

Surgical Threshold Policy

Nasal Surgery for Obstruction or Deformity

Scope

This policy covers the management of patients with nasal obstruction or deformity. It covers causes of obstruction such as septal deviation, nasal polyps and/or chronic rhinosinusitis, and cosmetic nasal deformity.

Policy

It is the responsibility of referring and treating clinicians to ensure compliance with this policy. Referral proforma should be attached to the patient notes to aid the clinical audit process and provide evidence of compliance with the policy. For patients not meeting the policy criteria, clinicians can apply for funding to the Exceptional Cases Panel by completing the exceptional funding section of the [referral proforma](#).

Nasal surgery will be funded in cases of:

1. Cleft lip and/or palate. **Or**
2. Immediate post-traumatic reconstruction. **Or**
3. A nasal deformity with obstruction where the following are met:
 - moderate to severe symptoms - as defined by SNOT-22 score >20 or other equivalent measure; **And**
 - chronic (symptoms for >12 weeks); **And**
 - unresponsive to all conventional medical treatment; **And**
 - continuous (i.e., all times of day).

Chronic rhinosinusitis (CRS)

1. **Referral:** Patients are eligible to be referred for specialist secondary care assessment in any of the following circumstances:
 - 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; **And**
 - In addition, for patients with bilateral nasal polyps there has been no improvement in symptoms and patient still has moderate / severe symptoms after 4 weeks 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

Note 1: 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)

2. **Endoscopic sinus surgery:** Patients are eligible for endoscopic sinus surgery if they meet the following criteria:

- 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

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.

Note 2: The following patients should not be subjected to the above eligibility criteria for endoscopic surgery and continue to be routinely funded:

- Any suspected or confirmed neoplasia.
- Emergency presentations with complications of sinusitis (e.g., orbital abscess, subdural or intracranial abscess)
- Patients with immunodeficiency
- Fungal Sinusitis
- Patients with conditions such as Primary Ciliary Dyskinesia, Cystic Fibrosis or NSAID-Eosinophilic Respiratory Disease (NSAID-ERD, Samter's Triad Aspirin Sensitivity, Asthma, CRS)
- Treatment with topical and / or oral steroids contra-indicated.
- As part of surgical access or dissection to treat non-sinus disease (e.g., pituitary surgery, orbital decompression for eye disease, nasolacrimal surgery).

Rhinoplasty/Septoplasty/Septorhinoplasty will not be funded as cosmetic procedures

Smoking

Patients who smoke should be advised to attempt to stop smoking – see [stop smoking policy](#).

Evidence and Rationale

Septoplasty, Rhinoplasty and Septorhinoplasty

The anatomy of the nose and surrounding structures is complex; multiple structures have a role in maintaining normal function and ventilation and thus may be responsible for obstructive symptoms and/or be points of intervention for medical treatment or surgery.

There is evidence that some patients who have failed medical treatment may have some functional benefit from surgery (see reference 1 to 4). In line with other policies, cosmetic nasal procedures are not funded.

Other Nasal Surgery

NHS England Evidence Based Interventions guidance (see reference 5 to 6) suggests the following:

- There is a strong evidence base and expert consensus opinion to support the medical management of chronic rhinosinusitis with intranasal steroids and nasal saline irrigation as a first-line treatment. They are low cost and low risk, with newer generations of nasal steroids safe for long-term use owing to minimal systemic absorption.
- There is also evidence to support the trial of oral steroids, but only when nasal polyposis is present. The benefits of oral steroids should be balanced against the risks when considering repeated courses. A Cochrane review has demonstrated the benefits of oral steroids can last up to three months; however, the risks and side effects must be balanced against benefit for the patient with repeated courses.
- There is evidence to support that when endoscopic sinus surgery is performed in appropriately selected patients it will lead to a significant and durable improvement in symptoms. There is also evidence that patients who undergo surgery early in their disease course will have a longer and more beneficial impact from the surgery. All national and international guidelines support consideration of endoscopic sinus surgery once appropriate medical therapy has failed. Endoscopic sinus surgery is generally safe but carries some risks that include bleeding, infection, scar tissue formation, and very rarely orbital injuries or cerebrospinal fluid leak (with associated risk of meningitis). Patients should also be counselled that there is a risk of recurrent symptoms, and that ongoing medical treatment is often required to maintain symptom improvement after endoscopic sinus surgery.

References

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3. Zheng J, Yu L, Hu W, Yu Y. Systematic review and meta-analysis of the curative effects and safety of endoscopic sinus surgery in children with chronic sinusitis with nasal polyps. *Transl Pediatr*. 2022 Jul 1;11(7):1171–81.
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7. Toma S, Hopkins C. Stratification of SNOT-22 scores into mild, moderate or severe and relationship with other subjective instruments. *Rhinology*. 2016 Jun;54(2):129–33.

Glossary

Chronic rhinosinusitis:	The cavities around the nasal passages (sinuses) become inflamed and swollen for at least twelve weeks.
Endoscopic sinus surgery:	An endoscope (small telescope) is inserted into the nose, allowing the surgeon to get a view of the inside of the nose. Surgical instruments are inserted along the endoscope to widen the passage between the sinus and the nose so that mucus no longer becomes trapped.
Nasal polyps:	Swelling of the normal nasal lining that occurs inside the nasal passages and sinuses.
Saline irrigation:	Rinsing of nasal passages with salt water.
Septal deviation:	Displacement of the bone and cartilage (nasal septum) that separates the nostrils.
SNOT-22: (see reference 6)	Sino-nasal outcome test – 22.

Policy effective from:	Reviewed policy ratified by QPF Reviewed policy approved by JCPEG Reviewed policy approved by CPF Policy adopted by NHS C&P (ICB) 1 July 2022 Policy developed by C&P Public Health Team
Policy to be reviewed:	
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