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| **2C — Surgical intervention for chronic rhinosinusitis** |
| **Summary of Intervention** |
| Chronic rhinosinusitis (CRS) is defined as inflammation (swelling) of the nasal sinuses that lasts longer than 12 weeks. The sinuses are mucus secreting, air filled cavities in the face and head that drain into the nose; their normal function may be disrupted by environmental, infectious or inflammatory conditions which damage the epithelial lining and disturb the balance of the natural microbial community. Patients report a number of symptoms including nasal blockage, discharge, alteration to smell, and facial pressure or pain. They often have a relapsing course, with recurrence after treatment Com monplace. Absenteeism and presenteeism are widespread.  It is a common chronic condition that affects approximately 11% of adults and has a significant detrimental effect on the quality of life of those affected, thus creating a significant disease burden. CRS as a term encompasses a wide range of phenotypes but can broadly be divided into two main types. Chronic rhinosinusitis with Nasal Polyposis (CRSwNP) and Chronic Rhinosinusitis without Nasal Polyposis (CRSsNP). First-line treatment is with appropriate medical therapy, which should include intranasal steroids and nasal saline irrigation. In the case of CRSwNP a trial of a short course of oral steroids should also be considered. Where first-line medical treatment has failed patients should be referred for diagnostic confirmation and they then may be considered for endoscopic sinus surgery. This involves surgery using a telescope via the nasal cavity to open the sinuses and, if present, remove nasal polyps, both improving the effectiveness of ongoing medical therapy and relieving obstruction. The surgery is usually undertaken under general anaesthetic as a day-case procedure in otherwise healthy individuals.  **This guidance applies to adults and children.** |
| **Number of interventions in 18/19** |
| **12,610** |
| **Proposal** |
| Patients are eligible to be referred for specialist secondary care assessment in any of the following circumstances:  — A clinical diagnosis of CRS has been made (as set out in RCS/ENT-UK Commissioning guidance) in primary care and patient still has moderate / severe symptoms after a 3-month trial of intranasal steroids and nasal  saline irrigation.  AND  — In addition, for patients with bilateral nasal polyps there has been no improvement in symptoms 4 weeks after a trial of 5-10 days of oral steroids (0.5mg/kg to a max of 60 mg)  OR  — Patient has nasal symptoms with an unclear diagnosis in primary care  OR  — Any patient with unilateral symptoms or clinical findings, orbital, or neurological features should be referred urgently / via 2-week wait depending on local pathways.  No investigations, apart from clinical assessment, should take place in primary care or be a pre-requisite for referral to secondary care (e.g. X-ray, CT scan). There is no role for prolonged courses of antibiotics in primary care. Patients can be considered for endoscopic sinus surgery when the following criteria are met:  — A diagnosis of CRS has been confirmed from clinical history and nasal endoscopy and / or CT scan  AND  — Disease-specific symptom patient reported outcome measure confirms moderate to severe symptoms e.g. Sinonasal Outcome Test (SNOT-22) after trial of appropriate medical therapy (including counselling on  technique and compliance) as outlined in RCS/ENT-UK commissioning guidance ‘Recommended secondary care pathway’.  AND  — Pre-operative CT sinus scan has been performed and confirms presence of CRS. Note: a CT sinus scan does not necessarily need to be repeated if performed sooner in the patient’s pathway.  AND  — Patient and clinician have undertaken appropriate shared decision making consultation regarding undergoing surgery including discussion of risks and benefits of surgical intervention.  OR  — In patients with recurrent acute sinusitis, nasal examination is likely to be relatively normal. Ideally, the diagnosis should be confirmed during an acute attack if possible, by nasal endoscopy and/or a CT sinus scan.  There are a number of medical conditions whereby endoscopic sinus surgery may be required outside the above criteria and in these cases they should not be subjected to the above criteria and continue to be routinely funded:  — Any suspected or confirmed neoplasia  — Emergency presentations with complications of sinusitis (e.g. orbital abscess, subdural or intracranial abscess)  — Patients with immunodeficiency  — Fungal Sinusitis  — Patients with conditions such as Primary Ciliary Dyskinesia, Cystic Fibrosis or NSAID-Eosinophilic Respiratory Disease (NSAID-ERD, Samter’s Triad Aspirin Sensitivity, Asthma, CRS)  — Treatment with topical and / or oral steroids contra-indicated.  — As part of surgical access or dissection to treat non-sinus disease (e.g. pituitary surgery, orbital decompression for eye disease, nasolacrimal surgery) |
| **Rationale for Recommendation** |
| There is a strong evidence base and expert consensus opinion to support the medical management of chronic rhinosinusitis with intranasal steroids and nasal saline irrigation as a first-line treatment. They are low cost and low  risk, with newer generations of nasal steroids safe for long-term use owing to minimal systemic absorption.  There is also evidence to support the trial of oral steroids, but only when nasal polyposis is present. The benefits of oral steroids should be balanced against the risks when considering repeated courses. A Cochrane review has demonstrated the benefits of oral steroids can last up to three months; however the risks and side effects must be balanced against benefit for the patient with repeated courses.  There is evidence to support that when endoscopic sinus surgery is performed in appropriately selected patients (as outlined in the recommendation), it will lead to a significant and durable improvement in symptoms. There is also evidence that patients who undergo surgery early in their disease course will have a longer and more beneficial impact from the surgery. All national and international guidelines support consideration of endoscopic sinus surgery once appropriate medical therapy has failed.  It is important to note that there is currently a UK multidisciplinary randomised controlled trial (RCT) comparing medical therapy with surgery in the management of chronic rhinosinusitis (MACRO Trial: <https://www>. themacroprogramme.org.uk). he outcome of this trial may lead to modification of guidance for sinus surgery in due course.  Endoscopic sinus surgery is generally safe and low risk. Risks include bleeding, infection, scar tissue formation, and very rarely, orbital injury or cerebrospinal fluid leak (with associated risk of meningitis). Patients should be counselled that there is a risk of recurrent symptoms and that ongoing medical treatment is normally required to maintain symptom improvement after endoscopic sinus surgery.  Reference |
| **References** |
| 1. RCS Commissioning Guide: Chronic Rhinosinusitis. 2016: <https://www.rcseng.ac.uk/standards-and> research/commissioning/commissioningguides/topics/  2. NICE Clinical Knowledge Summary – Sinusitis: <https://cks.nice.org.uk/>sinusitis  3. Hastan D, Fokkens WJ, Bachert C, et al. Chronic rhinosinusitis in europe-an underestimated disease. A GA(2)LEN study. Allergy. 2011;66(9):1216-1223.doi: 10.1111/j.1398-9995.2011.02646.x [doi].  4. Orlandi RR, Kingdom TT, Hwang PH, et al. International consensus statement on allergy and rhinology: Rhinosinusitis. Int Forum Allergy Rhinol. 2016;6 Suppl 1:22. doi: 10.1002/alr.21695 [doi].  5. Fokkens WJ, Lund VJ, Mullol J, et al. EPOS 2012: European position paper on rhinosinusitis and nasal polyps 2012. A summary for otorhinolaryngologists. Rhinology. 2012;50(1):1-12. doi: 10.4193/Rhino50E2 [doi]. |