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Delivering better results for patients through core outcomes, measuring evidence and patient participation

Nasal obstruction is one of the most frequent and bothersome symptoms in rhinosinal disease[1-3]. Although we are able to measure nasal airflow, the correlation between the feeling of nasal obstruction and objective measurements has been shown to be average at most[4,5]. A significant proportion of the European population has a more or less deviated nasal septum and deviated septa have received a lot of attention from otorhinolaryngologists. In sharp contrast is the amount of hard evidence concerning septoplasty with or without turbinate surgery. In this issue of the Journal, van Egmond et al.[6] systematically evaluate the effectiveness of septoplasty versus non-surgical management, and the addition of turbinate surgery versus septoplasty alone. They found no studies comparing septoplasty to non-surgical management, and for that reason a few years ago they started a large national trial with exactly that question in mind[7,8]. We eagerly await the results. The addition of turbinate surgery to septoplasty, evaluated in 11 papers, of which only 5 were RCTs showed no additional benefit. There was also no difference in objective and subjective benefits. The criteria for inclusion in this systematic review was nasal obstruction caused by septal deviation (in the eyes of the authors) without allergic mucosal disease unresponsive to treatment. Recently in this journal it was shown that both allergic and non-allergic patients gained benefit from surgery (turbinate surgery with or without septoplasty) to relieve nasal obstruction[1]. One of the papers included had 35/134 patients who also had nasal valve surgery[7]. Two studies indicated that patients with nasal valve problems were excluded[7]. Recently, a very interesting paper evaluating the cause of nasal obstruction in a large cohort of 1906 patients showed 2/3 of the patients to have nasal valve collapse, and 82% percent of the 236 patients with severe/extreme NOSE scores who reported prior septoplasty and/or inferior turbinate reduction had nasal valve collapse[9]. In this group surgery is not always necessary; the Leuven group reported very positive results and acceptance of nasal valve dilatators[10]. The Rhinologic Society has spent a lot of time and effort on evaluating the evidence for our daily practice[11-17]. An important outcome of these analyses is the lack of strong evidence for many aspects of our daily clinical care. This is especially true in evaluation of surgery, and septal surgery does not seem to be an exception. It has proven difficult to carry out randomized trials[18] and we are still struggling as to how to combine other forms of evidence, such as large cohort studies[1,9,19,20], real-life studies[13,21,22] and e-studies[23-26] to deliver the best possible care for our patients. Moreover, we have not always been able to decide among us what the most relevant outcome measures are for different diseases[27]. Quite often we still encounter unvalidated outcome measures, such as SNOT scores used in rhinitis, or validated outcome measures still have to be developed[28,29]. For rhinosinusitis, an outcome measure set was recently developed using an e-Delphi process allowing 110 patients and healthcare practitioners to individually rate outcomes in terms of importance and core outcomes for trials of interventions: CHronic Rhinosinusitis Outcome MEasures (CHROME)[12,30]. The set can be freely downloaded from the rhinology or ERS website (www.rhinology.com). It would be good if these outcome sets were also developed for other diseases in rhinology such as AR and NAR, and maybe also related to interventions like septoplasty. When we have gathered all the available evidence we need to incorporate it in our daily patient care. Guidelines and position papers are easy and renowned ways to update our knowledge in daily practice [31-33]. We now want to include the available knowledge in our consultations with patients, and using shared decision making[34] find the best management for the disease of individual patients. However, we are more and more aware that evidence collected on groups of patients with more or less equal phenotype, e.g. patients with CRSwNP, might not be applicable to all patients in that group[35]. We do realize that we need precision medicine to optimize patient care[36,37]. The combination of personalized care by implementing endotyping[38-42]. Prediction of treatment success[43,44] and deciding about the best moment to start a certain treatment[43,44], prevention of disease[45-47] and patient participation in the elaboration of the treatment plan[48] is expected to substantially improve the therapeutic approach for individuals suffering from chronic disabling conditions. In this issue of the journal, we report on the use of mySinusitisCoach, an excellent way to involve patients with chronic rhinosinusitis in the management of their disease using mobile technology[48]. The use of mySinusitisCoach facilitates evaluation of patient reported outcome measures and allows not only tailoring of treatment to the level of control of the disease but will also allow us in future to collect longitudinal data about our patient care. This issue of the journal is full of very interesting papers about different subjects; from cystic fibrosis[49,50] to autonomic disfunction[51], and from calvarian bone for the reconstruction of frontal defects[52] to upregulation of TRPV1 expression in chronic rhinosinusitis with nasal polyps[53]. I wish you all a wonderful summer, with lots of sunshine.

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