Chronic rhinosinusitis (CRS) is an inescapable disease considered to impair day by day work. Typical mucociliary clearance depends on suitable functioning of the epithelium, cilia, and of the bodily fluid itself. Adjustments to any part of this system can prompt the symptomatology of rhinosinusitis. CRS patients fall into four subgroups dependent on the nearness or nonappearance of polypi and additionally mucosal eosinophilia and these correspond with preoperative imaging and nasal endoscopy data. CRS treatment has been restricted by unclear subtype.

In this retrospective study, records of all the patients (age above 10 years) who underwent FESS from January 2012 to September 2017 were obtained from the Shifa Foundation Clinic and 166 patients were included. Nasal polyp is defined as a mass emerging from the nose or para nasal sinus mucosa, because of edema of the connective tissue stroma which contains inflammatory mediators. It is one of the commonest reasons for nasal obstruction. In the order of the most to the less regular site, are of the ethmoid, maxillary, frontal and sphenoid sinuses which can be included. Clinical manifestations facial pain or pressure, nasal obstruction or blockage, nasal release or purulence or stained postnasal release, hyposmia or anosmia, purulence in nasal cavity, and fever. In 2003, the RTF's definition was revised to require corroborative radiographic or nasal endoscopic or physical examination findings in addition to suggestive history.

INTRODUCTION
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Chronic rhinosinusitis (CRS) is an inescapable disease considered to impair day by day work. Typical mucociliary clearance depends on suitable functioning of the epithelium, cilia, and of the bodily fluid itself. Adjustments to any part of this system can prompt the symptomatology of rhinosinusitis. CRS patients fall into four subgroups dependent on the nearness or nonappearance of polypi and additionally mucosal eosinophilia and these correspond with preoperative imaging and nasal endoscopy data. CRS treatment has been restricted by unclear subtype. Rhinologists overall will in general send all removed nasal polyps for histopathological examination. More often than not, the clinical determination is the same as the histological report. The diagnosis is usually made on clinical grounds and confirmed on radiology. This condition, if not responding to medical treatment like intranasal steroids and antihistamines, is managed surgically through functional endoscopic sinus surgery (FESS). The purpose of this study was to assess the necessity of histopathological examination in all patients undergoing FESS.

METHODOLOGY
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were recruited. The information including the demographic and clinical features were noted. As this was a retrospective study and record was obtained from the hospital record, therefore, there was no direct consent form was taken from patients. The patients with malignancy and bleeding disorders, pregnant and lactating women and patient who underwent conventional procedures for CRS were excluded from the study.

In our clinical setting, specimen after FESS is sent routinely for histopathological examination to pathology department of the hospital.

**Statistical Analysis:** Statistical analysis was performed using SPSS version 20.

**RESULTS**
Out of those 166 individuals, only 49 (29.5%) were female. Mean age was 38.74±9.43 years All patients had nasal obstruction. The nasal discharge was present in only 59 (35.5%) patients. Headache was present in 50% patients.

The solid connection between clinical inspection and pathologic finding of FESS material brings up the issue of need of histological confirmation. In the event that the surgeon is left with the decision of asking for pathology investigation or disposing of examples there is a danger of missing significant diagnoses. When a decision has been made to dispose the tissue samples without pathology, a less experienced clinician may make a wrong choice. If that histological examination has a little clinical value, it is fascinating to talk about why and when pathology of FESS material is needed. One reason to proceed with routine examination could be to take a look at eosinophils versus neutrophils. Despite the fact that there is some trust this has little help for different postoperative approaches in neutrophilic and eosinophilic polyps.

**DISCUSSION**
Ceaseless rhino sinusitis (CRS) with/without nasal polyposis (NP) is a common disease, found in 16% United States population. Different signs for FESS may be doubt of (pre)malignancy or potentially an expanded risk of orbital, endocranial as well as septic complications. This is not just quality control, yet pure confirmation or exclusion of suspected other pathology.

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Routinely, all nasal polyps removed at operation ought to be sent for histopathological examination. To date, there is no broad agreement on the requirement for routine examination of nasal polyps among otolaryngologists. The present pattern of management of nasal polyp is to biopsy all the unilateral nasal mass and not the clinically diagnosed polyp in the outpatient facility. But that
as it may, in any case the clinical finding, it is the basic practice in concentrate focus to send all the removed tissues intraperatively for histopathological assessment.

It has been shown from this study that in spite of the fact that the biopsy taken in the center from the unilateral nasal mass ended up being a nasal polyp, two post-operative assessment of the specimen were positive for malignancy. If routine evaluation was not done, the true diagnosis of the mass would have been missed. The commonest signs for asking for histology were one-sided polyps, with irregular appearance and history of bleeding. Previous studies of retrospective review of all nasal polypectomy operations at the Radcliffe Infirmary, Oxford and the Freeman Hospital, Newcastle hospitals were analyzed. An aggregate number of 2866 nasal polypectomy operations were performed between 1982 and 1988 and histopathological reports were explored. Just 74% of cases in Oxford and 33% in Newcastle were analyzed histologically. There were no reported cases of unsuspected malignancy found in that study. The authors feel that the majority of the cases can be analyzed clinically and they reasoned that it is pointless to send every single nasal polyp for histological examination.

On the other hand, there are number of researchers who found the opposite results and conclusions. In spite of the fact that the quantity of routine samples that turned out harmful were little (less than 1%), routine histopathological examination of nasal polyps is basic particularly era of evidence-based medicine where medicolegal cases are on the rise. Kale et al found that there was 99.7% correlation among clinical and histopathological finding and there was one unsuspected case of inverted papilloma in a polyp specimen.

In a retrospective series by Garavelo et al, eight instances of clinically significant sudden findings were recognized, comparing to a recurrence of 0.37%. Inverted papilloma happened in seven cases and neoplasia in one case. They presumed that although rare, unexpected clinically relevant findings may be identified during routine histologic examination of nasal polyp specimens. Inability to send all tissues removed during surgery for histopathological examination may miss important diagnosis and postponement the suitable treatment.

CONCLUSION
The results of this study suggest that all nasal polyp specimens removed intraoperatively must be submitted for histopathological examination. Failure to do so may delay the proper treatment planned out with impending medico legal issues.

REFERENCES


