

## Referral Support Service

ENT

### ENT17

### Rhinosinusitis

#### Definition

Inflammation of the mucous membranes of the paranasal sinuses, more accurately described as rhino-sinusitis. Distinguish acute rhinosinusitis (up to four weeks) vs. chronic rhinosinusitis (more than 90 days). A diagnosis of rhinosinusitis requires the presence of at least two of facial pain/ nasal blockage/ rhinorrhoea.

#### Exclude Red Flag Symptoms

- Excessive pain perception with little or no response to normal analgesia.
- Persistent bloody nasal discharge.
- History of head injury or other possible facial/cranial trauma, especially if within the last 6 months.
- Facial pain without any nasal discharge.
- Ocular symptoms, sickness, severe dizziness, memory or behaviour issues etc.
- Persistent or severe unilateral symptoms.
- Systemic upset such as persistent low-grade fever, lymphadenopathy or unexplained weight loss.

#### General Points

- The expectation of patients to receive antibiotic treatment for rhinosinusitis remains commonly high, although the evidence of effectiveness is mixed and not convincing, unless there are significant acute features (fever, associated nasal discharge).
- Patients will often rationalise all forms of facial pain as 'sinus problems', but a high proportion of patients referred to secondary care with a diagnosis of rhinosinusitis in fact have clear sinuses. Consider alternative diagnoses such as migraines, cluster headaches, muscular tension, dental issues etc.; without the presence of at least two of facial pain, nasal blockage or rhinorrhoea, rhinosinusitis is unlikely.

#### Management of Acute Rhinosinusitis

- Establish duration of unilateral or bilateral nasal symptoms, post nasal drip & facial pain.
- Experience with recurrent problems or possible triggers?
- Allergy history.
- Actions taken so far by patient (ask amount and duration of decongestant use).
- Enquire awareness of dental problems.
- Ideas, concerns and expectations of patient (experience with antibiotics?)
- Check general health of patient, temperature, sensitivity of sinuses, nasal cavities.

- Consider temporary use of **sodium chloride 0.9% nasal drops +/- intranasal decongestant (as ephedrine 0.5% nasal drops) +/- nasal steroid spray (as beclometasone dipropionate 50mcg)**. These can take several weeks to take full effect. Oral decongestants are not recommended, as can lead to rebound symptoms and antihistamines are no longer recommended for sinusitis (unless co-existing allergic rhinitis).
- Advise steam, fluids, simple analgesia (avoid combination products over the counter – they are often excessively expensive and may contain several products with sub-optimal dosages of each). Consider nasal douches for ongoing post nasal drip problems.
- The use of antibiotics for acute sinusitis remains controversial and inconsistent. Local advice is to avoid antimicrobials as many cases of Rhino-sinusitis are viral and 80% resolve within 14 days without antibiotic treatment. Antimicrobials only offer marginal benefit after 7 days (NNT 15).
- Therefore consider watchful waiting or delayed scripts to use if there is not improvement after 10 days, or if the patient gets systemically unwell. Best evidence is available for **amoxicillin** 500mg tds for 7 days (if penicillin allergy prescribe **doxycycline** 200mg stat and then 100mg od for 6 days)
- Treatment failures may require an-aerobic choices, such as **co-amoxiclav** (625 mg TDS for 7 days).
- Refer to [North Yorkshire Antibiotic Guidance](#) for full information
- Lack of evidence for surgical interventions such as sinus “wash-out” etc. or vitamin supplements.
- Like in other conditions (e.g. migraines) there can be a certain risk of secondary gain.

### Management of Chronic Rhinosinusitis

- It is reasonable to manage chronic rhinosinusitis as for acute rhinosinusitis initially
- There may however be a need for ongoing and long-term use of an intra-nasal steroid spray to counteract the effects of underlying allergic rhinitis
- There is considerable evidence that high volume daily saline douching (eg via an **OTC NeilMed®** sinus rinse bottle or **Netipot®**) aids mucociliary clearance and is an effective adjunct in chronic rhinosinusitis.
- If despite these interventions the problems persist, a referral to secondary care may be indicated
- Upon discharge back to primary care, **ongoing intra nasal steroids** ([see page 2 for CCG preferred steroid nasal sprays](#)) along with daily douching may be required to avoid further exacerbations
- In the presence of underlying allergic rhinitis, adjuvant **antihistamines** either by mouth or nose may provide further additional benefit

### Referral Information

#### Indications for referral

- Red flag symptoms or concerns.
- Persistent and disruptive symptoms with failure to respond to primary care management options outlined above.

### Information to include in referral letter

Occupational history.

Advice given so far to patient.

- Duration +/- recurrence of episode(s) of perceived or clinical sinusitis.
- Response to over the counter medications / measures and prescribed medications.
- Specific experiences or expectations from patient.
- Known allergies.
- Smoking history.

### Investigations prior to referral

Usually none needed, but could consider FBC and ESR if symptoms persist after acute phase.  
X-rays are generally of little value in a primary care setting.

### Patient information leaflets/ PDAs

- <http://www.nhs.uk/conditions/sinusitis/pages/introduction.aspx>
- [NeilMed® sinus rinse and Netipot® how to use video](#)

### References

- [North Yorkshire Antibiotic Guidance](#)
- [NICE October 2013 - https://cks.nice.org.uk/sinusitis#!scenario](https://cks.nice.org.uk/sinusitis#!scenario)
- [Amber Huntzinger .Guidelines for the Diagnosis and Management of Rhinosinusitis in Adults. American Family Physician 2007;76:10](#)