Rhinology, 48, 123-124, 2010

# Is it time to abandon chronic rhinosinusitis? (Or at least to introduce the term unexplained chronic rhinosinusitis).

*What is chronic rhinosinusitis?*

Chronic rhinosinusitis is a disease with high prevalence and a substantial impact on quality of life [1-3]. But what is chronic rhinosinusitis [4,5]? The term chronic rhinosinusitis (CRS) embraces a whole range of different disease entities. For example, CRS with or without polyps, with or without asthma, with or without allergy, with or without bacterial infection or with or without fungal infection. Other pre-existing conditions includes, atopy, immunodeficiency, cystic fibrosis and primary ciliary dyskinesia to mention a few. To further complicate matters, patients may move from one group to another during different stages of the disease. For example, a CRS patient with non-allergic asthma may become infected and the added burden of bacterial driven inflammation will call for temporarily treatment with antibiotics. Another common example is the CRS patients with seasonal allergies. Which calls for a more intense anti-inflammatory treatment during the allergic season. It is not always easy for the caregiver to distinguish the cause of impairment in the patient with CRS disease.

Progress in understanding the disease in terms of disease triggers, progression, and response to treatment has been full of contradictory findings. Unifying theories are tempting to the human nature. But an hypothesis such as the fungal theory as an explanation for all CRS or the super antigen theory being staged as two opposing theories at many ENT meetings have been entertaining, but has not reflected the diversity of CRS [6, 7].

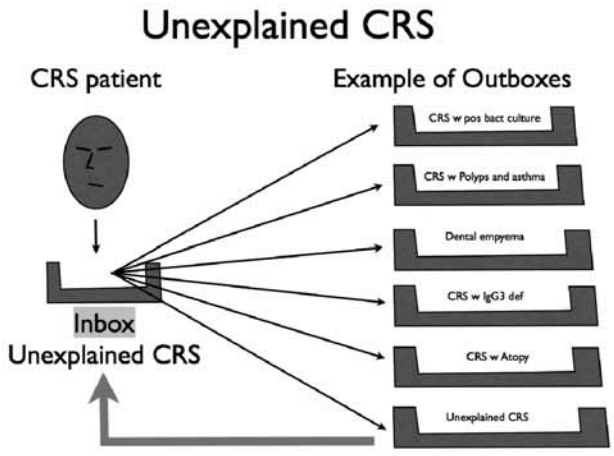


Figure 1. Illustrating that CRS is not a diagnosis per se. Using the term unexplained CRS, prompting diagnostic measures and stop fooling patients and doctors alike.

However, fortunately enough, a general consensus is now emerging that, CRS is unlikely to be a single disease entity [8]. However, contrary to where the active researchers stand, the clinical definition is still based on the temporal and macromorphological aspects of the disease.

The newer approach among scientist interested in CRS to distinguish different phenotypes and sub phenotypes (i.e. people with different predispositions), sensitive to different triggers leading to different cellular and molecular responses (but unfortunately often similar clinical response) is an acknowledgement that CRS is not a single disease entity. But still clinical studies emerge where the definition of the CRS patients is poor, making it difficult to draw conclusions or making comparisons.

To avoid further confusion, this may be the time to abandon the all encompassing term of CRS and I would like to quote an editorial from Lancet in 2006 on asthma. It is elegantly put and I have just substituted asthma for chronic rhinosinusitis.

”So why wait? Rather than confusing scientists, doctors, and patients even further, is it not time to step out of the straightjacket of a seemingly unifying name that has outlived its usefulness? The conclusion should surely be that it is best to abolish the term chronic rhinosinusitis* (asthma) altogether”. (Lancet 2006; 368:705, Editorial, *Dr Cervin’s alteration).

*A compromise or how to unravel your CRS patient*

Now, if you find it difficult to abandon the term CRS, I would like to propose a compromise. A way of intellectually managing the fact that CRS is a number of diseases. Any patient that walks in to your office that meet with the current definition of CRS is labelled ”unexplained CRS”. This is your mental inbox for all your CRS patients. This will stress the point that now is the time to flex your intellectual muscles and try to move the patient from inbox ”unexplained” to a box with a more specific diagnosis. As our instruments in this day and time are blunt many of your patients will eventually end up in the unexplained box anyway but at least this mental course of action will highlight the fact that, where possible, a more specific diagnosis is called for.

So if it is too early to abandon the term ‘chronic rhinosinusitis’, introducing the term ‘unexplained chronic rhinosinusitis’ in order to emphasize diagnostic measures will at least loosen up the mental straightjacket of the seemingly unifying name of

chronic rhinosinusitis and be a fair way of describing the disease to patients and caregivers alike. By the way a suitable term for vasomotor rhinitis or non-allergic, non-infectious rhinitis or whatever name used, should in concordance be; unexplained rhinitis. But that's another story.

REFERENCES

1. Collins JG. Prevalence of selected chronic conditions: United States, 1990-1992. Vital Health Stat 10. 1997;194: 1-89.
2. Gliklich RE, Metson R. Effect of sinus surgery on quality of life. Otolaryngol Head Neck Surg. 1997; 117: 12-17.
3. Metson RB, Gliklich RE. Clinical outcomes in patients with chronic sinusitis. Laryngoscope. 2000; 110: 24-28.
4. Fokkens W, Lund V, Mullol M. European Position Paper on Rhinosinusitis and Nasal polyps 2007. Rhinology. 2007; Suppl 20.
5. Report of the Rhinosinusitis Task Force Committee Meeting. Alexandria, Virginia, August 17, 1996. Otolaryngol Head Neck Surg. 1997 ;117: S1-68.
6. Ponikau JU, Sherris DA, Kern EB, Homburger HA, Frigas E, Gaffey TA, et al. The diagnosis and incidence of allergic fungal sinusitis. Mayo Clin Proc. 1999; 74: 877-884.
7. Bachert C, Gevaert P, van Cauwenberge P. Staphylococcus aureus superantigens and airway disease. Curr Allergy Asthma Rep. 2002; 2: 252-258.
8. Van Cauwenberge P, Van Hoecke H, Bachert C. Pathogenesis of chronic rhinosinusitis. Curr Allergy Asthma Rep. 2006; 6: 487-494.

Anders Cervin, MD, PhD
Associate Professor,
Clinical Sciences, Faculty of Medicine, Lund University
Consultant Dep. of Ear, Nose and Throat, Helsingborg Hospital
Helsingborg Hospital
Södra Vallgatan 5
251 87 Helsingborg
Sweden

Tel: +46 42 4063194
E-mail: anders.cervin@med.lu.se (Univ.)
E-mail: anders.cervin@skane.se (Hosp.)

# Reply to the letter

*'Pushing against an open door.....'*

The editors and, I am sure, most Rhinology readers would agree with the sentiments expressed in Dr Cervin's letter - the term 'chronic rhinosinusitis' is indeed a catch-all to cover all forms of inflammation and has never been intended to indicate a single pathophysiology - quite the contrary. A significant part of EPOS 2007 is devoted to the many forms of inflammation but I am not sure that the term 'unexplained CRS' will catch on with clinicians or patients however well-intentioned its origin.

Valerie J. Lund
*Editor in Chief*