

## Correspondence

**Nasal endoscopy to characterize sinonasal disease**

*To the Editor:*

The data from Dixon et al<sup>1</sup> suggest that using 100-200 µg/d intranasal mometasone spray does not improve asthma control in patients who also have sinonasal disease. Pointedly, no mention was made as to what instructions were given to patients regarding nasal spray technique. For example, patients with nasal polyposis and associated osteomeatal complex disease are unlikely to benefit from using a nasal spray with a technique that results in preferential deposition to the inferior turbinates. Moreover, higher doses of intranasal mometasone (ie, 400 µg/d) might be required to effectively treat nasal polyposis, along with correct advice regarding directing the spray toward the osteomeatal complex area. For example, in the United Kingdom we routinely use fluticasone propionate drops at doses of 400 to 800 µg/d for both induction and maintenance therapy for such patients.<sup>2</sup>

The term sinonasal disease is rather vague and does not accurately describe a clinically relevant patient phenotype in terms of predicting response to medical therapy with topical corticosteroids. In this regard we routinely perform rigid nasal endoscopy on all new patients attending the Dundee Rhinology Mega-clinic<sup>3</sup> to assess the extent of polyp disease in addition to excluding other conditions, such as inferior turbinate hypertrophy, septal deviation, concha bullosa, and adenoidal hypertrophy, which might require surgical intervention. Without first making a proper endoscopic diagnosis, one cannot make any meaningful conclusions regarding treating the unified allergic airway with

intranasal corticosteroids, especially in terms of their effect on concomitant asthma control. Further prospective studies are required in more carefully characterized patients who have uncomplicated allergic rhinitis and persistent asthma to assess the effects of intranasal corticosteroids for the unified allergic airway.

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