

CLINICAL POLICY ADVISORY GROUP (CPAG)

Surgical Intervention for Chronic Rhinosinusitis Policy

Criteria

- Black – criteria required to be met prior to referral
- Blue – criteria to be met prior to procedure

Statement

Derby and Derbyshire ICB, in line with its principles for procedures of limited clinical value, has deemed that surgery for chronic rhinosinusitis should not routinely be commissioned unless the criteria listed within the policy are met.

These commissioning intentions will be reviewed periodically. This is to ensure affordability against other services commissioned by the ICB.

1. Background

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 commonplace. 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).

Endoscopic sinus surgery involves 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.

2. Recommendation

Adults and children can be considered for endoscopic surgery for the treatment of Chronic Rhinosinusitis where criteria **1 and 2** apply

Criteria 1

- A clinical diagnosis of CRS has been made (as set out in RTSC/ENT-UK commissioning Guidance <https://www.rcseng.ac.uk/>) and patient still has moderate/severe symptoms after a 3 month trial of intranasal steroids and nasal saline irrigation,

AND

- 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

OR

- Patient has nasal symptoms with an unclear diagnosis

NB – no investigations apart from clinical assessment should take place in primary care (e.g. X-ray or CT scan)

Criteria 2

- A diagnosis of CRS has been confirmed from clinical history and a 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/EBT-UK commissioning guidance “Recommended secondary care pathway”

AND

- Pre-operative CT sinus 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

- As nasal examination in patients with recurrent acute sinusitis, 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

Any patient with unilateral symptoms or clinical findings, orbital or neurological features should be referred urgently or via the 2 week wait.

Exception Criteria

Referrals for the following indications are considered as being exceptions and therefore are excluded from the policy:

- 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)

3. 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

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>). The 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.

4. Useful Resources

- Evidence-based Interventions Guidance List 2, Academy of Medical Royal Colleges, November 2020, accessed March 2021, <https://www.aomrc.org.uk/evidence-based-interventions>
- Sinusitis (Sinus infection), NHS UK, 02/02/2021, accessed 23/03/2021, <https://www.nhs.uk/conditions/sinusitis-sinus-infection/>

5. References

- RCS Commissioning Guide: Chronic Rhinosinusitis. 2016:accessed April 2021 <https://www.rcseng.ac.uk/standards-and-research/commissioning/commissioning-guides/topics/>
- Evidence-based Interventions Guidance List 2, Academy of Medical Royal Colleges, November 2020, accessed March 2021, <https://www.aomrc.org.uk/evidence-based-interventions>
- NICE Clinical Knowledge Summary – Sinusitis: <https://cks.nice.org.uk/topics/sinusitis/>
- Chronic rhinosinusitis in Europe – an underestimated disease, Hastan D, Fokkens WJ, Bachert C, et al. A GA(2)LEN study. Allergy. 2011;66(9):1216-1223. doi: 10.1111/j.1398-9995.2011.02646.x [doi], accessed 23/03/2021
- International consensus statement on allergy and rhinology, Orlandi RR, Kingdom TT, Hwang PH, et al. Rhinosinusitis. Int Forum Allergy Rhinol. 2016;6 Suppl 1:22. doi: 10.1002/alr.21695 [doi], accessed 23/03/2021
- European position paper on rhinosinusitis and nasal polyps 2012. A summary for otorhinolaryngologists. Rhinology Fokkens WJ, Lund VJ, Mullol J, et al. EPOS 2012:. 2012;50(1):1-12. doi: 10.4193/Rhino50E2 [doi], accessed 23/02/2021

6. Appendices

Appendix 1 - Consultation

All relevant providers/stakeholders will be consulted via a named link consultant/specialist. Views expressed should be representative of the provider/stakeholder organisation. CPAG will consider all views to inform a consensus decision, noting that sometimes individual views and opinions will differ.

Consultee	Date
Consultant Ear, Nose and Throat, Head and Neck Surgeon, CRHFT	April 2021
Consultant Ear, Nose and Throat Surgeon, UHDBFT	April 2021
Clinical Policy Advisory Group (CPAG)	May 2021
Clinical and Lay Commissioning Committee (CLCC)	June 2021
Consultant Ear, Nose and Throat Surgeon, UHDBFT	November 2023
Consultant Ear, Nose and Throat Surgeon, CRHFT	November 2023
Clinical Policy Advisory Group (CPAG)	November 2023

Appendix 2 - Document Update

Document Update	Date Updated
<u>Version 1.0</u> <ul style="list-style-type: none">Published	May 2021
<u>Version 1.1</u> <ul style="list-style-type: none">CPAG agreed to extend the review date of this policy by 12 months due to reduced capacity within the Clinical Policies team	November 2023
<u>Version 1.2</u> <ul style="list-style-type: none">In line with risk profile, CPAG agreed further extension to review date	September 2024

Appendix 3 - OPCS Code(s)

OPCS codes for this intervention:

Y76.1, Y76.2, E12.1, E12.2, E12.3, E12.4, E12.8, E12.9, E13.1, E13.2, E13.3, E13.4, E13.5, E13.6, E13.8, E13.9, E14.1, E14.2, E14.3, E14.4, E14.5, E14.6, E14.7, E14.8, E14.9, E15.1, E15.2, E15.3, E15.4, E15.8, E15.9, E16.1, E16.2, E16.8, E16.9, E17.1, E17.2, E17.3, E17.4, E17.8, E17.9, E08.1