

Authors' affiliations:

V. Lund, Professor in Rhinology, Honorary Consultant Otorhinolaryngologist, University College London Medical School, Institute of Laryngology and Otology, London, UK

Symptomatic polyposis occurs in less than 1% of the population of Western Europe (1). However, a study conducted by Larsen & Tos (2) indicates that polyposis may be far more prevalent.

Larsen & Tos investigated mortuary specimens of individuals who had no known history of sinusitis or nasal polyposis (2). Simple observation of the nasal passages showed evidence of nasal polyps in 2% of the cadavers. However, this incidence increased to 26% after simple endoscopic investigation, and to 42% after further endoscopic investigation of the ethmoid system. These increases indicate, therefore, that the prevalence of nasal polyposis is dependent on the intensity of the observation and that polypoid changes are far more common in a "normal" population than previously supposed.

A number of pathological processes may be involved in the development of nasal polyposis. The role of allergy has been considered by many authors, but there has been little

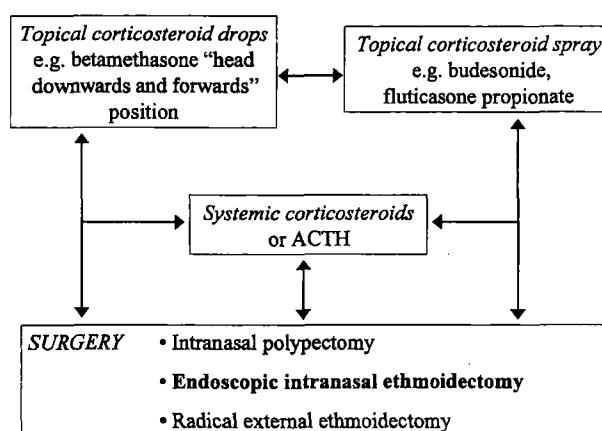


Figure 1. Algorithm of drug and surgical treatment of nasal polyposis (from *BMJ* 1995;311:1414).

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evidence for the implication of IgE-mediated allergy in the development of nasal polyps (3, 4).

Nasal polyposis is a condition which is multifactorial and is usually managed by a combination of medication in the form of corticosteroid therapy and surgery (Fig. 1) (5).

The author of a 1994 position paper (6) concluded that pharmacotherapy is usually the first-choice treatment in nasal polyposis. Intranasal betamethasone drops adminis-

tered in the "head downwards and forwards" position are used for primary therapy. Other corticosteroids, including beclomethasone dipropionate, flunisolide, budesonide and fluticasone propionate, are also available as intranasal preparations, but their use has been limited to secondary maintenance therapy. A recently developed drop formulation of fluticasone propionate promises to be of benefit in the primary treatment of nasal polyposis.

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