Chronic Inflammatory conditions of the Nose/ sinuses:

The Irish Rhinologic Society are committed to supporting education in Rhinology.

In 2024 we launched a podcast series “Follow your Nose’ supporting patient education that is available free to the general public online I

In this document please find FAQs to guide you in your practice. These are based on frequently asked questions we have noted by colleagues in practice.

Diagnosis in Rhinology :
Chronic rhinitis versus Sinusitis

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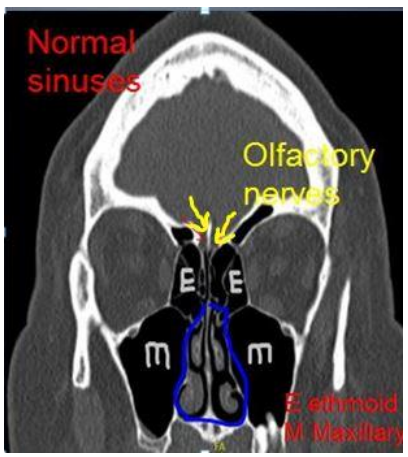
Chronic inflammatory disorders , allergic or non-allergic, encompass the majority of nasal / sinus disorders.

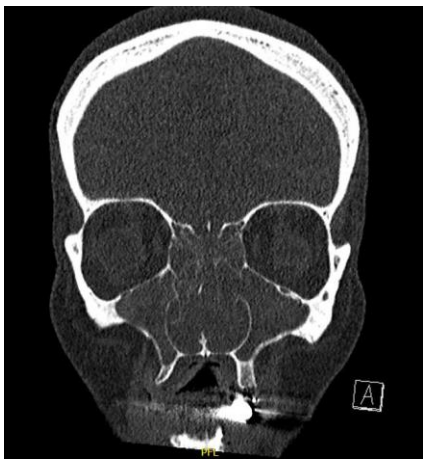
Chronic rhinitis and rhinosinusitis share common symptoms so when should I consider a diagnosis of chronic rhinosinusitis versus chronic rhinitis ? When should I refer to an ENT specialist?

The 4 MAJOR symptoms in rhinology are nasal obstruction, discharge (rhinorrhoea anterior or posterior), headaches/ facial pain and smell dysfunction.

Nasal obstruction & rhinorrhoea are common symptoms in both sinusitis and rhinitis but are not very specific for distinguishing between the two. In both conditions they are overlapping features however it's the additional symptoms, in particular smell loss or endoscopic evidence of sinus disease that are more important for differentiation between both.

The smell fibres are located high and more posteriorly in the nasal cavity. Significant smell loss (moderate/ severe) is more likely associated with sinus disease or less commonly tumours of the skull base/ nose. If present in rhinitis, smell loss is usually mild and /or fluctuating and would often respond well to an INCS.
So the association of moderate/ severe smell loss unresponsive to an appropriate course of medical management would benefit from an ENT specialist opinion.





Headache/ Facial pain:

While facial pain and headache is more likely associated with sinusitis than rhinitis, facial pain is **not** a highly reliable or sensitive symptom for diagnosing sinusitis. In fact chronic facial pain is rarely rhinogenic.
In one study of 100 patients with self -diagnosed sinus headache, 90% were not sinus related despite 70% reporting nasal obstruction and 56% reporting post nasal drip .

Sinus headache , when present, is usually throbbing or aching in nature, exacerbated by pressure changes, and responds sometimes but not always to antibiotic treatment or decongestants

The top 3 important conditions in the differential diagnosis of sinus pain include

- Tension type headaches,
- Facial migraine
- Cluster Headaches.

Unfortunately all of these are associated with autonomic symptoms including nasal obstruction and rhinorrhoea and all can be triggered by sinus disease so diagnosis can be challenging.
Thus, a detailed headache history is essential including attention to migraine features especially where headache is the predominant symptom or there are no associated nasal symptoms/ examination is normal.
Reference: Hu S et al American J Otolaryngology 2019 40: 155-120

Post-nasal drip

Post nasal drip, as a symptom, needs to be distinguished from a sensation of throat phlegm. It is a common symptom that increases with age and which can be frustrating sometimes to diagnose or treat. For some, it is allergy in origin so a detailed allergy history is essential and treatment targeted for this. However a sensation of mucus in the throat does not often imply a rhinogenic cause so other diagnoses need to be considered., especially in the absence of other nasal symptoms or allergy symptoms.
Include extraesophageal reflux within your differential and consider treatment for this. Viral reactivation is another cause so include viral PCR swabs.

Medical management:
INCS Intranasal corticoid steroid sprays / rinses are the mainstay of most chronic disorders of the nose/ sinuses

Intranasal corticoid steroid treatment is an **integral** part of medical management for chronic nasal disorders, both rhinitis and sinusitis. Failure to benefit from an INCS will require referral to a specialist ENT clinician thus every attempt should be made to ensure that any patient with a chronic nasal condition has had a **reasonable** trial period of an **appropriate** spray delivered via a correct technique.

A wide selection exist on the market with variability on bioavailability, cost and prescriptive details while the literature reports widely on their safety profile/ efficacy. There is often a lack of certainty about product choice however as the patient is a key player in management outcome, it is important to engage the patient in discussion and tailor a treatment plan accordingly that acknowledges the individual symptoms, severity, of symptoms patient age, allergic vs non allergic aetiology and cost for the patient. Engaging the patient early in their treatment is important thus first choice of INCS important. Refer to a specialist early if there has been no or little benefit from an appropriate course of a nasal spray.

Common causes of failure are relating to poor technique, choice of INCS for severity of symptoms, timepoint of treatment and continuation of treatment when effective patient compliance due to anxieties or lack of awareness about their condition. Ref Follow your Nose podcast series

1. What is the best technique for nasal spray use?
   Poor technique is a frequent cause of poor compliance/ poor symptom control. Any discussion about treatment should include a demonstration of proper technique or the patient directed to an approved website with educational guidance eg..Euforea.eu . Bleeding/ crusting and indeed an unpleasant taste are frequent factors that negatively impact on compliance and can often be corrected by guidance on correct spray technique.

2. When should I consider a trial of an INCS?

   INCS are the foundation for management of chronic inflammatory conditions, allergic or non allergic, causing nasal obstruction and rhinorrhoea. In addition they should be prescribed for patients with a history of recurrent infections prior to consideration of referral to an ENT specialist as uncontrolled rhinitis can predispose patients to recurrent infections, a frequent cause of presentation especially for non -seasonal rhinitis. In consideration of the above 2 scenarios, the trial period for patients can differ.

3. How long should I prescribe this treatment for ?

   There are no specific guidelines on this however the trial period should acknowledge the goal of treatment. In general, chronic inflammatory conditions of the nose/ sinuses contributing to daily nasal obstruction/ rhinorrhoea should demonstrate a response to treatment within a few days. If after continued treatment over 4-8 weeks, the response is poor or insufficient referral to an ENT specialist should be considered. When considering uncontrolled rhinitis as a cause of recurrent infections, the treatment time might need to be extended and should acknowledge the frequency of infections eg..a patient experiencing 2/3 infections per 4-6 months, may require an extended time period after 4 months in order to determine the benefit.

   Prior to referral ensure that a reasonable trial of an appropriate spray has been completed. In addition it is also valuable to advice the patient to recommence the spray a few weeks before their ENT clinical appointment.

4. Is an OAH / INAH more beneficial than an INCS

   INCS is the key medication for most chronic inflammatory conditions of the nose. Anti- histamine treatment plays only a minor role and should be considered predominantly for relief of allergy symptoms including nasal / eye itchiness, rhinorrhoea and sneezing or where symptoms are mild and intermittent Refer to the ARIA guidelines which support their role for management of mild/ intermittent symptoms.

5. What is the role of antibiotic treatment in management of chronic conditions of the nose/ sinuses?

Antibiotic treatment should be reserved for acute bacterial infections of the nose/ sinuses. There is a very limited role for antibiotic treatment in chronic conditions of the sinuses which should only be considered by ENT specialists in select clinical scenarios. On average most individuals will experience 2/3 URT infections per year. If your patient is experiencing frequent recurrent infections of the nose/ sinuses, its important to confirm clinically that these are indeed true infections and distinguish from recurrent episodic

pain/ headaches. If deemed true infections, where there is a clear history of mucus/ infected secretions enquire/ exclude a dental cause and consider an extended trial period of an INCS as often recurrent infections can be due to an underlying uncontrolled rhinitis.

6. What is the role of OCS for chronic conditions of the nose?

A single trial of an OCS can be considered when there are clinical symptoms or signs that suggest a diagnosis of chronic sinusitis / polyposis. and the patient has failed an appropriate trial of an INCS.
There are significant side effects from repeat or prolonged use of OCS thus any patient who has required and had limited/ no benefit from an OCS trial, should be referred to an ENT specialist.

Referral to an ENT specialist:
When should I refer/ considerations prior to referral

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Insufficient / no benefit from an appropriate trial of an INCS

Chronic moderate/ severe smell loss unresponsive to an appropriate trial of an INCS/ one course of an OCS

Unstable asthma

Red flag symptoms including facial pain, numbness, bleeding