Nasal polyps in patients with asthma: prevalence, impact, and management challenges

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Abstract: Patients with chronic rhinosinusitis with nasal polyps (CRSwNP) often have coexisting asthma under the concept of “United Airway Disease”, being the combination of both diseases, which is one of the most challenging phenotypes to treat. Although clinicians have recognized this difficult-to-treat phenotype for many years, it remained poorly characterized. There is increasing epidemiological evidence linking chronic rhinosinusitis and asthma, but a good understanding of the pathophysiology and the combined management is still lacking. Bronchial asthma is more prevalent in patients who suffer chronic rhinosinusitis, while asthmatic patients have a greater prevalence of CRSwNP than patients without asthma. The effect of CRSwNP treatment, whether medical or surgical, in asthma is today less controversial after some studies have shown improvement of asthma after medical and/or surgical treatment of CRSwNP. However, direct comparisons between surgical and medical treatments are limited. Further randomized clinical trials are, however, still needed to better understand the management when both asthma and CRSwNP occur together. This review aims at summarizing the prevalence, impact, and management challenges regarding both asthma and CRSwNP.

Keywords: chronic rhinosinusitis, asthma, united airways, rhinosinusitis, corticosteroids, sinus surgery

Introduction

Chronic rhinosinusitis with nasal polyps (CRSwNP) is a chronic inflammatory disease of the upper airways. It is defined as the presence of two or more symptoms that persist for more than 12 weeks. Symptoms include facial pain/pressure, purulent nasal discharge, nasal obstruction, and decreased sense of smell during chronic inflammation and confirmed the presence of nasal polyps through endoscopy.1 On the other hand, asthma is a chronic inflammation of the lower airways involving episodic breathlessness and wheezing, with airway hyperresponsiveness to environmental stimuli, with a prevalence of 5%–10% in the general population.2 Asthmatic patients have a higher rhinosinusitis severity score than nonasthmatic patients, and more presence of nasal polyps regardless of atopic status, indicative of a strong relationship between CRSwNP severity and chronic airway inflammatory diseases.3

Since the introduction of the “United Airway Disease” concept,4 a large body of evidence from clinical epidemiology, pathophysiology, histology, and treatment outcomes has correlated asthma and CRSwNP. CRSwNP and asthma frequently coexist,1 both conditions sharing similar features of inflammation and remodeling. This association has been supported by numerous observations of similar histopathological changes5 and common inflammatory mediator infiltration.6 Typical histopathological
findings of asthma, including airway remodeling (epithelial shedding and basement membrane thickening), eosinophilic infiltration, T-helper cell involvement, and IL-5 production are present in both asthma and CRSwNP, suggesting similar physiopathological processes.  

Although the argument for the existence of a link between upper and lower airway diseases is strong, the mechanism that underlies this connection remains under investigation. In this review, we will analyze the prevalence and the impact of management challenges regarding both asthma and CRSwNP.

**Epidemiology and prevalence**

CRSwNP is an inflammatory condition of the nose and paranasal sinuses of unknown cause, which is present in 2%–4% of the adult population.  

CRSwNP is often associated with other respiratory diseases such as asthma, aspirin sensitivity, and idiopathic bronchiectasis. It has been reported that 20%–60% of patients with CRSwNP have asthma.

The association between CRSwNP and asthma patients can be considered from two different perspectives: percentage of asthmatic patients developing CRSwNP and patients diagnosed with CRSwNP and with asthma. Bronchial asthma is more prevalent in patients suffering from CRS. On the other hand, patients with asthma have a greater prevalence of CRS than patients without asthma. Jarvis et al included over 52,000 adults, aged 18–75 years, recruited in 19 centers from 12 European countries. In all centers and at all ages, a strong association between asthma and CRS (adjusted OR: 3.47; 95% CI: 3.20–3.76) was observed. The association with asthma was stronger in patients reporting both CRS and rhinitis. Dixon et al included 2,031 asthmatic patients and demonstrated that the association with CRS was related to severe asthma, poorly controlled asthma, and asthma exacerbations, but not to decreased lung function. Interestingly, most patients with CRS without clinical asthma showed bronchial hyper-responsiveness when a methacholine challenge test was performed. Furthermore, up to 45% of CRSwNP patients have or will develop asthma. The prevalence of CRSwNP is higher in asthmatics (7%) compared to the general population (4%), and females present a greater proportion of CRSwNP in combination with asthma. In addition, Caucasian patients have shown a greater prevalence of CRSwNP and asthma than Asiatic patients, while the severity of CRS is higher when concomitant asthma exists. In non-atopic asthma and late-onset asthma, CRSwNP was found even more frequently, from 15% to 26% depending on the study, while more than 60% of CRSwNP patients have some level of lower airway involvement.  

Aspirin-exacerbated respiratory disease (AERD), a syndrome characterized by the presence of aspirin sensitivity/intolerance, asthma, and CRSwNP, has an estimated prevalence of 1% in the general population and 10%–20% among asthmatics. During the natural evolution of the disease, a clinical history of rhinitis or CRS usually precedes asthma and the development of aspirin hypersensitivity. In the European Network on Aspirin-Induced Asthma cohort study, the disease followed a typical pattern: persistent rhinitis/rhinosinusitis appeared first (mean age 30 years), being associated to a flulike infection in half of the patients. This was followed by asthma after 2 years (mean age 32 years), and aspirin-induced respiratory reactions and nasal polyposis after 4 years (mean age 34 years). The clinical presentation in the different European countries was remarkably similar. In women, who outnumbered men by a ratio of 2.3:1, the onset of symptoms occurred significantly earlier, and the disease was more severe than in men. Once developed, CRSwNP and asthma evolution is usually independent of the aspirin and nonsteroidal anti-inflammatory drug avoidance.

The typical clinical picture of patients with CRSwNP and asthma has been characterized by older age, longer duration of nasal symptoms, higher incidence of allergic rhinitis, bronchial obstruction, higher computed tomography (CT) and endoscopy scores, and higher number of sinonasal surgeries. Bilodeau et al showed that, among asthmatic subjects, those with CRSwNP presented more poorly controlled asthma, increased airway obstruction, and more marked lower airway inflammation than those without CRSwNP. The same authors have suggested that a subgroup of asthmatic patients may have a more intense lower airway inflammation in relation to the presence of CRSwNP. They observed that asthmatic subjects using intranasal corticosteroids (ICS) to treat nasal polyps had a more intense inflammation and a poorer asthma control compared to patients with chronic rhinosinusitis without nasal polyps, reflecting a more severe subset of asthma.  

Asthma and CRSwNP have been also linked with an impaired quality of life (QoL); patients suffering from asthma and CRS reporting a poorer quality QoL. Alobid et al reported 109 patients with CRSwNP who were randomized to either receive oral prednisone for 2 weeks or to undergo endoscopic sinus surgery, all patients being treated with intranasal budesonide for 12 months. They observed a considerable impact of CRSwNP on patients’ QoL, this being...
even worse in patients with concomitant asthma mainly on physical functioning, body pain, and vitality \((P<0.05)\). The same group evaluated different outcomes of patients with CRSwNP and found that asthma and especially persistent asthma have an accumulative impact on the loss of smell, proposing the loss of smell as a predictive symptom to identify severe asthma. Other authors have also found lower olfactory outcomes in patients who have associated CRSwNP and asthma or AERD.

**Management challenges**

The European position paper on rhinosinusitis and nasal polyps provides a specific treatment guideline for patients with CRSwNP with and without asthma. On the basis of available evidence, medical therapy for CRSwNP should begin with daily application of a topical ICS in conjunction with high-volume saline irrigation, and subsequent therapies are based on the patient’s polyp status, severity of symptoms, and/or QoL impairment. Regarding the question about how sinus surgery and medical CRSwNP treatment may modify the course of bronchial asthma, different authors have concluded that the weight of evidence suggests a beneficial effect. A recent systematic review analyzed the effect of upper airway intervention in the subpopulation of patients with coexisting CRSwNP and asthma and did not find marked differences between outcomes after endoscopic sinus surgery (ESS) or medical treatment with montelukast, omalizumab, or erythromycin.

**Medical treatments**

When analyzing the evidence of medical treatment specifically for patients with CRSwNP and coexisting asthma, there are a few randomized controlled trials and uncontrolled prospective interventional studies that evaluated the efficacy of different treatments. Alobid et al prospectively studied 109 patients with CRSwNP with and without asthma. They observed that patients with CRSwNP have a significantly worse QoL than the general population and that steroid treatment and ESS lead to similar QoL improvement in CRSwNP, either with or without asthma; both steroid and ESS treatments improve nasal symptoms in patients with CRSwNP. Two montelukast trials with follow-up times of 10 weeks and 13 weeks were done. Schäper et al investigated the effect of montelukast (10 mg/d) in a double-blinded, placebo-controlled crossover trial (6 weeks of intervention, 4 weeks of placebo) in 24 patients. Short acting \(\beta\)-agonists and baseline doses of inhaled steroids were allowed. Ragab et al studied 44 patients with montelukast (10 mg/d) treatment for 3 months as an add-on therapy to inhaled steroids and intranasal steroids (INCS) in an uncontrolled prospective trial. Significant improvements in nasal and pulmonary symptoms, results of endoscopy and CT scanning of the paranasal sinuses, and asthma medication intake were reported in both trials. Nevertheless, no significant improvements were found in nasal and pulmonary function test results; however, Schäper et al found montelukast to increase peak expiratory flow significantly \((P<0.05)\).

Immunoglobulin E (IgE) activates mast cells, and its levels are elevated in people with allergic diseases. The monoclonal antibody omalizumab lowers the level of IgE through selective binding, and anti-IgE is used in the treatment of uncontrolled allergic asthma. Omalizumab significantly improved nasal outcomes (symptoms, nasal endoscopy, and CT results) and QoL but did not significantly improve pulmonary outcomes (symptoms and pulmonary function test results). Gevaert et al studied 24 patients with and without allergy in a 16-week double-blinded, placebo-controlled trial. Omalizumab was given as an add-on to “standardized asthma treatment”, and during the trial oral steroids and antibiotics were prohibited. They observed significant improvements in nasal symptoms, endoscopy results, and opacification on CT scans in the omalizumab group over those in the placebo group, irrespective of allergy status. Vague results in the omalizumab group were seen in relation to the lower airways; significant improvements were found in two of three pulmonary symptoms, but no significant changes were found in pulmonary function test results. The same group, in a randomized, double-blind, placebo-controlled trial of 30 patients with severe nasal polyposis, observed in 12 patients who received mepolizumab (two doses) radiographic and endoscopic improvement in nasal polyp burden compared to patients in the placebo arm, after 8 weeks of treatment. Although mepolizumab led to a reduction in loss of smell, postnasal drip, and nasal congestion, these results did not reach statistical significance, and the benefit in nasal symptoms normalized after a period of time, except for improvement in olfaction. Gevaert et al showed that a single injection of reslizumab, another anti-IL-5 monoclonal antibody, improved nasal polyp scores in 50% of patients with CRSwNP, and nasal IL-5 levels predicted the response to treatment. These studies support that a select population of patients with severe nasal polyposis may benefit from anti-IL-5 therapy, although, once again, larger studies are needed to corroborate these findings.

Finally, in addition to the known antimicrobial effects, long-term low-dose treatment with a macrolide such as...
erythromycin is believed to have immunomodulatory effects. Erythromycin improved nasal symptoms and was superior
to ESS in improving pulmonary outcomes (symptoms and pulmonay function test results).\(^{40}\) Ragab et al\(^{48}\) randomized
a heterogeneous group of chronic rhinosinusitis without
nasal polyps and CRSwNP patients with asthma who failed
initial medical therapy with INCS and nasal lavage to con-
tinued medical therapy or surgery. Patients randomized to
continued medical therapy received erythromycin for 12
weeks, nasal lavage, and fluticasone drops, and some patients
with CRSwNP received oral steroids. Both the medical and the surgery
groups had improved asthma at 12-month follow-up; evermore the continued medical therapy group
(erythromycin group) had greater improvement in objective
pulmonary function tests. When analyzing treatments used
in both CRSwNP and asthma, the most used treatments are
eukotriene antagonists, monoclonal antibodies, and mac-
rolide antibiotics.

Surgical treatments
The surgical treatment of nasal polyps by means of ESS
leads to a subjective improvement of asthma symptoms and
a decrease in hospital admissions, emergency department
visits, asthma exacerbations, and the need of medication
for disease control. There is also growing evidence sup-
porting that aggressive surgical management of CRSwNP
can consequently lead to a greater improvement of asthma
severity.\(^{47–49}\) Palmer et al\(^{50}\) retrospectively re-evaluated the
clinical histories of 15 subjects who had both CRS and
steroid-dependent asthma, investigating the asthma relapse
days and total dose of oral corticosteroid or antibiotics needed
before and after ESS. They observed that 93% of patients
significantly reduced their postoperative prednisone or anti-
biotic needs by total number of days. Senior et al\(^{51}\) reported
that 90% of asthmatic patients (n=30) who underwent ESS
for CRS reduced the number of asthma exacerbations and
need for medication after a follow-up period of 6.5 years. In
the same line of research, Manning et al\(^{52}\) found that chil-
dren with CRS and asthma (n=14) who underwent ESS had
a decreased number of asthma hospitalizations and missed
schooldays. Other authors\(^{56,57}\) have observed that asthma
patients undergoing ESS for CRSwNP had a significant
improvement in pulmonary function and a reduction of
systemic medication, respectively, but they failed to show
improvement in AERD patients. Trials studying impact of
CRSwNP treatment on asthma are summarized in Table
1. Recently, Leung et al\(^{54}\) simulated an evidence-based
risk analysis using literature-reported complication rates,
QoL changes, and Medicare costs to identify the threshold
at which the risks of repeated courses of corticosteroid
exceeded the risks of surgery. They found that the risks of
oral corticosteroid exceed the risks of ESS when patients
exceed 0.20 (CRSwNP), 0.53 (CRSwNP/asthma), or 1.81
(Samter’s triad) of oral corticosteroids per year or need oral corticosteroid more frequently than every 5 years,
2 years, or 6 months, respectively. In ESS trials, all nasal
outcomes (symptoms, nasal endoscopy, and pulmonary func-
tion test results) and QoL improved significantly although
ambiguous results were reported for pulmonary outcomes
(symptoms, pulmonary function test results, and asthma
medication intake). A systematic review has found that ESS
improves asthma control while decreasing asthma exacer-
bations, hospitalizations, and use of systemic and inhaled corti-
costeroids, pulmonary function being however unchanged.\(^{55}\)
According to these findings, the current widespread belief
is that comorbid asthmatic conditions of CRSwNP patients
improve after ESS.

On the other hand, some authors have reported that
asthma does not represent a predictor of poor symptomatic
outcome after primary\(^{56,57}\) or revision\(^{58}\) ESS. Concomitant
asthma was associated with worse postoperative endo-
sopic findings in two retrospective analyses, but had no
significant weight on other objective outcomes. Symptoms
improved significantly in both asthmatics and nonasthmatics
postoperatively, but asthmatics exhibited worse postopera-
tive endoscopic outcomes.\(^{59,60}\) In a series of 120 patients
undergoing ESS, Kennedy\(^{28}\) reported that asthma did not
affect the surgical outcomes when comparing patients
with similar sinonasal disease severity, excluding the worst
patients in whom asthma negatively affected the outcome.
Seybt et al\(^{54}\) did not find differences in CRS patients with or
without asthma in terms of the need for primary sinonasal
surgery, but they observed that asthmatics had a significantly
increased number of secondary surgeries. Uri et al\(^{62}\) reported
that in patients with CRSwNP and asthma, ESS did not affect
the asthma status. Lin et al,\(^{54}\) in a prospective trial including
224 CRS patients, could not confirm the beneficial effect
of ESS on modifying the severity of asthma measured by
objective lung function.

These findings suggest a benefit of early therapy for CRS
in asthmatics if CRS is considered a reason for poor asthma
control. Similarly, asthma in difficult-to-control illness
should be assessed for unsuspected CRS, with CT scanning
or nasal endoscopy, since CRS signs and symptoms may be
Table 1  Trials evaluating the impact of CRS surgical treatment on asthma

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<td>2. Medication needs</td>
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<td>3. Hospitalization rate</td>
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<td>4. Emergency visits</td>
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<td>5. FEV&lt;sub&gt;1&lt;/sub&gt; change</td>
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Abbreviations: LOE, level of evidence; AIA, asthma intolerant to nonsteroidal antinflammatory drugs; ATA, asthma tolerant to nonsteroidal anti-inflammatory drugs; AD, aspirin desensitization; CRSSNP, chronic rhinosinusitis without nasal polyps; CRSwNP, chronic rhinosinusitis with nasal polyps; FESS, functional endoscopic sinus surgery; SNOT, sinonasal outcome test; QoL, quality of life; FPND, fluticasone propionate nasal drops; FEV<sub>1</sub>, forced expiratory volume in 1 second.

subtle and overlooked if not specifically sought. We have highlighted that there exist only a few good quality studies of the treatment for CRSwNP with coexisting asthma, which underlines the need for further research in terms of both quality and quantity of the studies. The effect of ESS on pulmonary outcomes has been a question of great debate. We found low evidence to support a positive effect of both ESS and medical intervention on pulmonary function tests and asthma medication intake. Rix et al<sup>40</sup> and Vashishta et al<sup>55</sup> observed that patients who underwent ESS had an improvement in clinical asthma outcomes, but no significant change in pulmonary function test results. The effect of montelukast and other leukotriene antagonists on CRSwNP was evaluated in a recent systematic review and meta-analysis;<sup>63</sup> improvements in symptoms and clinical outcomes were described by all 12 included studies after leukotriene antagonist treatment,
but pulmonary function test results were sparse. Ragab et al. published a randomized, prospective trial on patients with chronic rhinosinusitis without nasal polyps or CRSwNP and asthma comparing surgical versus medical treatment. They found that medical as well as surgical treatments for CRS showed improvements in asthma status with a good correlation to the improvement achieved in upper airway symptoms. Exhaled nitric oxide levels and forced expiratory volume in 1 second (FEV1) improved in both groups with predominance in the medical treatment group of patients with CRSwNP.

Conclusion

Although there has been major advances in this field, there is still a lack of consistent evidence to reach firm conclusions about the relationship between upper and lower airway inflammatory diseases, their natural history, pathophysiology, and medical/surgical management. Research on the basic pathophysiology of the nose and demonstration of the unified airway concept are mandatory. Clarification is also required concerning whether CRS management affects other comorbid lower airway diseases such as asthma, chronic obstructive respiratory disease, and bronchiectasis. Randomized clinical trials with a good level of scientific evidence need to be performed to better understand the available treatments for comorbid upper and lower inflammatory diseases.

Disclosure

The authors report no conflicts of interest in this work.

References


Nasal polyps in patients with asthma