very young

Frail older adult

Asthma or COPD

Cardiac/pulmonary disease

Kidney disease / diabetes

Immunocompromised

CONCERNING SYMPTOMS

Persisting fever and productive/severe cough

Pleuritic chest pain

Delirium

Unresolved earache

Suspected pneumonia / sinusitis

TREATMENT FAILURE

No response to appropriate OTC medicine

Symptoms not improving by 14 days

Suspected secondary bacterial infection

7 | MANAGEMENT: general + non-drug

Before pharmacological treatment

INFECTION CONTROL

Antibiotics do NOT treat uncomplicated viral colds or influenza.

Avoid crowded places and sick contacts.

Wash hands after blowing nose.

Discard used tissues.

Keep rooms ventilated.

SUPPORTIVE CARE

Saline nasal drops/sprays moisten mucosa and loosen mucus; useful for infants and young children.

With influenza: rest, adequate sleep and fluids, particularly with fever.

Annual reformulated influenza vaccine exists; no vaccine for common cold.

8 | Decongestants: systemic (oral)

DRUGS + ACTION

Sympathomimetic decongestants constrict dilated nasal blood vessels.

Examples: Pseudoephedrine and phenylephrine.

Used in cough/cold combinations where nasal blockage is present.

IMPORTANT CAUTIONS

May increase blood pressure, stimulate the heart and alter diabetic control.

Use with caution or avoid in:

- Diabetes
- Coronary heart disease/angina
- Hypertension
- Hyperthyroidism

9 | Topical nasal decongestants: classification

Classification by duration of action

SHORT-ACTING

Naphazoline

Phenylephrine

Tetrahydrozoline

Topical nasal drops / sprays

LONG-ACTING

Xylometazoline: 8–10 hours

Oxymetazoline: ~12 hours

Topical options may be preferred where oral sympathomimetics are less suitable, but systemic precautions still matter.

10 | Topical nasal decongestants: dose table

Strengths, ages, dosing intervals and duration

DRUG / STRENGTH	AGE	DOSE
Naphazoline 0.05%	>12 years	1–2 drops/sprays per nostril; no more often than q6h
Naphazoline	6–<12 years	Not recommended
Oxymetazoline 0.05% (Nazordine®)	>12 years	2–3 drops/sprays per nostril q10–12h; max 2 doses/24h
Oxymetazoline 0.025%	6–<12 years	2–3 drops/sprays per nostril q10–12h; max 2 doses/24h
Xylometazoline 0.1% (Otrivine®)	>12 years	2–3 drops, 2–3 times daily PRN; maximum 7 days
Xylometazoline 0.05%	6–<12 years	1–2 drops, 1–2 times daily PRN; maximum 5 days

11 | Topical decongestants: duration & rebound

COUNSELLING

Avoid use beyond 5–7 days; product-specific limits may be shorter.

Prolonged topical use → rebound nasal congestion (rhinitis medicamentosa), particularly with short-acting agents.

Oral agents do not cause this topical rebound phenomenon.

IF REBOUND OCCURS

Management:

- Gradual withdrawal (sometimes one nostril at a time)
- Replace with normal saline
- Consider topical corticosteroid / systemic decongestant if needed

Recovery may take 2–6 weeks.

12 | Nasal route + combination preparation

SPRAY vs DROPS

Administration point:

Sprays: often preferred in adults and children >6 years, covering a larger mucosal area.

Drops: may be easier for younger children; more likely to be swallowed and produce systemic effects.

IPRATROPIUM + XYLOMETAZOLINE

Anticholinergic–decongestant nasal spray combination.

For symptomatic nasal congestion and rhinorrhea associated with common colds.

Licensed for adults >18 years.

13 | Antihistamines: overview and sedating agents

EFFECT ON COLD SYMPTOMS

Can reduce rhinorrhea and sneezing; less effective for nasal congestion.

No strong evidence indicates that one antihistamine is superior for rhinorrhea; individual response varies.

Groups: Sedating / Non-sedating.

SEDATING: AGENTS + RISKS

Chlorphenamine (chlorpheniramine)

Diphenhydramine

Drowsiness; dry mouth; blurred vision; constipation; urinary retention.

Anticholinergic burden increases with TCAs / neuroleptics. Avoid in glaucoma, prostatic hypertrophy and older adults.

14 | Antihistamines: non-sedating + combinations

NON-SEDATING

Loratadine • Fexofenadine

Acrivastine • Cetirizine

Loratadine adult dose: 10 mg once daily.

Sedation is less common but driving/skilled-task warning remains.

Antimuscarinic adverse effects are not a major issue.

COMBINATION PRODUCTS

Sympathomimetic → nasal congestion

Antihistamine → rhinorrhea and sneezing

Combination rationale:

1. Sympathomimetic may offset congestion accompanying reduced rhinorrhea.
2. CNS stimulation may partially counter antihistamine-related sedation.

Note: this does not make driving safe.

15 | Other symptom treatments

Symptom treatment options

ANALGESICS / ANTIPYRETICS

Paracetamol

Aspirin

Ibuprofen

Relieve fever, headache, muscle aches and general discomfort.

Aspirin: do NOT give to children under 16 years (Reye syndrome risk).

INHALANTS

Preparations with volatile substances inhaled directly or with steam.

May create a sensation of nasal clearing.

These products generally have few contraindications, but product-specific precautions still apply.

VITAMIN C

High doses >1 g/day provide minimal benefit for the common cold.

Effervescent tablets can contain substantial sodium bicarbonate: caution with cardiovascular disease or sodium restriction.

16 | How to use NASAL DROPS

Counselling workflow

PREPARE

1. Gently blow nose.
2. Wash hands.
3. Shake bottle if needed (suspension).
4. Remove cap; fill integral dropper if present.
5. Position head as demonstrated.

ADMINISTER + FINISH

6. Instil prescribed number into each nostril; avoid touching nose with dropper.
7. Hold position for ~2 minutes to prevent runoff into nose/throat.
8. Replace cap.

17 | How to use NASAL SPRAY

Counselling workflow

PREPARE + DELIVER

1. Blow nose and wash hands.
2. Shake spray if needed; remove cap.
3. Tilt head slightly forward.
4. Close one nostril.
5. Insert nozzle into open nostril; keep bottle upright.
6. Breathe gently in as spray is actuated.

AFTER SPRAY

7. Remove spray; exhale through mouth.
8. Tilt the head back for about a minute to reduce runoff.
9. Repeat on opposite side as directed.
10. Replace cap.
11. Avoid blowing nose for several minutes.

18 | References & clinical note

REFERENCES

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2. Rutter, Community Pharmacy: Symptoms, Diagnosis and Treatment, 6th ed. (2026).
3. Blenkinsopp et al., Symptoms in the Pharmacy, 10th ed. (2025).
4. FastTrack: Managing Symptoms in the Pharmacy (2008).
5. British National Formulary (BNF 90).
6. Non-prescription Medicines, 4th ed. (2010).
7. Martindale, 36th ed. (2009).

Medication doses and clinical claims should be verified against product-specific labelling and current guidelines before clinical application.