

“Whodunnit” in rhinology

Rhinology is an interesting medical specialty to work in. Patients generally have a limited number of complaints, but their conditions vary widely. This makes a good rhinologist somewhat like a good detective. Trouble with nasal breathing, trouble with smell, trouble with rhinorrhoea, feeling facial fullness, creation of crusts, and epistaxis are the witnesses testifying to a large variety of patterns and diagnoses.

For a physician, to diag-Nose also means choosing what is normal and what is (s)not. This issue of Rhinology will add to your knowledge of ‘normal’. The paper of Mori et al. provides insight into normal olfactory development in childhood and how it is stimulated by regular conversation about odours and olfaction. Also, the normality of the nasal cycle, or better: the normality of having a mixed pattern in your nasal cycle is described by Lindemann et al., adding knowledge to the comprehensive review on this matter ⁽¹⁾.

In case of disease, there is also a ‘normal’ to be described: the natural course of the disease and how certain complaints will develop. This issue contains a number of interesting papers in that respect. In COVID-19 patients, Boscolo-Rizzo et al. found long-term psychophysical olfactory, gustatory, and chemesthesis impairment. It shows that the sudden onset anosmia syndrome as first sign of a COVID-19 infection ⁽²⁾, has long-lasting sequelae (which is an unfortunate ‘normal’ to define). Likewise, Pagella et al. show how a sudden symptom as epistaxis can have long-lasting influence on the quality of life in patients with hereditary haemorrhagic telangiectasia.

It is also good to know the usual MO (modus operandi) of a disease so that you can more easily recognize the suspect at hand. For a number of important suspects of the past two years, such as chronic rhinitis, chronic rhinosinusitis (CRS) and COVID-19, the editors of Rhinology have written an update on the most important development for this issue of Rhinology. If crimes are left unchecked, society would suffer greatly. In the same analogy, to leave a disease like CRS ‘unchecked’ would

also infer a great burden to society. Not only in terms of costs ^(3,4), but also in terms of additional health care consumption: Phillips et al. show in this issue that patient-reported disease control is a valid measure of disease burden. In another paper they help us interpret the SNOT-22 questionnaire further by showing that for medically managed CRS the minimal clinically relevant difference is 12 points. This information provides us with further tools to define CRS control and burden.

As such, the rhinologist-detective should listen carefully to the witnesses (patient history), survey the available evidence (nasal endoscopy, laboratory and imaging data, etc.) and point out the suspect (diagnosis). We then should ‘convict’ the suspect to the proper measures, i.e., treatment. Just like a punishment should be proportional to the crime, so should the treatment be proportional to the severity of the disease.

Much debate is ongoing on the place of biological treatment in CRS. Given the current pricing, biologicals should only be considered in those failing other treatment options ⁽⁵⁻⁷⁾. For omalizumab, this principle can also be applied for patients with allergic rhinitis, as is now shown by Tsubouri et al. in a systematic review.

Dear colleagues, dear rhinologists, on behalf of the editorial board I wish you happy hunting with this issue!



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