THE ANSWERS

OF

20 EXPERTS

TO

30

CONSENSUS QUESTIONS

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Dr. P. Castelnuovo
Varese, Italy

1. Is nasal polyposis local or systemic disease?
   It is a local manifestation of an immunological disease.
2. Can you make a distinction between «simple» polyposis and «diffuse» polyposis concerning the background of the disease?
   Yes, I can: diffuse polyposis shows an eosinofilic hyperractivity or an association with systemic diseases like cystic fibrosis, Kartagener sindrome........
3. Are they separate etipathogenetic entities, thus requiring different therapeutic approach?
   Yes, they are, but till now we haven't found out the actual etiopathogenesis, we only know the different disease association that requires different therapeutic association
4. Do you believe in any of the theories that are published so far ? If yes, in which one?
   No. I'm not sure about any definitive theory.
5. Is nasal polyposis exclusively a surgical disease?
   No, it isn't
6. Is nasal polyposis a disease more appropriate for a conservative treatment?
   Generally speaking we can say yes; actually nasal polyposis is not one single disease entity, so it depends wich type of polyposis we are in to treat. In fact diffuse polyposis requires a combined treatment: medical and surgical.
7. How do you estimate the role of the fungi in the ethiology of the nasal polyposis?
   The fungi are superantigens, they are able to provoke an exaggerated eosinophilic reaction by means of an immunologic mechanism not yet completely understood
8. Do you personally use antifungal drugs in your polypous patients? If yes, in which way (local, systemic or both) and what kind of a drug do you prefer?
   Yes, I use antifungal drugs in patients with a nasal swab positive to fungi with the eosinophilic mucin background. I'm used to give local antifungal drugs (B amphotericin) delivered by nasal aerosol. I combine local and systemic therapy in drug-resistant patients.
9. Do you believe that underlying osteitis in the cases of so called chronic sinusitis, can provoke the onset of polyposis?
   No, I don't
10. Do you recommend long term antibiotic treatment to your polypous patients?
    I do it only when there is either an overriding infection, or an associated rhinosinusitis.
11. If yes, which antibiotic do you prefer, and for how long time do you apply it?
    I prefer either clavulanate/amoxicillin or ciprofloxacin for 3 weeks.
12. How do you feel about the montelucast sodium regarding preoperative or postoperative treatment in polypous patients?
    I use montelucast sodium in polypous patients presenting with an eosinophilic hyperreactivity.

13. How do you feel about the steroid treatment? Preoperatively? Postoperatively? Both?
    I use both preoperative and postoperative steroid treatment in case of diffuse polyposis.
14. If you do use steroids, for how long time do you treat the patient preoperatively? What is your timing? How do you know when to stop and operate? Do you use peroral steroids or local ones? Maybe both of them?
    In case of diffuse polyposis I treat patients with local steroids for repeated cycles of 3 months with a 1 month interruption between them. I give oral steroids preoperatively for 7 days, and postoperatively for a 15 days cycle in case of recurrent disease.
15. Do you have any experience with the topical use of the furosemide?
    Yes I have, but I haven't got any persuasive data about its effectiveness.
16. How do you feel about the role of the GP doctor in the modern treatment of the patient with polyposis?
    I think GP doctor must have a real knowledge of the different evidences of polypous disease, so that he can coordinate the different diagnostic tools (those of the otolaryngologist, pneumologist, allergologist, radiologist).Anyway, the evaluation of the entity of the disease can be fully appreciated only by the ENT examination.
17. Does the diminuition of the massive polyposis influence the status of the asthmatic patient? If yes, which kind of diminuition you prefer: surgical or conservative?
    Yes, it does, but along an extended period of observation. And expecially when there's a reduction of the overriding infection. In massive polyposis I use a combined approach: medical and surgical in a prospective program.
18. Do you feel that pulmologist should be consulted in all cases of nasal polyposis? Why yes, why not?
    I think that pneumologists should be consulted in all cases of diffuse nasal polyposis, because it is very important to evaluate the associated bronchopulmonar conditions.
19. Do you feel that CT scanning of the polypous patient is necessary. If yes, when: before or after the conservative treatment, i.e. just before the surgery?
    Yes I do: CT scan is the most important imaging examination for the polypous patient. We prefer polypous patients to undergo a CT examination just before surgery, preparing them with a one week oral steroid treatment. We think that CT examination allows us to have:
    - *a real definition of disease extension and a better evaluation of disease nature (actually sometimes we need MRI);*
    - *a clear morphological definition of the specific anatomy of patients;*
    - *an important surgical guide wich may help to avoid surgical complications.*
20. What staging system do you believe in? Can we at this consensus conference accept Lund-Mackay's as most practical one?
    Yes, we can.
21. Do you believe that some septal deformities can influence chronic ostiomeatal disease? If yes, what kind of deformity (try to express your attitude using the Mladina's classification)

Yes, I do. I think that Mladina's type 3 septal deformity can create an ostio-meatal blockage with following sinus inflammatory disease.

22. Are chronic bacterial or viral infections important in the onset of nasal polyposis?
Chronic infection are important in the onset of nasal polyposis associated with cronic inflammatory diseases (Stammberger class no.3 group).

23. Do you remove or leave alone the middle turbinate showing superficial polypoid changes of the mucosa in cases of maxi-polyposis?
In the first operation I try to leave in place middle turbinate and I use microdebrider to remove the polypoid mucosa. In case of post-surgical reccurrencies I prefer to remove middle turbinate, aiming to widen the surgical field for local debridement of polyps.

24. Do you insist on radical and complete clearance of the skull base in cases of diffuse polyposis, or you prefer to leave some polypous tissue there to be treated by means of conservative methods?
Usually I prefer to leave some polypous tissue, expecially in olphactory fissure: my surgery points to realise a sinus ostium disobstruction.

25. Have you ever heard about or personally tried the method of desenzitation of the patient to the antigen prepared from his own polyps in difficult cases of recurrent, voluminous diffuse polyposis and asthma?
No, I have no experience.

26. How do you feel about the topical use of mometasone?
I think it is a good therapeutic option.

27. How do you feel about the powered instrumentation (shavers) in the treatment of nasal polyposis: just one of the surgical tools or something more?
I think it is a real revolution. The importance of its role in the treatment of nasal polyposis is comparable to topical steroids, in a surgical and medical perspective, respectively.

28. How do you imagine the antipolypous drug of the future: viral transfer of correct gene to replace the wrong one, a sort of antiinterleukin 5 (or which one?) or something else?
I think we have to improve our immunologic knowledge about the real reason of eosinophilic hyperreactivity.

29. Do you believe that nasal polyps will disappear in a near future from the list of surgical diseases?
I hope so, but I think it won'take a short time.

30. How do you feel nowadays when you are faced to nasal polyposis: a) frustrated because of the fact that this is a typical chronic, recurrent disease, b) ready for the fight in every single patient, c) embarrassed because this disease sometimes discredit your capabilitiesas a medical doctor and takes to much of your time?
No, I put myself in a realistic way. I inform the patient that the actual medical knowledge has not clarified the real ethipathogenetical reasons of the disease yet, so I can offer him only a symptomatic therapy. However I tell him that we have a good combined therapy (medical and surgical) wich helps us to improve his quality of life, avoiding the twenty operations some patients underwent in the past, according to anecdotal reports.

Dr. P.A.R. Clement
Brussels, Belgium

1. Is nasal polyposis local or systemic disease?
   The etiology of nasal polyposis is not well known, both can be true
2. Can you make a distinction between «simple» polyposis and «diffuse» polyposis concerning the background of the disease?
   In some extreme cases you can do, but there is an important overlap
3. Are they separate etiopathogenetic entities, thus requiring different therapeutic approach?
   There are probably etiopathogenic different entities, as some polyps are reacting very well on oral corticosterods and others not. It is, however, for the moment impossible with the routine investigations. We have now to differentiate between both entities
4. Do you believe in any of the theories that are published so far ? If yes, in which one?
   No, I do not believe in any of the theories, I think we need more proofs (evidence based medicine)
5. Is nasal polyposis exclusively a surgical disease?
   That nasal polyposis that does not disappear with a conservative treatment is an exclusively surgical disease
6. Is nasal polyposis a disease more appropriate for a conservative treatment?
   Conservative treatment should always be tried first
7. How do you estimate the role of the fungi in the etiology of the nasal polyposis?
   An interesting theory
8. Do you personally use antifungal drugs in your polypous patients? If yes, in which way (local, systemic or both) and what kind of a drug do you prefer?
   No
9. Do you believe that underlying osteitis in the cases of so called chronic sinusitis, can provoke the onset of polyposis?
   It could be a contributing factor
10. Do you recommend long term antibiotic treatment to your polypous patients?
    No
11. If yes, which antibiotic do you prefer, and for how long time do you apply it?
    No
12. How do you feel about the montelucast sodium regarding preoperative or postoperative treatment in polyposiss patients?
    The only treatment which is worth trying is that treatment were you have a statistically significant result which is clinically relevant to the patient
13. How do you fill about the steroid treatment? Preoperatively? Postoperatively? Both?
    According to our knowledge and the trials we did, oral corticosteroids will give in 50 % of the cases a spectacular result
14. If you do use steroids, for how long time do you treat the patient preoperatively? What is your timing? How do you know when to stop and operate? Do you use oral steroids or topical ones? Maybe both of them?

I use oral steroids when after an antibiotic treatment there still remains important polyposis (on a CT scan examination). The patient is given an oral corticosteroid treatment lasting 20 days starting with a dosis of 64 mg a day and tapering down. The local steroids are only used postoperatively

15. Do you have any experience with the topical use of the furosemide?
    No
16. How do you feel about the role of the GP doctor in the modern treatment of the patient with polyposis?
    I don't think that this disease should be treated by GP
17. Does the diminuition of the massive polyposis influence the status of the asthmatic patient? If yes, which kind of diminuition you prefer: surgical or conservative?
    According to our preliminary data there is an improvement of the small airway disease in patients with massive polyposis treated by functional endoscopic sinus surgery. We didn't test bronchial function systematically after the use of steroids
18. Do you feel that pulmologist should be consulted in all cases of nasal polyposis? Why yes, why not?
    If there is important astma I think a pulmologist should be consulted
19. Do you feel that CT scanning of the polypous patient is necessary. If yes, when: before or after the conservative treatment, i.e. just before the surgery?
    We always make a CT scan after conservative treatment and the day before surgery
20. What staging system do you believe in? Can we at this consensus conference accept Lund-Mackay's as most practical one?
    Yes
21. Do you believe that some septal deformities can influence chronic ostiomeatal disease? If yes, what kind of deformity (try to express your attitude using the Mladina's classification)
    I do not have any experience with the Mladina's classification. I think that a septal spur posteriorly that closes the ostiomeatal complex probably influences chronic rhinosinusitis
22. Are chronic bacterial or viral infections important in the onset of nasal polyposis?
    No idea
23. Do you remove or leave alone the middle turbinate showing superficial polypoid changes of the mucosa in cases of maxi-polyposis?
    I try to preserve the middle turbinate as much as possible except in those cases when it is severely diseased
24. Do you insist on radical and complete clearance of the skull base in cases of diffuse polyposis, or you prefer to leave some polypous tissue there to be treated by means of conservative methods?
    For massive polyposis I mostly try to be as radical as possible, leaving as much normal mucosa as possible
25. Have you ever heard about or personally tried the method of desenzitation of the patient to the antigen prepared from his own polyps in difficult cases of recurrent, voluminous diffuse polyposis and asthma?
    No
26. How do you feel about the topical use of mometasone?
    On massive polyposis I don't think there is any clinical relevant action.

To stop the recurrence after surgery there is maybe an indication

27. How do you feel about the powered instrumentation (shavers) in the treatment of nasal polyposis: just one of the surgical tools or something more?
I think a shaver is very useful, because you can remove the polyps and still preserve the anatomy of the middle meatus. It stays, however, only a surgical instrument
28. How do you imagine the antipolypous drug of the future: viral transfer of correct gene to replace the wrong one, a sort of antiinterleukin 5 (or which one?) or something else?
I don't have any idea yet
29. Do you believe that nasal polyps will disappear in a near future from the list of surgical diseases?
There is no indication of this yet
30. How do you feel nowadays when you are faced to nasal polyposis: a) frustrated because of the fact that this is a typical chronic, recurrent disease, b) ready for the fight in every single patient, c) embarrassed because this disease sometimes discredit your capabilities as a medical doctor and takes to much of your time?
Some of the nasal polyposis can be treated very well. In 20 % we have to realise that recurrence will occur. But also recurrences can be treated in a conservative way and when the results are not satisfactory completed by a surgical act.

Dr H. Kawauchi
Izumo, Japan

1. Is nasal polyposis local or systemic disease?
   Local disease
2. Can you make a distinction between «simple» polyposis and «diffuse» polyposis concerning the background of the disease?
   Yes
3. Are they separate etipathogenetic entities, thus requiring different therapeutic approach?
   Yes
4. Do you believe in any of the theories that are published so far ? If yes, in which one?
   No
5. Is nasal polyposis exclusively a surgical disease?
   No
6. Is nasal polyposis a disease more appropriate for a conservative treatment?
   No
7. How do you estimate the role of the fungi in the ethiology of the nasal polyposis?
   Fungal infection has no contribution to induce nasal polyposis
8. Do you personally use antifungal drugs in your polypous patients? If yes, in which way (local, systemic or both) and what kind of a drug do you prefer?
   No
9. Do you believe that underlying osteitis in the cases of so called chronic sinusitis, can provoke the onset of polyposis?
   No
10. Do you recommend long term antibiotic treatment to your polypous patients?
    Yes, in some cases
11. If yes, which antibiotic do you prefer, and for how long time do you apply it?
    Macrolide series
12. How do you feel about the montelucast sodium regarding preoperative or postoperative treatment in polypous patients?
    In case where eosinophilic inflammation is prominent. In either way preoperatively or postoperatively.
13. How do you feel about the steroid tretment? Preoperatively? Postoperatively? Both?
    Nasal topical steroids can be only utilized preoperatively or postoperatively
14. If you do use steroids, for how long time do you treat the patient preoperatively? What is your timing? How do you know when to stop and operate? Do you use peroral steroids or local ones? Maybe both of them?
    Topical steroids or nebulizer therapy is recommended for routine use as long as we need.
15. Do you have any experience with the topical use of the furosemide?
    No
16. How do you feel about the role of the GP doctor in the modern treatment of the patient with polyposis?
    Impossible
17. Does the diminuition of the massive polyposis influence the status of the asthmatic patient? If yes, which kind of diminuition you prefer: surgical or conservative?
    Yes, and surgical intervention should be prefered

18. Do you feel that pulmologist should be consulted in all cases of nasal polyposis? Why yes, why not?
    No. In some cases, needed for pulmonary respiratory function
19. Do you feel that CT scanning of the polypous patient is necessary. If yes, when: before or after the conservative treatment, i.e. just before the surgery?
    Yes, ideal is to have CT scan before and after treatment
20. What staging system do you believe in? Can we at this consensus conference accept Lund-Mackay's as most practical one?
    I have no idea, but even in Japan, staging for chronic paranasal sinusitis with polyposis has already begun
21. Do you believe that some septal deformities can influence chronic ostiomeatal disease? If yes, what kind of deformity (try to express your attitude using the Mladina's classification)
    Partially believed.
22. Are chronic bacterial or viral infections important in the onset of nasal polyposis?
    Of course, yes
23. Do you remove or leave alone the middle turbinate showing superficial polypoid changes of the mucosa in cases of maxi-polyposis?
    I do remove
24. Do you insist on radical and complete clearance of the skull base in cases of diffuse polyposis, or you prefer to leave some polypous tissue there to be treated by means of conservative methods?
    I prefer FESS with conservative methods.
25. Have you ever heard about or personally tried the method of desenzitation of the patient to the antigen prepared from his own polyps in difficult cases of recurrent, voluminous diffuse polyposis and asthma?
    No
26. How do you feel about the topical use of mometasone?
    It is acceptable
27. How do you feel about the powered instrumentation (shavers) in the treatment of nasal polyposis: just one of the surgical tools or something more?
    Just one of the surgical tools.
28. How do you imagine the antipolypous drug of the future: viral transfer of correct gene to replace the wrong one, a sort of antiinterleukin 5 (or which one?) or something else?
    Gene therapy can be the case, but more appropriate methods like eosinophil-downregulating treatment strategy such as anti-interleukin 5 or our routine use of immunomodifying agents such suplatast tosilate (IPD).
29. Do you believe that nasal polyps will disappear in a near future from the list of surgical diseases?
    No
30. How do you feel nowadays when you are faced to nasal polyposis: a) frustrated because of the fact that this is a typical chronic, recurrent disease, b) ready for the fight in every single patient, c) embarrassed because this disease sometimes discredit your capabilitiesas a medical doctor and takes to much of your time?

b)

Dr. E. Kern
Mayo, Rochester, Minnesota, USA

1. Is nasal polyposis local or systemic disease?
   Systemic
2. Can you make a distinction between «simple» polyposis and «diffuse» polyposis concerning the background of the disease?
   No
3. Are they separate etipathogenetic entities, thus requiring different therapeutic approach?
   Probably
4. Do you believe in any of the theories that are published so far ? If yes, in which one?
   Primarily immunologic mediated by eosinophils, triggered by fungi
5. Is nasal polyposis exclusively a surgical disease?
   No
6. Is nasal polyposis a disease more appropriate for a conservative treatment?
   After the removal of the diffuse disease
7. How do you estimate the role of the fungi in the ethiology of the nasal polyposis?
   Probably 80-90% of cases
8. Do you personally use antifungal drugs in your polypous patients? If yes, in which way (local, systemic or both) and what kind of a drug do you prefer?
   Yes, I do. I use Amphotericin B exclusively, locally applicated.
9. Do you believe that underlying osteitis in the cases of so called chronic sinusitis, can provoke the onset of polyposis?
   Possibly, but just few cases, not a majority.
10. Do you recommend long term antibiotic treatment to your polypous patients?
    No
11. If yes, which antibiotic do you prefer, and for how long time do you apply it?
    #
12. How do you feel about the montelucast sodium regarding preoperative or postoperative treatment in polypous patients?
    No experience
13. How do you feel about the steroid tretment? Preoperatively? Postoperatively? Both?
    To help control asthma
14. If you do use steroids, for how long time do you treat the patient preoperatively? What is your timing? How do you know when to stop and operate? Do you use peroral steroids or local ones? Maybe both of them?
    #
15. Do you have any experience with the topical use of the furosemide?
    No
16. How do you feel about the role of the GP doctor in the modern treatment of the patient with polyposis?
    Referal to ENT
17. Does the diminuition of the massive polyposis influence the status of the asthmatic patient? If yes, which kind of diminuition you prefer: surgical or conservative?
    Yes, it does. Usually surgical diminuition first
18. Do you feel that pulmologist should be consulted in all cases of nasal polyposis? Why yes, why not?

Yes in patients with paralell asthma (about 60-70% of cases)

19. Do you feel that CT scanning of the polypous patient is necessary. If yes, when: before or after the conservative treatment, i.e. just before the surgery?
    Just before the surgery
20. What staging system do you believe in? Can we at this consensus conference accept Lund-Mackay's as most practical one?
    Yes
21. Do you believe that some septal deformities can influence chronic ostiomeatal disease? If yes, what kind of deformity (try to express your attitude using the Mladina's classification)
    Yes, I do. First of all imapctions which interfere with mucociliary activity
22. Are chronic bacterial or viral infections important in the onset of nasal polyposis?
    Can be because of disturbed mucociliary activity: stasis
23. Do you remove or leave alone the middle turbinate showing superficial polypoid changes of the mucosa in cases of maxi-polyposis?
    Only strip
24. Do you insist on radical and complete clearance of the skull base in cases of diffuse polyposis, or you prefer to leave some polypous tissue there to be treated by means of conservative methods?
    First of all: save turbinates and never risk injury. So it is O.K. to leave some tissue and treat it conservatively
25. Have you ever heard about or personally tried the method of desenzitation of the patient to the antigen prepared from his own polyps in difficult cases of recurrent, voluminous diffuse polyposis and asthma?
    No
26. How do you feel about the topical use of mometasone?
    Excellent
27. How do you feel about the powered instrumentation (shavers) in the treatment of nasal polyposis: just one of the surgical tools or something more?
    O.K. as a tool
28. How do you imagine the antipolypous drug of the future: viral transfer of correct gene to replace the wrong one, a sort of antiinterleukin 5 (or which one?) or something else?
    That which will interfere with the mechanisms of antiinterleukin 13, 5 etc.
29. Do you believe that nasal polyps will disappear in a near future from the list of surgical diseases?
    No
30. How do you feel nowadays when you are faced to nasal polyposis: a) frustrated because of the fact that this is a typical chronic, recurrent disease, b) ready for the fight in every single patient, c) embarrassed because this disease sometimes discredit your capabilities as a medical doctor and takes to much of your time?
    b)

Dr. I. Klapan
Zagreb, Croatia

1. Is nasal polyposis local or systemic disease?
   Systemic disease.
2. Can you make a distinction between «simple» polyposis and «diffuse» polyposis concerning the background of the *disease?*
   Yes, I can make a distinction between «simple» and «diffuse» polyposis concerning the beckground of the disease.
3. Are they separate etipathogenetic entities, thus requiring different therapeutic approach?
   I do believe so.
4. Do you believe in any of the theories that are published so far ? If yes, in which one?
   No
5. Is nasal polyposis exclusively a surgical disease?
   No, it is a systemic disease and also a surgical problem.
6. Is nasal polyposis a disease more appropriate for a conservative treatment?
   Bilateral: conservative and surgical therapy.
7. How do you estimate the role of the fungi in the ethiology of the nasal polyposis?
   I do not believe that fungi play the important role in the aethiology of the nasal polyposis.
8. Do you personally use antifungal drugs in your polypous patients? If yes, in which way (local, systemic or both) and what kind of a drug do you prefer?
   No
9. Do you believe that underlying osteitis in the cases of so called chronic sinusitis, can provoke the onset of polyposis?
   No
10. Do you recommend long term antibiotic treatment to your polypous patients?
    No
11. If yes, which antibiotic do you prefer, and for how long time do you apply it?
    #
12. How do you feel about the montelucast sodium regarding preoperative or postoperative treatment in polypous patients?
    I have no experience in this treatment.
13. How do you feel about the steroid tretment? Preoperatively? Postoperatively? Both?
    Both
14. If you do use steroids, for how long time do you treat the patient preoperatively? What is your timing? How do you know when to stop and operate? Do you use peroral steroids or local ones? Maybe both of them?
    Five days. When the mass of polyps is reduced et least 1/3. I use systemic and local application of steroids.
15. Do you have any experience with the topical use of the furosemide?
    Until now, only in some cases.
16. How do you feel about the role of the GP doctor in the modern treatment of the patient with polyposis?
    In time sufficient diagnosis of the disease.
17. Does the diminuition of the massive polyposis influence the status of the

asthmatic patient? If yes, which kind of diminuition you prefer: surgical or conservative?
Yes. Both surgical and conservative treatment.

18. Do you feel that pulmologist should be consulted in all cases of nasal polyposis? Why yes, why not?
Only in the asthmatic patients because it is a systemic disease and it needs bilateral consultation.
19. Do you feel that CT scanning of the polypous patient is necessary. If yes, when: before or after the conservative treatment, i.e. just before the surgery?
Yes, it is necessary after conservative treatment and before the surgery.
20. What staging system do you believe in? Can we at this consensus conference accept Lund-Mackay's as most practical one?
Yes
21. Do you believe that some septal deformities can influence chronic ostiomeatal disease? If yes, what kind of deformity (try to express your attitude using the Mladina's classification)
Yes. Mladina's type 3.
22. Are chronic bacterial or viral infections important in the onset of nasal polyposis?
Possibly, if one has reccurent infections of the region mentioned above.
23. Do you remove or leave alone the middle turbinate showing superficial polypoid changes of the mucosa in cases of maxi-polyposis?
I remove the middle turbinate in the cases of maxi-polyposis.
24. Do you insist on radical and complete clearance of the skull base in cases of diffuse polyposis, or you prefer to leave some polypous tissue there to be treated by means of conservative methods?
I prefer to leave some polypous tissue there to be treated by means of conservative methods.
25. Have you ever heard about or personally tried the method of desenzitation of the patient to the antigen prepared from his own polyps in difficult cases of recurrent, voluminous diffuse polyposis and asthma?
No
26. How do you feel about the topical use of mometasone?
This is a new topical corticosteroid, and I believe that it is going to be useful in mentioned therapy.
27. How do you feel about the powered instrumentation (shavers) in the treatment of nasal polyposis: just one of the surgical tools or something more?
It is very useful tool in the surgery of the SN- polyposis.
28. How do you imagine the antipolypous drug of the future: viral transfer of correct gene to replace the wrong one, a sort of antiinterleukin 5 (or which one?) or something else?
The antagonist of the LTC4 receptor would be maybe helpful in mentioned therapy.
29. Do you believe that nasal polyps will disappear in a near future from the list of surgical diseases?
Yes, if mentioned conservative therapy would be useful.
30. How do you feel nowadays when you are faced to nasal polyposis: a) frustrated because of the fact that this is a typical chronic, recurrent disease,

b) ready for the fight in every single patient, c) embarrassed because this disease sometimes discredit your capabilities as a medical doctor and takes to much of your time?

Dr. V. Kozlov
Yaroslavl, Russia

1. Is nasal polyposis local or systemic disease?
   NP is local disease, but in case of aspirin intolerance it is systemic disease
2. Can you make a distinction between «simple» polyposis and «diffuse» polyposis concerning the background of the disease?
   No
3. Are they separate etipathogenetic entities, thus requiring different therapeutic approach?
   No
4. Do you believe in any of the theories that are published so far ? If yes, in which one?
   No
5. Is nasal polyposis exclusively a surgical disease?
   No
6. Is nasal polyposis a disease more appropriate for a conservative treatment?
   No
7. How do you estimate the role of the fungi in the ethiology of the nasal polyposis?
   Fungi can make the role in NP, but in very few cases
8. Do you personally use antifungal drugs in your polypous patients? If yes, in which way (local, systemic or both) and what kind of a drug do you prefer?
   Yes. I use untifungal drug only after microbiological test. I apply amphotericyn B(Russian name) in solution via YAMIK. But only after surgery
9. Do you believe that underlying osteitis in the cases of so called chronic sinusitis, can provoke the onset of polyposis?
   No
10. Do you recommend long term antibiotic treatment to your polypous patients?
    No
11. If yes, which antibiotic do you prefer, and for how long time do you apply it?
12. How do you feel about the montelucast sodium regarding preoperative or postoperative treatment in polypous patients?
    I have no experience
13. How do you feel about the steroid tretment? Preoperatively? Postoperatively? Both?
    Postop
14. If you do use steroids, for how long time do you treat the patient preoperatively? What is your timing? How do you know when to stop and operate? Do you use peroral steroids or local ones? Maybe both of them?
15. Do you have any experience with the topical use of the furosemide?
    No
16. How do you feel about the role of the GP doctor in the modern treatment of the patient with polyposis?
    GP doctor can not play any role in modern treatment of NP
17. Does the diminuition of the massive polyposis influence the status of the asthmatic patient? If yes, which kind of diminuition you prefer: surgical or conservative?
    Surgical
18. Do you feel that pulmologist should be consulted in all cases of nasal

polyposis? Why yes, why not?
Pulmonologist can be consulted only if patient has NP and astma

19. Do you feel that CT scanning of the polypous patient is necessary. If yes, when: before or after the conservative treatment, i.e. just before the surgery?
Before surgery
20. What staging system do you believe in? Can we at this consensus conference accept Lund-Mackay's as most practical one?
Yes
21. Do you believe that some septal deformities can influence chronic ostiomeatal disease? If yes, what kind of deformity (try to express your attitude using the Mladina's classification)
All kind of deformities
22. Are chronic bacterial or viral infections important in the onset of nasal polyposis?
No
23. Do you remove or leave alone the middle turbinate showing superficial polypoid changes of the mucosa in cases of maxi-polyposis?
I try to leave alone MT in all cases
24. Do you insist on radical and complete clearance of the skull base in cases of diffuse polyposis, or you prefer to leave some polypous tissue there to be treated by means of conservative methods?
In case of massive polyposis I try to remove all polypous tissue. Of course it is not possible in all cases
25. Have you ever heard about or personally tried the method of desenzitation of the patient to the antigen prepared from his own polyps in difficult cases of recurrent, voluminous diffuse polyposis and asthma?
Yes I heard, but never tryed
26. How do you feel about the topical use of mometasone?
I have no experience
27. How do you feel about the powered instrumentation (shavers) in the treatment of nasal polyposis: just one of the surgical tools or something more?
Just one of the surgical tools, but more convenient.
28. How do you imagine the antipolypous drug of the future: viral transfer of correct gene to replace the wrong one, a sort of antiinterleukin 5 (or which one?) or something else?
I think it can be a local drag in more or less near future.
29. Do you believe that nasal polyps will disappear in a near future from the list of surgical diseases?
No
30. How do you feel nowadays when you are faced to nasal polyposis: a) frustrated because of the fact that this is a typical chronic, recurrent disease, b) ready for the fight in every single patient, c) embarrassed because this disease sometimes discredit your capabilities as a medical doctor and takes to much of your time?
b)

Dr. S. Lacroix
Geneva, Switzerland

1. Is nasal polyposis local or systemic disease?
   Nasal polyposis can be a systemic disease in some patients and a local one in others.
2. Can you make a distinction between «simple» polyposis and «diffuse» polyposis concerning the background of the disease?
   A simple polyposis is often unilateral or limited to the anterior ethmoid; the prognosis is good after short local and systemic corticotherapy and FESS.
3. Are they separate etipathogenetic entities, thus requiring different therapeutic approach?
   The pathophysiological mechanisms of NP remain unknown but are most likely multifactorial. Therefore the treatments are different.
4. Do you believe in any of the theories that are published so far ? If yes, in which one?
   Several theories may apply. Genetic as well as immunological factor could be involved in the development of nasal polyposis.
5. Is nasal polyposis exclusively a surgical disease?
   No, surgery is not the first treatment of nasal polyposis. The aim of endonasal surgery in nasal polyposis is to improve the access of the mediacl treatment to the ostiomeatal complex.
6. Is nasal polyposis a disease more appropriate for a conservative treatment?
   Conservative treatment should be tried in all cases.
7. How do you estimate the role of the fungi in the ethiology of the nasal polyposis?
   The role of fungi in nasal polyposis has not been proven yet.
8. Do you personally use antifungal drugs in your polypous patients? If yes, in which way (local, systemic or both) and what kind of a drug do you prefer?
   I use Amphotericine B suspension as nasal lavage or as nasal spray (in addition with saline lavages and topic corticosteroid spray) with about 40% of success. Ketoconasole spray seems to work too.
9. Do you believe that underlying osteitis in the cases of so called chronic sinusitis, can provoke the onset of polyposis?
   Yes, in some cases osteitis associated with chronic rhinosinusitis can be associated with nasal polyposis.
10. Do you recommend long term antibiotic treatment to your polypous patients?
    Sometimes long term antibiotic treatment can be useful after surgery for nasal polyposis
11. If yes, which antibiotic do you prefer, and for how long time do you apply it?
    For long-term antibiotic treatment we use trimetoprim/sulphometoxasole (Bactrim) for 6 weeks.
12. How do you feel about the montelucast sodium regarding preoperative or postoperative treatment in polypous patients?
    We were very disappointed with the poor effect of montelucast sodium treatment

13. How do you feel about the steroid tretment? Preoperatively? Postoperatively? Both?
Steroid treatment should be used both pre and post operatively, locally and systemically.

14. If you do use steroids, for how long time do you treat the patient preoperatively? What is your timing? How do you know when to stop and operate? Do you use peroral steroids or local ones? Maybe both of them?
Local and systemic corticosteroids should be used at least 6 months before surgery. Topical steroid spray giving 50 mg per push, 2 pushes in each nostril twice a day=total daily dose 400 mg. Peroral steroids should be given at the dose of 1 mg/kg/day for 5 days at the begining of the treatment and 5 days before surgery.

15. Do you have any experience with the topical use of the furosemide?
No

16. How do you feel about the role of the GP doctor in the modern treatment of the patient with polyposis?
The GP doctor should be aware of the chronicity of NP and prescribe topical steroids spray for several months or years without fear of dangerous side effects.

17. Does the diminuition of the massive polyposis influence the status of the asthmatic patient? If yes, which kind of diminuition you prefer: surgical or conservative?
Diminuition of massive polyposis improves asthma. Both surgical and topical or systemic corticosteroids should be proposed.

18. Do you feel that pulmologist should be consulted in all cases of nasal polyposis? Why yes, why not?
Pulmologist should be consulted in most of the cases of nasal polyposis because chronic inflammation of the lower airways is very frequently associated with chronic rhinosinusitis.

19. Do you feel that CT scanning of the polypous patient is necessary. If yes, when: before or after the conservative treatment, i.e. just before the surgery?
CT scanning is necessary before surgery of nasal polyposis.

20. What staging system do you believe in? Can we at this consensus conference accept Lund-Mackay's as most practical one?
Staging system for nasal polyposis is useful. The Lund-Mackay's is good, the Malm's system is good too.

21. Do you believe that some septal deformities can influence chronic ostiomeatal disease? If yes, what kind of deformity (try to express your attitude using the Mladina's classification)
Several types of anatomical variations of the ostiomeatal complex can be associated with chronic sinusitis.

22. Are chronic bacterial or viral infections important in the onset of nasal polyposis?
Any kind of chronic infection can influence the onset of nasal polyposis.

23. Do you remove or leave alone the middle turbinate showing superficial polypoid changes of the mucosa in cases of maxi-polyposis?
In case of maxi-polyposis, we remove the antero-inferior part of the middle turbinate.

24. Do you insist on radical and complete clearance of the skull base in cases of diffuse polyposis, or you prefer to leave some polypous tissue there to

be treated by means of conservative methods?
Radical and complete clearance of the skull base in case of diffuse polyposis can be sometimes dangerous. Post surgery care (crust removal and continuation of topical steroid spray) are very important. Radical surgery outcomes can be very disappointing when post surgery care is poorly managed.

25. Have you ever heard about or personally tried the method of desensitzation of the patient to the antigen prepared from his own polyps in difficult cases of recurrent, voluminous diffuse polyposis and asthma?
We have no experience with desensitization method.
26. How do you feel about the topical use of mometasone?
Topical use of mometasone fluorate is probably the safest and most efficient treatment of massive polyposis.
27. How do you feel about the powered instrumentation (shavers) in the treatment of nasal polyposis: just one of the surgical tools or something more?
The shaver is just a useful surgical tool in order to save time during the surgical treatment of massive polyposis.
28. How do you imagine the antipolypous drug of the future: viral transfer of correct gene to replace the wrong one, a sort of antiinterleukin 5 (or which one?) or something else?
The antipolypous drug of the future will be a powerful anti-inflammatory agent. However, since nasal polyposis is most likely a multifactorial disease, the treatments of the future will be multiple.
29. Do you believe that nasal polyps will disappear in a near future from the list of surgical diseases?
I hope nasal polyposis will not be a surgical disease in the future.
30. How do you feel nowadays when you are faced to nasal polyposis: a) frustrated because of the fact that this is a typical chronic, recurrent disease, b) ready for the fight in every single patient, c) embarrassed because this disease sometimes discredit your capabilities as a medical doctor and takes to much of your time?
In case of nasal polyposis I am ready for the fight in every single patient.

Dr. A. Lopatin
Moscow, Russia

1. Is nasal polyposis local or systemic disease?
   There are some cases which are definitely local: antrochoanal polyps, "contact" polyps in the narrow sites caused by anatomical abnormalities; and some definitely systemic: associated with bronchial asthma, aspirin sensitivity, mucoviscidosis etc.
2. Can you make a distinction between «simple» polyposis and «diffuse» polyposis concerning the background of the disease?
   There is no strict border and simple polyposis can (and often does) proceed to the diffuse one
3. Are they separate etipathogenetic entities, thus requiring different therapeutic approach?
   For me, basic approach is the same
4. Do you believe in any of the theories that are published so far ? If yes, in which one?
   Results of the series of C.Bachert's researches published during last 10 years look quite realistic. But not his latest studies of St.aureus and microbial allergy
5. Is nasal polyposis exclusively a surgical disease?
   Mostly medical.
6. Is nasal polyposis a disease more appropriate for a conservative treatment?
   Yes
7. How do you estimate the role of the fungi in the ethiology of the nasal polyposis?
   I do believe that in some severe cases frequent recurrences of nasal polyps can be caused by fungi. Can not imagine that all different types of nasal polyps have the same fungal etiology.
8. Do you personally use antifungal drugs in your polypous patients? If yes, in which way (local, systemic or both) and what kind of a drug do you prefer?
   I have only some personal experience with systemic use of itraconasole and ketoconasole. It seems that they work in severe cases, but this is only a feeling, not evidence based
9. Do you believe that underlying osteitis in the cases of so called chronic sinusitis, can provoke the onset of polyposis?
   It could cause some local polypoid changes of mucosa but not typical diffuse polyposis
10. Do you recommend long term antibiotic treatment to your polypous patients?
    Only for cases of purulent inflammation in the sinuses (polypous-purulent form according to Russian classification, or neutrofilic polyps), and not for long-term use.
11. If yes, which antibiotic do you prefer, and for how long time do you apply it?
    I believe latest generation of phtorquinolones like laevofloxacin and moxifloxacin are the most effective in such cases. Better to study individual sensitivity of a pathogen
12. How do you feel about the montelucast sodium regarding preoperative or postoperative treatment in polypous patients?
    There are some preliminary results that antileucotrienes might work in aspirin sensitive patients with polyposis

13. How do you feel about the steroid tretment? Preoperatively? Postoperatively? Both?
    Usually postoperatively, preoperatively in patients with associated asthma
14. If you do use steroids, for how long time do you treat the patient preoperatively? What is your timing? How do you know when to stop and operate? Do you use peroral steroids or local ones? Maybe both of them?
    In asthmatics – 3 to 5 days of oral prednisolone 30-40 mg a day, than continue for the same term post-op
15. Do you have any experience with the topical use of the furosemide?
    No
16. How do you feel about the role of the GP doctor in the modern treatment of the patient with polyposis?
    No role
17. Does the diminuition of the massive polyposis influence the status of the asthmatic patient? If yes, which kind of diminuition you prefer: surgical or conservative?
    Yes, of course. Usually asthmatics come to me with total polyposis of all sinuses. I would prefer conservative way and I do in some cases, but usually steroids only do not achieve the same results as surgery. My way is combination of surgery performed during a short course of systemic steroids and further long-term topical steroid therapy.
18. Do you feel that pulmologist should be consulted in all cases of nasal polyposis? Why yes, why not?
    At least, FEV has to be studied in all, if there were pathology —refer to pulmonologist!
19. Do you feel that CT scanning of the polypous patient is necessary. If yes, when: before or after the conservative treatment, i.e. just before the surgery?
    Yes, after a course of conservative treatment or right before surgery.
20. What staging system do you believe in? Can we at this consensus conference accept Lund-Mackay's as most practical one?
    This is the best one
21. Do you believe that some septal deformities can influence chronic ostiomeatal disease? If yes, what kind of deformity (try to express your attitude using the Mladina's classification).
    Yes. It is clear. I think local spur or ridge in the middle or posterior part of the septum is Mladina's type 5
22. Are chronic bacterial or viral infections important in the onset of nasal polyposis?
    Might be a triggering factor, also for onset of recurrence
23. Do you remove or leave alone the middle turbinate showing superficial polypoid changes of the mucosa in cases of maxi-polyposis?
    I remove only thick diseased mucosa using a shaver
24. Do you insist on radical and complete clearance of the skull base in cases of diffuse polyposis, or you prefer to leave some polypous tissue there to be treated by means of conservative methods?
    The latter
25. Have you ever heard about or personally tried the method of desenzitation of the patient to the antigen prepared from his own polyps in difficult cases of recurrent, voluminous diffuse polyposis and asthma?
    No personal experience but there were some reports in Russian literature some 10 or 20 years ago

26. How do you feel about the topical use of mometasone?
    Maybe this is the best topical corticosteroid I have ever tried
27. How do you feel about the powered instrumentation (shavers) in the treatment of nasal polyposis: just one of the surgical tools or something more?
    I believe that extreme surgical traumatism inevitably causes further recurrences. Removing only diseased mucosa, shaver makes the surgery minimally invasive and this less traumatic technique gives better results. For me this is not just a tool but surgical philosophy
28. How do you imagine the antipolypous drug of the future: viral transfer of correct gene to replace the wrong one, a sort of antiinterleukin 5 (or which one?) or something else?
    Maybe antiinterleukin IL-5
29. Do you believe that nasal polyps will disappear in a near future from the list of surgical diseases?
    Unfortunately not
30. How do you feel nowadays when you are faced to nasal polyposis: a) frustrated because of the fact that this is a typical chronic, recurrent disease, b) ready for the fight in every single patient, c) embarrassed because this disease sometimes discredit your capabilities as a medical doctor and takes to much of your time?
    In primary cases – b, in recurrent, especially with turbinates removed somewhat between a and b

Dr. V. Lund
London, U.K.

1. Is nasal polyposis local or systemic disease?
   Nasal polyps are the end product of a number of disease processes, many of which represent systemic disease
2. Can you make a distinction between «simple» polyposis and «diffuse» polyposis concerning the background of the disease?
   I am not sure what is ment by «simple» and «diffuse» and therefore the answer is no.
3. Are they separate etipathogenetic entities, thus requiring different therapeutic approach?
   There are a number of aetiologies that predispose to nasal polyposis though inflammation plays a role in most of them, hence the response to steroids in the various forms.
4. Do you believe in any of the theories that are published so far ? If yes, in which one?
   The various theories of polyp formation are not mutually exclusive and Mirko Tos's epithelial rupture theory, for example, is compatibile with theories relating to infection be it bacterial or fungal.
5. Is nasal polyposis exclusively a surgical disease?
   No.
6. Is nasal polyposis a disease more appropriate for a conservative treatment?
   Not necessarily, it depends upon a number of factors not least of which are related to the patient.
7. How do you estimate the role of the fungi in the ethiology of the nasal polyposis?
   It is unlikely that fungi are responsible for the development of all nasal polyps though they may certainly be more important than previously realised and allergic fungal rinosinusitis is undoubtedly more common than we previously thought.
8. Do you personally use antifungal drugs in your polypous patients? If yes, in which way (local, systemic or both) and what kind of a drug do you prefer?
   I do not normally use antifungal drugs unless I have strong clinical, pathohistological or mycological evidence of mucosally invasive fungi. We are, however, about to start a multicentre trial with colleagues in Holland, Germany and Belgium looking at the use of topical amphotericin douching as outlined by the mayo Clinic group in patients with nasal polyposis.
9. Do you believe that underlying osteitis in the cases of so called chronic sinusitis, can provoke the onset of polyposis?
   Changes in the underlying bone can undoubtedly occur in both chronic rhinosinusitis and nasal polyposis. As to whether this is reactive or causative remains unclear though more likely the former.
10. Do you recommend long term antibiotic treatment to your polypous patients?
    Relatively rarely in the absence of overt and symptomatic infection producing facial pain or headache.
11. If yes, which antibiotic do you prefer, and for how long time do you apply it?
    When used (more often in acute or chronic rhinosinusitis) I would use

a long term course of macrolide e.g. erythromycin 500mg bd for two weeks followed by 500 mg once a day for ten weeks or claritromycin 250 mg tds for two weeks followed by 250 mg bd for ten weeks.

12. How do you feel about the montelucast sodium regarding preoperative or postoperative treatment in polypous patients?
    Dr. Scadding has used montelucast in a number of our patients with nasal polyps which seems to be effective in a proportion and without side effects. I would refer colleagues to her answer.
13. How do you feel about the steroid tretment? Preoperatively? Postoperatively? Both?
    In my view nasal polyposis is a mediacl condition in which surgery plays a role but the mainstay of management remains steroids, in drop, spray, oral and systemic form. Any of these forms may be used in initial treatment dependent upon the patient themselves, the extent of disease and their previous experience and treatment. These various forms may be used throughout the course of the disease with sprays used largely for long term maintenance and the others used for acute exacerbations. Surgery and other medical therapies are reserved for those patients where the strategies are not successful in controling symptoms.
14. If you do use steroids, for how long time do you treat the patient preoperatively? What is your timing? How do you know when to stop and operate? Do you use peroral steroids or local ones? Maybe both of them?
    Drops
    Betamethasone sodium phosphate is used for 6-8 weeks thought not generally for the long term due to systemic absorption.
    Fluticasone propionate nasules may be used once or twice a day in the short or long term as there is no evidence of systemic absorption.
    Oral steroids
    Prednisolone (enterically coated) is given as a short course e.g. 1o mg for five days but is not given routinely as a preoperative treatment. In selected cases they are given postoperatively, the timing of which varies from patient to patient.
    Parenteral
    Injections of ACTH (Synacthen 1 mg im: 2 injections 48 hours apart) may be given, though again not as a routine, prior to surgery but rather as a primary treatment modality. All the contra-indications of oral steroids pertain to this treatment. We would not normally give more than three or four courses of oral or parenteral steroids a year.
15. Do you have any experience with the topical use of the furosemide?
    We have had very limited success with topical furosemide.
16. How do you feel about the role of the GP doctor in the modern treatment of the patient with polyposis?
    The most important role of the GP is to ensure that patients with significant nose and sinus problems are seen and properly evaluated by a ENT/rhinologist who determines the diagnosis and offers advice on optimal treatment.
17. Does the diminuition of the massive polyposis influence the status of the asthmatic patient? If yes, which kind of diminuition you prefer: surgical or conservative?

Yes, and our study suggest that either surgery or mediacl therapy can be effective.

18. Do you feel that pulmologist should be consulted in all cases of nasal polyposis? Why yes, why not?
    Ideally yes and definitely if there is any evidence of lower respiratory tract reactivity.
19. Do you feel that CT scanning of the polypous patient is necessary. If yes, when: before or after the conservative treatment, i.e. just before the surgery?
    CT scanning is largely a preoperative investigation.
20. What staging system do you believe in? Can we at this consensus *conference accept Lund-Mackay's as most practical one?*
    Naturally I have a personal bias in this answer though it should be remembered that all staging/scoring systems correlate poorly with patient's symptoms. Their main value is in the confirmation and quantification of disease extent. For comparison of patient population and inclusion criteria in trials.
21. Do you believe that some septal deformities can influence chronic ostiomeatal disease? If yes, what kind of deformity (try to express your attitude using the Mladina's classification)
    No
22. Are chronic bacterial or viral infections important in the onset of nasal polyposis?
    Possibly
23. Do you remove or leave alone the middle turbinate showing superficial polypoid changes of the mucosa in cases of maxi-polyposis?
    I generally preserve the middle turbinate as a landmark unless grossly affected in nasal polyposis.
24. Do you insist on radical and complete clearance of the skull base in cases of diffuse polyposis, or you prefer to leave some polypous tissue there to be treated by means of conservative methods?
    The radicality of surgical clearance relates to some extent with the «symptom free» interval but rarely produces cure and may increase the chances of complications, particularly in the less experienced surgeon's hands. Therefore the amount of clearance relates as usual to patient, surgeon and disease factors, but as a general principle I leave behind a rim of tissue at the skull base. I have no personal experience of this technique.
25. Have you ever heard about or personally tried the method of desenzitation of the patient to the antigen prepared from his own polyps in difficult cases of recurrent, voluminous diffuse polyposis and asthma?
    No
26. How do you feel about the topical use of mometasone?
    All topical steroids probably work equally well in nasal polyposis.
27. How do you feel about the powered instrumentation (shavers) in the treatment of nasal polyposis: just one of the surgical tools or something more?
    Powered instruments are a surgical tool which allows one to clear polyps quickly and nothing more.
28. How do you imagine the antipolypous drug of the future: viral transfer of correct gene to replace the wrong one, a sort of antiinterleukin 5 (or which one?) or something else?

Given the various aethiological factors it is unlikely that one medical treatment in the future will serve all purposes but it is quite likely that other «anti-inflammatory agents», «anti-infective» or «gene targeting» could play a significant role.

29. Do you believe that nasal polyps will disappear in a near future from the list of surgical diseases?
    Unlikely.

30. How do you feel nowadays when you are faced to nasal polyposis: a) frustrated because of the fact that this is a typical chronic, recurrent disease, b) ready for the fight in every single patient, c) embarrassed because this disease sometimes discredit your capabilities as a medical doctor and takes to much of your time?
    I am afraid I do not have a unifying emotional response to these questions.

Dr. W. Mann
Mainz, Germany

1. Is nasal polyposis local or systemic disease?
   Both
2. Can you make a distinction between «simple» polyposis and «diffuse» polyposis concerning the background of the disease?
   Yes
3. Are they separate etipathogenetic entities, thus requiring different therapeutic approach?
   Yes
4. Do you believe in any of the theories that are published so far ? If yes, in which one?
   None
5. Is nasal polyposis exclusively a surgical disease?
   No
6. Is nasal polyposis a disease more appropriate for a conservative treatment?
   No
7. How do you estimate the role of the fungi in the ethiology of the nasal polyposis?
   Cofactor in some patients
8. Do you personally use antifungal drugs in your polypous patients? If yes, in which way (local, systemic or both) and what kind of a drug do you prefer?
   In some local ampho and/or H_2O_2, systemic itraconazol
9. Do you believe that underlying osteitis in the cases of so called chronic sinusitis, can provoke the onset of polyposis?
   No
10. Do you recommend long term antibiotic treatment to your polypous patients?
    In some
11. If yes, which antibiotic do you prefer, and for how long time do you apply it?
    Ciprofloxacin-low dose 6 weeks
12. How do you feel about the montelucast sodium regarding preoperative or postoperative treatment in polypous patients?
    Postoperatively in some
13. How do you feel about the steroid tretment? Preoperatively? Postoperatively? Both?
    Both
14. If you do use steroids, for how long time do you treat the patient preoperatively? What is your timing? How do you know when to stop and operate? Do you use peroral steroids or local ones? Maybe both of them?
    1 mg per kg body weight for 5 days and longtime topical steroids
15. Do you have any experience with the topical use of the furosemide?
    No
16. How do you feel about the role of the GP doctor in the modern treatment of the patient with polyposis?
    No role.
17. Does the diminuition of the massive polyposis influence the status of the asthmatic patient? If yes, which kind of diminuition you prefer: surgical or conservative?
    Both
18. Do you feel that pulmologist should be consulted in all cases of nasal polyposis? Why yes, why not?
    Only if ENT doctor does not know to measure FEV1 and has no expe-

rience as an allergologist and does not use provocation testing

19. Do you feel that CT scanning of the polypous patient is necessary. If yes, when: before or after the conservative treatment, i.e. just before the surgery?
Before treatment
20. What staging system do you believe in? Can we at this consensus conference accept Lund-Mackay's as most practical one?
Yes
21. Do you believe that some septal deformities can influence chronic ostiomeatal disease? If yes, what kind of deformity (try to express your attitude using the Mladina's classification).
Yes, but I don't use any classification
22. Are chronic bacterial or viral infections important in the onset of nasal polyposis?
Yes
23. Do you remove or leave alone the middle turbinate showing superficial polypoid changes of the mucosa in cases of maxi-polyposis?
Leave in place but contour turbinate with shaver.
24. Do you insist on radical and complete clearance of the skull base in cases of diffuse polyposis, or you prefer to leave some polypous tissue there to be treated by means of conservative methods?
Leave tissue.
25. Have you ever heard about or personally tried the method of desensitization of the patient to the antigen prepared from his own polyps in difficult cases of recurrent, voluminous diffuse polyposis and asthma?
No
26. How do you feel about the topical use of mometasone?
Very good but sometimes a little dry
27. How do you feel about the powered instrumentation (shawers) in the treatment of nasal polyposis: just one of the surgical tools or something more?
Just one tool
28. How do you imagine the antipolypous drug of the future: viral transfer of correct gene to replace the wrong one, a sort of antiinterleukin 5 (or which one?) or something else?
Something else
29. Do you believe that nasal polyps will disappear in a near future from the list of surgical diseases?
No
30. How do you feel nowadays when you are faced to nasal polyposis: a) frustrated because of the fact that this is a typical chronic, recurrent disease, b) ready for the fight in every single patient, c) embarrassed because this disease sometimes discredit your capabilities as a medical doctor and takes to much of your time?
b

Dr. R. Mladina
Zagreb, Croatia

1. Is nasal polyposis local or systemic disease?
   Systemic in about 70% of cases.
2. Can you make a distinction between «simple» polyposis and «diffuse» polyposis concerning the background of the disease?
   Yes, I can.
3. Are they separate etipathogenetic entities, thus requiring different therapeutic approach?
   In certain cases. Difficult to predict.
4. Do you believe in any of the theories that are published so far ? If yes, in which one?
   None entirely.
5. Is nasal polyposis exclusively a surgical disease?
   No way.
6. Is nasal polyposis a disease more appropriate for a conservative treatment?
   It seems so, more and more....
7. How do you estimate the role of the fungi in the ethiology of the nasal polyposis?
   Like all other factors (bacterial and viral infections, allergy, septal deformities etc.). Just a peace of a huge puzzle.
8. Do you personally use antifungal drugs in your polypous patients? If yes, in which way (local, systemic or both) and what kind of a drug do you prefer?
   Yes, I use Amphotericin B locally like nasal drops after the nasal douching by means of saline solution
9. Do you believe that underlying osteitis in the cases of so called chronic sinusitis, can provoke the onset of polyposis?
   Yes, I do.
10. Do you recommend long term antibiotic treatment to your polypous patients?
    Yes, I do. But not in all of them. The clinical endoscopic picture leads me in this sense.
11. If yes, which antibiotic do you prefer, and for how long time do you apply it?
    I prefer klindamycin since this antibiotic is the only one which really penetrates the bone. I recommend a long course, lasting up to two months (if possible). I also like a long course of trimetoprim/sulphometoxasole (Bactrim).
12. How do you feel about the montelucast sodium regarding preoperative or postoperative treatment in polypous patients?
    In cases of diffuse polyposis with ASA intolerance and asthma this drug has a tremendous beneficial effect both to the nasal and pulmonary symptoms. Otherwise I did not realize a spectacular and promising results. I am still trying.
13. How do you feel about the steroid tretment? Preoperatively? Postoperatively? Both?
    Preopratively until the clinical impression that no further drug administration will reduce the polypous tissue. This is the best time for the surgery, but the steroids must be continued (both systemic-peroral and topical). Immediately after the surgery mometasone spray or furosemide inhalations are sufficient to keep the local finding under the control.

14. If you do use steroids, for how long time do you treat the patient preoperatively? What is your timing? How do you know when to stop and operate? Do you use peroral steroids or local ones? Maybe both of them?
    I exclusively use mometasone topically, usualy tri times daily, one puff each nostirl, after blowing the nose. As to the systemic administration, I prefer peroral use of dexamethasone tablets, 5 mg three times a day for 2-3 weeks, than gradually diminishing the dose untill reaching the optimal clinical status.
15. Do you have any experience with the topical use of the furosemide?
    Yes, I have. I am very satisfied with the results, but only postoperatively, i.e. to maintain the achieved local finding and to avoid steroids at the same time.
16. How do you feel about the role of the GP doctor in the modern treatment of the patient with polyposis?
    GP should be instructed how to approach polypous patient since this disease is a chronic one. In the telemedicine era it seems quite possible to present the endoscopic appearance of the disease to GP and vice versa, making possible for GP and ENT to collaborate in drug administration, avoiding at the same time the annoying, multiple patient's visits to the ENT who normally is very busy (surgeries, consultations, difficult cases in the hospital etc.).
17. Does the diminuition of the massive polyposis influence the status of the asthmatic patient? If yes, which kind of diminuition you prefer: surgical or conservative?
    Yes. Both.
18. Do you feel that pulmologist should be consulted in all cases of nasal polyposis? Why yes, why not?
    It would be ideal to have an experienced and motivated pulmologist next to the ENT during dealing with polypous patient since nasal polyposis is not anything else but «asthma of the nose».
19. Do you feel that CT scanning of the polypous patient is necessary. If yes, when: before or after the conservative treatment, i.e. just before the surgery?
    Just before the surgery, i.e. after realising that conservative diminuition of polypous masses is not effective any more. The conservative treatment has now the role of maintaining the local finding in its optimal form while preparing the patient for surgery. To perform CT scann at that stage has a good rationale since what one can see on these CT scans is in fact what can be expected during the surgery. CT scanning before conservative treatment is absolutely wrong, be it from ethical (useless irradiation of the patient) or surgical point of view (contradictory to the minimally invasive and functional surgery tendency).
20. What staging system do you believe in? Can we at this consensus conference accept Lund-Mackay's as most practical one?
    I do not believe in any staging system for nasal polyposis. Nasal polyposis is so changable, even within 24 hours if properly treated, so that any attempt to artificaly «fixate» it is something that belongs to the fairytales.
21. Do you believe that some septal deformities can influence chronic ostiomeatal disease? If yes, what kind

of deformity (try to express your attitude using the Mladina's classification)

Probably. I don't like to see type 3. The narrowness of the middle meatus which this type produces on one side, and extreme enlargement of the nasal cavity on the other side are extremely non-physiological conditions which certainly disturbe normal mucociliary transport rate, allow mucus stasis and could be the trigger for cascade of biochemical events coming from the eosinophils.

22. Are chronic bacterial or viral infections important in the onset of nasal polyposis?

    I have no idea. But I believe there must be some relationship, more significant in sense of bacterial role.

23. Do you remove or leave alone the middle turbinate showing superficial polypoid changes of the mucosa in cases of maxi-polyposis?

    Never! Since nobody knows the real role of the middle turbinate, nobody is allowed to remove it from its position, except in cases of malignant tumors of the nose and in cases of inverted papilloma.

24. Do you insist on radical and complete clearance of the skull base in cases of diffuse polyposis, or you prefer to leave some polypous tissue there to be treated by means of conservative methods?

    I never insist on complete clearance except in cases of inverted papilloma where I always perform a «horseshoe» dissection of the mucosa and periosteum in one block, begining from the upper half of the nasal septum via nasal roof towards (and including) middle turbinate itself.

25. Have you ever heard about or personally tried the method of desenzitation of the patient to the antigen prepared from his own polyps in difficult cases of recurrent, voluminous diffuse polyposis and asthma?

    I have good and extense experience with this method in selected cases. It seems that polyps have some sort of tissue antigene which serves to obtain the desensitization to the polyps. It does not work preoperatively, but postoperatively works perfect in almost all of so called difficult cases of massive polyposis with asthma and numerous recurrences.

26. How do you feel about the topical use of mometasone?

    I like mometasone very much. It gives perfect results in more than 89% of patients.

27. How do you feel about the powered instrumentation (shavers) in the treatment of nasal polyposis: just one of the surgical tools or something more?

    Just a surgical tool, beyond any doubt very elegant and safe. I like it very much.

28. How do you imagine the antipolypous drug of the future: viral transfer of correct gene to replace the wrong one, a sort of antiinterleukin 5 (or which one?) or something else?

    Viral transfer of the correct gene. In the meantime (semifuture): anti-IL-5 and topically applied steroid drugs.

29. Do you believe that nasal polyps will disappear in a near future from the list of surgical diseases?

    Not likely in the near future, but in 10-20 years definitely yes.

30. How do you feel nowadays when you are faced to nasal polyposis: a) frus-

trated because of the fact that this is a typical chronic, recurrent disease, b) ready for the fight in every single patient, c) embarrassed because this disease sometimes discredit your capabilities as a medical doctor and takes to much of your time?
a, b, and c

Dr. P. Nicolai
Brescia, Italy

1. Is nasal polyposis local or systemic disease?
   Isolated polyps (i.e., antrochoanal polyp, choanal polyp) are local diseases, but diffuse polyposis is a systemic disease.
2. Can you make a distinction between «simple» polyposis and «diffuse» polyposis concerning the background of the disease?
   The pathogenesis of antrochoanal polyps is still unknown, even though it seems that they are not related to systemic diseases. Other forms of isolated polyps are probably due to contact areas, often related to anatomic variations. Diffuse polyposis is common in patients with bronchial hyperreactivity, asthma, ASA-syndrome, cystic fibrosis, Churg-Strauss syndrome, etc.; all the aforementioned situations can be considered systemic diseases.
3. Are they separate etipathogenetic entities, thus requiring different therapeutic approach?
   Yes
4. Do you believe in any of the theories that are published so far ? If yes, in which one?
   Eosinophils play certainly a major role in the forms associated with bronchial hyperreactivity; evidence that fungi are the causative agents of a cascade of events leading to eosinophils activation is still uncertain.
5. Is nasal polyposis exclusively a surgical disease?
   Diffuse polyposis is a disease requiring both medical and surgical treatment.
6. Is nasal polyposis a disease more appropriate for a conservative treatment?
   If conservative means medical treatment I think that any form of minimal disease should be first treated medically.
7. How do you estimate the role of the fungi in the ethiology of the nasal polyposis?
   Already answered.
8. Do you personally use antifungal drugs in your polypous patients? If yes, in which way (local, systemic or both) and what kind of a drug do you prefer?
   We are currently using amphotericin B locally in those patients who have radiologic, intraoperative, and lab findings suggestive for eosinophilic fungal rhinosinusitis.
9. Do you believe that underlying osteitis in the cases of so called chronic sinusitis, can provoke the onset of polyposis?
   On a theoretical basis, I would say yes.
10. Do you recommend long term antibiotic treatment to your polypous patients?
    Only when there is clear evidence of recurrent infections.
11. If yes, which antibiotic do you prefer, and for how long time do you apply it?
    If the patient has recurrent rhinosinusitis, we usually take cultures and treat the patient for at least three weeks accordingly.
12. How do you feel about the montelucast sodium regarding preoperative or postoperative treatment in polypous patients?
    We are trying to test the efficacy of antileukotrienic agents in patients

with sino-bronchial syndrome; however, good responses are anecdotical likewise.

13. How do you feel about the steroid tretment? Preoperatively? Postoperatively? Both?
    We routinely treat the patients with diffuse polyposis pre and postoperatively with oral steroids for at least 15 days (5 days preop and 10 days postop). A topical steroid therapy is subsequently started.
14. If you do use steroids, for how long time do you treat the patient preoperatively? What is your timing? How do you know when to stop and operate? Do you use peroral steroids or local ones? Maybe both of them?
    I think that using both oral and topical steroids at the same time is a nonsense.
15. Do you have any experience with the topical use of the furosemide?
    No
16. How do you feel about the role of the GP doctor in the modern treatment of the patient with polyposis?
    Periodic follow-up visits are of paramount importance provided they are done under endoscopic control by an ENT doctor. The GP should refer to the specialist the patient any time there is a worsening of symptoms.
17. Does the diminuition of the massive polyposis influence the status of the asthmatic patient? If yes, which kind of diminuition you prefer: surgical or conservative?
    We usually go first for a conservative treatment; in case of failure, surgery is advised.
18. Do you feel that pulmologist should be consulted in all cases of nasal polyposis? Why yes, why not?
    Pneumologic consultation should be looked for in any case of diffuse polyposis.
19. Do you feel that CT scanning of the polypous patient is necessary. If yes, when: before or after the conservative treatment, i.e. just before the surgery?
    CT is required when medical treatment fails and the patient is candidate for surgery.
20. What staging system do you believe in? Can we at this consensus conference accept Lund-Mackay's as most practical one?
    Yes
21. Do you believe that some septal deformities can influence chronic ostiomeatal disease? If yes, what kind of deformity (try to express your attitude using the Mladina's classification)
    Apart from the type 1, any other type of septal deformity can potentially interfere with the ostiomeatal complex.
22. Are chronic bacterial or viral infections important in the onset of nasal polyposis?
    They are probably more important in determining a recurrence in a patient already treated with surgery for diffuse polyposis.
23. Do you remove or leave alone the middle turbinate showing superficial polypoid changes of the mucosa in cases of maxi-polyposis?
    If the middle turbinate has only minimal polypoid changes and is stable at the end of surgery I leave it in place. However, it is clear in my mind that conservation of the middle turbinate is not a dogma and I do not hesitate to sacrify it whenever massive polypoid degeneration is present.

24. Do you insist on radical and complete clearance of the skull base in cases of diffuse polyposis, or you prefer to leave some polypous tissue there to be treated by means of conservative methods?

    I do prefer to spare mucosa along skull base as well as along lamina papyracea.

25. Have you ever heard about or personally tried the method of desenzitation of the patien to the antigen prepared from his own polyps indifficult cases of recurrent, voluminous diffuse polyposis and asthma?

    No

25. How do you feel about the topical use of mometasone?

    At present we are alternatively using mometasone fluorate and budesonide, but we have no personal data available yet. Similarly, there are no data in the literature on the treatment of polyposis; several studies are available on allergic rhinitis.

27. How do you feel about the powered instrumentation (shavers) in thetreatment of nasal polyposis: just one of the surgical tools or something more?

    Powered instrumentation is in our experience a very important tool to minimize surgical trauma to the mucosa.

28. How do you imagine the antipolypous drug of the future: viral transfer of correct gene to replace the wrong one, a sort of antiinterleukin 5 (or which one?) or something else?

    To be realistic, I would say that it is very problematic at present to answer this question.

29. Do you believe that nasal polyps will disappear in a near future from the list of surgical diseases?

    I am sure that in the future nasal polyposis will become more amenable for medical treatment than for surgery. How near will be this future is difficult to say.

30. How do you feel nowadays when you are faced to nasal polyposis: a) frustrated because of the fact that this is a typical chronic, recurrent disease, b) ready for the fight in every single patient, c) embarrassed because this disease sometimes discredit your capabilities as a medical doctor and takes to much of your time?

    a

Dr M. Onerci
Ankara, Turkey

1. Is nasal polyposis local or systemic disease?
   It is both local and systemic disease
2. Can you make a distinction between «simple» polyposis and «diffuse» polyposis concerning the background of the disease?
   The clinical picture, the natural course of the disease and associated diseases help us differentiate simple polyposis from diffuse polyposis. However in some cases simple and diffuse forms may exist together.
3. Are they separate etipathogenetic entities, thus requiring different therapeutic approach?
   Absolutely yes
4. Do you believe in any of the theories that are published so far ? If yes, in which one?
   Several etiological factors are important in the development of polyps. All are based upon observations. Epithelial rupture theory and fungi theory have their own merits which deserve attention
5. Is nasal polyposis exclusively a surgical disease?
   No, not at all
6. Is nasal polyposis a disease more appropriate for a conservative treatment?
   Yes
7. How do you estimate the role of the fungi in the ethiology of the nasal polyposis?
   The fungi play a very important role in the pathogenesis of diffuse nasal polyposis, i.e. triad cases.
8. Do you personally use antifungal drugs in your polypous patients? If yes, in which way (local, systemic or both) and what kind of a drug do you prefer?
   No
9. Do you believe that underlying osteitis in the cases of so called chronic sinusitis, can provoke the onset of polyposis?
   No
10. Do you recommend long term antibiotic treatment to your polypous patients?
    #
11. If yes, which antibiotic do you prefer, and for how long time do you apply it?
    #
12. How do you feel about the montelucast sodium regarding preoperative or postoperative treatment in polypous patients?
    In nasal polyposis cases we dont use it.
13. How do you feel about the steroid treatment? Preoperatively? Postoperatively? Both?
    Steroid treatment is the most important part of the treatment both preoperatively and postoperatively.
14. If you do use steroids, for how long time do you treat the patient preoperatively? What is your timing? How do you know when to stop and operate? Do you use peroral steroids or local ones? Maybe both of them?
    Initial therapy is topical steroid treatment for one month. If the treatment is successful topical nasal steroid treatment is continued. If initial steroid treatment is not successful we start oral steroid therapy, 40 mg/

per day by tapering the dose. At the end of one week if it is successful, we continue with topical steroid treatment. If it is not successful we proceed to surgery. We start topical steroid therapy one week after the surgery and continue for two months.

However each polyp case is different and evaluated on an individual basis. Some simple polyps need no treatment, some diffuse polyp cases need advanced sinus surgery with systemic or topical steroid treatment.

15. Do you have any experience with the topical use of the furosemide?

    No

16. How do you feel about the role of the GP doctor in the modern treatment of the patient with polyposis?

    GP doctors should consult all polyp cases which have symptoms despite adequate medical therapy.

17. Does the diminuition of the massive polyposis influence the status of the asthmatic patient? If yes, which kind of diminuition you prefer: surgical or conservative?

    In our series, it helps in 98% of cases. I first prefer conservative treatment and if unsuccessful, surgical treatment.

18. Do you feel that pulmologist should be consulted in all cases of nasal polyposis? Why yes, why not?

    Yes. First to exclude asthma and analgesic intolerance, and secondly to have pulmonary function tests

19. Do you feel that CT scanning of the polypous patient is necessary. If yes, when: before or after the conservative treatment, i.e. just before the surgery?

    Yes. After conservative treatment. It is not always before surgery. Sometimes you decide to continue with conservative treatment. CT shows us the extension of the disease and also associated pathologies, such as bony erosions, fungal balls, etc.

20. What staging system do you believe in? Can we at this consensus conference accept Lund-Mackay's as most practical one?

    I think Lund-Mackay's staging system is the most practical one.

21. Do you believe that some septal deformities can influence chronic ostiomeatal disease? If yes, what kind of deformity (try to express your attitude using the Mladina's classification)

    If septal deviation pushes the middle turbinate and obstructs the OMC area by creating contact areas it may influence chronic OMC disease. This corresponds Mladina type 3.

22. Are chronic bacterial or viral infections important in the onset of nasal polyposis?

    I don't know

23. Do you remove or leave alone the middle turbinate showing superficial polypoid changes of the mucosa in cases of maxi-polyposis?

    If it blocks the entrance to the ethmoid cavity, or if it touches the lateral nasal wall I remove it.

24. Do you insist on radical and complete clearance of the skull base in cases of diffuse polyposis, or you prefer to leave some polypous tissue there to be treated by means of conservative methods?

    I insist on radical and complete clearance of the skull base in cases of diffuse polyposis with ASA

25. Have you ever heard about or personally tried the method of desenzitation of the patient to the antigen prepared from his own polyps in difficult cases of recurrent, voluminous diffuse polyposis and asthma?
    No
26. How do you feel about the topical use of mometasone?
    Steroids are the working horse of the polyp treatment
27. How do you feel about the powered instrumentation (shavers) in the treatment of nasal polyposis: just one of the surgical tools or something more?
    Shavers give the surgeon to operate in a bloodless field and preserve the mucosa.It is of course a surgical tool, but if you get used to using it, you can not do the surgery without it.
28. How do you imagine the antipolypous drug of the future: viral transfer of correct gene to replace the wrong one, a sort of antiinterleukin 5 (or which one?) or something else?
    A drug which decreases the inflammation with no side effects.
29. Do you believe that nasal polyps will disappear in a near future from the list of surgical diseases?
    No
30. How do you feel nowadays when you are faced to nasal polyposis: a) frustrated because of the fact that this is a typical chronic, recurrent disease, b) ready for the fight in every single patient, c) embarrassed because this disease sometimes discredit your capabilities as a medical doctor and takes to much of your time?
    b

Dr. J. Ponikau
Mayo, Rochester, Minnesota, USA

1. Is nasal polyposis local or systemic disease?
   Systemic
2. Can you make a distinction between «simple» polyposis and «diffuse» polyposis concerning the background of the disease?
   No, except for choanal polyp
3. Are they separate etipathogenetic entities, thus requiring different therapeutic approach?
   No
4. Do you believe in any of the theories that are published so far ? If yes, in which one?
   Chronic inflammed tissue (eos) with fungi as trigger.
5. Is nasal polyposis exclusively a surgical disease?
   No
6. Is nasal polyposis a disease more appropriate for a conservative treatment?
   Yes
7. How do you estimate the role of the fungi in the ethiology of the nasal polyposis?
   Major, if not the only role. Let the data speak...
8. Do you personally use antifungal drugs in your polypous patients? If yes, in which way (local, systemic or both) and what kind of a drug do you prefer?
   Only local (ampho B, itraconasole)
9. Do you believe that underlying osteitis in the cases of so called chronic sinusitis, can provoke the onset of polyposis?
   No, osteitis most likely due to the bone toxic granule proteins released from eosinophils.
10. Do you recommend long term antibiotic treatment to your polypous patients?
    No, only in acute bacterial onsets.
11. If yes, which antibiotic do you prefer, and for how long time do you apply it?
    #
12. How do you feel about the montelucast sodium regarding preoperative or postoperative treatment in polypous patients?
    It should be useful, lack of clinical data so far...
13. How do you feel about the steroid tretment? Preoperatively? Postoperatively? Both?
    Both, if possible topical.
14. If you do use steroids, for how long time do you treat the patient preoperatively? What is your timing? How do you know when to stop and operate? Do you use peroral steroids or local ones? Maybe both of them?
    #
15. Do you have any experience with the topical use of the furosemide?
    No
16. How do you feel about the role of the GP doctor in the modern treatment of the patient with polyposis?
    Lacks expertise. Need speacialist.
17. Does the diminuition of the massive polyposis influence the status of the asthmatic patient? If yes, which kind of diminuition you prefer: surgical or conservative?
    Yes, conservative with steroids. Asthma is the same disease!
18. Do you feel that pulmologist should be consulted in all cases of nasal

polyposis? Why yes, why not?
Yes, asthma is the same disease!

19. Do you feel that CT scanning of the polypous patient is necessary. If yes, when: before or after the conservative treatment, i.e. just before the surgery?
Yes, to get an idea about the extent of disease.
20. What staging system do you believe in? Can we at this consensus conference accept Lund-Mackay's as most practical one?
Agreed.
21. Do you believe that some septal deformities can influence chronic ostiomeatal disease? If yes, what kind of deformity (try to express your attitude using the Mladina's classification)
#
22. Are chronic bacterial or viral infections important in the onset of nasal polyposis?
Yes, they cause temporarily stasis of the cilia, thus an increase of the antigenic stimulus from fungi.
23. Do you remove or leave alone the middle turbinate showing superficial polypoid changes of the mucosa in cases of máxi-polyposis?
Leave, why remove healthy structure and cause disease through surgery.
24. Do you insist on radical and complete clearance of the skull base in cases of diffuse polyposis, or you prefer to leave some polypous tissue there to be treated by means of conservative methods?
Leave some tissue, just make sure that the mucus is removed.
25. Have you ever heard about or personally tried the method of desenzitation of the patient to the antigen prepared from his own polyps in difficult cases of recurrent, voluminous diffuse polyposis and asthma?
Heard about, lack of efficacy so far. Not good rationale for this concept.
26. How do you feel about the topical use of mometasone?
Best steroid.
27. How do you feel about the powered instrumentation (shavers) in the treatment of nasal polyposis: just one of the surgical tools or something more?
Elegant tool.
28. How do you imagine the antipolypous drug of the future: viral transfer of correct gene to replace the wrong one, a sort of antiinterleukin 5 (or which one?) or something else?
IL-5 is good approach, desensitization to fungi.
29. Do you believe that nasal polyps will disappear in a near future from the list of surgical diseases?
Yes, just a matter of time.
30. How do you feel nowadays when you are faced to nasal polyposis: a) frustrated because of the fact that this is a typical chronic, recurrent disease, b) ready for the fight in every single patient, c) embarrassed because this disease sometimes discredit your capabilities as a medical doctor and takes to much of your time?
b*) Love the challenge.*

Dr. G. Scadding
London, U.K.

1. Is nasal polyposis a local or systemic disease?
   Both
2. Can you make a distinction between "simple" polyposis and "diffuse" polyposis concerning the background of the disease?
   Yes
3. Are they separate etiopathogenetic entities, thus requiring different therapeutic approach?
   Etiopathogenisis / allergic infective / structural other
4. Do you believe in any of the theories that are published so far?
   If yes, in which one?
   Prof. Tos's
5. Is nasal polyposis exclusively a surgical disease?
   No way
6. Is nasal polyposis a disease more appropriate for a conservative treatment?
   Yes
7. How do you estimate the role of the fungi in the ethiology of the nasal polyposis?
   In allergic fungal sinusitis, they are very relevant, I am unsure of their relevance in other forms of polyposis
8. Do you personally use antifungal drugs in you polyposis patients? If yes, in which way (local, systemic or both), and what kind of a drug do you prefer?
   Doing a trial of intranasal amphotericin in a double blind, placebo controlled fashion
9. Do you believe that underlying osteitis in the cases of so called chronic sinusitis can provoke the onset of polyposis?
   No
10. Do you recommend long-term antibiotic treatment to you polyposis patients?
   Sometimes
11. If yes, which antibiotic do you prefer, and for how long a time do you apply it?
   Erymax
12. How do you feel about the montelukast sodium regarding preoperative or postoperative treatment in polyposis patients?
   A trial of this drug for two to four weeks is sensible in all polyp patients with monitoring of symptoms and signs. Only those with genuine response should be continued on it
13. How do you feel about steroid treatment both pre-operatively / postoperatively or both?
   Always
14. If you do use steroids for how long do you treat the patient preoperatively? What is you timing?How do you know when to stop and operate?Do you use peroral steroids or local ones or perhaps both?
   I use a medical polypectomy with enteric-coated prednisolone 0.5mgs/kg orally in the morning for five days with food plus betnesol nose drops 2 per nostril tds for five days, bd until the bottle runs out. After this, I switch to a non-absorbed steroid, usually flixonase nasules
15. Do you have experience with the topical use of furosemide?
   Yes. I did a study of furosemide in one nostril, amyloride in the other in nasal polyp patients with no ma-

jor effect in the group, although some individuals responded extremely well. This has never been published

16. How do you feel about the role of the GP in the modern treatment of patients with polyposis?
    Once the nature of the polyp is known, the GP can take care of the patient in the long-term, returning them to the Rhinology clinic when symptoms are out of control
17. Does the diminution of the massive polyposis influence the status of the asthmatic patient? If yes, which kind of diminution do you prefer; surgical or conservative?
    Sami Ragab, Valerie Lund and I have just undertaken a randomized prospective control trial of medical and surgical treatment of chronic rhinosinusitis, noting the effect on the lower respiratory tract. Both treatments helped asthma symptoms, however medical treatment was superior where polyp patients were concerned. After conservative treatment, unless there is a suspicion of malignancy or other problem.
18. Do you feel that pulmologist should be consulted in all cases of nasal polyposis? If yes why. If no, why not?
    Yes
19. Do you feel that CT scanning of the polyposis patient is necessary. If yes, when: before or after the conservative treatment ie just before surgery?
    Yes. Both.
20. What staging system do you believe in? Can we at this consensus conference accept Lund-Mackay's as most practical?
    Lund-Mackay system is too insensitive. There is a more recent system from Sweden which I think is superior.
21. Do you believe that some septal deformities can influence chronic ostiomeatal disease? If yes, what kind of deformity (try to express your attitude using the Mladina's classification).
    No
22. Are chronic bacterial or viral infections important in the onset of nasal polyposis?
    Not chronic, but possibly acute are involved in the onset. Intermittent intercurrent viral infections appear to increase nasal polyposis once established.
23. Do you remove or leave alone the middle turbinate showing superficial polypoid changes of the mucosa in cases of maxi-polyposis?
    Leave alone
24. Do you insist on radical and complete clearance of the skull base in cases of diffuse polyposis, or do you prefer to leave some polyposis tissue there to be treated by means of conservative methods?
    No
25. Have you ever heard about or personally tried the method of desensitization of a patient to an allergen prepared from his own polyps in difficult cases of recurrent, voluminous diffuse polyposis and asthma?
    No
26. How do you feel about the topical use of mometasone?
    Okay
27. How do you feel about the powered instrumentation (shavers) in the treatment of nasal polyposis: just one of the surgical tools or something more:
    Just one of the surgical tools
28. How do you imagine the antipolypous drug of the future: viral transfer of

correct gene to replace the wrong one or a sort of anti-interleukin 5 or something else?
Something else

29. Do you believe that nasal polyps will disappear in a near future from the list of surgical diseases?
Decreased use of surgery

30. How do you feel nowadays when you are faced with nasal polyposis:

a) frustrated because of the fact that this is a typical chronic recurrent disease?
b) ready for the fight in every single patient?
c) embarrassed as a medical doctor because it takes too much of your time?
c

Dr. R. Setliff
Sioux Falls, South Dacota, USA

1. Is nasal polyposis local or systemic disease?
   Probably more systemic than local
2. Can you make a distinction between «simple» polyposis and «diffuse» polyposis concerning the background of the disease?
   No
3. Are they separate etipathogenetic entities, thus requiring different therapeutic approach?
   No
4. Do you believe in any of the theories that are published so far ? If yes, in which one?
   Fungal and genetic
5. Is nasal polyposis exclusively a surgical disease?
   No
6. Is nasal polyposis a disease more appropriate for a conservative treatment?
   No
7. How do you estimate the role of the fungi in the ethiology of the nasal polyposis?
   More significant than hertofore thought
8. Do you personally use antifungal drugs in your polypous patients? If yes, in which way (local, systemic or both) and what kind of a drug do you prefer?
   Both. I use itraconasole.
9. Do you believe that underlying osteitis in the cases of so called chronic sinusitis, can provoke the onset of polyposis?
   No
10. Do you recommend long term antibiotic treatment to your polypous patients?
    No
11. If yes, which antibiotic do you prefer, and for how long time do you apply it?
    #
12. How do you feel about the montelucast sodium regarding preoperative or postoperative treatment in polypous patients?
    Probably more significant than heretofore thought
13. How do you feel about the steroid tretment? Preoperatively? Postoperatively? Both?
    Both, for reduction of polyp mass before and for continued supression after
14. If you do use steroids, for how long time do you treat the patient preoperatively? What is your timing? How do you know when to stop and operate? Do you use peroral steroids or local ones? Maybe both of them?
    Depo-Medrol, pre and post, 40-60 mg, 2-4 weeks preop and immediately postop.
15. Do you have any experience with the topical use of the furosemide?
    No
16. How do you feel about the role of the GP doctor in the modern treatment of the patient with polyposis?
    Should refer the patient to ENT
17. Does the diminuition of the massive polyposis influence the status of the asthmatic patient? If yes, which kind of diminuition you prefer: surgical or conservative?
    Probably. Both.
18. Do you feel that pulmologist should be consulted in all cases of nasal polyposis? Why yes, why not?

No. The interest in naso-sino-pulmonary relationships is lacking.

19. Do you feel that CT scanning of the polypous patient is necessary. If yes, when: before or after the conservative treatment, i.e. just before the surgery?
    Initially, and before surgery.
20. What staging system do you believe in? Can we at this consensus conference accept Lund-Mackay's as most practical one?
    Yes
21. Do you believe that some septal deformities can influence chronic ostiomeatal disease? If yes, what kind of deformity (try to express your attitude using the Mladina's classification)
    Yes, if compromise of hiatus semilunaris superior and/or ethmoidal infundibulum and/or frontal drainage occurs.
22. Are chronic bacterial or viral infections important in the onset of nasal polyposis?
    Probably; bacterial more significant
23. Do you remove or leave alone the middle turbinate showing superficial polypoid changes of the mucosa in cases of maxi-polyposis?
    Leave
24. Do you insist on radical and complete clearance of the skull base in cases of diffuse polyposis, or you prefer to leave some polypous tissue there to be treated by means of conservative methods?
    Diseased membrane left at limits of dissection-no exposed bone
25. Have you ever heard about or personally tried the method of desenzitation of the patient to the antigen prepared from his own polyps in difficult cases of recurrent, voluminous diffuse polyposis and asthma?
    No experience
26. How do you feel about the topical use of mometasone?
    OK
27. How do you feel about the powered instrumentation (shavers) in the treatment of nasal polyposis: just one of the surgical tools or something more?
    Instrumentation of choice.
28. How do you imagine the antipolypous drug of the future: viral transfer of correct gene to replace the wrong one, a sort of antiinterleukin 5 (or which one?) or something else?
    No clue
29. Do you believe that nasal polyps will disappear in a near future from the list of surgical diseases?
    Probably not; most likely a legitimate nasal response to a variety of provocations.
30. How do you feel nowadays when you are faced to nasal polyposis: a) frustrated because of the fact that this is a typical chronic, recurrent disease, b) ready for the fight in every single patient, c) embarrassed because this disease sometimes discredit your capabilities as a medical doctor and takes to much of your time?
    a,b, and c

Dr. V.P. Sood
New Delhi, India

1. Is nasal polyposis local or systemic disease?
   Infective nasal polyposis secondary to chronic inflammatory disease of sinuses that is chronic sinusitis is a local disease while allergic nasal polyposis may be a nasal manifestation of the allergy in atopic individuals. Nasal polyposis in cystic fibrosis is again systemic because of autosomal recessive disorder.
2. Can you make a distinction between «simple» polyposis and «diffuse» polyposis concerning the background of the disease?
   Yes
3. Are they separate etipathogenetic entities, thus requiring different therapeutic approach?
   Yes, they are separate ethiopatho-genetic entities. Surgery is the treatment of choice for simple polyposis while in diffuse polyps it may be conservative treatment initially, followed by surgery, if required
4. Do you believe in any of the theories that are published so far ? If yes, in which one?
   Allergy and inflammation play an important role in the formation of polyps.
5. Is nasal polyposis exclusively a surgical disease?
   Symple polyps require surgery as the first line of treatment. For allergic nasal polyposis medical treatment is the mainstay of treatment while surgery is reserved for non-responders or to give good nasal airways.
6. Is nasal polyposis a disease more appropriate for a conservative treatment?
   Initially yes.
7. How do you estimate the role of the fungi in the ethiology of the nasal polyposis?
   In an atopic individual, nasal polyposis may be an immunologic reaction secondary to inhalation of fungal spores. Fungi in the sinus cavity may cause mucosal edema, inflammation and exudate as an immunological reaction. Patients showing white cheesy material or hyperattenuated shadow on CT are more likely to have allergic fungal sinusitis.
8. Do you personally use antifungal drugs in your polypous patients? If yes, in which way (local, systemic or both) and what kind of a drug do you prefer?
   Earlier all patients of allergic nasal polyposis and allergic fungal sinusitis were being managed by topical steroids. But for last 2 years I have started using itraconasole 200-400 mg/day for two months or more (depending on the response) in the patients of fungal polyps proved pathohystologically and micologically. In allergic fungal sinusitis I prefer systemic steroids.
9. Do you believe that underlying osteitis in the cases of so called chronic sinusitis, can provoke the onset of polyposis?
   Not really convinced.
10. Do you recommend long term antibiotic treatment to your polypous patients?
    Started just recently, but not long term experience.
11. If yes, which antibiotic do you pre-

fer, and for how long time do you apply it?
Started giving Roxithromycin 300 mg/od for 4-6 weeks.

12. How do you feel about the montelucast sodium regarding preoperative or postoperative treatment in polypous patients?
No experience.
13. How do you feel about the steroid tretment? Preoperatively? Postoperatively? Both?
In allergic nasal polyposis systemic steroids are given both pre and post operatively. Preoperative steroids help in reducing inflammation and thus decrease bleeding during surgery if surgery is contemplated. Preoperative steroids help in reducing size of maxi polyps and recurrence rate. I avoid using systemic steroids in potential or known diabetic patients.
14. If you do use steroids, for how long time do you treat the patient preoperatively? What is your timing? How do you know when to stop and operate? Do you use peroral steroids or local ones? Maybe both of them?
I use preoperative oral steroids for two weeks if polyps regress then medical treatment is continued. In patients with persistent polyps and blockage despite the use of steroids surgery is planned. Postoperatively oral steroids are continued for about four weeks in tapering doses and then followed by topical steroids.
15. Do you have any experience with the topical use of the furosemide?
No.
16. How do you feel about the role of the GP doctor in the modern treatment of the patient with polyposis?
GP's should refer any case of nasal polyposis to ENT doctor for suitable management.
17. Does the diminuition of the massive polyposis influence the status of the asthmatic patient? If yes, which kind of diminuition you prefer: surgical or conservative?
Yes, diminuition of massive polyposis does improve the status of the asthmatic patient. We prefer conservative treatment to reduce the polyps in the beginning followed by surgery if the response is not good.
18. Do you feel that pulmologist should be consulted in all cases of nasal polyposis? Why yes, why not?
Pulmologist should be consulted in those cases of nasal polyposis having co-existent chest problems and intractable bronchospasm causing respiratory problem.
19. Do you feel that CT scanning of the polypous patient is necessary. If yes, when: before or after the conservative treatment, i.e. just before the surgery?
CT scanning of polyposis patients is necessary before the surgery for precise assessment and to know extent of the involvement of sinuses. CT scans also provide useful road map during surgery.
20. What staging system do you believe in? Can we at this consensus conference accept Lund-Mackay's as most practical one?
Yes.
21. Do you believe that some septal deformities can influence chronic ostiomeatal disease? If yes, what kind of deformity (try to express your attitude using the Mladina's classification)
High and posterior deviated nasal

septum can influence chronic ostiomeatal disease

22. Are chronic bacterial or viral infections important in the onset of nasal polyposis?
Probably not.
23. Do you remove or leave alone the middle turbinate showing superficial polypoid changes of the mucosa in cases of maxi-polyposis?
Part of anterior and lateral part of the middle turbinate is removed if it is big and polypoidal.
24. Do you insist on radical and complete clearance of the skull base in cases of diffuse polyposis, or you prefer to leave some polypous tissue there to be treated by means of conservative methods?
We sometimes leave some polypoidal mucosa near the skull base but all visible polyps are removed under endoscopic control.
25. Have you ever heard about or personally tried the method of desenzitation of the patient to the antigen prepared from his own polyps in difficult cases of recurrent, voluminous diffuse polyposis and asthma?
No
26. How do you feel about the topical use of mometasone?
No experience-not available in India as yet.
27. How do you feel about the powered instrumentation (shavers) in the treatment of nasal polyposis: just one of the surgical tools or something more?
Microdebrider is a very good surgical tool for diffuse polyposis; if this is not available then through-cutting forceps are good substitute.
28. How do you imagine the antipolypous drug of the future: viral transfer of correct gene to replace the wrong one, a sort of antiinterleukin 5 (or which one?) or something else?
Probably anti interleukin 5.
29. Do you believe that nasal polyps will disappear in a near future from the list of surgical diseases?
Not in the near future.
30. How do you feel nowadays when you are faced to nasal polyposis: a) frustrated because of the fact that this is a typical chronic, recurrent disease, b) ready for the fight in every single patient, c) embarrassed because this disease sometimes discredit your capabilities as a medical doctor and takes to much of your time?
Ready for the fight in every single patient

Dr. P. Stierna
Stockholm, Sweden

1. Is nasal polyposis local or systemic disease?
   Both
2. Can you make a distinction between «simple» polyposis and «diffuse» polyposis concerning the background of the disease?
   Possibly educated, guess.
3. Are they separate etipathogenetic entities, thus requiring different therapeutic approach?
   Yes
4. Do you believe in any of the theories that are published so far ? If yes, in which one?
   Not one disease. Multiple reasons.
5. Is nasal polyposis exclusively a surgical disease?
   No. Combined treatment necessary.
6. Is nasal polyposis a disease more appropriate for a conservative treatment?
   No. We are probably treating the agressive cases to late and not with enough combinations.
7. How do you estimate the role of the fungi in the ethiology of the nasal polyposis?
   Local trigger for immunological events.
8. Do you personally use antifungal drugs in your polypous patients? If yes, in which way (local, systemic or both) and what kind of a drug do you prefer?
   No, except that steroids are partly antifungal on host defence.
9. Do you believe that underlying osteitis in the cases of so called chronic sinusitis, can provoke the onset of polyposis?
   No
10. Do you recommend long term antibiotic treatment to your polypous patients?
    In certain cases.
11. If yes, which antibiotic do you prefer, and for how long time do you apply it?
    Erytromycin, for months.
12. How do you feel about the montelucast sodium regarding preoperative or postoperative treatment in polypous patients?
    Doubtful
13. How do you feel about the steroid tretment? Preoperatively? Postoperatively? Both?
    Both
14. If you do use steroids, for how long time do you treat the patient preoperatively? What is your timing? How do you know when to stop and operate? Do you use peroral steroids or local ones? Maybe both of them?
    Depends how aggresive disease is. Both sometimes.
15. Do you have any experience with the topical use of the furosemide?
    No
16. How do you feel about the role of the GP doctor in the modern treatment of the patient with polyposis?
    Only in simple, reversible cases.
17. Does the diminuition of the massive polyposis influence the status of the asthmatic patient? If yes, which kind of diminuition you prefer: surgical or conservative?
    Both and Yes.
18. Do you feel that pulmologist should be consulted in all cases of nasal polyposis? Why yes, why not?

Not necessary in all cases, but to often the pulmologist comes in to late in the treatment.

19. Do you feel that CT scanning of the polypous patient is necessary. If yes, when: before or after the conservative treatment, i.e. just before the surgery?
For surgery and in sinusitis cases.
20. What staging system do you believe in? Can we at this consensus conference accept Lund-Mackay's as most practical one?
There is a new one published in Acta otolaryngologica that is more sensitive. It is called lateral imaging. I was coauthor and we have now also proved the sensitivity by a clinical trial.
21. Do you believe that some septal deformities can influence chronic ostiomeatal disease? If yes, what kind of deformity (try to express your attitude using the Mladina's classification).
Possibly in some cases.
22. Are chronic bacterial or viral infections important in the onset of nasal polyposis?
Yes. Trigger eosinophils responses.
23. Do you remove or leave alone the middle turbinate showing superficial polypoid changes of the mucosa in cases of maxi-polyposis?
Trim, if necessary only.
24. Do you insist on radical and complete clearance of the skull base in cases of diffuse polyposis, or you prefer to leave some polypous tissue there to be treated by means of conservative methods?
Clear, totally.
25. Have you ever heard about or personally tried the method of desenzitation of the patient to the antigen prepared from his own polyps in difficult cases of recurrent, voluminous diffuse polyposis and asthma?
Some good reports.
26. How do you feel about the topical use of mometasone?
Positive
27. How do you feel about the powered instrumentation (shavers) in the treatment of nasal polyposis: just one of the surgical tools or something more?
Good in diffuse cases but have some limitations.
28. How do you imagine the antipolypous drug of the future: viral transfer of correct gene to replace the wrong one, a sort of antiinterleukin 5 (or which one?) or something else?
Antiinflammatory, cytostatic type.
29. Do you believe that nasal polyps will disappear in a near future from the list of surgical diseases?
No
30. How do you feel nowadays when you are faced to nasal polyposis: a) frustrated because of the fact that this is a typical chronic, recurrent disease, b) ready for the fight in every single patient, c) embarrassed because this disease sometimes discredit your capabilities as a medical doctor and takes to much of your time?
a, b and c

Dr. P. van Cauwenberge
Gent, Belgium

1. Is nasal polyposis local or systemic disease?
   A systemic disease in view of its relationship with asthma and aspirine intolerance in a substantial number of cases.
2. Can you make a distinction between «simple» polyposis and «diffuse» polyposis concerning the background of the disease?
   No
3. Are they separate etipathogenetic entities, thus requiring different therapeutic approach?
   Probably yes, but we do not know enough about it today.
4. Do you believe in any of the theories that are published so far ? If yes, in which one?
   I only believe in results that are confirmed by other independent teams. So far, this is not the case. I am waiting for scientific confirmation of the fungal and bacterial theories.
5. Is nasal polyposis exclusively a surgical disease?
   Not exclusively, but mainly yes
6. Is nasal polyposis a disease more appropriate for a conservative treatment?
   Till now, not yet
7. How do you estimate the role of the fungi in the ethiology of the nasal polyposis?
   Interesting theory. I am waiting for a study that shows the real impact in the polyp patient population.
8. Do you personally use antifungal drugs in your polypous patients? If yes, in which way (local, systemic or both) and what kind of a drug do you prefer?
   No
9. Do you believe that underlying osteitis in the cases of so called chronic sinusitis, can provoke the onset of polyposis?
   No
10. Do you recommend long term antibiotic treatment to your polypous patients?
    Yes, 4 weeks in the severe cases, prior to possible surgery.
11. If yes, which antibiotic do you prefer, and for how long time do you apply it?
    Systemic 2nd generation cephalosporins or new generation quinolones.
12. How do you feel about the montelucast sodium regarding preoperative or postoperative treatment in polypous patients?
    No convincing data available yet.
13. How do you feel about the steroid tretment? Preoperatively? Postoperatively? Both?
    Preoperatively I try them –oral route- (together with the antibiotics). I realize that it only rarely works.
    Postoperatively I use them for many months-years via nasal administration.
14. If you do use steroids, for how long time do you treat the patient preoperatively? What is your timing? How do you know when to stop and operate? Do you use peroral steroids or local ones? Maybe both of them?
    Pre-op: 2 weeks prednisolone 32 mg for 1 week, 16 mg the next week. Then I stop and I judge the situation 1 month after start of the treatment.

If the patient feels good enough, I do not operate at that time (regardless of the CT findings). I operate if the subjective symptoms are important enough for the patient.

I only use topical steroids in grade 1 polyps.

15. Do you have any experience with the topical use of the furosemide?
No
16. How do you feel about the role of the GP doctor in the modern treatment of the patient with polyposis?
No role. Only the ENT specialist can judge the clinical situation and the indications for surgery.
17. Does the diminuition of the massive polyposis influence the status of the asthmatic patient? If yes, which kind of diminuition you prefer: surgical or conservative?
Yes. Which treatment: dependent on the patient's answer to the consevative treatment. Mostly only surgery will help.
18. Do you feel that pulmologist should be consulted in all cases of nasal polyposis? Why yes, why not?
In fact, yes, because of the concommitant astma in > 30% of the patients.
19. Do you feel that CT scanning of the polypous patient is necessary. If yes, when: before or after the conservative treatment, i.e. just before the surgery?
Yes, in all new cases. Before any treatment. If surgery is planned, CT is mandatory when it is available and affordable.
20. What staging system do you believe in? Can we at this consensus conference accept Lund-Mackay's as most practical one?
Yes, the Lund-Mackay one is excellent.
21. Do you believe that some septal deformities can influence chronic ostiomeatal disease? If yes, what kind of deformity (try to express your attitude using the Mladina's classification)
I do not know
22. Are chronic bacterial or viral infections important in the onset of nasal polyposis?
I believe that micro-organisms (infection or colonisation) may initiate polyp formation or worsen the situation. I do not know if it is viral, bacterial, fungal or all.
23. Do you remove or leave alone the middle turbinate showing superficial polypoid changes of the mucosa in cases of maxi-polyposis?
I usually leave it alone in these cases.
24. Do you insist on radical and complete clearance of the skull base in cases of diffuse polyposis, or you prefer to leave some polypous tissue there to be treated by means of conservative methods?
A radical removal is not necessary and remains dangerous.
25. Have you ever heard about or personally tried the method of desenzitation of the patient to the antigen prepared from his own polyps in difficult cases of recurrent, voluminous diffuse polyposis and asthma?
No, I do not believe in it. What is the antigen?
26. How do you feel about the topical use of mometasone?
Like any other topical steroid: maybe useful in grade 1 and helpful postoperatively.

27. How do you feel about the powered instrumentation (shavers) in the treatment of nasal polyposis: just one of the surgical tools or something more?
    It is faster, but more dangerous.
28. How do you imagine the antipolypous drug of the future: viral transfer of correct gene to replace the wrong one, a sort of antiinterleukin 5 (or which one?) or something else?
    I do not know. Probably something against the microorganism(s) involved.
29. Do you believe that nasal polyps will disappear in a near future from the list of surgical diseases?
    Not within the next 10 years.
30. How do you feel nowadays when you are faced to nasal polyposis: a) frustrated because of the fact that this is a typical chronic, recurrent disease, b) ready for the fight in every single patient, c) embarrassed because this disease sometimes discredit your capabilities as a medical doctor and takes to much of your time?
    Rather b), although sometimes I feel a).

Dr. J. Zinreich (radiologist)
Baltimore, USA

1. Is nasal polyposis local or systemic disease?
   Local
2. Can you make a distinction between «simple» polyposis and «diffuse» polyposis concerning the background of the disease?
   No
3. Are they separate etipathogenetic entities, thus requiring different therapeutic approach?
   No
4. Do you believe in any of the theories that are published so far ? If yes, in which one?
   Question non specific
5. Is nasal polyposis exclusively a surgical disease?
   No
6. Is nasal polyposis a disease more appropriate for a conservative treatment?
   Yes
7. How do you estimate the role of the fungi in the ethiology of the nasal polyposis?
   Probable co-contributor
8. Do you personally use antifungal drugs in your polypous patients? If yes, in which way (local, systemic or both) and what kind of a drug do you prefer?
   Can not answer
9. Do you believe that underlying osteitis in the cases of so called chronic sinusitis, can provoke the onset of polyposis?
   Osteitis is a complication of chronic rhinosinusitis
10. Do you recommend long term antibiotic treatment to your polypous patients?
    Can not answer
11. If yes, which antibiotic do you prefer, and for how long time do you apply it?
    Can not answer
12. How do you feel about the montelucast sodium regarding preoperative or postoperative treatment in polypous patients?
    Can not answer
13. How do you feel about the steroid tretment? Preoperatively? Postoperatively? Both?
    Can not answer
14. If you do use steroids, for how long time do you treat the patient preoperatively? What is your timing? How do you know when to stop and operate? Do you use peroral steroids or local ones? Maybe both of them?
    Can not answer
15. Do you have any experience with the topical use of the furosemide?
    Can not answer
16. How do you feel about the role of the GP doctor in the modern treatment of the patient with polyposis?
    Should be limited. Not for chronic disease
17. Does the diminuition of the massive polyposis influence the status of the asthmatic patient? If yes, which kind of diminuition you prefer: surgical or conservative?
    Can not answer
18. Do you feel that pulmologist should be consulted in all cases of nasal polyposis? Why yes, why not?
    ?

19. Do you feel that CT scanning of the polypous patient is necessary. If yes, when: before or after the conservative treatment, i.e. just before the surgery?
Pre-surgery
20. What staging system do you believe in? Can we at this consensus conference accept Lund-Mackay's as most practical one?
Yes
21. Do you believe that some septal deformities can influence chronic ostiomeatal disease? If yes, what kind of deformity (try to express your attitude using the Mladina's classification)
No
22. Are chronic bacterial or viral infections important in the onset of nasal polyposis?
Yes
23. Do you remove or leave alone the middle turbinate showing superficial polypoid changes of the mucosa in cases of maxi-polyposis?
Can not answer
24. Do you insist on radical and complete clearance of the skull base in cases of diffuse polyposis, or you prefer to leave some polypous tissue there to be treated by means of conservative methods?
Can not answer
25. Have you ever heard about or personally tried the method of desenzitation of the patient to the antigen prepared from his own polyps in difficult cases of recurrent, voluminous diffuse polyposis and asthma?
Can not answer
26. How do you feel about the topical use of mometasone?
Good
27. How do you feel about the powered instrumentation (shavers) in the treatment of nasal polyposis: just one of the surgical tools or something more?
Just one of the tools-This phase shall pass!!!
28. How do you imagine the antipolypous drug of the future: viral transfer of correct gene to replace the wrong one, a sort of antiinterleukin 5 (or which one?) or something else?
Can not answer
29. Do you believe that nasal polyps will disappear in a near future from the list of surgical diseases?
Yes
30. How do you feel nowadays when you are faced to nasal polyposis: a) frustrated because of the fact that this is a typical chronic, recurrent disease, b) ready for the fight in every single patient, c) embarrassed because this disease sometimes discredit your capabilities as a medical doctor and takes to much of your time?
a) Frustrated because of the fact that this is a typical chronic, recurrent disease

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