

**Programme Title: Clinical Policies**

Clinical Policies aim to prevent avoidable harm to patients by only offering treatments on the NHS that are evidence-based, clinically safe and effective, as well as cost effective and a good use of resources.

**Cambridgeshire, Peterborough, Bedfordshire, Luton, Milton Keynes and Hertfordshire**

<b>Title of policy and version:</b>	<b>ENT - Rhinosinusitis – Chronic</b>  Version: v1.0
<b>Commissioning position:</b>	<b>Criteria based access</b>
<b>Scope:</b>	<p><b>Covers</b></p> <ul style="list-style-type: none"> <li>Assessment and surgical management of Chronic Rhinosinusitis (CRS).</li> </ul> <p><b>Out of Scope:</b></p> <ul style="list-style-type: none"> <li>Any suspected or confirmed neoplasia</li> <li>Emergency presentations with complications of sinusitis (e.g., orbital abscess, subdural or intracranial abscess)</li> <li>Patients with immunodeficiency</li> <li>Fungal Sinusitis</li> <li>Patients with conditions such as Primary Ciliary Dyskinesia, Cystic Fibrosis or NSAID-Eosinophilic Respiratory Disease (NSAID-ERD/ Samter's Triad - Aspirin Sensitivity, Asthma, CRS)</li> <li>Where topical and / or oral steroids are contra-indicated.</li> <li>As part of surgical access or dissection to treat non-sinus disease (e.g., pituitary surgery, orbital decompression for eye disease, nasolacrimal surgery)</li> </ul>
<b>Cohort:</b>	Patients of any age (adults and children) with Chronic Rhinosinusitis.
<b>Other relevant Clinical Policy</b>	TBC

<b>Treatments routinely funded:</b>	<p>The ICB will fund referral for specialist secondary care assessment when:</p> <ul style="list-style-type: none"> <li>A clinical diagnosis of CRS has been made (as set out in RCS/ENT-UK Commissioning guidance) in primary care and patient still has moderate / severe symptoms after a 3-month trial of intranasal steroids and nasal saline irrigation;</li> </ul> <p><b>AND</b></p>
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- 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.

Any patient with unilateral symptoms or clinical findings, orbital, or neurological features should be referred urgently in line with local 2-week wait or emergency pathways. These cases are not subject to the routine CRS referral criteria above.

Note:

- 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 for CRS.

The ICB will fund endoscopic sinus surgery **if ALL** of 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) > 20 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.

Recurrent Acute Sinusitis:

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.

<b>Treatments not funded:</b>	Any nasal surgery performed for cosmetic improvement
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**Rationale:**

Chronic Rhinosinusitis (CRS) is common and most patients improve with appropriate medical management in primary care. A stepped-care approach ensures referral and surgery are reserved for patients with confirmed disease and persistent moderate to severe symptoms despite optimal treatment. Requiring objective diagnosis, appropriate trials of medical therapy, and use of validated outcome measures supports equitable, evidence-based access to surgery while avoiding unnecessary intervention.

**IFR Statement Clinical Exceptionality:**

Where a patient does not meet the policy criteria or the intervention is not normally funded by the NHS, an application for clinical exceptionality can be considered via the ICB's Individual Funding Request (IFR) Policy and Process.

**Coding list:**

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

Policy document record:	ENT - Rhinosinusitis – Chronic Version: v1.0
Ratification date:	1st April 2026
Record of significant change:	v1.0 – New harmonised policy for Central East ICB, based on predecessor ICB policies (C&P, HWE, BLMK).
Planned review date:	TBC

**Document Environmental Impact statement:**

Neutral environmental impact. Policy to be shared and stored electronically where possible; if printed, use double-sided printing and minimal copies.