GLOBAL CRSwNP POLICY POSITION PAPER

Co-developed by

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European Federation of Allergy and Airways Diseases Patients' Associations

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GLOBAL ALLERGY & AIRWAYS PATIENT PLATFORM

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01/ Executive Summary

Understanding the actual burden of CRSwNP on patients and on society

Chronic Rhinosinusitis with Nasal Polyps (CRSwNP) is a Chronic Respiratory Diseases (CRDs) affecting 0.5% to 4% of the general population.[9] In Europe, CRSwNP is primarily driven by an inflammatory/immune response that also contributes to other chronic illnesses like asthma, and allergic rhinitis. Due to its cold-like symptoms and low public awareness, CRSwNP is often misdiagnosed, yet it significantly impacts those living with the condition. The loss of smell, an often-overlooked disability, can result in poor nutrition, safety hazards, cognitive decline, and emotional and social difficulties. Patients also frequently suffer from poor sleep quality, mental health issues, social isolation, and decreased work productivity. Challenges are compounded by delayed diagnosis, suboptimal treatment that leads to overuse of systemic corticosteroids that may harm patients in the long term, and unequal access to advanced therapies such as biologics. These factors severely affect patients' quality of life and strain healthcare systems. Additionally, the co-occurrence of CRSwNP with other conditions like asthma, allergic rhinitis, and COPD intensifies the disease burden, complicates management, and raises healthcare costs.

The urgent need for policy action

In anticipation of the 4th High-level Meeting of the UN General Assembly on Non-Communicable Diseases (NCDs) in 2025, there is a pressing need to advance the global response to CRDs to ensure that they are prevented, recognized, prioritized, and effectively managed within the broader context of NCDs. CRSwNP represents a significant, yet underrecognized, burden within the spectrum of CRDs. This position paper advocates for the inclusion and prioritization of CRSwNP in global health policies to improve disease management and outcomes for patients.

Recommendations for better and more consistent care

To address the challenges faced by CRSwNP patients, and build on the existing momentum, EUFOREA, GAAPP, EFA, and all the endorsing stakeholders would like to call on policy-makers to:

1. Recognize CRSwNP, and CRS more widely, as a CRD both in the new NCDs political declaration at the UN meeting and in national respiratory health strategies.

2. Enable the implementation of multidisciplinary care for CRDs through creation of centers of excellence for global airway diseases and enhance primary care practitioners' awareness of CRSwNP to ensure optimal patient follow-up and referrals.

3. Ensure timely access to treatments that achieve at least control, and preferably remission, improving health outcomes and allowing HCPs and patients to find the best approach to surgery and biologics based on the latest medical guidelines and shared decision-making.

4. Fund the collection of Real-World Evidence (RWE) through the establishment of real-world registries and funding of research projects to fill existing data gaps (e.g. direct and indirect costs) and improve health equity.

02/ Why do we need a position paper on CRSwNP?

In the fall of 2025, Heads of State and Government will convene at the 4th High-level Meeting of the UN General Assembly on the Prevention and Control of Non-Communicable Diseases (NCDs) to review progress, commit to accelerated action, and adopt a new political declaration on NCDs in pursuit of their vision for 2050.

This is a pivotal opportunity to advance the global response to Chronic Respiratory Diseases (CRDs), to ensure that they are prevented, recognized, prioritized, and effectively managed within the broader context of NCDs.

While not yet politically recognized as such, Chronic Rhinosinusitis with Nasal Polyps (CRSwNP) is a CRD affecting 0.5% to 4% of the general population[9], with severe symptoms that substantially impact quality of life. CRSwNP often coexists with other CRDs, particularly asthma and allergic rhinitis, as well as COPD in some instances. This exacerbates disease burden and complicates management, with untreated or poorly managed CRSwNP contributing to the onset or worsening of asthma and COPD.

Despite its prevalence and impact, CRSwNP remains underdiagnosed and inadequately managed, resulting in significant healthcare costs and impacted patient well-being and ability to contribute to society. Recognizing the urgency of addressing these issues, the global CRSwNP advocacy community views the 2025 meeting as a pivotal opportunity to advocate for improved and more consistent care.

In anticipation of the 2025 UN High-level Meeting, this policy position paper is vital for ensuring that CRSwNP is adequately represented and addressed within the broader context of CRDs. By articulating the specific needs and challenges associated with CRSwNP, the paper seeks to inform global health policies, promote accelerated action, and contribute to a comprehensive political declaration that advances the prevention and control of CRDs, including CRSwNP, fostering better health outcomes worldwide.

03/ Challenges faced by CRSwNP patients globally and in Europe

What is CRSwNP?

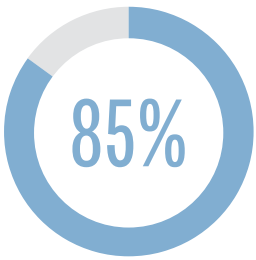
A chronic inflammatory disorder of the sinuses

Chronic rhinosinusitis (CRS) is a **chronic inflammatory disorder of the sinuses** which can develop with nasal polyps (CRSwNP) or without (CRSsNP).[1,2]

The nose is the gateway to breathing, and CRSwNP can cause a wide range of persistent respiratory symptoms, which start with the nose. These include **nasal congestion, runny nose, post-nasal drip, breathing difficulties, loss of smell (anosmia), and facial pressure/pain.**[3,4,5,6] The **average age for first symptoms is 32** – according to a study of adults with moderate-to-severe CRSwNP across European countries[7] – while **peak prevalence occurs in those aged 50-60**.[7,8]

Despite representing just under 30% of those diagnosed with CRS – and affecting 0.5% to 4% of the general population[9] – CRSwNP symptoms tend to be more severe, with a greater impact on quality of life.[2,9,10,11]

While it remains unclear what exactly initially causes CRSwNP, it is known that environmental factors (e.g. infectious agents, air pollution, tobacco smoke) and individual susceptibility (e.g. genetics) represent risk factors.[4,12,13] Moreover, one of the main drivers of the ongoing inflammation has been found to be a **chronic immune response also known as type 2 inflammation (T2i).** [2,14,15]



In Europe, approximately 85% of CRSwNP patients present T2i.[14]

T2i can also be a driver of other chronic inflammatory diseases such as asthma, certain phenotypes of COPD, allergic rhinitis, atopic dermatitis, eosinophilic esophagitis, as well as non-steroidal anti-inflammatory drugs-exacerbated respiratory disease.[16]

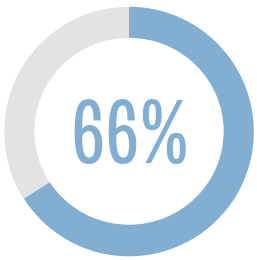
A disorder often mistaken for a cold but with a devastating impact on those affected by it

Due to the common symptoms and a general lack of disease awareness, **CRSwNP is often mistaken for a common cold or an allergy.**[7,17] However, unlike a cold, symptoms of CRSwNP can persist and have a major impact on a patient's daily life[18], and can be **as debilitating as other serious chronic diseases such as diabetes**, COPD, and congestive heart failure.[19,20]

The continuous loss of smell, and effects on taste and nasal congestion, are, from the perspective of Italian and Spanish patients, the symptoms that most impact patients' lives.[21,22] And, the more severe the disease is, the more frequent and intense the symptoms.[23]

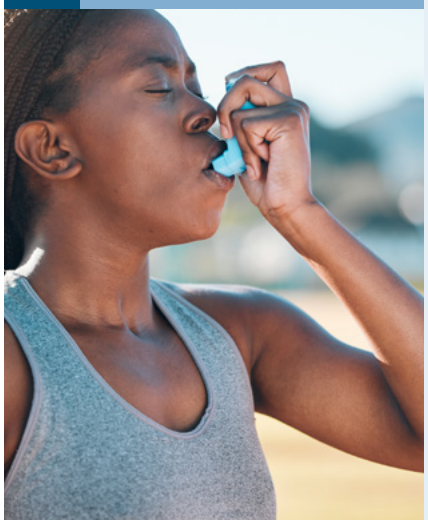
A disorder which often co-exists with and worsens other conditions

In Europe, **66% of moderate-to-severe CRSwNP patients report living with 1-3 T2i-driven additional conditions**[24] including allergic rhinitis/allergies (up to 75%) [4,25] and asthma (30%-70%).[1,26]



66% of CRSwNP patients in Europe report living with 1-3 T2i comorbidities.[24]

SPOTLIGHT ON ASTHMA



For patients with CRSwNP, asthma often remains undiagnosed[26] and patients living with comorbid asthma and CRSwNP also experience a greater burden of disease and difficulty to breathe, due to **higher disease recurrence and difficulty to achieve disease control.**[1,26,27]

In Italy, data from the Severe Asthma Network Italy (SANI) registry shows that severe asthma patients who also suffer from CRSwNP experience significantly more exacerbations per year and **use oral corticosteroids for longer periods of time,**[27] **which leads to severe health effects.**[28]

Evidence suggests that **untreated or poorly managed CRS**, including CRSwNP, can **impact other CRDs like asthma and COPD**, potentially **worsening them**, including through more frequent and severe exacerbations, or even **triggering their appearance**.[29,30,31] In fact, a study found the prevalence of CRS in COPD patients to be 22.5%, of which 82% were undiagnosed and untreated for their CRS.[29]

In Europe, patients feel that a **lack of medical attention is given to comorbid conditions.**[18] This leads to a disconnect between the high prevalence of comorbidities and the care patients receive, ultimately highlighting a critical gap in the management of CRSwNP.

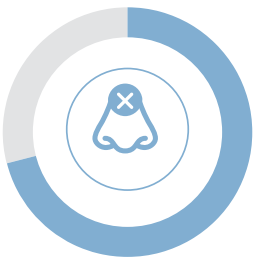
Anosmia – or the loss of smell – is an **invisible and underappreciated disability**, with people not realizing how important smell is until it is gone.[32]

Often associated with a loss of taste,[33] anosmia impacts how patients are able to enjoy food and drinks,[5, 32, 34, 35] potentially leading to **poor nutrition, unintended weight changes, and other diet-related health risks**.[34]

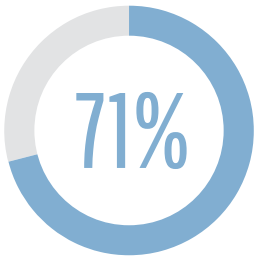
Anosmia also **prevents patients from detecting environmental dangers** like smoke or spoiled food, heightening risk.[5,35] Furthermore, loss of smell can have broader cognitive implications, and is associated with **cognitive impairment and neurodegeneration.**[36]

How does CRSwNP affect a patient's quality of life?

By having a significant and underappreciated impact on patients' lives due to the loss of smell



67%-78% of CRSwNP patients experience loss of smell.[14]



71% of patients in the U.K. identified loss of smell as the most debilitating symptom of CRSwNP.[35]

Additionally, research highlights that the psychosocial impact is significant.[35] A global survey of patients with smell or taste disorders found **anxiety and depression being reported by more than 60%** of participants.[37]

"I lost my sense of smell when I was 25. The hardest thing was that I could no longer taste the flavor of food or check if the food was rotten. My family would eat the food I cooked and get sick. I didn't know when to change my baby's diaper, so I was worried about it frequently. I couldn't smell perfume or aroma, so I was sad that I couldn't wear my favorite scent. Also, because I couldn't smell my own body odor, I was sometimes worried about making other people uncomfortable. Once, I couldn't detect a gas leak. Thankfully, my husband noticed it, so it didn't lead to a major accident. More, I have asthma attacks in response to cigarettes and certain scents. But because I couldn't avoid them, sometimes I would suddenly have an asthma attack and even collapse."

Tomomi Sekine,
patient living with CRSwNP in Japan

The loss of smell associated with CRSwNP has also been found to **disrupt relationships, impact social support and alter sexual behaviors**.[34] In the UK, 39% of patients surveyed indicated that loss of smell "often or always" impacted their relationships, while a third saw a **negative impact on work**, [35] especially for those relying on smell for safety or ability to perform their job (e.g. a chef).[34]

By impairing sleep quality and increasing daytime drowsiness

Symptoms such as nasal obstruction, runny nose, and post-nasal drip [18,38] are associated with **reduced sleep quality, which worsens with disease severity**.[5]

CRSwNP patients have their sleep impacted on 72 days per year.[21]

In Italy, **CRSwNP patients and their caregivers report an average of 72 and 52 days respectively with poor night's sleep per year.**[21] The prolonged lack of quality sleep resulted in **daytime drowsiness** for patients and caregivers – 48 and 39 days per year respectively – leading to reduced productivity, which in turn **interferes with work/school** and even leads to **withdrawal from social life** in extreme cases.[21]

By taking a toll on the mental health, social well-being and ability to work of patients

CRSwNP's reach extends beyond physical health, placing a **significant burden on a patient's mental health**,[18] as they experience reduced concentration, frustration, sadness, anxiety, and depression.[5]

The majority of patients (65%) frequently think about the management of their CRSwNP, with 1 in 5 reporting that it is on their mind daily. This emphasizes the importance of comprehensive care that addresses both the physical and mental aspects of the disease.[40]

These psychological struggles are further exacerbated by daytime somnolence, **impacting overall performance at work.**[18] In **Italy**, CRSwNP accounts for an average of **49.8 days per year of work or school impairment, equally split between presenteeism and absenteeism.**[21] In addition to fatigue and mental health, physical pain and long recovery times from surgery are key contributors to this burden.[18]

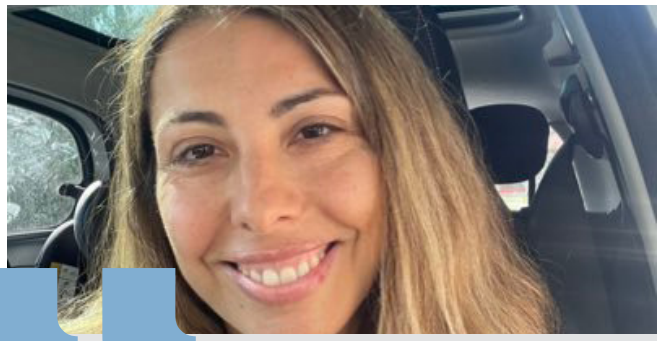
CRSwNP also affects **social well-being,** with **self-consciousness of the disease** reducing enjoyment in social settings and causing loss of confidence.[19]

These aspects are often underestimated by healthcare professionals (HCPs), further demonstrating the suboptimal care experienced by CRSwNP patients in Europe.[18]

"The loss of the sense of smell means living with a disability. This makes you a social outsider, and is consequently accompanied by severe psychological problems, and depression."

Patient living with CRSwNP in Germany

In the UK, anxiety and depression affect 50% and 40% of CRSwNP patients, respectively.[39]



"I have been living with CRSwNP for almost 30 years. It started when I was very young, a very delicate age when socializing was very important.

It was terrible. I slept very badly, waking up thousands of times, and wasn't able to fully focus. My colleagues would keep asking me why I always had a cold. I felt so tired at night that I didn't want to go out to dinner with anyone. A simple glass of wine made my nose swell up a lot. These were psychologically very hard years for me, which also greatly affected my social life. I have shed many tears of despair.

The loss of my sense of smell was a huge trauma for me. Many years missing pieces of life: the smell of spring, the smell of my babies, new fragrances, etc. I had planned to become a perfumer, but my dream was shattered by CRSwNP."

Vanessa Limonge,
patient living with CRSwNP in Spain

What are some of the main challenges patients face along their care journey?

Delayed diagnosis prevents patients from being treated before significant loss of nasal function

Depending on the country they live in, it may take up to 7 years for CRSwNP patients to be correctly diagnosed.[7, 21]

In Europe, it takes an average of 2.1 years from first symptoms to diagnosis.[7] This means patients will often experience **a significant loss of nasal function by the time they are diagnosed** and, in particular, more limited nasal flow and smell function.[12] In **Italy**, this **delay extends to 7.2 years**.[21] In Spain, 22% of patients with T2i diseases, including CRSwNP, wait over 5 years.[16]

"It took me 10 years to be referred to an allergist and diagnosed with CRSwNP. At that point, regrettably, it was too late, as I already had severe damage to my nose (i.e. nasal walls and maxillary). This was partially due to my own underestimation of the condition - 'it's just allergies' - as well as time spent trying to navigate healthcare systems in several countries which all tend to keep patients in primary care for longer than appropriate."

Victor Gascon Moreno,
patient living with CRSwNP in Austria

Some of the reasons put forward for delayed diagnosis or underdiagnosis include: delays in patients seeking medical care (and consequent ineffective self-management);[7] a lack of disease awareness among primary care physicians (PCPs);[7] misdiagnosis (with patients receiving inadequate treatment);[17] and the necessity for timely referral to physicians specializing in several different areas, especially in the presence of comorbidities (e.g. allergy/immunology, pulmonology, ear nose and throat [ENT], internal medicine)[17]. Across **Europe**, over a **third of patients experience an initial incorrect diagnosis.** [7]

Conventional therapies do not help all patients and can even harm their health and quality of life

The heterogeneous inflammatory nature of CRSwNP means that patients will show different responses to treatment, with T2i-driven CRSwNP often showing higher resistance to conventional treatments.[25] It is estimated that **one third of all CRSwNP patients struggle to achieve control** of their persistent or recurring symptoms, despite long-term treatment with intranasal corticosteroids and having received at least 1 course of oral corticosteroids (OCS) in the preceding 2 years and/or previous sinonasal surgery.[41,42]

1 in 3 CRSwNP patients live with uncontrolled disease[42]

European guidelines recommend **OCS** for the management of disease exacerbations and recurring symptoms.[43] However, they often only **provide short-term relief**.[43] **Repeated and long-term use of OCS can lead to severe health effects** (e.g. osteoporosis, diabetes, hypertension, anxiety, mood swings, weight gain), especially in older adults[18,44,45] making them, as per the guidelines, unfit for maintenance treatment.[44] Despite these risks, many **healthcare providers continue to overprescribe**

them. In **Italy**, for instance, **20% of doctors prescribe OCS for every exacerbation of the disease**.[46]

It is estimated that around 46% of CRSwNP patients in Europe have had endoscopic sinus surgery (ESS).[25] Unfortunately, the **recurrence rate for nasal polyps ranges from 20%-60% within 1.5–4 years,**[4,19] and reaches as high as **60%–90% in T2i-driven CRSwNP patients with comorbidities** such as asthma.[15] Furthermore, **20%-37% of patients may need revision surgeries within 5 to 12 years**,[5,10] which are more complicated due to scarring and altered anatomy. This can also result in **a higher risk of complications and longer recovery periods,**[44] adding a further toll on a patient's quality of life and healthcare budgets.

As a result, **patients flag concerns** about uncertain benefits on smell restoration, temporary relief from surgery, the need for repeated surgeries, long recovery times, and potential complications.[18]

"It took more than five years for a definitive diagnosis to be made. Even after undergoing treatment with nasal drops and medication, my sense of smell did not return, so I underwent endoscopic surgery. Unfortunately, my sense of smell still did not return. Just when I had given up, my ENT doctor recommended for me to undergo a biologic."

Tomomi Sekine,
patient living with CRSwNP in Japan

Severe uncontrolled CRSwNP patients could benefit from biologics, but many cannot access them

Biologic therapies can significantly reduce disease burden by shrinking polyps, easing symptoms, and lowering the need for OCS and surgery.[47]

This impact is suggested by real-world evidence (RWE), such as the French national registry BIOPOSE, which reported that after 6 months of biologic treatment, 59% of patients were classified as excellent responders according to the EUFOREA-EPOS 2023 criteria.[48] In the presence of asthma, they also improve asthma symptoms, lung function tests, and asthma control.[47]

Currently, three biologics targeting T2i have been approved for the treatment of CRSwNP.[25] These offer **hope to severe uncontrolled CRSwNP patients whose disease responds to neither topical/ systemic corticosteroids nor surgery.**[25,47]

Despite the promise of biologics in treating CRSwNP, and partially due to different allocation of healthcare budgets according to national priorities, **access to them varies significantly between and within countries.**

In France[49,50] and Spain[51,52] 1 and 2 surgeries are required before biologics can be prescribed.

In the UK, biologics are not yet available for CRSwNP due to delayed pricing negotiations where those medicines are indicated for multiple diseases.[53]

Italy restricts prescriptions to recognized healthcare centers, creating disparities across the country.[54]

Moreover, according to an international patient survey, while **48% of CRSwNP patients preferred to first undergo surgery** and then take a biologic if needed, **40% favoured undergoing biologic treatment first** to avoid surgery entirely. However, **50% of those who had surgery report that they were not given the option to try a biologic first.**

This discrepancy highlights how an increase in shared decision-making could benefit patients, with regards to being informed about all options for the treatment of their CRSwNP.[40]

Therefore, there is still work to be done. Firstly, to **ensure that all eligible patients get access to the right treatment**, and secondly, that **shared decision-making covers all options available** for the treatment of CRSwNP.

What are the costs associated with CRSwNP?

Conventional care drives a high cost for healthcare systems

Across European countries, it is reported that CRSwNP drives high costs for healthcare systems, from the multitude of specialist visits, repeated surgeries, and related hospitalizations that patients must endure, in addition to multiple courses of OCS.[20,56,57] These costs rise further in patients with severe uncontrolled CRSwNP.[41]

In the Netherlands, the economic burden of CRSwNP on the healthcare system is estimated at €1,501.20 per patient per year.[55,56]

The situation in Catalonia (Spain) reflects the high cost of CRSwNP care across Europe, with mean annual costs for each patient with CRSwNP reaching €1,611.5, as does the situation in England (U.K.), where **surgery-related costs reached £2,173 per patient, per year**.[56]

Data on out-of-pocket costs for patients in Europe is unfortunately very limited and needs to be further enhanced. In **Italy**, 68.5% of CRSwNP patients report yearly costs of up to €480, with the amount reaching **€960 for 1 in 4 patients**.[21]

Getting patients on the right treatment sooner is essential to reduce their healthcare utilization and decrease associated direct and indirect costs.[10,41]

Comorbidities further increase the cost for healthcare systems

It has been shown that the co-existence of CRSwNP and other conditions can significantly increase costs for healthcare systems. Looking into comorbid asthma and CRSwNP, the mean annual direct **costs rise by €1,909 in the presence of CRSwNP**.[27]

Costs rise by €1,909 in asthma patients with CRSwNP.[27]

In **Catalonia (Spain)**, the direct healthcare **costs associated with severe forms of both diseases (€4,441.3) are double** those with both conditions in milder forms (€2,196.8).[56]

In **Finland**, the average **cost per patient with CRSwNP and severe, uncontrolled asthma reaches €12,673**.[57] These costs stem mainly from the overuse of OCS and the cost related to their severe health effects (e.g. osteoporosis, diabetes, hypertension, anxiety), with an analysis of the SANI registry in Italy finding that patients with comorbid asthma and CRSwNP use them for longer periods than those with just asthma – thus increasing the annual healthcare-related costs as a result.[27]

Indirect costs remain largely underexplored

Research shows that there is very limited data evaluating the cost of absenteeism and presenteeism due to CRSwNP. In the **Netherlands**, however, it is estimated that the **financial impact of CRSwNP on employers reaches €5,659.28 per patient per year**, arising from productivity losses in 35% of patients and an average of 10.55 days of absences per patient, per year. Moreover, **indirect costs represent 79% of total annual costs (€1.9 billion/year in the Netherlands)**, forming a substantial burden to society[55]

In the Netherlands,[55] total indirect costs amount to at least €5,659.28 per patient per year, of which €1,447.28 are due to presenteeism.

04/ Recommendations for better and more consistent care

Stemming from the various challenges described in the previous chapter, EUFOREA, GAAPP, EFA, and all the endorsing stakeholders would like to call on policy-makers to:

1. Recognize CRSwNP, and CRS more widely, as a CRD, by:

- Ensuring the new political declaration on NCDs to be adopted at the 4th High-level Meeting of the UNGA on NCDs prioritizes prevention and control of CRDs, including CRSwNP, alongside asthma and COPD.
- Ensuring the Integrated Lung Health Resolution, to be adopted at the 2026 World Health Assembly, prioritizes CRSwNP as a CRD alongside lower airway diseases.
- Developing or reviewing existing respiratory health strategies to ensure they prioritize CRSwNP, a disease that often is comorbid with asthma and occasionally with COPD, to holistically address the burden of airway diseases (upper and lower airways).

2. Enable the implementation of multidisciplinary care for CRDs, by:

- **Investing in primary care providers and pharmacist training** to ensure they have the appropriate knowledge, tools, and incentives to:
  - recognise CRSwNP symptoms and refer patients to specialized care for timely diagnosis and treatment;
  - be able to continue following CRSwNP patients on a regular basis and refer them to more specialized care when necessary (e.g. in case of disease progression or need for treatment escalation).
- **Incentivizing the creation of centers of excellence for the treatment of global airway diseases** (upper and lower airways), so that CRSwNP and associated comorbidities, as well as their multidimensional impact on patients, can be holistically managed from diagnosis onwards. From a CRSwNP perspective, these centers should enable collaboration between pulmonologists, ENT specialists, allergologists, immunologists, and psychologists.
- **Learning from best practices from other disease areas,** from tertiary care centers for cystic fibrosis to oncology, to implement the best models for integrated care, ensuring that we have a unified airways approach and considering mental health / well-being.

3. Ensure timely access to treatments that achieve at least control, and preferably remission, improving health outcomes, by:

» **Enabling HCPs and patients to find the best approach to surgery and biologics** for each patient, based on:

- the latest EPOS (European Position Paper on Rhinitis) and EUFOREA guidelines and standards, allowing for quality surgery as well as timely escalation of treatment to biologics for patients showing uncontrolled severe disease and/or presence of T2i comorbidities;
- recent advances in screening and evaluation tools, such as the new Sinonasal Radiological combined with the Lund-Mackay score which enhance the prediction of relapse and revision surgery risk[58], as well as consensus definitions of control and remission, e.g. as put forward by EUFOREA; and ultimately;
- shared decision-making, so that decisions consider patients' concerns, preferences, and needs as well as patient-reported outcomes.

4. Fund the collection of RWE and research, by:

» **Establishing real-world registries** for collecting RWE that can support better and more consistent care, including treatment selection and personalized care, as well as a better understanding of cost-offset of different treatments for healthcare systems and out of pocket costs for patients.

» **Funding research projects** to mitigate current data gaps, including but not limited to the direct and indirect costs of CRSwNP, to support healthcare decision-making, as well as improve health equity.

05/ Methodology

At the start of the project, research was conducted by Weber Shandwick in the form of a rapid literature review with a focus on the global landscape, Europe and five European countries: France, Germany, Italy, Spain, and the United Kingdom. The review included free-access scientific and academic articles published between January 2020 and February 2025, accessible through two platforms: PubMed and EMBASE. It was complemented by desk research looking at data generated/relevant information published by relevant organizations (e.g. patient/advocacy organizations) over the same period. This research aimed to collect information around a number of key questions across 4 pillars of research:

RESEARCH PILLAR

RESEARCH AREAS	Disease background 1	Burden of illness 2	Unmet needs 3	Barriers in access to medicines 4
	Sub-types / phenotypes / endotypes	Signs and symptoms	Diagnosis challenges	Barriers in access to non-biologics
	Grades of severity	Co-morbidities	Challenges in medical management and care	Barriers in access to biologics
	Causes and risk factors	Mental, emotional, and social well-being	Treatment challenges (surgery)	
	Incidence and prevalence	Ability to work and stay active	Treatment challenges (non-biologics)	
	Prognosis	Direct healthcare costs	Treatment challenges (biologics)	
		Indirect cost		

Once the data was collected, the position paper was developed by Weber Shandwick in close collaboration with the 3 authors of this paper (representatives from EUFOREA, GAAPP, and EFA) – the Steering Committee - with the support of Sanofi & Regeneron. This collaborative process included a total of 4 meetings in addition to offline work/review time. The wider group of patient advocacy group representatives and individual patient advocates that ultimately endorsed the paper and its policy recommendations – the Advocacy Board - was also invited to attend one of these meetings. This group ultimately reviewed, validated, and endorsed the paper. Both the Steering Group and the Advocacy Board were convened by Sanofi & Regeneron.

06/ Disclaimers

This position paper represents the views and opinions of its authors only, who bear sole responsibility for its content.

This document aims to provide a comprehensive overview of the current landscape of CRSwNP management in Europe and globally, but it is important to note that it does not constitute an exhaustive or scientific review. Instead, the rapid literature review, conducted by Weber Shandwick, offers valuable insights into various issues affecting a diverse cross-section of CRSwNP patients. The information collected was reviewed by authors of the position paper, ensuring that the most relevant and up-to-date data was incorporated into the final document.

The position paper was developed with the unrestricted support of Sanofi & Regeneron, reflecting the necessity of collaboration between the CRSwNP patient advocacy community and the pharmaceutical industry in addressing the gaps in the care pathway for CRSwNP patients.

07/ References

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