

Changing habits

At the start of a new year, we all have good intentions: eat and drink and fly less, sport and enjoy life more, etc. We also all know how difficult it is to change routines into new and better habits.

Also in our work, we heavily rely on routines when treating our patients and it is not always easy to implement new developments in the field. For years our main base for choices in treatment of chronic rhinosinusitis (CRS) was phenotyping: the endoscopic view: does the patient has polyps or not, do we see purulence, thick mucus, closed sinuses when needed combined with CT scan and a little bit of history. The rest was usually trial and error: does the patient's signs and symptoms of disease becomes controlled: continue, if not try something else.

In EPOS2020, published 3 years ago, for the first time it was proposed to use endotyping in our management of patients with CRS⁽¹⁾. In the proposed integrated care pathways, after a common trunk of appropriate medical treatment with nasal corticosteroids, rinsing with saline and checking treatable traits (e.g. smoking cessation) and co-morbidities, followed by systemic treatment and/or sinus surgery, it is now advised to endotype the more severe patient. And the endotyping has consequences for the treatment choice.

But many of us still keep the old routine of only phenotyping our patient when deciding on the management, potentially inducing unnecessary costs and burden to our patients⁽²⁾.

Endotyping sounds very difficult, but actually it is not. With a few simple questions, like what is your main complaint, what are the co-morbidities, the endoscopic view and some simple blood tests, one can easily differentiate in the vast majority of cases between type 2 and non-type 2 disease in CRS. In type

2 disease we have the option to use aspirin desensitization (in patients with NSAID intolerance) or biologics^(3,4). In non-type 2 disease long-term antibiotics or xylitol rinsing can be considered⁽⁵⁾.

To help us all in implementing optimal care for our CRS patients, in this issue of Rhinology, EUFOREA presents a pocket-guide. In a very simple figure, the management steps, based on control of symptoms (VAS \geq 5, SNOT \geq 40), are proposed. Might be worthwhile to stick on the wall of your office. Also in this issue, Dietz de Loos et al. show a strong correlation between individual items measured as VAS or in the SNOT-22.

In the last three years another aspect of our life has considerably changed and a lot of papers in Rhinology and other journals has highlighted the huge impact of COVID-19 in our profession. The loss of smell, being a hall-mark symptom of the disease, has further highlighted the importance of smell. In this issue Asvapoositkul et al. help us with a very important systematic review and meta-analysis showing that the mainstay of post-COVID anosmia treatment should be olfactory training and that additional medical treatment, including oral and/or nasal corticosteroids have no additional effect. Also in this issue, Winkelman et al. show that more than a third of all COVID patients have remaining olfactory dysfunction, 9 months after the infection. I sincerely hope this message will change the routine of giving corticosteroids in all these COVID patients suffering from olfactory dysfunction and that we start giving them olfactory training instead. The many developments in our field consistently drive us to change our routines. I hope Rhinology inspires to do so. Wishing you all a very happy, healthy and productive 2023.

References

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