PRIORITIES AND CLINICAL EFFECTIVENESS FORUM

MANAGEMENT OF NASAL POLYPOSIS

- This is a new guideline
- It includes a stepwise approach to the management
- It includes a patient information leaflet for the administration of nasal drops
**Primary Care ENT Guidelines**

**Nasal Polyposis (Benign inflammatory polyps)**

### History

- **Past Hx of polyps? Aspirin sensitivity/Asthma?** (polyps more likely to recur)
- **Hyposmia / Rhinorrhea / Constant blockage** are the cardinal symptoms. Rarely an antro-choanal polyp will "ball-valve" i.e. blockage on exhalation, not inhalation
- The aetiology is unknown and they are NOT associated with allergic rhinitis, although the 2 conditions may co-exist, the incidence of allergic rhinitis is no higher in polyp patients than the rest of the population
- **Any bleeding?** - Suggests this may not be a straightforward inflammatory polyp

### Examination

- Polyps are generally grey/translucent, are **not** sensitive to touch, which is a discriminatory sign (the turbinates are sensitive to probing!)
- Looking with an otoscope, is useful.
  - **"RED FLAGS":**
    - If the polyp appears to be unilateral, and there is no previous history of "idiopathic" polyps, then refer as this could be a non inflammatory polyp, such as inverted papilloma, or even a frank malignancy (e.g. adenocarcinoma from sinus, SCC, lymphoma etc). If, however there is a past history of inflammatory polyps, then a month’s trial of treatment as below is reasonable, with referral if no response.

### Treatment

Thankfully, **most** idiopathic inflammatory polyps are steroid responsive. Akin to the BTS asthma guidelines, we can think of a "ladder" or stepped approach, but ideally patients shouldn’t be left long term on anything other than the 1**st** "rung".

**Step 1:** REGULAR use of a nasal steroid spray (a 3 month trial suggested)

**Step 2:** Betnesol nasal drops 2 tds each nostril for a month, in the "head hanging" position* (proven to improve distribution to the target area, and reduce amount passing directly to the pharynx to be swallowed). Equivalent to 0.5mg of Prednisolone per day, hence not recommended for long term use

**Step 3:** Oral Prednisolone 60mg o.d. for 3/7, then 40mg 3/7, then 20mg 3/7, then 10mg 3/7, to be followed by step 2, then step 1 as maintenance. Usual contraindications apply.

**Step 4:** Referral for consideration of surgery/confirmation of diagnosis.

Steroid nasal spray should be continued indefinitely as this is proven to decrease recurrence

Many patients find nasal douching with saline prior to administration of topical steroids helpful, e.g. with Sterimar which is an OTC preparation (approx £6 per can)

The hyposmia is very hard to treat and often only improves whilst on oral steroids

*see overleaf
How to use your nasal drops correctly:

1. Lie on your back with head hanging over the edge of the bed/couch

2. Turn your head slightly to one side and place the drops in that side of the nose

3. Maintain that position for 30 seconds

4. Turn your head to the other side and repeat

For drops to be effective:

1. They must be used regularly

2. With steroid drops, it takes several weeks before any improvement will be noted. Do not expect to feel any improvement “straight away”, as these are not “decongestant” drops.

Decongestant drops will not shrink polyps and prolonged use (for more than a week) can cause long-term damage to the lining of the nose, known as Rhinitis Medicamentosa, which leads to a dependency on decongestants, and constant feeling of blockage.