NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

CHRONIC RHINOSINUSITIS (ADULTS AND CHILDREN)

CRITERIA BASED ACCESS

Rhinosinusitis is defined as inflammation of the nose and paranasal sinuses. In acute rhinosinusitis, there is complete resolution of symptoms within 12 weeks of onset. If symptoms persist for more than 12 weeks this is categorised as chronic rhinosinusitis (CRS).

Diagnosis is made by the presence of two or more persistent symptoms for at least 12 weeks, one of which should be:

- Nasal obstruction

AND/OR

- Nasal discharge

AND/OR

- Facial pain/pressure or anosmia.

Chronic rhinosinusitis is sub-categorised by the presence or absence of nasal polyps (CRSwNP or CRSsNP respectively).

- 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 may then be considered for endoscopic sinus surgery.

Recommended Primary Care Pathway as per the Royal College of Surgeons (RCS) Commissioning Guide (2016) on Chronic Rhinosinusitis is detailed in Appendix 1.

Patients are eligible to be referred for specialist secondary care assessment in 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.

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 prerequisite 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 regarding surgical treatment, including discussions regarding the risks and/or the benefits of surgical intervention.

OR

In patients with recurrent acute sinusitis, nasal examination is likely to be normal. Ideally, the diagnosis should be confirmed during an acute attack, if possible, by nasal endoscopy and/or a CT sinus scan

Appendix 1. Recommended Primary Care Pathway

(Royal College of Surgeons Commissioning Guide: Chronic Rhinosinusitis, 2016)

<table>
<tr><td colspan="3"><u>2 or more persistent symptoms for at least 12 weeks</u>
One of which must be either nasal obstruction and/or nasal discharge and/or facial pain, pressure, or loss of smell</td></tr>
<tr><td colspan="2">Assessment of severity of symptoms into mild, moderate, or severe</td><td>• Examination of anterior nasal cavity
• Any unilateral findings should raise suspicion of neoplasia
• Look for visible nasal polyps (consider turbinate hypertrophy in differential diagnosis</td></tr>
<tr><td colspan="3">▼</td></tr>
<tr><td colspan="3">Consider diagnosis of allergic rhinitis and/or asthma</td></tr>
<tr><td colspan="2">If associated with epiphora, itching, sneezing in addition to rhinorrhoea – manage according to ARIA guidelines</td><td>Assess for lower airway symptoms and control of asthma</td></tr>
<tr><td colspan="3">▼</td></tr>
<tr><td colspan="3">Consider alternate diagnosis and urgent (2WW) referral when the following are present:</td></tr>
<tr><td>Unilateral symptoms</td><td>Crusting</td><td>Severe frontal headache</td></tr>
<tr><td>Cacosmia</td><td>Epistaxis</td><td>Signs or symptoms of meningitis</td></tr>
<tr><td>Diplopia</td><td>Globe displacement</td><td>Neurological signs</td></tr>
<tr><td>Reduced visual acuity</td><td colspan="2">Periorbital oedema</td></tr>
<tr><td colspan="3">▼</td></tr>
<tr><td colspan="3">Treatment for all CRS patient (critical to ensure they have a good technique</td></tr>
<tr><td colspan="2">Nasal douching</td><td>Intranasal corticosteroids (mometasone or fluticasone)</td></tr>
<tr><td colspan="3">▼</td></tr>
<tr><td colspan="3">If bilateral large nasal polyps visible on anterior rhinoscopy, consider trial of oral Prednisolone (0.5mg/kg for 5-10 days) followed by topical drops (fluticasone propionate 400mg bd or beclomethasone tds) applied in the head upside down position</td></tr>
<tr><td colspan="3">▼</td></tr>
<tr><td colspan="3">Options NOT indicated in any circumstances</td></tr>
<tr><td colspan="2">Plain x-rays</td><td>Prolonged course of oral macrolides antibiotics</td></tr>
<tr><td colspan="3">▼</td></tr>
<tr><td colspan="3">Reassess symptoms after 3 months</td></tr>
<tr><td colspan="3">▼</td></tr>
<tr><td colspan="3">Refer to secondary care if not improving</td></tr>
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