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"Recurrence" in rhinology

For some time now, I have been struggling with the concept of 'recurrence' in rhinology. The word in its own right is quite straightforward and means "the fact of happening again" (Cambridge English Dictionary). In conditions that are primarily treated surgically, such as an inverted papilloma, the application of the concept of recurrence is easy and really helpful. By extension, the word has also been applied to any other 'growth' in the nose and paranasal sinuses that one could remove by surgery. This is defendable for unilateral or localized disease, such as an antrochoanal polyp, or chronic rhinosinusitis (CRS) secondary to a fungal ball. However, the concept of recurrence is rather confusing when applied to the presence of nasal polyps in primary diffuse CRS, which in Western countries usually has a type 2 endotype dominance [1].

Using 'recurrence' in the context of nasal polyps suggests that with surgery one could ***cure*** the patient, and that after a disease-free period, polyps then recur. Obviously, for nasal polyps surgery is one of the tools to (temporarily) improve the patient's complaints [2]. The same is true for other options, such as the application of local or systemic corticosteroids. However, the formation of nasal polyps is a sign of an underlying inflammatory condition which is not cured by surgery. In our multi-centre randomized-controlled trial comparing surgery and medication to medication alone, this is exactly what we found: after surgery or intensified medical therapy, patients with nasal polyps do better [3]. But they are not free of disease!

To determine 'recurrence' of nasal polyps can also cause problems. How reliable is nasal endoscopy? Ask three colleagues to rate the presence (or recurrence) of polyps and you will have three different answers as you enter into a discussion on oedema, cobblestone mucosa, polypoid changes of middle turbinates etc. Not to mention the limitations of several scoring systems for nasal polyps [4]. Moreover, what does the presence or recurrence of a nasal polyp mean for the patient exactly? Is one 'quiet' polyp, which is not associated with any complaints, a relevant finding? Interestingly, a consistent result in cohorts of nasal polyp patients treated with biologicals is that their nasal polyp scores do not always go down to zero, although their nasal complaints often normalize [5,6]. This shows that the presence of residual or recurrent polyps does not necessarily constitute a problem to the patient. To complicate matters further, such polyps might actually be concurrent respiratory epithelial adenomatoid hamartoma [7].

Rather than describing polyp 'recurrence', we should think of CRS as a chronic disease and thus report on 'disease control'. Although we still lack a validated definition, it is generally viewed as "the extent to which manifestations of CRS are within acceptable limits". In this issue, Sedaghat et al. describe the consensus criteria for CRS control as obtained through a Delphi process from an international panel of rhinologists. Interestingly, nasal endoscopy (and by extension the 'recurrence' of nasal polyps) did not reach full consensus. Until we have a validated definition of CRS control, the concept of 'recurrent disease' (i.e., loss of control) should be defined broader than nasal endoscopy alone, as Xie et al. have done in their paper in this issue: "The recurrence of CRSwNP was defined by the reappearance of ***clinical symptoms***, endoscopic signs, (…)" I hope these articles will help sharpen your thinking on (treatment goals in) primary diffuse (type 2) chronic rhinosinusitis. Enjoy!

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