Buckinghamshire, Oxfordshire & Berkshire West
Integrated Care Board

BOB ICB and Frimley ICB Priorities Committee Clinical Commissioning Policy Statement

Policy Number/ Name	BOBFPC21 Chronic Rhinosinusitis (Adults and Children)
Date of BOB ICB Adoption	February 2024

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. Persistence of symptoms for more than 12 weeks is categorised as chronic rhinosinusitis.

The aetiology of chronic rhinosinusitis is largely unknown but is likely to be multifactorial, with inflammation, infection and obstruction of sinus ventilation playing a part.

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 then may be considered for endoscopic sinus surgery.

Recommended Primary Care Pathway as per the Royal College of Surgeons (RCS) Commissioning Guide (2016) 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 Appendix 1) 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.

Clinical coding (as per EBI2):
J32.0 Chronic maxillary sinusitis
J32.1 Chronic frontal sinusitis
J32.2 Chronic ethmoidal sinusitis
J32.3 Chronic sphenoidal sinusitis
J32.4 Chronic pansinusitis
J32.8 Other chronic sinusitis
J32.9 Chronic sinusitis, unspecified
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J33.0 Polyp of nasal cavity
J33.1 Polypoid sinus degeneration
J33.8 Other polyp of sinus
J33.9 Nasal polyp, unspecified

Y76.1 Functional endoscopic sinus surgery
Y76.2 Functional endoscopic nasal surgery
E12.1 Ligation of maxillary artery using sublabial approach

E12.2 Drainage of maxillary antrum using sublabial approach
E12.3 Irrigation of maxillary antrum using sublabial approach
E12.4 Transantral neurectomy of vidian nerve using sublabial approach
E12.8 Other specified operations on maxillary antrum using sublabial approach
E12.9 Unspecified operations on maxillary antrum using sublabial approach
E13.1 Drainage of maxillary antrum NEC
E13.2 Excision of lesion of maxillary antrum
E13.3 Intranasal antrostomy
E13.4 Biopsy of lesion of maxillary antrum (we will leave in unless we hear otherwise)
E13.5 Closure of fistula between maxillary antrum and mouth
E13.6 Puncture of maxillary antrum
E13.7 Neurectomy of vidian nerve NEC
E13.8 Other specified other operations on maxillary antrum
E13.9 Unspecified other operations on maxillary antrum
E14.1 External frontoethmoidectomy
E14.2 Intranasal ethmoidectomy
E14.3 External ethmoidectomy
E14.4 Transantral ethmoidectomy
E14.5 Bone flap to frontal sinus
E14.6 Trephine of frontal sinus
E14.7 Median drainage of frontal sinus
E14.8 Other specified operations on frontal sinus
E14.9 Unspecified operations on frontal sinus
E15.1 Drainage of sphenoid sinus
E15.2 Puncture of sphenoid sinus
E15.3 Repair of sphenoidal sinus
E15.4 Excision of lesion of sphenoid sinus
E15.8 Other specified operations on sphenoid sinus
E15.9 Unspecified operations on sphenoid sinus
E16.1 Frontal sinus osteoplasty
E16.2 Drainage of frontal sinus NEC
E16.8 Other specified other operations on frontal sinus
E16.9 Unspecified other operations on frontal sinus
E17.1 Excision of nasal sinus NEC
E17.2 Excision of lesion of nasal sinus NEC
E17.3 Biopsy of lesion of nasal sinus NEC
E17.4 Lateral rhinotomy into nasal sinus NEC
E17.8 Other specified operations on unspecified nasal sinus
E17.9 Unspecified operations on unspecified nasal sinus
E08.1 Polypectomy of internal nose

NOTES:

- Potentially exceptional circumstances may be considered by a patient's ICB where there is evidence of significant health status impairment (e.g. inability to perform activities of daily living) and there is evidence that the intervention sought would improve the individual's health status.
- This policy was developed and recommended by Thames Valley Priorities Committee which was the predecessor of Buckinghamshire, Oxfordshire, and Berkshire West ICB and Frimley ICB Priorities Committee.
- This policy will be reviewed in the light of new evidence or new national guidance, e.g., from NICE.
- BOBFPC clinical policy statements can be viewed at Clinical Commissioning Policy Statements & IFRs | BOB ICB

Recommendation made by TVPC	May 2015 Reviewed July 2018 March 2021
Date adopted and issued by OCCG	July 2021
Date of BOB ICB adoption	February 2024 – reformatted and rebadged only

Appendix 1: Recommended Primary Care Pathway
(Royal College of Surgeons Commissioning Guide: Chronic Rhinosinusitis, 2016)