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Chronic sinusitis with rofecoxib

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To the editor:

I read with interest Dr. Hamilos' review article entitled "Chronic sinusitis,"¹ in which he describes sinusitis as one of the most important diseases treated by the Allergy-Immunology subspecialist. Nonsteroidal anti-inflammatory medications were not mentioned in his treatment program, and I therefore submit to your readers' attention the superb results of a patient with chronic sinusitis treated with rofecoxib (Vioxx).

The patient is a 56-year-old white man who had a gradual onset of cough in April 2000. This progressed to severe postnasal drip causing extreme bouts of coughing (lasting up to 8 hours), choking, and dyspnea, interrupting sleep and activities.

Multiple courses of antibiotics, along with lengthy courses of prednisone, were at most partially and only very slowly helpful. Treatment for gastroesophageal reflux with proton-pump inhibitors was ineffective. Treatment for possible asthma with inhaled steroids and long-acting β_2 -agonists, as well as quick-acting β_2 -agonists, were ineffective, as were nasal saline irrigation, multiple nasal steroids, antihistamines, leukotrine antagonists, and ipratropium nasal spray. Prednisone (up to 60 mg/d) and antibiotics took several weeks to provide even partial relief. The patient did not have nasal polyposis and was not allergic to

aspirin. He has a history of mild seasonal allergic rhinitis in the grass pollen season, which has greatly improved over the past decade.

Initial laboratory data included the following: normal complete blood count, except for 8.1% eosinophils; erythrocyte sedimentation rate of 7; normal chest computed tomography (CT) results; CT of sinuses showing mild mucosa thickening of both the maxillary and ethmoid sinuses; some mucosa thickening of the right sphenoid sinus; negative cytoplasmic antineutrophil cytoplasmic antibodies and perinuclear antineutrophil cytoplasmic antibodies results; normal IgG, IgA, and IgM levels; an IgE level of 102 IU/mL (equivocal); no antibodies to *Aspergillus*, *Bipolaris*, and *Alternaria* species; and positive skin prick test results to inhalants only for grass pollen. Nasal smears were not done.

Because of intolerable symptoms (eg, coughing, wheezing, profuse stringy mucoid to mucopurulent postnasal drip, and choking), the patient had functional endoscopic sinus surgery performed (bilateral anterior ethmoidectomy and bilateral middle meatal antrostomy) about 8 months after symptoms began. The pathology report showed focal chronic inflammation consistent with chronic sinusitis but with no evidence of vasculitis.

Refocoxib (Vioxx), 25 mg daily, was added just before surgery, and the patient believed it decreased the symptoms greatly. He continued it for 6 weeks after surgery and had relief of symptoms for the first time during the 6 weeks on rofecoxib. However, he discontinued it after 6 weeks, and the symptoms returned.

Culture done on rhinoscopy grew *Streptococcus pneumoniae* and *Staphylococcus aureus* (both sensitive to amoxicillin/clavulanate potassium [Augmentin]), and prophylactic Augmentin was begun. However, the patient continued to have frequent symptoms requiring multiple bouts of antibiotics, as well as hydrocodone for partial symptomatic relief. Long courses of prednisone were interrupted by hip pain, which was evaluated by means of magnetic resonance imaging for possible avascular necrosis of the hips; fortunately, the magnetic resonance imaging results were negative for avascular necrosis.

CT of the sinuses was repeated 1 year after symptoms began and showed the following. The frontal sinuses were aplastic. The infundibula of the maxillary sinuses were obstructed by mucosa thickening, and there was opacification of the maxillary sinuses. A small fluid level was noted in the left maxillary sinus. Ethmoid air cells were severely opacified throughout. Sphenoethmoid recesses were obstructed bilaterally. The sphenoid sinus on the right was nearly completely opacified, but the left sphenoid was clear.

Further sinus surgery was scheduled because of continued severe symptoms while receiving prophylactic Augmentin, Claritin-D, nasal steroids, and saline irrigation. However, the patient decided to restart 25 mg of rofecoxib on June 13, 2001 (about 14 months after the start of symptoms), and all symptoms disappeared within a day. All other medications were stopped without any problem. The patient continues to receive only 25 mg of rofecoxib daily and has had virtually no further symptoms for the past 2¹/₂ months. Because of the 1¹/₄-year history of such severe symptoms, the patient is unwilling to stop the rofecoxib at

this time. Repeat rhinoscopic examination showed marked improvement with rofecoxib. Because the patient's symptoms almost completely cleared with rofecoxib, he did not wish to repeat the computed tomographic scan of the sinuses. I look forward to hearing from other allergists as to their experiences with this therapy (rofecoxib) and perhaps with other nonsteroidal anti-inflammatory drugs in patients with severe chronic sinusitis who are not intolerant of such products.**1/8/121531**

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ABSTRACT

FULL TEXT