bulletin

American Academy of Otolaryngology—Head and Neck Surgery December 2012—Vol.31 No.12

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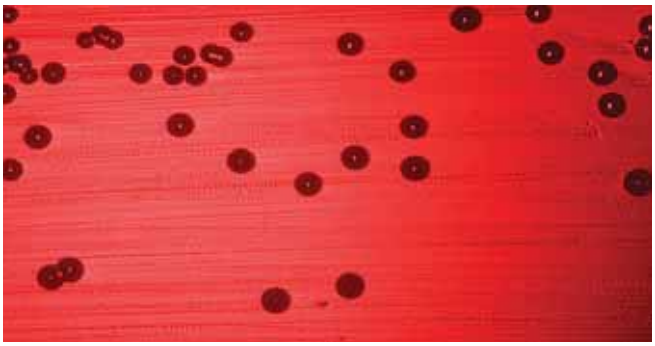
Infecting Organism:

Haemophilus influenzae

Gram Negative Bacteria



Medications that may be prescribed depending on culture and sensitivity reports:

Levofloxacin	Ceftriaxone

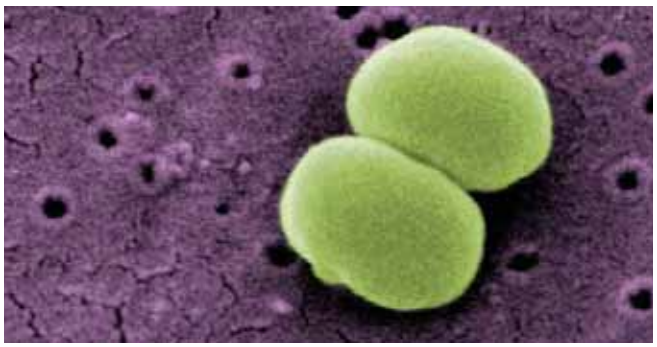
Many ENT surgeons have prescribed combinations to treat polymicrobial infections that may include an antibiotic, corticosteroid and anti-fungal.

Levofloxacin + Mometasone + Amphotericin B
Ceftriaxone + Mometasone + Itraconazole

Infecting Organism:

Staphylococcus epidermidis

Gram Positive Bacteria



Medications that may be prescribed depending on culture and sensitivity reports:

Vancomycin	Levofloxacin
Mupirocin	

Many ENT surgeons have prescribed combinations to treat polymicrobial infections that may include an antibiotic, corticosteroid and anti-fungal.

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Mupirocin + Budesonide + Tobramycin
Levofloxacin + Mometasone + Itraconazole

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[1]Athanasiadis T, Beule AG, Robinson BH, et al. Effects of a novel chitosan gel on mucosal wound healing following endoscopic sinus surgery in a sheep model of chronic rhinosinusitis. Laryngoscope 2008;118:1088–1094; [2]Valentine R, Wormald PJ, Nasal dressings after endoscopic sinus surgery: what and why? Current Opinion in Otolaryngology & Head and Neck Surgery 2010;18:44–48.

2012-01 REV AC

bulletin

American Academy of Otolaryngology—Head and Neck Surgery DECEMBER 2012—Vol.31 No.12

Education: Meeting the Needs of All Our Learners

With this issue of the *Bulletin,* we focus on how the AAO-HNS is putting its members first by prioritizing education.

20

AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY

David R. Nielsen, MD
Executive Vice President, CEO, and Editor, the *Bulletin*

Letters to the Editor Questions, concerns, or comments about *Bulletin* articles and other content may be addressed to the Editor via email at bulletin@entnet.org.

Article Submissions Author guidelines are online at www.entnet.org/press/bulletin/ and AAO-HNS members are encouraged to submit articles via email to bulletin@entnet.org. *Bulletin* staff will contact the author at the completion of the editorial review process for any article submitted.

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bulletin

DECEMBER 2012 | Vol.31 No.12

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Triological Society Research Grants

The Triological Society continues to promote research into the causes of and treatments for otolaryngic diseases by providing financial support for the research efforts of young otolaryngologists. Since 1974, the Society has awarded more than $3 million to otolaryngologists-head and neck surgeons in support of clinical and basic research. The Society's two competitive research grant programs are described here.

Triological Society Research Career Development Awards

Research Career Development Awards are available to otolaryngologists who hold full-time, part-time and contributed service medical school faculty appointments. These awards provide support for the research career development of otolaryngologists-head and neck surgeons who have made a commitment to focus their research endeavors on patient-oriented research such as clinical trials, translational research, outcomes research and health services research. Five awards are available for up to $40,000 each to be expended over a one or two year period.

Letters of intent are due December 17, 2012 (midnight ET) and applications are due January 15, 2013 (midnight ET) through the CORE grant program.

Guidelines and additional information are available at http://www.triological.org/researchgrants.htm. Questions may be referred to Gail Binderup at info@triological.org or 402-346-5500.

Triological Society/American College of Surgeons Clinical Scientist Development Award

This award provides supplemental funding to otolaryngologists-head and neck surgeons who receive a new NIH Mentored Clinical Scientist Development Award (K08/K23) in 2011/2012 or have an existing award with a minimum of 3 years remaining in the funding period as of June 1, 2013. This award is being offered as a means to facilitate the research career development of otolaryngologists-head and neck surgeons, with the expectation that the awardee will have sufficient pilot data to submit a competitive R01 proposal prior to the conclusion of the K award. This award will provide financial support in the amount of $80,000 per year for up to five years, or for the remainder of the term of existing grants, to supplement the K08/K23 award. Funding is dependent upon receipt of meritorious applications.

The application deadline is May 5, 2013.

Details are available at http://www.triological.org/researchgrants.htm. Questions may be referred to Gail Binderup at info@triological.org or 402-346-5500.

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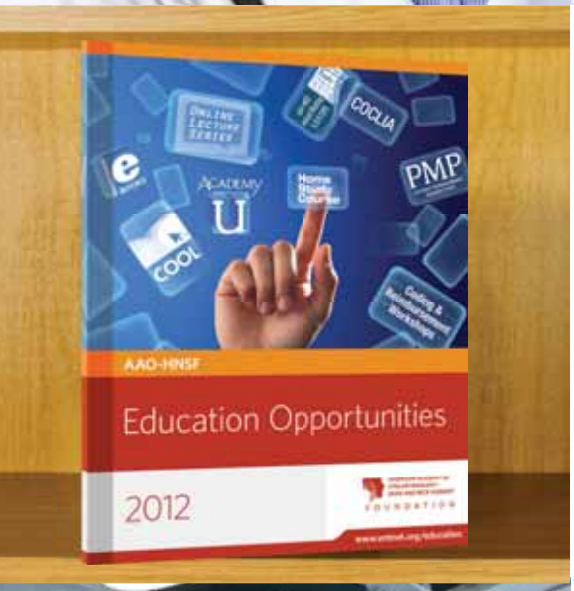

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A Cycle of Learning

As the calendar year moves to the end of its rotation, we naturally can see more clearly where we have been during the past 11 months, and we can look ahead to set new goals. This calendar cycle is not unlike the professional cycle that all physicians maintain. We commit to a life of learning that winds through each year (annual meeting to annual meeting) and through our career stages as well. The need to improve our knowledge and competence is as important and compelling as our time diagnosing and treating patients. Neither of these efforts can be overlooked. Each activity needs to be relevant to maximize our effectiveness and the outcomes of our care.

Since 2002, the ABO's Maintenance of Certification requirements have also addressed this cycle, establishing a formal program for a "lifetime of study"[1] to retain appropriate specialty certification.

The AAO-HNS Foundation has shaped its program to address these educational needs. This December's *Bulletin* is the Education Issue, and I am glad to recognize the educational accomplishments of the Foundation and its plans for the coming year.

> To make the products easily viewable and accessible to you and staff, a new "Education Opportunities" booklet will be mailed with the January *Bulletin*.

As the 2012 planning cycle began, Education and Meetings set out to push forward our stated 2012 goal:

We will enhance the quality of patient care and remain the premier source of otolaryngology education and knowledge. We will deliver resources and educational activities that address gaps in care and improve the knowledge and competence of otolaryngologist-head and neck surgeons, residents, medical students, non-otolaryngologist physicians, allied healthcare professionals, and the public.

The specific actions include consolidating and enhancing the otolaryngology practice gap analysis and needs assessment process; developing the next generation of otolaryngology education and knowledge resources through continuous assessment and redesign; providing resources for board certification preparation, business of medicine, trauma, robotic surgery, surgical simulation and resident education; and increasing member awareness and engagement in the generation and usage of education and knowledge resources to improve patient care and outcomes.

As a result of these actions, some existing products were modified for relevance to fill gaps in educational content. The scope of offerings for physicians expanded, as have offerings to facilitate learning for physician extenders. Ongoing education products in 2012 include:

- Four Home Study Course issues
- Eight Patient Management Perspective issues
- A variety of online courses for both physicians and physician extenders
- Eight coding and reimbursement workshops

To add to the options available, the AAO-HNSF added these new products in 2012:

COCLIA—Questions enhanced with full-color images and a new mobile optimized website.

ENT Exam—This online digital video demonstrates a thorough ENT exam.

***Resident Manual of Trauma to the Face, Head, and Neck*—**Primarily for residents and healthcare extenders, this new e-book is a concise, and easily accessible, source of diagnostic and therapeutic guidelines.

AcademyQ: Otolaryngology Knowledge Assessment Tool—Designed as an exam preparation tool, this mobile app facilitates knowledge self-assessment.

2013 AcademyU® Your Otolaryngology Education Source

Looking ahead to 2013, the AAO-HNSF has a new message: The new AcademyU is the single source for all your educational activities. You will see that expressed in this tagline: **"AcademyU Your Otolaryngology Education Source."** The refreshed resource better represents the entire "portfolio" of educational opportunities available to members including online, print, and live activities.

James L. Netterville, M.D.

James L. Netterville, MD
AAO-HNS/F President

To make the products easily viewable and accessible to you and staff, a new "Education Opportunities" booklet will be mailed with the January *Bulletin*. The five different formats of learning will be clearly distinguished: e-books (four titles), subscriptions (HSC and PMP) live (coding workshops and annual meeting), online education (COOL, online lecture series, and courses), and online knowledge resources (AcademyQ, ENT Exam, Video Series, COCLIA). Each will be described in the catalog. And, of course, a complete listing of all online courses available for all stages of the career will be included.

So, looking toward 2013 with the AAO-HNSF educational resource, AcademyU, in mind, I can see that the pathways are clear and the roadway is smooth. Make sure to read pages 20-29 and the Education section for additional information on this essential member value.

Reference

Cornett MP, *Bulletin,* Vol. 31, 09, p.33.

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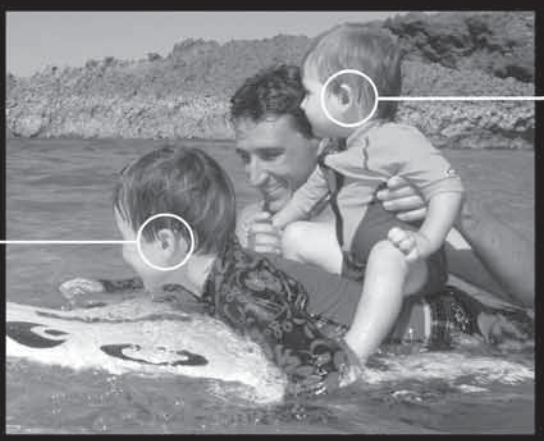

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Meeting Needs, Exceeding Expectations in Education

David R. Nielsen, MD
AAO-HNS/F EVP/CEO

Our Academy as we know it is actually two entities: the Academy, responsible for membership, advocacy, and health policy; and the Foundation, which includes the annual meeting, educational programming, and research activities. So when I refer to the Foundation, I am speaking primarily of our meeting, educational, and quality improvement enterprises.

In spite of the fact that members rate the Foundation's educational offerings as one of their most valued benefits, it is paradoxical that survey data and member responses indicate less awareness of our current and expanding education offerings than expected. Our goal for this issue is to improve everyone's knowledge and use of our expanding education resources and the numerous ways the Foundation works to both meet member education needs and also exceed expectations.

In the past, any ACCME-accredited provider of Continuing Medical Education (CME), such as the Foundation, fulfilled a requirement to do a "needs assessment" of our members and their educational desires and demands. In the current environment of assessing and reporting on quality, this has been replaced by a requirement to identify "gaps in care," using a method to look for ways to demonstrate our educational offerings fill such a gap and the learning that takes place leads to improved care and better patient outcomes. Related research reforms employ Comparative Effectiveness Research (CER) to look for the best care among many acceptable choices, and try to achieve the three aims of the National Quality Strategy: better individual patient care, better population health, and reduced cost of care.

The AAO-HNSF is richly blessed with resources for educational content. Our members, whether academic or community-based, supply the profession with invaluable material from their research and professional practices and experience. However, there is a big difference between "content" or educational material and effective educational programming. It has been repeatedly demonstrated and published that simply presenting and learning new facts, basic science, and clinical material does not change clinical behavior for the better, nor lead to improved patient care or clinical outcomes. In the past two decades, new methods of designing educational programming, increasing interactivity between teachers and learners, focusing on the application of knowledge, and holding learners accountable for describing how they will employ what they learn seem to speed the implementation of new ideas and improve patient outcomes. Future accreditation of CME will not only require documentation of how the learner will apply new knowledge, but also eventually require documentation and reporting that the knowledge was actually applied and that measurable improvement in patient outcomes can be demonstrated.

"The AAO-HNSF is richly blessed with resources for educational content. Our members, whether academic or community-based, supply the profession with invaluable material from their research and professional practices and experience."

Throughout this issue of the *Bulletin*, you will see reference to a broad agenda of advancing educational initiatives: sharing our programming with developing nations, expanding international access, and use of our content and entirely new products, such as our AcademyQ mobile application, the "Resident Manual of Trauma to the Face, Head, and Neck," and the ENT Exam Video Series. Shortly, a few dozen lectures from this year's annual meeting will be added to the growing programming of online courses and lectures, and new comprehensive products to aid our members in their exam preparation will be added to the Home Study Course and Patient Management Perspectives that are already so useful in this regard. As important as all these products are, creating a comprehensive organized structure, shared with all of us, for all our programming is our goal.

The integration of research, education, application, documentation, delivery reform, and payment reform with all of their health policy implications is now more obvious than ever. We are fortunate as a specialty to have such a collaborative culture, supportive members, effective specialty societies and leaders to guide us through this rapid transition. The Academy/Foundation will continue to develop and provide superior products for our residents, young physicians, and experienced senior practitioners, as well as the students and allied professionals we work with. I encourage you to become even more familiar with all the Academy offers in education, and to aggressively employ these to benefit our patients. Nowhere is the Academy's mission to empower physicians to provide the best patient care more visible than through our educational and meeting activities. Thanks to all of you for your contributions to this great enterprise.

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The Board of Governors and You: Sign Up and Speak Up for Your Region

Wendy R. Stern, MD
BOG Secretary

The Board of Governors (BOG) is the grassroots arm of the Academy. It serves as a conduit for all of us and our Academy through state/local representation. The BOG meets twice a year. Every otolaryngology society in the country elects a governor and two representatives who serve on the BOG. The governor of each society is a voting member on the BOG. During the biannual meetings, the governors and representatives are invited to participate in the BOG Legislative Committee and the BOG Socioeconomic and Grassroots Committee meetings as members or guests. Issues include pending bills, current legislation, scope of practice, carrier relations, and access to care, among others.

The BOG Legislative Committee conducts an annual conference call with society representatives, governors, and committee members to help monitor legislative activity around the country. This information aids our Academy's Government Affairs division to maintain its vigilance and advocacy. This committee keeps our membership informed and invites activism through emailed action alerts. The BOG Socioeconomic and Grassroots Committee is forming a network of regional representation so issues affecting the practice of medicine nationwide will have direct and timely access to the committee. These forums are venues for the critical exchange of information. They present an invaluable opportunity for the BOG to learn about pressing issues facing Academy members, and conversely, for the governors and representatives to relay information to their society members of events happening in other locations that might affect their practice.

The spring meeting takes place in the Washington area near the Academy headquarters. This meeting is open to anyone who wants to be more involved with the BOG. There are often workshops, leadership training sessions, and an ENT PAC (political action committee) event. This past spring, attendees participated in workshops on media, entrepreneurship, and the nuts and bolts of meaningful use. This meeting is also an excellent opportunity to network and meet colleagues from around the country. Following the meeting, the BOG promotes advocacy through participation in the OTO Advocacy Summit, which offers political guest speakers, advocacy workshops, and meetings with Members of Congress.

The fall meeting, which dovetails with the AAO-HNSF Annual Meeting & OTO EXPO, is more focused on the committees' agendas. The BOG General Assembly meeting occurs during the annual meeting. Governors are formally given reports by the BOG leadership and committee chairs as well as the opportunity to vote on referendums that will be presented to the Academy's Board of Directors. The BOG also sponsors a miniseminar that takes place during the annual meeting.

This past meeting the BOG Executive Committee was proud to present, "Hot Topics in Otolaryngology: 2012." This was a successful seminar that delved into the changing relationship between the physician and the hospital. Pressures to produce a more integrated relationship are increasing partially due to healthcare reform laws and in response to Medicare, Medicaid, and Congressionally-directed efforts to reduce healthcare costs and the deficit. Darlene Burgess, vice president of corporate government affairs for the Henry Ford Health System spoke to us about her experience with one of the nation's leading and largest integrated healthcare systems. Raymund C. King, MD, JD, an otolaryngologist and now healthcare and corporate attorney, described laws such as Stark, anti-kickback compliance, and the Patient Affordable Care Act in an easily understood fashion. He then described how they lead to the changes we are seeing, specifically citing the formation of Accountable Care Organizations.

Joy Trimmer, JD, senior director of Government Affairs for the Academy, updated us on the Academy's advocacy efforts and described the potential political scenarios that may arise from the presidential election and how they might affect many of the reforms that are currently underway. The BOG is committed to producing a miniseminar salient to our members and their ability to practice medicine. We are paying attention to the changing healthcare environment and are looking forward to producing another meaningful miniseminar next year in Vancouver.

Wendy R. Stern, MD
BOG Secretary

As the practice of medicine changes, the BOG must hear your grassroots voice. I urge each of you to be an active member of your state/local or special interest otolaryngology society and make sure your society participates in the BOG. If your society is not an active BOG member, step forward and volunteer to make sure that your society's voice is represented.

We need to know what is happening in your offices, your hospitals, your community, and in your state legislative bodies. It is the best way to be proactive and effective. The Academy cannot connect with your BOG representatives unless staff has accurate and up-to-date records of your society officers. To view your individual BOG society's information, visit: http://www.entnet.org/Community/BOGSocieties.cfm?View=State. Email bog@entnet.org to update your society information or ask any BOG-related questions.

See you at our next BOG Spring Meeting, May 5-6, and OTO Advocacy Summit, May 6-7, 2013 (www.entnet.org/bog&summit).

A Silent and Imminent Threat

Richard A. Chole, MD, PhD
and Michael J. McKenna, MD
Task Force Co-chairs

On September 12, 2012, during this year's AAO-HNSF Annual Meeting & OTO EXPO in Washington, DC, an Otopathology Task Force was convened to address a serious and imminent threat to our specialty. This Task Force was organized because of an initiative by **Michael M. Paparella, MD.** It was chaired by **Richard A. Chole, MD, PhD,** and sanctioned by the American Academy of Otolaryngology—Head and Neck Surgery. Present were some of the preeminent leaders in our field. There was no debate regarding the gravity or seriousness of the problem at hand. The specialty of otolaryngology is on the verge of losing its ability to examine the pathology of the human ear. If this were to occur, we would no longer be able to characterize the pathology of a host of problems that we see and treat on a daily basis. It will stifle our ability to develop new and effective treatments and to evaluate the results of our clinical interventions. Without this fundamental discipline, our specialty will justifiably lose all credibility with our medical and surgical colleagues and our patients. To better understand the scope of the problem, it is essential to review how we got here in the first place.

The study of human otopathology is unlike all other pathologic endeavors. It requires a specialized laboratory and unique and intricate processing techniques that take years to master. These techniques cannot be learned from a book or instructional video, but rather take years of mentorship and practice. Similarly, the expertise required to examine and evaluate pathologic specimens takes years of dedicated study and is not a component of the formal educational process in either pathology or otolaryngology training programs. Historically, the great majority of otopathologists have been otolaryngologists.

In 1980, there were 32 active temporal bone laboratories throughout the world with 25 located in the United States. The field was thriving with a critical mass of investigators. The work performed within these facilities is largely responsible for the pathologic characterization of many of the diseases we treat on a frequent basis, including otosclerosis, Meniere's disease, chronic otitis media and many others. Today, there are three remaining labs in the world, all located within the United States. Insufficient operating funds threaten two of these labs, which are on the verge of closing. This abrupt decline resulted from a significant reduction in research funding for human otopathology and departmental discretionary funds used to support these labs. Most alarming is the near extinction of the technical and pathological expertise. Despite this, there remains a multitude of otologic disorders for which the pathology has not been well characterized with poor treatment options for our patients.

Several years ago, a group of concerned leaders in the field approached the National Institute on Deafness and Other Communication Disorders (NIDCD) with their concerns. These discussions led to the formation of a human temporal bone registry and a research network, resulting in the acquisition of pathologic specimens and for funding of a limited number of labs. This funding is specifically for hypothesis driven research and does not support the ongoing processing and evaluations of new pathologic specimens that only become available when a patient with a well documented otologic problem dies. It has been this slow and steady process of investigation that has led to the greatest advancements in our understanding of human otopathology and without which our field will almost certainly begin to stagnate.

The solution to this impending problem is not entirely clear. It will likely require both financial and institutional support. To this end, Michael Paparella, MD, has personally pledged more than $500,000 during the next 14 years and established an annual lectureship in human otopathology to be given at the AAO-HNSF meeting. **Joseph Nadol, Jr., MD,** gave the inaugural lecture at this year's annual meeting where he eloquently highlighted the importance of human otopathology to the clinical practice of otology and reviewed the dilemma outlined above. The purpose of this communication is to educate the AAO-HNS membership. The task force will continue to actively explore all options to circumvent this potential disaster. There will come a time in the near future when we will call upon the AAO-HNS membership for support. This is a problem that will certainly affect the future of our specialty and will require a unified response.

Call for 2013 Jerome C. Goldstein Public Service Award Nominees

The Jerome C. Goldstein Public Service Award is given annually to recognize an outstanding member for his/her commitment and achievement in service, either to the public or to other organizations, when such service promises to improve patient welfare. Any Academy member in good standing is eligible to be nominated—or to nominate another member—for this prestigious award. The finalist will be selected on February 12, 2013, by the Executive Committee of the Board of Directors. The recipient will receive a certificate and honorarium in recognition of his/her achievements during the 2013 Annual Meeting & OTO EXPO Opening Ceremony in Vancouver, BC, Canada.

Deadline for submission of nominee forms is January 30, 2013. Please visit http://www.entnet.org/Community/Goldstein-Award.cfm for more information on the award criteria and nomination form.

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Please see Brief Summary of Full Prescribing Information on the following pages.

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*As listed in the Full Prescribing Information, in 3 pivotal trials, symptom relief was measured by change from baseline in Total Nasal Symptom Score (TNSS) averaged over the 14-day study period. Dymista provided a statistically significant improvement in TNSS compared with both azelastine hydrochloride (HCl) and fluticasone propionate. The azelastine HCl and fluticasone propionate comparators used the same device and vehicle as Dymista and are not commercially marketed. Additionally, Dymista provided a statistically significant, rapid improvement in TNSS as early as 30 minutes after administration when compared with placebo.[1]

MEDA PHARMACEUTICALS®
Somerset, New Jersey 08873-4120

References: 1. Dymista [package insert]. Somerset, NJ: Meda Pharmaceuticals Inc; 2012.

 9/12 DYM-12-0167

DYMISTA (AZELASTINE HYDROCHLORIDE 137 MCG / FLUTICASONE PROPIONATE 50 MCG) NASAL SPRAY

Brief Summary (for Full Prescribing Information, see package insert)

1 INDICATIONS AND USAGE

Dymista Nasal Spray is indicated for the relief of symptoms of seasonal allergic rhinitis in patients 12 years of age and older who require treatment with both azelastine hydrochloride and fluticasone propionate for symptomatic relief.

5 WARNINGS AND PRECAUTIONS

5.1 Somnolence

In clinical trials, the occurrence of somnolence has been reported in some patients (6 of 853 patients) taking Dymista Nasal Spray [*see Adverse Reactions (6.1)*]. Patients should be cautioned against engaging in hazardous occupations requiring complete mental alertness and motor coordination such as operating machinery or driving a motor vehicle after administration of Dymista Nasal Spray. Concurrent use of Dymista Nasal Spray with alcohol or other central nervous system depressants should be avoided because additional reductions in alertness and additional impairment of central nervous system performance may occur [*see Drug Interactions (7.1)*].

5.2 Local Nasal Effects

In clinical trials of 2 to 52 weeks' duration, epistaxis was observed more frequently in patients 38 treated with Dymista Nasal Spray than those who received placebo [*see Adverse Reactions (6)*].

Instances of nasal ulceration and nasal septal perforation have been reported in patients following the intranasal application of corticosteroids. There were no instances of nasal ulceration or nasal septal perforation observed in clinical trials with Dymista Nasal Spray. Because of the inhibitory effect of corticosteroids on wound healing, patients who have experienced recent nasal ulcers, nasal surgery, or nasal trauma should not use Dymista Nasal Spray until healing has occurred. In clinical trials with fluticasone propionate administered intranasally, the development of localized infections of the nose and pharynx with *Candida albicans* has occurred. When such an infection develops, it may require treatment with appropriate local therapy and discontinuation of treatment with Dymista Nasal Spray. Patients using Dymista Nasal Spray over several months or longer should be examined periodically for evidence of *Candida* infection or other signs of adverse effects on the nasal mucosa.

5.3 Glaucoma and Cataracts

Nasal and inhaled corticosteroids may result in the development of glaucoma and/or cataracts. Therefore, close monitoring is warranted in patients with a change in vision or with a history of increased intraocular pressure, glaucoma, and/or cataracts.

Glaucoma and cataract formation were evaluated with intraocular pressure measurements and slit 56 lamp examinations in a controlled 12-month study in 612 adolescent and adult patients aged 12 years and older with perennial allergic or vasomotor rhinitis (VMR). Of the 612 patients enrolled in the study, 405 were randomized to receive Dymista Nasal Spray (1 spray per nostril twice daily) and 207 were randomized to receive fluticasone propionate nasal spray (2 sprays per nostril once daily). In the Dymista Nasal Spray group, one patient had increased intraocular pressure at month 6. In addition, three patients had evidence of posterior subcapsular cataract at month 6 and one at month 12 (end of treatment). In the fluticasone propionate group, three patients had evidence of posterior subcapsular cataract at month 12 (end of treatment).

5.4 Immunosuppression

Persons who are using drugs, such as corticosteroids, that suppress the immune system are more susceptible to infections than healthy individuals. Chickenpox and measles, for example, can have a more serious or even fatal course in susceptible children or adults using corticosteroids. In children or adults who have not had these diseases or been properly immunized, particular care should be taken to avoid exposure. How the dose, route, and duration of corticosteroid administration affect the risk of developing a disseminated infection is not known. The contribution of the underlying disease and/or prior corticosteroid treatment to the risk is also not known. If exposed to chickenpox, prophylaxis with varicella zoster immune globulin (VZIG) may be indicated. If exposed to measles, prophylaxis with pooled intramuscular immunoglobulin 74 (IG) may be indicated. (See the respective package inserts for complete VZIG and IG prescribing information.) If chickenpox develops, treatment with antiviral agents may be considered.

Corticosteroids should be used with caution, if at all, in patients with active or quiescent tuberculous infections of the respiratory tract; untreated local or systemic fungal or bacterial infections; systemic viral or parasitic infections; or ocular herpes simplex because of the potential for worsening of these infections.

5.5 Hypothalamic-Pituitary-Adrenal (HPA) Axis Effects

When intranasal steroids are used at higher than recommended dosages or in susceptible individuals at recommended dosages, systemic corticosteroid effects such as hypercorticism and adrenal suppression may appear. If such changes occur, the dosage of Dymista Nasal Spray should be discontinued slowly, consistent with accepted procedures for discontinuing oral corticosteroid therapy. The concomitant use of intranasal corticosteroids with other inhaled corticosteroids could increase the risk of signs or symptoms of hypercorticism and/or suppression of the HPA axis. The replacement of a systemic corticosteroid with a topical corticosteroid can be accompanied by signs of adrenal insufficiency, and in addition some patients may experience symptoms of withdrawal, e.g., joint and/or muscular pain, lassitude, and depression. Patients previously treated for prolonged periods with systemic corticosteroids and transferred to topical corticosteroids should be carefully monitored for acute adrenal insufficiency in response to stress. In those patients who have asthma or other clinical conditions requiring long-term systemic corticosteroid treatment, too rapid a decrease in systemic corticosteroids may cause a severe exacerbation of their symptoms.

5.6 Use of Cytochrome P450 3A4 Inhibitors

Ritonavir and other strong cytochrome P450 3A4 (CYP3A4) inhibitors can significantly increase plasma fluticasone propionate exposure, resulting in significantly reduced serum cortisol concentrations [*see Drug Interactions (7.2) and Clinical Pharmacology (12.3)*]. During postmarketing use, there have been reports of clinically significant drug interactions in patients receiving fluticasone propionate and ritonavir, resulting in systemic corticosteroid effects including Cushing syndrome and adrenal suppression. Therefore, coadministration of Dymista Nasal Spray and ritonavir is not recommended unless the potential benefit to the patient outweighs the risk of systemic corticosteroid side effects.

Use caution with the coadministration of Dymista Nasal Spray and other potent CYP3A4 inhibitors, such as ketoconazole [*see Drug Interactions (7.2) and Clinical Pharmacology (12.3)*].

5.7 Effect on Growth

Corticosteroids may cause a reduction in growth velocity when administered to pediatric patients. Monitor the growth routinely of pediatric patients receiving Dymista Nasal Spray [*see Use in Specific Populations (8.4)*].

6 ADVERSE REACTIONS

Systemic and local corticosteroid use may result in the following:

- Somnolence [*see Warnings and Precautions (5.1)*]
- Local nasal effects, including epistaxis, nasal ulceration, nasal septal perforation, impaired wound healing, and *Candida albicans* infection [*see Warnings and Precautions (5.2)*]
- Cataracts and glaucoma [*see Warnings and Precautions (5.3)*]
- Immunosuppression [*see Warnings and Precautions (5.4)*]
- Hypothalamic-pituitary-adrenal (HPA) axis effects, including growth reduction [*see Warnings and Precautions (5.5 and 5.7), Use in Specific Populations (8.4)*]

6.1 Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect rates observed in practice. The safety data described below reflect exposure to Dymista Nasal Spray in 853 patients (12 years of age and older; 36% male and 64% female) with seasonal allergic rhinitis in 3 doubleblind, placebo-controlled clinical trials of 2-week duration. The racial distribution for the 3 clinical trials was 80% white, 16% black, 2% Asian, and 1% other. In the 12-month open-label, active-controlled clinical trial, 404 Asian patients (240 males and 164 females) with perennial allergic rhinitis or vasomotor rhinitis were treated with Dymista Nasal Spray, 1 spray per nostril twice daily.

Adults and Adolescents 12 Years of Age and Older

In the 3 placebo-controlled clinical trials of 2-week duration, 3411 patients with seasonal allergic rhinitis were treated with 1 spray per nostril of Dymista Nasal Spray, azelastine hydrochloride nasal spray, fluticasone propionate nasal spray, or placebo, twice daily. The azelastine hydrochloride and fluticasone propionate comparators use the same vehicle and device as Dymista Nasal Spray and are not commercially marketed. Overall, adverse reactions were 16% in the Dymista Nasal Spray treatment groups, 15% in the azelastine hydrochloride nasal spray groups, 13% in the fluticasone propionate nasal spray groups, and 12% in the placebo groups. Overall, 1% of patients in both the Dymista Nasal Spray and placebo groups discontinued due to adverse reactions.

Table 1 contains adverse reactions reported with frequencies greater than or equal to 2% and more frequently than placebo in patients treated with Dymista Nasal Spray in the seasonal allergic rhinitis controlled clinical trials.

Table 1. Adverse Reactions with ≥2% Incidence and More Frequently than Placebo in Placebo-Controlled Trials of 2 Weeks Duration with Dymista Nasal Spray in Adult and Adolescent Patients With Seasonal Allergic Rhinitis

	1 spray per nostril twice daily			
	Dymista Nasal Spray (N=853)*	**Azelastine Hydrochloride Nasal Spray† (N=851)**	**Fluticasone Propionate Nasal Spray† (N=846)**	**Vehicle Placebo (N=861)**
Dysgeusia	30 (4%)	44 (5%)	4 (1%)	2 (<1%)
Headache	18 (2%)	20 (2%)	20 (2%)	10 (1%)
Epistaxis	16 (2%)	14 (2%)	14 (2%)	15 (2%)

*Safety population N=853, intent-to-treat population N=848

† Not commercially marketed

In the above trials, somnolence was reported in <1% of patients treated with Dymista Nasal Spray (6 of 853) or vehicle placebo (1 of 861) [*see Warnings and Precautions (5.1)*].

Long-Term (12-Month) Safety Trial:

In the 12-month, open-label, active-controlled, long-term safety trial, 404 patients (12 years of age and older) with perennial allergic rhinitis or vasomotor rhinitis were treated with Dymista Nasal Spray 1 spray per nostril twice daily and 207 patients were treated with fluticasone propionate nasal spray, 2 sprays per nostril once daily. Overall, adverse reactions were 47% in the Dymista Nasal Spray treatment group and 44% in the fluticasone propionate nasal spray group. The most frequently reported adverse reactions (≥ 2%) with Dymista Nasal Spray were headache, pyrexia, cough, nasal congestion, rhinitis, dysgeusia, viral infection, upper respiratory tract infection, pharyngitis, pain, diarrhea, and epistaxis. In the Dymista Nasal Spray treatment

group, 7 patients (2%) had mild epistaxis and 1 patient (<1%) had moderate epistaxis. In the fluticasone propionate nasal spray treatment group 1 patient (<1%) had mild epistaxis. No patients had reports of severe epistaxis. Focused nasal examinations were performed and no nasal ulcerations or septal perforations were observed. Eleven of 404 patients (3%) treated with Dymista Nasal Spray and 6 of 207 patients (3%) treated with fluticasone propionate nasal spray discontinued from the trial due to adverse events.

7 DRUG INTERACTIONS

No formal drug interaction studies have been performed with Dymista Nasal Spray. The drug interactions of the combination are expected to reflect those of the individual components.

7.1 Central Nervous System Depressants

Concurrent use of Dymista Nasal Spray with alcohol or other central nervous system depressants should be avoided because somnolence and impairment of central nervous system performance may occur [*see Warnings and Precautions (5.1)*].

7.2 Cytochrome P450 3A4

Ritonavir (a strong CYP3A4 inhibitor) significantly increased plasma fluticasone propionate exposure following administration of fluticasone propionate aqueous nasal spray, resulting in significantly reduced serum cortisol concentrations [*see Clinical Pharmacology (12.3)*]. During postmarketing use, there have been reports of clinically significant drug interactions in patients receiving fluticasone propionate and ritonavir, resulting in systemic corticosteroid effects including Cushing syndrome and adrenal suppression. Therefore, coadministration of fluticasone propionate and ritonavir is not recommended unless the potential benefit to the patient outweighs the risk of systemic corticosteroid side effects.

Ketoconazole (also a strong CYP3A4 inhibitor), administered in multiple 200 mg doses to steady-state, increased plasma exposure of fluticasone propionate, reduced plasma cortisol AUC, but had no effect on urinary excretion of cortisol, following administration of a single 1000 mcg dose of fluticasone propionate by oral inhalation route.

Caution should be exercised when Dymista Nasal Spray is coadministered with ketoconazole and other known strong CYP3A4 inhibitors.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Dymista Nasal Spray: Teratogenic Effects: Pregnancy Category C:

There are no adequate and well-controlled clinical trials of Dymista Nasal Spray, azelastine hydrochloride only, or fluticasone propionate only in pregnant women. Animal reproductive studies of azelastine hydrochloride and fluticasone propionate in mice, rats, and/or rabbits revealed evidence of teratogenicity as well as other developmental toxic effects. Because animal reproduction studies are not always predictive of human response, Dymista Nasal Spray should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Azelastine hydrochloride: Teratogenic Effects: In mice, azelastine hydrochloride caused embryo-fetal death, malformations (cleft palate; short or absent tail; fused, absent or branched ribs), delayed ossification, and decreased fetal weight at an oral dose approximately 610 times the maximum recommended human daily intranasal dose (MRHDID) in adults (on a mg/m2 basis at a maternal dose of 68.6 mg/kg). This dose also caused maternal toxicity as evidenced by decreased body weight. Neither fetal nor maternal effects occurred at a dose that was approximately 26 times the MRHDID (on a mg/m2 basis at a maternal dose of 3 mg/kg).

In rats, azelastine hydrochloride caused malformations (oligo- and brachydactylia), delayed ossification and skeletal variations, in the absence of maternal toxicity, at an oral dose approximately 530 times the MRHDID in adults (on a mg/m2 basis at a maternal dose of 30 mg/kg). At a dose approximately 1200 times the MRHDID (on a mg/m2 basis at a maternal dose of 68.6 mg/kg), azelastine hydrochloride also caused embryo-fetal death and decreased fetal weight; however, this dose caused severe maternal toxicity. Neither fetal nor maternal effects occurred at a dose approximately 53 times the MRHDID (on a mg/m2 basis at a maternal dose of 3 mg/kg).

In rabbits, azelastine hydrochloride caused abortion, delayed ossification, and decreased fetal weight at oral doses approximately 1100 times the MRHDID in adults (on a mg/m2 basis at a maternal dose of 30 mg/kg); however, these doses also resulted in severe maternal toxicity. Neither fetal nor maternal effects occurred at a dose approximately 11 times the MRHDID (on a mg/m2 basis at a maternal dose of 0.3 mg/kg).

Fluticasone propionate: Teratogenic Effects: Corticosteroids have been shown to be teratogenic in laboratory animals when administered systemically at relatively low dosage levels. Subcutaneous studies in the mouse and rat at doses approximately equivalent to and 4 times, respectively, the MRHDID in adults (on a mcg/m2 basis at maternal doses of 45 and 100 mcg/kg respectively), revealed fetal toxicity characteristic of potent corticosteroid compounds, including embryonic growth retardation, omphalocele, cleft palate, and retarded cranial ossification.

In the rabbit, fetal weight reduction and cleft palate were observed at a subcutaneous dose less than the MRHDID in adults (on a mcg/m2 basis at a maternal dose of 4 mcg/kg). However, no teratogenic effects were reported at oral doses up to approximately 25 times the MRHDID in adults (on a mcg/m2 basis at a maternal dose of 300 mcg/kg) of fluticasone propionate to the rabbit. No fluticasone propionate was detected in the plasma in this study, consistent with the established low bioavailability following oral administration [*see Clinical Pharmacology (12.3)*].

Experience with oral corticosteroids since their introduction in pharmacologic, as opposed to physiologic, doses suggests that rodents are more prone to teratogenic effects from corticosteroids than humans. In addition, because there is a natural increase in corticosteroid production during pregnancy, most women will require a lower exogenous corticosteroid dose and many will not need corticosteroid treatment during pregnancy.

Nonteratogenic Effects: Fluticasone propionate crossed the placenta following oral administration of approximately 4 and 25 times the MRHDID in adults (on a mcg/m2 basis at maternal doses of 100 mcg/kg and 300 mcg/kg to rats and rabbits, respectively).

8.3 Nursing Mothers

Dymista Nasal Spray: It is not known whether Dymista Nasal Spray is excreted in human breast milk. Because many drugs are excreted in human milk, caution should be exercised when Dymista Nasal Spray is administered to a nursing woman. Since there are no data from well-controlled human studies on the use of Dymista Nasal Spray by nursing mothers, based on data from the individual components, a decision should be made whether to discontinue nursing or to discontinue Dymista Nasal Spray, taking into account the importance of Dymista Nasal Spray to the mother.

Azelastine hydrochloride: It is not known if azelastine hydrochloride is excreted in human milk.

Fluticasone propionate: It is not known if fluticasone propionate is excreted in human milk. However, other corticosteroids are excreted in human milk. Subcutaneous administration to lactating rats of 10 mcg/kg of tritiated fluticasone propionate (less than the maximum recommended daily intranasal dose in adults on a mcg/m2 basis) resulted in measurable radioactivity in the milk.

8.4 Pediatric Use

Safety and effectiveness of Dymista Nasal Spray in pediatric patients below the age of 12 years have not been established.

Controlled clinical studies have shown that intranasal corticosteroids may cause a reduction in growth velocity in pediatric patients. This effect has been observed in the absence of laboratory evidence of HPA axis suppression, suggesting that growth velocity is a more sensitive indicator of systemic corticosteroid exposure in pediatric patients than some commonly used tests of HPA axis function. The long-term effects of this reduction in growth velocity associated with intranasal corticosteroids, including the impact on final adult height, are unknown. The potential for "catch-up" growth following discontinuation of treatment with intranasal corticosteroids has not been adequately studied. The growth of pediatric patients receiving intranasal corticosteroids, including Dymista Nasal Spray, should be monitored routinely (e.g., via stadiometry). The potential growth effects of prolonged treatment should be weighed against the clinical benefits obtained and the risks/benefits of treatment alternatives.

8.5 Geriatric Use

Clinical trials of Dymista Nasal Spray did not include sufficient numbers of patients 65 years of age and older to determine whether they respond differently from younger patients. Other reported clinical experience has not identified differences in responses between the elderly and younger patients. In general, dose selection for an elderly patient should be cautious, usually starting at the low end of the dosing range, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy.

10 OVERDOSAGE

Dymista Nasal Spray: Dymista Nasal Spray contains both azelastine hydrochloride and fluticasone propionate; therefore, the risks associated with overdosage for the individual components described below apply to Dymista Nasal Spray.

Azelastine hydrochloride: There have been no reported overdosages with azelastine hydrochloride. Acute azelastine hydrochloride overdosage by adults with this dosage form is unlikely to result in clinically significant adverse events, other than increased somnolence, since one (1) 23 g bottle of Dymista Nasal Spray contains approximately 23 mg of azelastine hydrochloride. Clinical trials in adults with single doses of the oral formulation of azelastine hydrochloride (up to 16 mg) have not resulted in increased incidence of serious adverse events. General supportive measures should be employed if overdosage occurs. There is no known antidote to Dymista Nasal Spray. Oral ingestion of antihistamines has the potential to cause serious adverse effects in children. Accordingly, Dymista Nasal Spray should be kept out of the reach of children.

Fluticasone propionate: Chronic fluticasone propionate overdosage may result in signs/symptoms of hypercorticism [*see Warnings and Precautions (5.2)*]. Intranasal administration of 2 mg (10 times the recommended dose) of fluticasone propionate twice daily for 7 days to healthy human volunteers was well tolerated. Single oral fluticasone propionate doses up to 16 mg have been studied in human volunteers with no acute toxic effects reported. Repeat oral doses up to 80 mg daily for 10 days in volunteers and repeat oral doses up to 10 mg daily for 14 days in patients were well tolerated. Adverse reactions were of mild or moderate severity, and incidences were similar in active and placebo treatment groups. Acute overdosage with this dosage form is unlikely since one (1) 23 g bottle of Dymista Nasal Spray contains approximately 8.5 mg of fluticasone propionate.

DYMISTA™

(azelastine hydrochloride and fluticasone propionate) Nasal Spray
137 mcg / 50 mcg per Spray

Distributed by:

MEDA Pharmaceuticals®
Meda Pharmaceuticals Inc.
Somerset, NJ 08873-4120

Star Reviewers and the Journal

The Academy journal, *Otolaryngology–Head and Neck Surgery,* has recognized its star performers since 2006. This award is a pathway to the journal's editorial board and associate editor positions, bringing recipients greater responsibility and recognizing achievement. The journal welcomes reviewers from all areas of expertise and stages of career, including residents.

By reviewing for the journal, you can earn up to 15 Continuing Medical Education (CME) credits per year and improve patient care and public health by providing thoughtful, timely reviews of journal articles. Reviewers who complete four or more reviews a year are listed in the journal's January issue every year.

The criteria for becoming a star reviewer are posted on the journal's website, http://www.otojournal.org. Many of our star performers, depending on their areas of expertise and interest, go on to be appointed to the journal's editorial board and may then serve as associate editors.

Star Reviewer recipients receive:

- One honor point
- A ribbon to wear at the annual meeting identifying them as a top reviewer
- Numerous mentions in Academy print and digital media, including the *Bulletin*, the *Meeting Daily*, and the official program issue of the journal.

Otolaryngology–Head and Neck Surgery encourages anyone who has an interest in becoming a reviewer to sign up today. Our website features a page specifically designed for reviewers, with free content including:

- The journal's first ever videocast, a discussion among two associate editors and the editor-in-chief, providing tips on what makes a great reviewer
- Access to the full text of the article "How to Review Journal Manuscripts," written by the journal's editor-in-chief and published in the April 2010 issue of the journal
- Suggestions from 2011 and 2012 top reviewers
- An example of a highly rated review
- A reviewer application form, which can be downloaded and emailed or faxed to the journal's editorial office

The 2012 Star Reviewers were recognized at the journal's editorial board meeting in Washington. DC, and **Michael Friedman, MD,** received a plaque for being named as a star performer for the fourth year.

1. Matthew T. Brigger, MD, MPH (second year)
2. David H. Darrow, MD, DDS (third year)
3. Michael Friedman, MD (fourth year)
4. M. Boyd Gillespie, MD (second year)
5. Babak Givi, MD (resident)
6. Maureen T. Hannley, PhD
7. Jack J. Jiang, MD, PhD (second year)
8. Helene J. Krouse, PhD (second year)
9. Stephen C. Maturo, MD (second year)
10. Edward D. McCoul, MD, MPH

Top row, L-R: David Darrow, MD, DDS; Babak Givi, MD; Matthew Brigger, MD, MPH; Stephen C. Maturo, MD; Jack Jiang, MD, PhD. Bottom row, L-R: M. Boyd Gillespie, MD; Richard M. Rosenfeld, MD, MPH; Michael Friedman, MD; Helene J. Krouse; PhD. Missing: Edward D. McCoul, MD, MPH; Maureen T. Hannley, PhD

Dates to Remember

At AAO-HNS/F

December 5
AAO-HNS Road Show at the Nassau Surgical Society, Inc. (Clinic Day) NSSSec1@ad.com

December 9
Deadline for AAO-HNS/F nominee.recommendations: http://www.entnet.org/aboutus/2012elections.cfm.

December 31
Membership renewals deadline: www.entnet.org/renew.

January 1, 2013
Bulletin feature: Oral Head and Neck Cancer Awareness; Summary of Guideline on Guidelines; read it online too at www.entnet.org.

January 21, 2013
Annual Meeting & OTO EXPO Call for Papers Deadlines for Scientific Oral & Poster: Jan 21-Feb 18, 2013 at www.entannualmeeting.org.

January 30, 2013
Nomination forms for the 2013 Jerome C. Goldstein Public Service Award due. www.entnet.org/community/Goldstein-Award.cfm.

February 1, 2013
2013 Committee Application Opens on November 15 and closes on February 1. www.entnet.org/committees.

In Otolaryngology

Details at http://www.entnet.org/conferencesandevents.

January 13-14, 2013
AACE Advances in Thyroid Cancer Diagnosis and Therapy http://www.entnet.org/calendar/calendardetail.cfm.

January 15-18, 2013
10th GCC Otorhinolaryngology HNS Conference

January 18-19, 2013
AACE Advances in Thyroid Cancer Diagnosis and Therapy

For more details visit http://www.entnet.org/conferences andevents

Call for 2013 AAO-HNS Election Candidates

The Nominating Committee of the Academy is calling for recommendations of individuals to be considered for an AAO-HNS elective office. The Academy member(s) you recommend must be in good standing, someone with proven leadership ability, is active in the Academy, is familiar with the strategic direction of the Academy, and can dedicate the necessary time to serve. Please direct your email to any member of the Nominating Committee and include the nominee's full name, contact information (business and cell phone numbers, email address, etc.) along with a short letter as to why you believe this person to be qualified to serve in an AAO-HNS elected leadership role.

Deadline for nominee recommendations is December 9, 2012.

For more information and for a list of the members of the Nominating Committee visit http://www.entnet.org/AboutUs/2012Elections.cfm.

Millennium Society Support–Advancing the Specialty

Thank you to each of you that support the Millennium Society. Your contribution provides an essential and vital source of ongoing operational funding for programs and activities essential to supporting the success to today's otolaryngologists—head and neck surgeons. Currently, costs related to producing the Foundation's relevant, high-quality, and innovative programs to empower otolaryngologists to deliver the best patient care exceeds $19,000,000 annually. As you may be aware, membership dues account for about 33 percent of our organization's annual operations budget. Dues alone would not even provide funding for our annual education programming, much less all the other highly-respected, invaluable resources and programs that we produce for the otolaryngology community. Your gift provides the much needed source of funding to ensure that our popular and trusted programs continue to thrive and transform as required to keep pace with the needs of today's otolaryngologists.

> "Your gift provides the much needed source of funding to ensure that our popular and trusted programs continue to thrive and transform as required to keep pace with the needs of today's otolaryngologists."

Specifically, your gift will be instrumental in facilitating:

- advancing the understanding and treatment of diseases through research;
- creating high-quality educational opportunities for the otolaryngology workforce;
- educating the public and patients about the specialty; and
- improving the quality of and access to healthcare; and providing critical financial resources for otolaryngology.

It's easy to donate today by visiting www.entnet.org/donate. Or, we invite you to consider a monthly or quarterly pledge; please contact Mary McMahon, Director, Development, at mmcmahon@entnet.org or phone 1-703-535-3717 for details.

During the 2012 AAO-HNSF Annual Meeting & OTO EXPO, the Millenium Society Donor Wall gave evidence of your support.

Education: Meeting the Needs of All Our Learners

Sonya Malekzadeh, MD
Coordinator for Education

Each December, the Board of Directors gathers at AAO-HNS headquarters for its annual strategic planning session. During the course of the two-and-a-half day meeting last year, the members reviewed and discussed the Academy's priorities in order to ensure that our programs benefit our patients and meet our members' needs in today's environment.

The education and knowledge outcomes from strategic planning were to:

- Consolidate and enhance the otolaryngology practice gap analysis and needs assessment process.
- Develop the next generation of otolaryngology education and knowledge resources through continuous assessment and redesign.
- Provide resources for board certification preparation, business of medicine, trauma, robotic surgery, surgical simulation, and resident education.
- Increase member awareness and engagement in the generation and usage of education and knowledge resources to improve patient care and outcomes.

Practice Gap Analysis and Needs Assessment

Extensive research demonstrates that traditional continuing medical education (CME)—based on a didactic model of lectures and reading, followed by testing—has little, if any, lasting influence on the practice patterns of physicians. As a result, the "new CME" emphasizes performance improvement rather than knowledge improvement. Therefore, our educational activities should be designed to change physicians' competence, (having the ability to apply knowledge, skills, or judgment in practice) physicians' performance (what a physician actually does in practice), and patient outcomes.

Effective design of any education activity requires understanding of the physicians' real-world practice needs or professional practice gaps. The Accreditation Council for Continuing Medical Education (ACCME) defines a professional practice gap as "the

Educational sessions deliver updates to core knowledge, while new learning formats help physicians to implement practice changes.

difference between actual and ideal performance and/or patient outcomes." In other words, a professional practice gap is the difference between what is and what should be.

During the next year, we will consolidate and enhance the otolaryngology practice gap analysis and needs assessment process by surveying key stakeholders and the general membership. Education Committee leaders will be asked to participate in a SWOT Analysis regarding current education strategies, education activity participants will be asked to assess the quality of these products, and the general membership will be involved in a comprehensive education survey and focus groups.

Furthermore, the depth and scope of the professional practice gaps will be explored through review of current literature and identification of new diagnostic methods, current treatments, and innovative technology. Once professional practice gap data sources are identified, we will also incorporate quality, research, and health policy gap data into education needs assessment and planning. Subsequently, corresponding education activities will be designed and prioritized to bridge the gaps between physician practice needs and desired quality outcomes.

Innovative Education and Knowledge Resources

The Education Committees have provided leadership and expertise to the development of the next generation of otolaryngology education and knowledge resources through continuous assessment and redesign. This year's focus has been on new products to support board exam preparation, resident education, and emerging topics including trauma, robotics, and simulation.

> "Extensive research demonstrates that traditional continuing medical education (CME)—based on a didactic model of lectures and reading, followed by testing—has little, if any, lasting influence on the practice patterns of physicians."

New this year:

- The online learning platform has been redesigned to improve access to all online courses and lectures.
- The ENT Exam Video Series is now available on YouTube.
- The Comprehensive Otolaryngologic Curriculum, Learning through Interactive Approach (COCLIA), has new web navigation with enhanced discussion questions.
- The Trauma Committee published a *Resident Trauma Manual* e-book.
- A Simulation Fair took place at this year's annual meeting sponsored by the Simulation Task Force.
- The Robotic Surgery Curriculum Group is developing a Robotic Surgery Policy Statement.

- Upgrades are being made to the Foundation's education tracking system to enhance evaluation and participation data and to ensure continued accreditation compliance.

Now that the ABO is in its third year of recertification, our membership has voiced concerns on the lack of exam preparation materials. With the Board's approval, we began the process of rapidly expanding our resources to support Maintenance of Certification (MOC).

- **AcademyQ: Otolaryngology Knowledge Assessment Tool™** debuted as a mobile application during the annual meeting. It presents hundreds of questions with answer explanations and reference material.
- **Maintenance Manual for Lifelong Learning (MMLL),** a comprehensive overview of core otolaryngology education content, is undergoing revision with an expected publication date of late 2013.
- **Clinical Fundamental Instruction Courses** were introduced to fulfill the ABO MOC requirements. Sessions on Anaphylaxis and Evidence-based medicine took place and were recorded for viewing and the remaining eight topics will take place and be recorded in 2013. MOC candidates will need to attend or view these sessions and pass a post-test.

Increased Member Awareness and Engagement

In an effort to ensure members are aware of the education opportunities available through the Foundation, emphasis has been placed on improving the quantity and quality of education and annual meeting communications.

These initiatives include:

- Improvements to the annual meeting website with targeted annual meeting news launched for registrants.
- Monthly *Bulletin* presence for education products and resources with a full-issue education focus in December and Education Opportunities insert annually.
- Resources and new e-books continually added to online bookshelf.
- Enhanced AcademyU® Learning Station at the annual meeting.

With these strategic goals in mind, we strive to remain the premier source of otolaryngology education and knowledge. In applying a systematic process that includes practice gap analysis, followed by development of innovative activities and ultimately meaningful evaluation of performance and patient outcomes, we will effectively link education with quality initiatives. Our team of dedicated leaders, volunteers, and staff are committed to achieving these goals for the ongoing strength and relevance of the organization. Stay tuned for new strategies and efforts in 2013 that support our continued commitment to excellence.

Academic Bowl Winner

Congratulations to Loma Linda University for winning the sixth Annual AAO-HNSF Academic Bowl at the AAO-HNSF 2012 Annual Meeting & OTO EXPO.

The Academy is grateful to the additional teams that competed:

- Eastern Virginia Medical School
- Henry Ford Hospital
- Southern Illinois University

Special thanks to **Mark K. Wax, MD,** who moderated the event.

New ENT Exam Video Series Released

In August, the AAO-HNSF released its first all digital video demonstrating how to perform a thorough examination of the ear, oral cavity, face, nose, neck, nasopharynx, and larynx. Images and video of normal anatomy, normal variances, and common abnormalities have been added to enhance the learning experience. The video is available at no cost on YouTube and on the Academy website, www.entnet.org/entexam.

There was noticeable buzz about the web series at the AcademyU® Learning Station during the AAO-HNSF 2012 Annual Meeting & OTO EXPO.

"I often train medical students and general surgery residents and this product is just what I need," an annual meeting attendee said. "I tried to develop a similar video at my institution, but the costs were just too high."

Mark K. Wax, MD, immediate past coordinator for education, conceived the project.

"I had been using an old VHS recording that was clearly out of date," he said. "When the hospital's VCR disappeared, I knew I could no longer wait to join the future. I thank Foundation staff for making it happen."

Lee D. Eisenberg, MD, MPH, with help from **Jane T. Dillon, MD,** enthusiastically took on the project and put in countless hours writing the script and gathering images. **Sonya Malekzadeh, MD,** coordinator for Education, and **Karen T. Pitman, MD,** General Otolaryngology Education Committee chair, oversaw the peer review process ensuring the script was thorough and unbiased. Numerous other volunteer experts willingly joined the project by reviewing the script and contributing images and video clips.

"The project was a real team effort," Dr. Malekzadeh said.

Dr. Dillon volunteered her office space for the recording, but no one had guessed that a big snowstorm was going to hit on the video day. As the snow piled up outside, Dr. Eisenberg patiently recorded take after take. Special thanks to our "patient," Rick Ramirez, assistant videographer, who never complained as he was repeatedly examined. The videographer, Stuart Meyer of Social Media Frequency, kept everyone on track and looking great.

"Now I know why it takes movies years to be made," Dr. Eisenberg said. "The process is tedious, but well worth the effort."

The web series is divided into four separate 10-minute episodes: The Ear Exam, The Oral Cavity and Neck Exam, The Face and Nose Exam, and The Nasopharynx and Larynx Exam. Each video begins with a review of anatomy and continues with discussions and illustrations of normal variances and common abnormalities found within this anatomy.

Since its release in August and as of November 1, the web series has been viewed more than 6,900 times in 89 different countries.

"When I taught medical students the ENT exam, I was always frustrated that they did not have a method to review the content," Dr. Eisenberg said. "These videos provide that opportunity. More importantly, the videos enhance their Academy experience by bringing them to the AAO-HNS website. The same can be said for all those whom we teach, including residents, PAs, and NPs. The videos are also a great way to introduce otolaryngology-head and neck surgery to the patient. One of our colleagues put the link on his practice website, which is a wonderful idea."

2013 Pediatric Otolaryngology Continuing Education Webinar Series

The American Academy of Otolaryngology—Head and Neck Surgery Foundation and American Society of Pediatric Otolaryngology are pleased to offer the 2013 Pediatric Otolaryngology Continuing Education Webinar Series.

This webinar series is designed to provide relevant, state-of-the art, and evidence-based education content in pediatric otolaryngology for practicing otolaryngologists. Complete registration information can be found at http://aspo-cme.us/

Program			
	January	**Craig S. Derkay, MD**	Recurrent Respiratory Papillomatosis: Update 2013
	February	**Gresham Richter, MD**	Diagnosis and Management of Vascular Malformations
	March	**Robert M. Naclerio, MD**	Update on Allergic Rhinitis—A Burdensome Disease
	April	**Sally Shott, MD**	Down Syndrome: Otolaryngologic Manifestations
	May	**Kenny H. Chan, MD**	Evaluation and Management of Sialorrhea in Children
	July	**Margaret A. Kenna, MD, MPH**	Hearing Tests and Hearing Aids: More Interesting Than You Thought
	August	**Hassan H. Ramadan, MD, MSc**	Complications of Acute Rhinosinusitis in Children
	September	**Richard M. Rosenfeld, MD, MPH**	Otitis Media Update
	October	**Kathleen Cy Sie, MD**	Assessment and Management of Velopharyngeal Dysfunction
	November	**Marci Lesperance, MD**	Evaluation of Pediatric Sensorineural Hearing Loss

New Resident Trauma Manual Is Practical, Concise, and User-Friendly

G. Richard Holt, MD, MSE, MPH, D-BE
Chair, Task Force on Resident Trauma Manual

The AAO–HNS Trauma Committee, chaired by Col. Joseph Brennan, MD, was formed to emphasize the role of trauma management in the military, academic, and community practice of otolaryngology-head and neck surgery. As with other surgical disciplines, significant advances in facial, head, and neck trauma care have occurred as a result of military conflict, where large numbers of combat-wounded patients require ingenuity, inspiration, and clinical experimentation to devise better ways to repair and reconstruct severe wounds.

Recognizing that resident physicians are normally the first responders in major trauma centers to consult on and manage patients with trauma to the face, head, and neck, the committee has developed a comprehensive resource. *The Resident Manual of Trauma to the Face, Head, and Neck* is a free, downloadable, easily referenced guide to the care of trauma patients directed to the practical and educational needs of the resident physician. The manual is designed to be readily accessible when called to the emergency center, developing a management plan, or performing reconstructive surgical procedures.

For many reasons, including poor reimbursement, high medical legal risks, schedule disruptions, and surgical challenges, there has been a perceived reduction in the willingness of otolaryngologist-head and neck surgeons to care for patients who sustain trauma to the face, head, and neck. The committee believes that education in trauma management is important in preparing young otolaryngologists and head and neck surgeons to accept the responsibility for caring for these injured patients—a responsibility that has helped shape the surgical skills and reputation of our specialty since its inception. For this reason too, the Trauma Committee recommends that all resident physicians in otolaryngology-head and neck surgery access the manual at www.entnet.org/trauma.

The manual is a "must have" for all resident physicians in otolaryngology-head and neck surgery. It contains 10 concise chapters addressing comprehensive care of the trauma patient with face, head, and neck injuries, as well as a chapter on outcomes and controversies.

This manual supplements, but does not replace, more comprehensive bodies of literature in the field. Use this manual well and often in the care of your patients.

You Asked and the Academy Answered: Introducing AcademyQ

The Academy recently published a question bank app, AcademyQ: Otolaryngology Knowledge Self Assessment Tool™. The app, available for iPhone, iPad, and iPod touch, contains hundreds of study questions to test your recall, interpretation, and problem solving skills within the practice of otolaryngology–head and neck surgery. The app can be downloaded free from the Apple App Store with 10 questions included. The entire question pack of 390 questions can be purchased for $49.99 at http://bit.ly/AcademyQ.

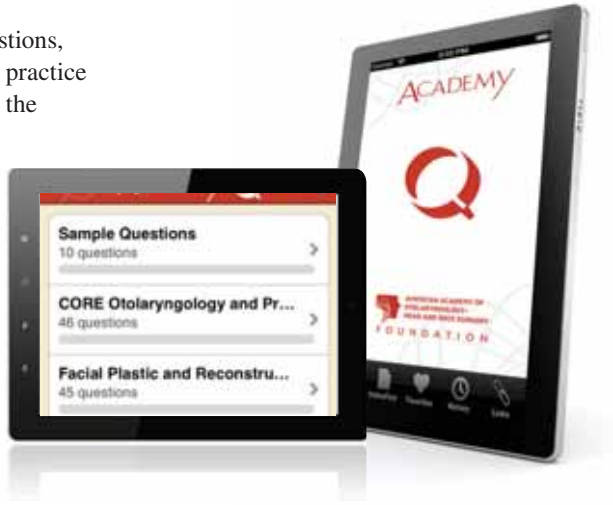
The question pack includes roughly 50 questions from each specialty area within otolaryngology–head and neck surgery: core otolaryngology and practice medicine, facial plastics and reconstructive surgery, general otolaryngology, head and neck surgery, laryngology and bronchoesophagology, otology and neurotology, pediatric otolaryngology, and rhinology and allergy. Each question includes an instant, detailed explanation and at least one reference. Related journal articles link to their abstracts in *PubMed*.

Early feedback indicates the app is meeting an obvious need within the otolaryngology–head and neck surgery community. Some feedback received so far:

"This program is excellent. I am reviewing for the written boards and usually like to do practice questions, and there is a lack of available practice question material out there for the writtens."

"The questions are excellent and there are good explanations. I would like to see an expanded question bank with even more questions!"

"I think this is a fantastic source for those taking the in-service and written certification exam. Thank you!"



Sonya Malekzadeh, MD, coordinator for education, and the AAO-HNSF Education Committee chairs, **Karen T. Pitman, MD; Richard W. Waguespack, MD; Brendan C. Stack, Jr., MD; Fred G. Fedok, MD; Dennis H. Kraus, MD; Richard V. Smith, MD; Catherine R. Lintzenich, MD; Bradley W. Kesser, MD; Kenny H. Chan, MD; Sukgi Choi, MD; Brent A. Senior, MD;** and **James A. Hadley, MD,** selected the most pertinent questions from a large bank of questions used in previous education activities such as the Academic Bowl and Home Study Course. The questions were updated and enhanced.

The Otolaryngology–Head and Neck Surgery Comprehensive Core Curriculum developed by the American Board of Otolaryngology (ABO) and the ABO Exam Blueprint were used as guides when deciding on the topics to cover within the app. (Both documents are available on the ABO's website, http://www.aboto.org/publications.htm.)

"The questions in AcademyQ comply with the standards of the National Board of Medical Examiners and represent many of the topics on the otolaryngology in-service and MOC exams. AcademyQ provides a great opportunity to practice test taking. More importantly, surgeons can participate in the process of continual self-assessment and review to identify areas where they can improve." Dr. Malekzadeh said.

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AcademyQ Features

- Complete answer explanations
- Questions in each specialty area
- Journal references link to *PubMed*
- Zoom in on images and videos
- Record audio or text notes
- Search by keyword or topic
- Mark questions for future review
- Study on the go; no connectivity is needed

AcademyU® is Your Source for Otolaryngology Education

Audrey E. Shively, MSHSE, MCHES, CCMEP
AAO-HNSF Director, Education

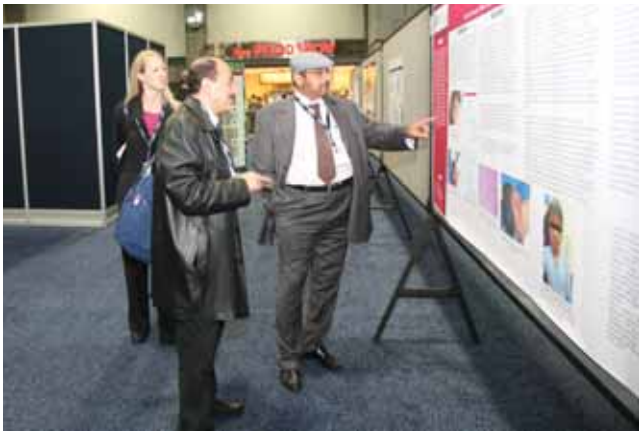
Where do you find all the otolaryngology education you need to stay on top of your profession? It's simple, AcademyU® is the window into all the education opportunities available to you as a member of the American Academy of Otolaryngology—Head and Neck Surgery. By visiting www.entnet.org/AcademyU you will be able to view a complete description of all our education resources, whether they are online courses, e-books, subscription products, live events, or knowledge products. You will be able to subscribe, register, download, or log onto any of these activities easily through this single portal.

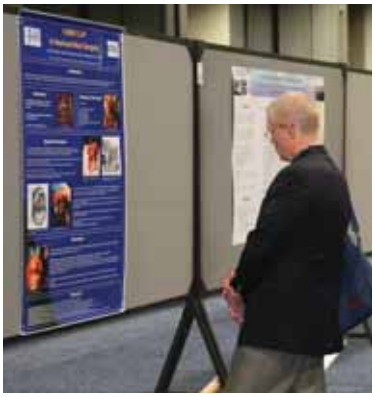
AcademyU brings you hundreds of education resources covering a variety of topics organized by the eight specialties within otolaryngology-head and neck surgery. Each resource appeals to the Foundation's primary audience, including physicians and physicians-in-training who specialize in otolaryngology-head and neck surgery. Specific activities also target general practice physicians, allied health professionals, and medical students. This article describes each resource.

ACADEMYU®
YOUR OTOLARYNGOLOGY EDUCATION SOURCE

AcademyQ: Otolaryngology Knowledge Assessment Tool

This mobile application provides a series of questions designed to assist the learner in certification/recertification preparation and to understand issues of practical importance to otolaryngologist—head and neck surgeons to improve patient care. To be used for test preparation and knowledge self-assessment, the app presents hundreds of questions in an interactive interface for iPhone, iPad, and iPod touch. Each question includes answer explanations and reference material, so users can learn as they go.
Audience: residents and practicing otolaryngologists





A glimpse of a few 2012 AAO-HNSF Annual Meeting & OTO EXPO.

AAO-HNSF Annual Meeting & OTO EXPO℠

- Instruction Courses: These one- or two-hour sessions address current diagnostic, therapeutic, and practice management topics, presented by both Academy members and non-members.
- Miniseminars: These presentations, case studies, and/or interactive discussions provide an in-depth, state-of-the-art look at a specific topic. This forum is reserved for new research in a clinical area.
- Oral Presentations: Hundreds of scientific papers are selected for presentation of innovative information and findings on original scientific research.
- Posters: Hundreds of posters are on display each day of the annual meeting. Posters contain innovative information and findings on original scientific research.

Audience: otolaryngology residents, practicing otolaryngologists, general practice physicians, allied health professionals, and medical students

Coding and Reimbursement Workshops

The course sessions are designed to help otolaryngologists and head and neck surgeons to run a better medical practice and ensure they are coding correctly.
Audience: otolaryngology residents and practicing otolaryngologists

Comprehensive Otolaryngologic Curriculum Learning through Interactive Approach℠ (COCLIA℠)

COCLIA is a teaching tool to help residents learn otolaryngology-head and neck surgery. This resource provides discussion questions for more than 100 major otolaryngology topics. New in 2012 are questions enhanced with full color images and a new mobile-optimized website.
Audience: otolaryngology residents and medical students

Clinical Otolaryngology Online℠ (COOL℠)

COOL courses are interactive patient scenarios built using the latest e-learning technology. These patient scenarios are designed to identify common treatment errors and enable the learner to avoid making a clinical mistake, or to teach new methods of treatment to improve patient care.
Audience: general practice physicians, allied health professionals, and medical students

ENT Exam Video Series℠

The AAO-HNSF has produced an online digital video series demonstrating a thorough ENT exam. It depicts how to perform a thorough examination of the ear, oral cavity, face, nose, neck, naso-pharnyx, and larynx. Images and video of normal anatomy, normal variances, and common abnormalities enhance the learning experience.
Audience: otolaryngology residents, general practice physicians, allied health professionals, and medical students

ENT ImageViewer

This resource provides access to oto-laryngology-related images via a simple search. Images have accompanying notes and annotations when available and new images are added when received. Images can be searched alphabetically, by donor, or by MeSH tree taxonomy.
Audience: otolaryngology residents, practicing otolaryngologists, general practice physicians, allied health profes-sionals, and medical students

Geriatric Care Otolaryngology Online

This e-book includes chapters from leading authors on otolaryngology topics unique to the geriatric patient.

Audience: otolaryngology residents, practicing otolaryngologists, general practice physicians, allied health professionals, and medical students

Guide to Antimicrobial Therapy in Otolaryngology-Head and Neck Surgery, 13th Edition

Now available as an e-book, this monograph helps physicians prescribe the most effective, least expensive antimicrobials for their patients, and provides an overview of antimicrobials by category, microbiology, drug selections, prophylaxis, ototoxicity, adverse interactions, and drugs of choice according to infecting organism, dosages, and cost.
Audience: otolaryngology residents, practicing otolaryngologists, general practice physicians, allied health professionals, and medical students

My Voice: A Physician's Personal Experience With Throat Cancer

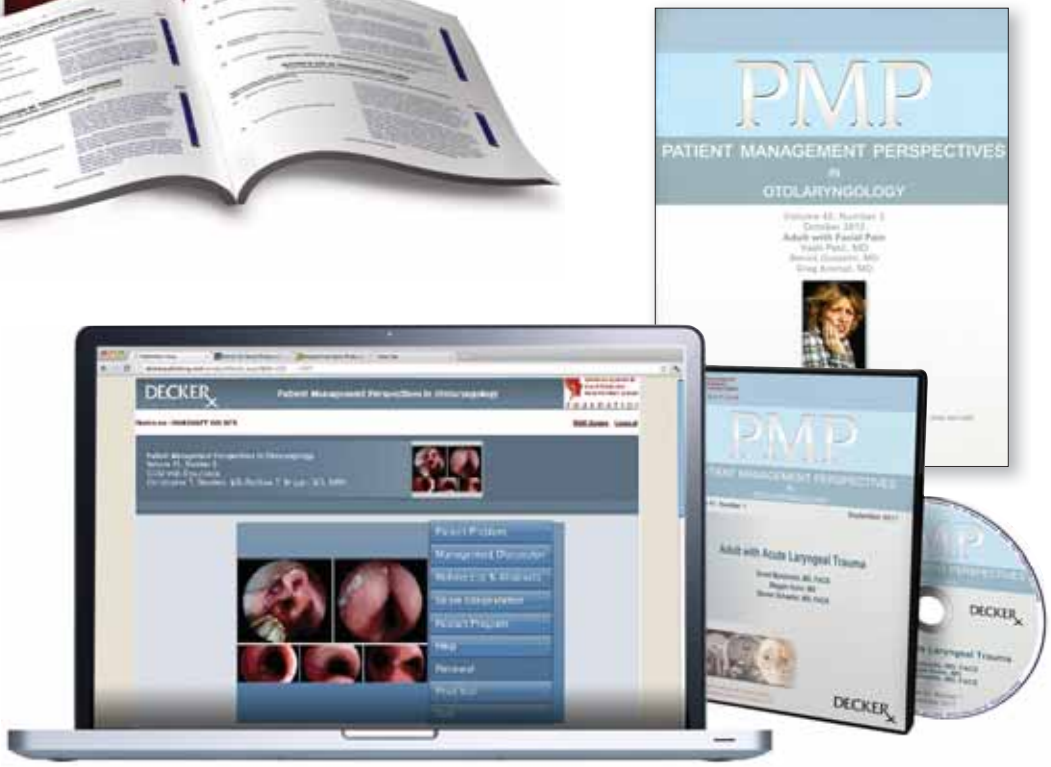
This book captures three years of the author's life following a diagnosis of throat cancer and tells the story of how Itzhak Brook, MD, faces and deals with medical and surgical treatments and adjusts to life afterward. As a physician with lifelong experience in caring for patients, the author shares his insights and perspective on these events as he undergoes the effects of a severe illness through the eyes of a patient.
Audience: otolaryngology residents, practicing otolaryngologists, general practice physicians, allied health professionals, and medical students

Online Courses and Online Lecture Series (OLS)

These online courses offer an opportunity for participants to learn at their own pace, using rich media elements to enhance the education experience. OLS transforms content from annual meeting instruction courses into brief interactive online activities.
Audience: otolaryngology residents, practicing otolaryngologists, general practice physicians, allied health professionals, and medical students

Patient Management Perspectives in Otolaryngology[SM] (PMP)

PMP is a subscription periodical that allows participants to manage an individual patient from presentation to discharge and follow-up with an interactive question-and-answer self-assessment component. The patient problem is designed to heighten awareness of the current range of possibilities for diagnosis and management and provides an opportunity to apply knowledge to real world scenarios. Like a real-life clinical



Home Study Course (HSC)

This subscription product covers all eight clinical subspecialty areas and is administered in four sections per course-year. Each section provides a format for discussion of recent literature in the field. A section contains journal article reprints, a 50-question self-assessment exam developed by the faculty, and a faculty symposium. Subscribers read the journal articles and complete the open-book exam.
Audience: otolaryngology residents, practicing otolaryngologists, and medical students

problem, the simulation must be solved by a series of inquiries, decisions, and actions.

Audience: otolaryngology residents, practicing otolaryngologists, and medical students

Pocket Guide to TNM Staging of Head and Neck Cancer and Neck Dissection Classification

This physician reference defines anatomic boundaries of lymph node dissections and fundamental principles of standardized terminology.

Audience: otolaryngology residents, practicing otolaryngologists, and medical students

Primary Care Otolaryngology, 3rd Edition

This primer on fundamental topics in general otolaryngology and practical handbook for non-ENT clinicians has 18 chapters, including a new chapter that addresses inhalant allergies. Each chapter reflects current clinical practice guidelines.

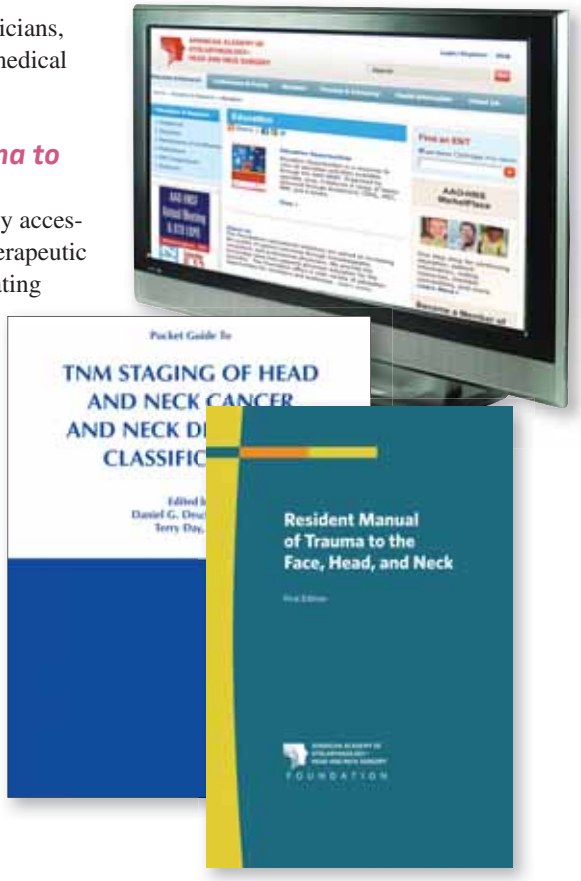
Audience: general practice physicians, allied health professionals, and medical students

Resident Manual of Trauma to the Face, Head, and Neck

This simple, concise, and easily accessible source of diagnostic and therapeutic guidelines for the examining/treating resident is an important tool, both educationally and clinically. It should be used as a quick-reference tool in the evaluation of a trauma patient and in the planning of surgical repair and/or reconstruction.

Audience: otolaryngology residents and medical students

As you can see, AcademyU remains your source for otolaryngology education, with many resources offered as a free member benefit to you. Visit www.entnet.org/academyu today and begin taking advantage of all the education resources at your fingertips.



A "Status Quo" Election

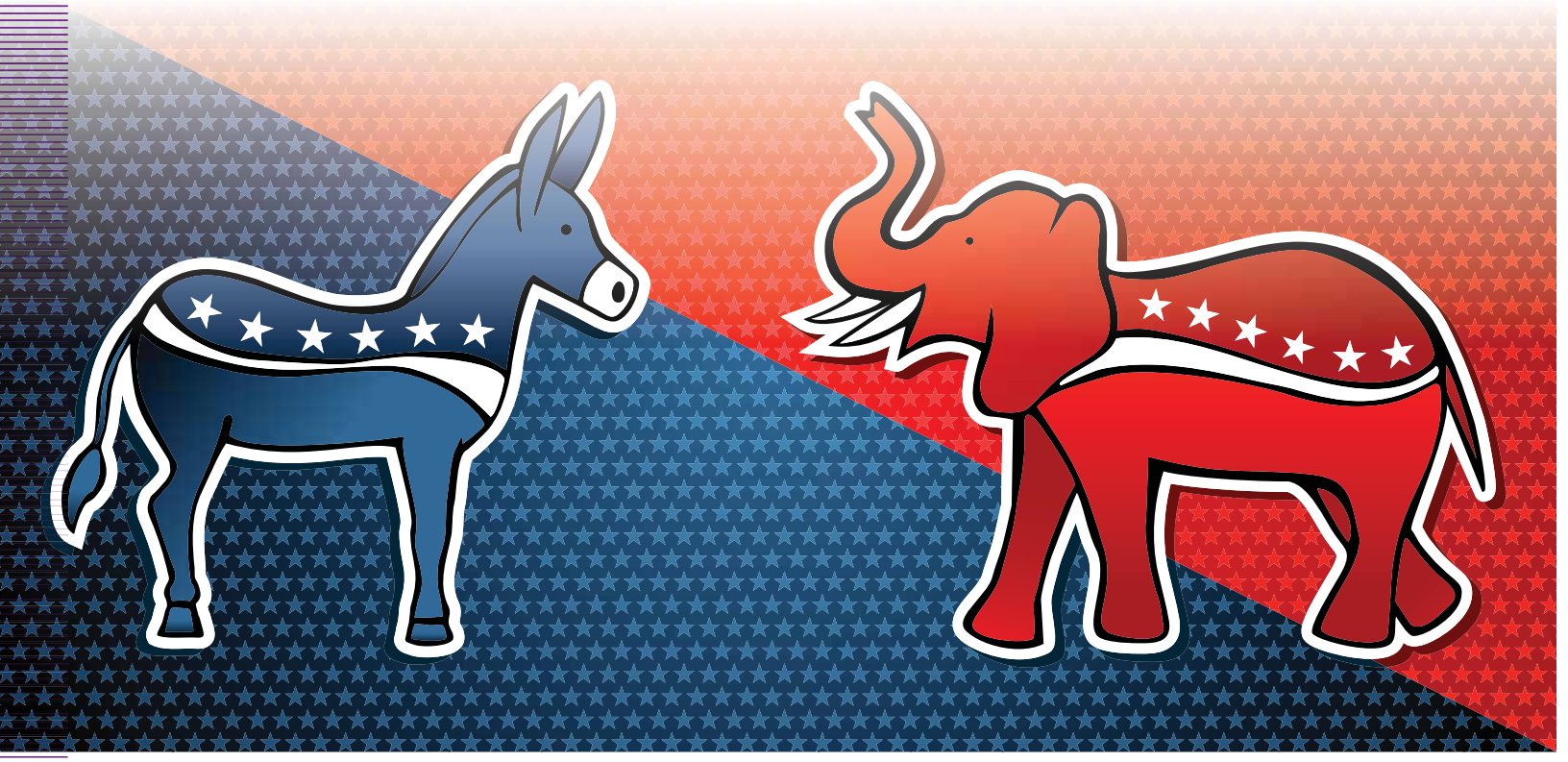
After a year (or more) of intense campaigning and billions of dollars spent, this year's elections yielded a "status quo" result that has many stakeholders reflecting upon what might happen next. Read on for a brief overview regarding what we know and what we don't know about the 113th Congress.

What We Know

In what turned out to be a not-so-close electoral race, President Barack Obama returns to the White House with an opportunity to solidify the implementation of his cornerstone achievement, the Affordable Care Act (ACA). The first thing this year's election results made clear was that the ACA is here to stay, and efforts to fully repeal the law are unlikely. However, attempts to fine-tune provisions of the ACA are possible since this year's electorate also returned a divided Congress. As the Election Day dust continues to settle, the make-up of the 113th Congress has become clearer. In the U.S. House of Representatives, Republicans retained their majority with a total of 233 seats (218 needed), slightly less than their majority in the 112th Congress. As of November 13, 2012, seven House races remained too close to call. Conversely, Democrats in the U.S. Senate succeeded in building upon their existing majority to garner a total of 53 seats. See the accompanying chart for a full U.S. House/Senate Election Day breakdown.

What We Don't Know

Everything else. Even though this year's elections returned the same political paradigm to Washington, DC, it doesn't necessarily mean overwhelming partisan warfare will continue to reign. While Republicans retained control of the U.S. House, their diminished majority could spur a heightened perspective about what it will take to remain in the majority. In addition, Democrats must be cognizant of the fact that many now view the Democrat-controlled Senate as a place where legislation goes to die. An optimistic view of this year's election results points toward both parties finally realizing that they can't effectively legislate from the far right or far left. A negative view dictates another "do-nothing" attitude in which no meaningful legislating occurs.



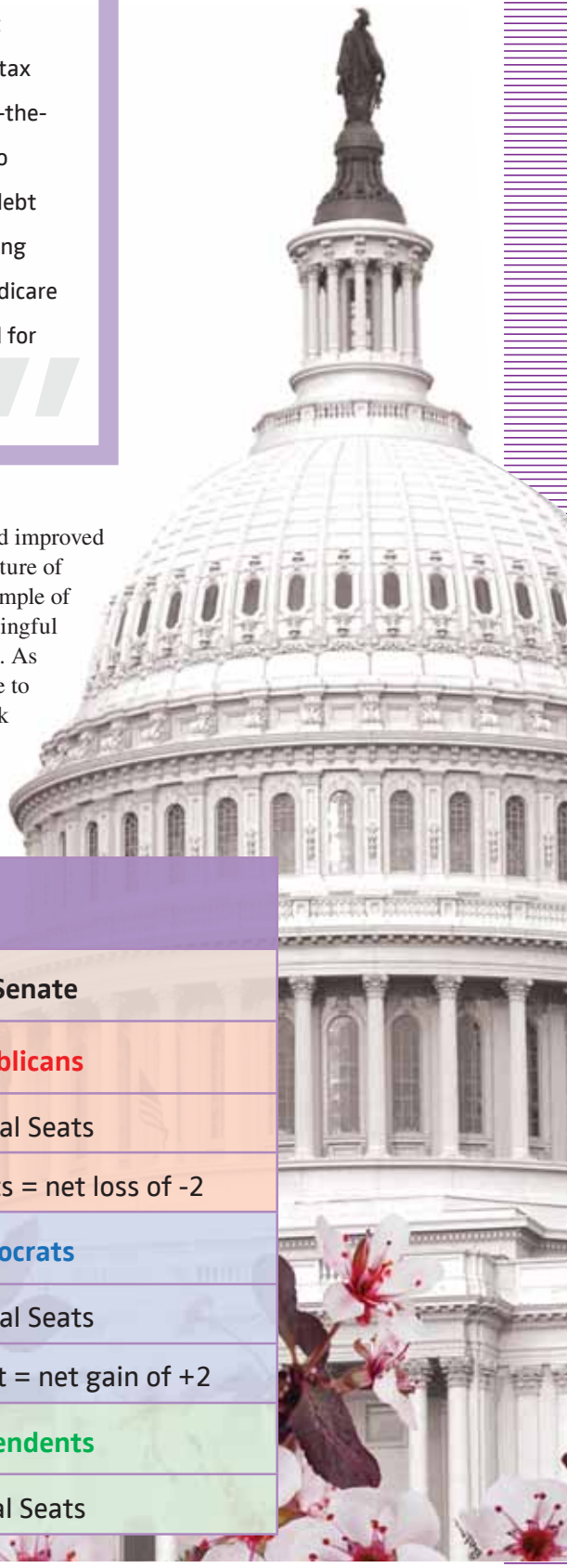
What Happens Now?

Members of the 112th Congress returned to Washington, DC, to convene a lame-duck session on November 13, 2012. The legislative activity or inactivity of the lame duck will drive much of the initial agenda for the 113th Congress. Before the end of this year, Congress must address (at least in concept): expiring tax provisions; looming across-the-board spending cuts due to sequestration; a pending debt ceiling increase; and avoiding the 26.5 percent cut in Medicare physician payments slated for January 1, 2013.

Conclusion

Perhaps the most important thing to remember about the 2012 elections is that the results may be viewed as deceptive. While the electoral vote results returned the President to the White House by a clear margin, there was only a two percentage point difference in the popular vote. Much talk is given to the ideological divide and partisanship that exists on Capitol Hill. However, this year's election results indicate that the same ideological divide is alive and well within the overall population of the United States. Elected leaders from both parties will be best-served to recognize that no clear power mandate has been deemed by Election Day and movement toward more "give-and-take" legislating will yield the most positive results (and improved approval ratings). The ongoing nature of healthcare reform is a perfect example of a critical issue that requires meaningful input and effort from both parties. As previously stated, the ACA is here to stay, and Congress must now work in earnest to find middle ground to move forward. However, only time will tell.

"Before the end of this year, Congress must address (at least in concept): expiring tax provisions; looming across-the-board spending cuts due to sequestration; a pending debt ceiling increase; and avoiding the 26.5 percent cut in Medicare physician payments slated for January 1, 2013."



Election Day Breakdown*

U.S. House of Representatives	U.S. Senate
Republicans	**Republicans**
233 Total Seats	45 Total Seats
+18 seats, -21 seats = net loss of -3 seats	+1 seat, -3 seats = net loss of -2
Democrats	**Democrats**
195 Total Seats	53 Total Seats
+26 seats, -17 seats = net gain of +9 seats	+3 seats, -1 seat = net gain of +2
	Independents
	2 Total Seats

*as of November 13, 2012

2012 State Legislative Wrap-Up

In 2012, the AAO–HNS reviewed thousands of bills introduced across the country to determine relevancy to the specialty. Of those bills, the Academy actively tracked nearly 800 state bills, including many held over from the 2011 sessions. More than 50 key bills were identified in 31 states, resulting in the Academy providing strategy, advocacy resources, and coalition engagement to state otolaryngology societies, as needed. Members can view a full listing of these bills through the State Advocacy website, www.entnet.org/Practice/members/stateAdvocacy.cfm, which provides real-time access to active state legislation and relevant information. The following is a brief summary of some of the Academy's 2012 priority state bills and other highlights from the year.

Scope of Practice

The AAO–HNS believes it is appropriate for non-physician providers to seek updates to statutes and regulations relating to their defined scope of practice to reflect advances in education and training. However, the AAO-HNS strongly opposes state legislation that would inappropriately expand the scope of practice of non-physician providers beyond their education and training. Enabling non-physician providers to independently diagnose, treat, or manage medical disorders could adversely affect the quality of patient care. This year, the AAO–HNS advocated to modify and/or defeat several potentially harmful bills that would have inappropriately expanded the scope of practice of non-physician professionals.

In West Virginia, the AAO–HNS successfully opposed a bill that would have inappropriately expanded the scope of practice for speech-language pathology and audiology to include medical diagnosis, management, and treatment.

Both Colorado and South Dakota passed legislation that essentially expands the scope of practice of speech-language pathologists. The AAO-HNS submitted letters of opposition to both state legislatures and will continue to monitor as the legislation is implemented.

A carry-over bill in New York sought to permit non-physician oral and maxillofacial surgeons to perform elective surgeries in the oral and maxillofacial regions if granted hospital privileges. The AAO–HNS worked as part of a coalition to defeat this legislation.

The California legislature passed a bill to allow audiologists to become qualified medical examiners to make determinations on workers' compensation claims, an effort strongly opposed by the AAO–HNS. The governor ultimately vetoed the legislation.

Taxes on Medical Procedures

Each year, there is a re-emergence of proposals to tax medical procedures, and in light of extensive state budget shortfalls, this year has been no exception. The Stop Medical Taxes Coalition, of which the AAO–HNS is a member, asserts that the taxation of medical procedures is unfair for patients and is a "slippery slope" toward the taxation of other medical services.

In California, there were two legislative proposals opposed by the AAO–HNS and the Coalition that would result in a tax on elective cosmetic procedures. Both proposals never progressed beyond committee.

The New Jersey legislature passed a proposal supported by the AAO–HNS and the Coalition that was signed into law by the governor in early 2012. The law provides for a gradual repeal of the 6 percent tax currently imposed on cosmetic procedures. The tax will be reduced by 2 percent each year, for three years, ending with a 0 percent tax rate.

Hearing Aid Services

The coverage, sale, and dispensing of hearing aids is an issue considered by several states in various forms each year, and 2012 was no different.

Arizona considered legislation that would have changed the requirements for hearing aid dispensing licensure. The bill, which was successfully opposed by the Academy and the state society, would have removed the current practicum exam and replaced it with a requirement of 160 hours of supervised work that would have included the identification of medical conditions.

In New York, the Academy continued its work with the Patient Access to Hearing Aids (PAHA) Coalition on legislation to expand patients' access to hearing aid services by amending an archaic law prohibiting physician practices from deriving a profit on hearing aid sales. In 2012, the PAHA Coalition attained introduction of both a Senate and Assembly amended bill.

Massachusetts considered legislation for the first time to allow otolaryngologists to dispense hearing aids in the state, which is currently prohibited. The legislation did not progress in the 2012 session, but the Academy will continue to work with the state society for the passage of this legislation in 2013.

Several states considered bills to require insurers to cover the cost of or expand benefits for hearing aids and/or cochlear implants, including Connecticut, Georgia, Hawaii, Illinois, Kansas, Maine, Massachusetts, Nebraska, New York, Rhode Island, Tennessee, Utah, Vermont, and Wyoming. A number of states also considered bills that would provide a tax credit and/or exemption for hearing aids, including Hawaii, Kansas, Michigan, Missouri, New Jersey, and Oklahoma.

Truth-in-Advertising

With the emergence of clinical doctorate programs for non-physician providers—which has led to many degree holders referring to themselves as "doctors"—there is growing confusion within the patient population about the level of training and education of their health-care providers. In 2012, there were 11 truth-in-advertising bills introduced in the states. Legislation passed in Maryland, Mississippi, and Utah.

In Maryland, the legislature passed a bill to require identification tags and advertisements to show the type of certification the practitioner holds subject to approval by the state medical board. The Academy worked with other national

specialty organizations and the state medical society to develop and advocate for language that closes loopholes, but applies to all AAO-HNS members' board certifications.

The Washington legislature considered a bill that would have required advertisements by those who identify themselves as "doctors" to list their license, registration, and/or certifications.

Tobacco Use and Smoking Cessation

The Academy supports legislation and regulations that help reduce the use of tobacco products and exposure to secondhand smoke in order to promote healthy environments and lifestyles for the public. This year, bills were introduced in 15 states that sought to strengthen existing smoking ban laws, including California, Iowa, Kansas, Maine, Maryland, Mississippi, Missouri, New Jersey, Oklahoma, Rhode Island, South Carolina, Virginia, and West Virginia. A number of states considered proposals to mandate insurance coverage and/or benefits for tobacco cessation, including Hawaii, Illinois, Indiana, Massachusetts, New Jersey, New York, and Washington. Alabama, Hawaii, and Illinois proposed legislation to exempt certain establishments from a smoking ban if they paid to become licensed as exempt.

Medical Liability Reform

In 2012, there were 10 state legislatures that considered various tort reform measures, including those related to affidavits of merit, alternative reforms, caps on non-economic damages, defensive medicine issues, expert witnesses, health courts, or pre-trial screening panels. New Hampshire and New Jersey considered enacting or modifying caps on non-economic damage awards in medical liability cases, while Rhode Island considered proposed legislation on apology inadmissibility. A comprehensive medical liability reform bill was considered in Washington. In Connecticut, the Academy, with the state specialty society and state medical society, successfully opposed legislation that would have weakened the current standards for certificates of merit. In addition, across the nation, there were a number of legal challenges relating to medical liability actions, specifically a number of states that reviewed the constitutionality of caps on damages.

In 2013, the Academy will continue to track and advocate on these important issues and others as they may arise. Many of these issues will continue into 2013 and beyond, as states look to adjust to the ever-changing healthcare environment. The Academy will continue to actively engage with specialty societies and state medical societies on these important issues to strengthen our voice in the state legislatures.

For more information on state legislative issues or specific measures, contact AAO–HNS State Legislative Affairs at legstate@entnet.org or 1-703-535-3794.

Save the Date for the 2013 BOG Spring Meeting & OTO Advocacy Summit

Mark your calendar for the 2013 BOG Spring Meeting & OTO Advocacy Summit—May 5-7, 2013—in Alexandria, VA, and Washington, DC. Next year's BOG Spring Meeting and Summit will provide a great opportunity for attendees to hear from experienced policymakers, participate in committee meetings, receive "insider" briefings, and take advantage of pre-scheduled visits with Members of Congress and/or their staffs on Capitol Hill. There will also be ample networking events and an exclusive ENT PAC fundraiser. Registration for both the BOG Spring Meeting and the OTO Advocacy Summit will open in February 2013. Additional information is available at www.entnet.org/BOG&Summit. Mark your calendar today, and we look forward to seeing you in May!

Physicians Unite to Declare Independence from the SGR Formula

During the AAO-HNSF 2012 Annual Meeting & OTO EXPO, the Academy debuted a petition titled the "Declaration of Independence from the SGR Formula," calling for the repeal of the flawed Sustainable Growth Rate (SGR) formula. This innovative idea was shared with other national physician groups, and as a result, a collaborative grassroots effort spearheaded by the AAO-HNS emerged. The petition was signed by more than a thousand physicians from all 50 states and included the names of more than 500 AAO-HNS members. In November, the Declaration was delivered to Members of Congress on Capitol Hill for consideration during this year's lame-duck session. A cover letter accompanied the petition explaining how physicians need stability in the Medicare system for their practices and their patients. To view the final petition, visit www.entnet.org/advocacy.

Stay Informed—Bookmark the AAO-HNS Legislative and Political Affairs Webpage

Do you want to be one of the first to know the status of healthcare bills moving through Congress or your state? Bookmark the Legislative and Political Affairs webpage today. By visiting the page, you can learn more about the issues affecting the specialty, including the flawed Sustainable Growth Rate (SGR) formula, medical liability reform, scope-of-practice battles, Graduate Medical Education (GME) funding, truth-in-advertising initiatives, and efforts to repeal the Independent Payment Advisory Board (IPAB). Visit www.entnet.org/advocacy.

Imaging Committee Health Policy, Quality, and Education Update

Gavin Setzen, MD, Chair
Jenna Kappel, MPH, MA, Director, Health Policy and Staff Liaison, Imaging Committee

Imaging Committee: Dual Charge

The Academy's Imaging Committee continues to educate members on CT imaging policy and regulation and will now also assume a more proactive role in ultrasound imaging in the head and neck region as this modality has become an integral part of contemporary management of patients with a variety of head and neck conditions. The Committee serves the members in a dual role: advocating for appropriate government regulations and fair insurance policies related to imaging services, and identifying educational needs and CME activities for CT imaging accreditation in otolaryngology practice.

The Clinical Consensus Statement: Appropriate Use of Computed Tomography for Paranasal Sinus Disease was released in November, 2012, and the committee is ready to assist members with any follow-up issues related to health policy matters.

Gavin Setzen, MD, Chair

Jenna Kappel, MPH, MA, Director

With the focus of the December *Bulletin* on Education, we wanted to take this opportunity to share with members some of the efforts of the Imaging Committee on the behalf of members, including developing a joint survey with the American Rhinologic Society on CT imaging, participating in the American College of Radiology (ACR) workgroups

Academy Works with WellPoint to Revise WellPoint's Policy on Tonsillectomy for Children

On October 16 the Academy submitted a letter to WellPoint regarding the WellPoint policy on Tonsillectomy in Children that inappropriately incorporated some statements from the AAO-HNS's Clinical Practice Guideline (CPG). On November 5, a conference call took place with WellPoint physician executives, Academy Research and Health Policy leaders and staff, to further discuss these concerns.

The conversation was very collegial and the WellPoint executive leaders attentively listened to comments made by the Academy leaders. The Academy's comments from the call and the October 16 letter were reviewed by the Medical Policy and Technology Assessment Committee (MPTAC) during their November 7-8 meeting. On November 12, WellPoint revised the policy on Tonsillectomy for Children, incorporating many of the Academy's comments. This change will affect all of the WellPoint affiliated plans–Anthem BCBS of CT, NH, ME, VA, OH, KY, IN, WI, MO, CO, NV, Anthem Blue Cross (CA), Empire BCBS (NY), BCBS of Georgia, and Unicare.

Please see an outline of the changes and a link to the full policy at http://aaobulletin-365.ascendeventmedia.com/Content.aspx?n=PolicyChanges

on Appropriateness Criteria to provide the Otolaryngology perspective, and providing members with resources to help meet accreditation, which is a requirement of the Centers for Medicare and Medicaid Services (CMS) to receive reimbursement for providing advanced imaging services to Medicare patients.

AAO-HNS/ARS CT Imaging Survey

The Academy's Imaging Committee joined with the American Rhinologic Society (ARS) to develop a questionnaire to jointly survey Academy and ARS members, including residents and fellows in training, regarding practice patterns and other aspects of CT imaging in patients with paranasal sinus disease. The Imaging Committee and the ARS will be able to analyze these data to assess potential areas to improve care provision, safety and quality, as well as address potential issues relating to knowledge gaps and educational opportunities as well. These data, together with the Clinical Consensus Statement on Appropriate Use of Computed Tomographyfor Paranasal Sinus Disease will be helpful to members and possibly payers and policy makers as well.

Academy Resources for Continuing Education Credit

With the adoption of in-office CT technologies, there continues to be an emphasis on quality and safety. Standardization through accreditation is an integral part of the quality initiative and is also required for reimbursement by CMS and many third party payers. Formalized standards for medical practices choosing to use in-office CT imaging have been established by the Intersocietal Accreditation Commission. The Academy offers resources that meet both ACCME standards and IAC standards. If you are a member, you can obtain the CME credit necessary to meet IAC requirements, via member benefits by:

1. **Attending the Annual Meeting CT-related Miniseminars or Instructional courses.**
   There are nearly 100 courses related to CT imaging, with many courses specific to CT, at the Annual Meeting & OTO Expo. Participation in any/all of these courses can provide credit toward the CME requirement for accreditation. A list of CT-related Miniseminars and Instruction courses that can be used towards your accreditation requirements can be found here. Recordings of these courses are available for purchase through the 2012 AAO-HNSF Annual Meeting & OTO EXPO webpage. However, CME credit is not available for these recordings.
2. **Taking Academy U CT-related courses from ANY year.**
   The Academy is currently working to flag all online courses available that are appropriate for this purpose. Check the Imaging Services webpage for future updates.
3. ***Otolaryngology-Head and Neck Surgery* Journal.**
   CT-relevant articles are published each year in the Academy's monthly journal. Online access to the journal can be found here. While journal CME credit is currently not available, these articles could be of value to your practice.
4. **IAC- Recommended CME Resources.**
   As a service to CT professionals looking for CT-related CE/CME, the IAC maintains a list of resources for CE/CME. To access this list of courses click here.

Contact Audrey Shively at ashively@entnet.org with any questions regarding education related to CT imaging and the accreditation process.

Contact Jenna Kappel with any questions regarding health policy or payment issues related to CT imaging. For specifics on regulatory and socioeconomic advocacy efforts, visit the Academy webpage on Imaging Services.

The Committee will continue its policy, advocacy and educational efforts to meet IAC accreditation requirements and assist members in providing optimal imaging care to their patients. If you are interested in joining the Imaging Committee, please contact Gavin Setzen, MD at gavinsetzenmd@albanyentandallergy.com.

Systematic Review Training

2013 Cochrane Colloquium, Quebec City, Canada
September 19-23, 2013

2013 Cochrane Scholars

The AAO-HNS/F leadership and SAGE, publisher of *Otolaryngology–Head and Neck Surgery,* have identified a need to train otolaryngologists in the conduct and publication of systematic literature reviews. Systematic reviews have a high citation impact, and serve as the foundation for evidence-based practice guidelines, clinical performance measures, and maintenance of specialty certification.

Four travel grants of up to $2,500 will be offered for the 2013 Colloquium in Quebec City, Canada, September 19-23, 2013. The Colloquium features a full scientific program and nearly 60 training and discussion workshops related to systematic review. In return for a travel grant to attend the meeting, grant recipients must agree to initiate and submit a systematic review to *Otolaryngology–Head and Neck Surgery* for publication consideration within 12 months (by September 23, 2014).

Attendees will be introduced to the Cochrane Collaboration, the world leader in evidence summaries of healthcare interventions, and will learn state-of-the-art techniques for producing systematic reviews and meta-analyses. The AAO-HNS/F has partnered with the staff and editors of the Cochrane ENT Disorders Group to create this unique educational opportunity.*

Apply by January 1, 2013

To learn more about how to apply, visit http://www.entnet.org/EducationAndResearch/Cochrane.cfm.

Questions? Contact Caitlin Murray at cmurray@entnet.org or 703-535-3748.

Residents and previous G-I-N or Cochrane Scholar recipients are not eligible to apply

How to Avoid CMS Quality Initiative Payment Penalties

Next year is a pivotal year in the development of numerous quality initiatives currently underway by the Centers for Medicare and Medicaid Services (CMS). These include the Electronic Prescribing (eRx) Incentive Program, Medicare and Medicaid's Electronic Health Records (EHR) Incentive Program, and the Physician Quality Reporting System (PQRS). This article is designed to serve as a primer for each of these programs and provide you with the information you need to take advantage of available incentives and avoid payment penalties by becoming compliant. Information on all of these programs can be found on the Academy's new webpage at www.entnet.org/cmspenalties.

> "Starting next year, CMS will be collecting reporting data from physicians for each of these programs that will be used to calculate payment penalties, which could add up to nearly five percent in payment reductions for non-participating physicians in 2015 (see Table 1)."

Starting next year, CMS will be collecting reporting data from physicians for each of these programs that will be used to calculate payment penalties, which could add up to nearly five percent in payment reductions for non-participating physicians in 2015 (see Table 1). It is essential that members take the necessary steps and begin participating in these programs as soon as possible. Incentive payments are available for physicians who begin participating in PQRS and EHR Meaningful Use to help offset the cost of implementing these systems in practice.

Electronic Prescribing (eRx) Incentive Program

The eRx Incentive program is designed to facilitate the transition to electronic prescribing software through incentive payments and penalties. E-prescribing can be achieved through stand alone software or through Electronic Health Records that have an e-prescribing capability. 2012 was the first year of the program with both incentive payments and payment adjustments (penalties). 2013 is the last year incentive payments are available for successful e-prescribers. Those who successfully report in 2013 are eligible for a .5 percent bonus for all of their reimbursed Medicare Part B claims.

In 2013, physicians must report the eRx measure for at least 25 unique electronic prescribing events in which the measure is reportable by the eligible professional during 2012 in order to be eligible for the .5 percent incentive payment. If a physician fails to report at least 25 prescribing events, or to report the G8553 code via claims for at least 10 unique denominator-eligible eRx events for services provided January 1, 2013, through June 30, 2013, they will be subject to a two percent payment penalty for all Medicare payments in 2014. Physicians who successfully reported in 2011 are exempt from 2013 payment penalties.

It is important to note that each year physicians do not meet the criteria for successful electronic prescribing, payment penalties increase. For example, in 2013, physicians will be subject to a 1.5 percent penalty, based on 2012 reporting and in 2014 this increases to a two percent payment penalty, based on 2013 reporting.

For more information on the eRx Incentive Program, see the Academy's information page at http://www.entnet.org/Practice/MedicareERxFactSheet.cfm.

Medicare and Medicaid's Electronic Health Records (EHR) Incentive Program

The Electronic Health Records Incentive Program is an initiative from CMS designed to facilitate the use of EHRs in clinical settings. Eligible professionals (EPs), hospitals, and critical access hospitals (CAHs) that demonstrate meaningful use of EHRs are eligible for incentive payments. For EPs, incentive payments can accumulate to up to $44,000 by 2015 if they began to successfully participate in 2012. It is important to note that physicians cannot participate in the eRx Incentive Program and the EHR Medicare Incentive Program simultaneously.

The EHR Incentive Program is structured in three stages, with a possible fourth stage starting as early as 2018. In order to successfully demonstrate meaningful use in Stage 1, which began in 2011, EPs must meet 20 objectives out of 25 possible. There are 15 required core objectives while the remaining five objectives may be chosen from the list of 10 menu set objectives. EPs must also report on six total clinical quality measures (CQMs): three required core measures (substituting alternate core measures where necessary) and three additional measures (selected from a set of 38 clinical quality measures).

The criteria for meaningful use for Stage 2, which is scheduled to begin in 2014, increases as physicians are required to report higher thresholds and more CQMs. In Stage 2, eligible professionals will have to report all 17 core objectives, which include several consolidated core and menu objectives from Stage 1, and three of six menu objectives. EPs will have two options for reporting CQMs in Stage 2 including reporting nine out of 64 measure choices or successfully reporting Physician Quality Reporting System (PQRS) CQMs through the PQRS EHR reporting option.

Just as in the eRx program, there are future penalties for professionals who

do not begin participating in the EHR Incentive Program. Beginning in 2015, EPs, hospitals, and CAHs that do not successfully demonstrate meaningful use of EHRs will be subject to a one percent penalty that increases annually up to five percent by 2020. It is important to note that these penalties will be based on reporting submitted two years prior, meaning 2015 payments will be based on 2013 reporting.

For more information on the EHR Incentive Program including information on Stage 1 and Stage 2 criteria, see the Academy's information page at http://www.entnet.org/Practice/ONC.cfm.

Physician Quality Reporting System (PQRS)

The Physician Quality Reporting System is currently a voluntary reporting program that provides an incentive payment to physicians or groups that report data on quality measures. In 2013, physicians who successfully report data on quality measures are eligible for .5 percent bonus payment on all Medicare claims. Individual eligible professionals may choose to report information on individual physician quality reporting quality measures, or measures groups, to CMS on their Medicare Part B claims, to a qualified Physician Quality Reporting registry, or to CMS via a qualified EHR product, or to a qualified Physician Quality Reporting data submission vendor. Participating physicians are eligible for an additional .5 percent bonus payment for working with a Maintenance of Certification entity and successfully reporting data, participating in, and completing a certified Maintenance of Certification Program practice assessment.

The Academy currently offers an online tool called the PQRI*wizard* to help members collect and report quality measure data for the PQRS program in 2013. The PQRI*wizard* offers automatic

CMS Quality Initiatives–Future Incentives and Penalties

Reporting year	2012	2013	2014	2015	2016	2017
Physician Quality Reporting Program (PQRS)	↑ .5%	↑ .5%	↑ .5%	-	-	-
	-	-	-	↓ 1.5% *based on 2013 reporting	↓ 1.5% *based on 2014 reporting	↓ 2% *based on 2015 reporting
Electronic Health Record (EHR) Meaningful Use	↑ $12k-18k	↑ $8k-15k	↑ $4k-12k	↑ $2k-8k	↑ $2k-4k	-
	-	-	-	↓ 1% *based on 2013 reporting	↓ 2% *based on 2013 reporting	↓ 3% *based on 2013 reporting
E-Prescribing (eRx)	↑ .5%	-	-	-	-	-
	↓ 1.5%	↓ 2%	↓ 2%	TBD	TBD	TBD

Key: ↑ Incentives ↓ Penalties

data validation, minimized data entry time, and retrospective or prospective data submission. Information for the PQRI*wizard* can be found at http://www.entnet.org/Practice/PQRS.cfm.

Beginning in 2015, CMS will adopt a payment penalty as part of the PQRS program similar to the eRx and EHR programs. Eligible professionals who do not satisfactorily submit PQRS quality measure data will incur a 1.5 percent payment penalty. This penalty rises to two percent in 2016. To avoid the 2015 payment penalty, an eligible professional must satisfactorily report PQRS quality measure data during the 2013 reporting period (January 1, 2013-December 31, 2013).

For more information on PQRS, see the Academy's information page at: http://www.entnet.org/Practice/cmsPQRIBonus.cfm.

There are several reasons for physicians to begin to adopt the technology and initiatives detailed above. There are incentives currently in place for practices and groups like yours to make the transition and adopt new technologies. Physicians are able to participate in several of these programs at the same time, and when combined with other initiatives' bonuses, there is the potential for increased revenue for practices. Along with these incentives, however, there are potential pitfalls along the way. The Academy encourages members to do their due diligence when investigating which programs and systems are right for their practice. Most importantly however, physicians and groups will begin to see financial penalties for failure to adopt new technologies and initiatives, which could potentially cost their practices up to a 10 percent reduction of all Medicare payments.

For any questions or information about these programs, please contact the Health Policy unit at healthpolicy@entnet.org, or visit the Academy's CMS Quality Initiative webpage at www.entnet.org/cmspenalties.

By the Numbers:
How the Academy's Health Policy Team Helps You

As an AAO-HNS member, you receive a multitude of benefits. One of these benefits is a Health Policy team dedicated to advocating on your behalf, representing otolaryngologists nationally and supporting state and local efforts. During the past year, the Academy's Health Policy department has been busier than ever, expanding its capabilities and advocating for members with regard to both private payer and federal regulatory policies. Here is a snapshot, by the numbers, of how the Academy's Health Policy department has helped members in 2012.

$12,000-$15,000

The return on your $840 dues as calculated by BOG Chairman Michael D. Seidman, MD, in 2011. For "card-carrying" members of the AAO-HNS, your $840 dues had a calculable return on investment of about $12,000 to $15,000 secured by coding changes and other efforts made by your leadership and staff at the AAO-HNS. The Academy continues to advocate on your behalf and your dues help to fund our efforts. For more information on these savings, access the June 2011 *Bulletin* article at http://aaobulletin-365.ascendeventmedia.com/highlight.aspx?id=3096&p=284.

294

As of October 3, 2012, the number of member questions the Health Policy department has responded to. Every day, members from across the country contact the Health Policy staff with questions, ranging from assistance with private payer denials and appeals to information and resources on how to achieve Meaningful Use in the EHR Incentive Program. Health Policy staff work to help members on many issues by providing up-to-date resources and expert analysis. For questions or more information, contact the Health Policy department at healthpolicy@entnet.org.

105

The average number of coding questions the AAO-HNS Coding Hotline answers each month for members. Members often have complex coding questions and as part of your membership dues, the Academy provides access to members to an AAO-HNS Coding Hotline that can answer your questions. Since January 2012, the coding hotline has answered 945 coding questions from members and their staff (through August 2012). You can reach the Coding Hotline from 9:00 am to 6:00 pm EST, at 1-800-584-7773, to have your coding questions answered within one to two business days. More complex questions and review of operative notes or Evaluation and Management encounters will be answered in three to five business days and not to exceed 10 business days.

> During the past year, the Academy's Health Policy department has been busier than ever, expanding its capabilities and advocating for members with regard to private payer, and federal regulatory, policies.

9

The number of updated Clinical Indicators the Academy released in 2012. In May, the Academy completed a review of outdated Clinical Indicators

and released nine updated documents designed to help members by defining a basis of medical necessity for a range of procedures. Indicators include definitions; procedures and CPT codes; indications, including history, physical examination, and tests; postoperative observations (if applicable); outcome reviews; associated ICD-9 diagnostic codes; and patient information. They can be accessed at http://www.entnet.org/Practice/clinicalIndicators.cfm.

39

The number of CPT for ENT articles available to help members. Academy coding experts have drafted numerous CPT for ENT articles designed to help members with complex coding issues. Article topics include stereotactic computer-assisted navigation, nasal sinus endoscopy, and Modifier-59. CPT for ENT articles can be found at http://www.entnet.org/Practice/cptENT.cfm.

8

The number of Appeal Template letters the Academy has produced to help members with denials. Appeal Template letters are designed by Academy socioeconomic experts and are offered as a resource for members to assist in the appeal process for specific procedures you feel were inappropriately denied. Letters include balloon dilation, septoplasty, and image guidance templates and can be accessed with other private payer advocacy resources at http://www.entnet.org/Practice/pmNews.cfm.

9

The number of private payer policies the Academy has commented on in 2012. Private Payers such as BlueCross BlueShield, WellPoint, and UnitedHealthcare often send drafts of national policies to the Academy for review. With the input of expert Academy clinical committees, the Academy provides comments to these payers on the appropriateness of the policies and their contents. The Academy has been successful in working with payers to ensure their policies allow physicians to make necessary medical decisions

to provide the highest quality of treatment for their patients, and to obtain appropriate reimbursement for their care. Notable efforts in 2012 include Academy-led advocacy for increased local coverage for balloon dilation procedures, which have resulted in coverage of balloon dilation-only procedures for roughly 194 million people nationwide.

20

The number of CPT codes the Academy successfully surveyed and presented to the AMA Relative Update Committee (RUC) during 2012. The Academy anticipates the high level of work in this area to continue into 2013. This is in large part due to the change in policy requiring families of codes to be surveyed, rather than individual CPT codes, when a code is identified by CMS as requiring review. Members should expect 2013 surveys to include nasal/sinus endoscopy codes, removal of cerumen, and chemodenervation for spasmodic dysphonia, among others.

6

The Academy submitted six Code Change Proposals (CCPs) in 2012 to the AMA CPT Editorial Panel and commented on two CCPs. This included proposals to clarify and expand on correct coding guidance for the large family of soft tissue codes, removal of cerumen, and dilation of the esophagus, as well as the development of new codes for rigid, transoral, and transnasal esophagoscopy and chemodenervation for spasmodic dysphonia; and the deletion of one complex wound repair code. Find out more about filling out surveys and participating in the CPT process at http://www.entnet.org/Practice/Applying-for-CPT-codes-and-Obtaining-RVU.cfm.

29

The number of Policy Statements under review by Academy clinical committees. Policy Statements serve the following functions: as a response to payer policies; a way to publicize our position or support a procedure; for use in advocacy efforts with state and federal regulatory bodies, or in response to federal policy or law; or to clarify the Academy's position on certain practices within the specialty. They are reviewed every three years to ensure the statements are current and useful for members. The Academy's policy statements can be accessed at http://www.entnet.org/Practice/policystatements.cfm

1

The number of members it takes to influence policies affecting otolaryngologists-head and neck surgeons. The Academy is dedicated to the pursuit of the best interests of otolaryngologists and works tirelessly on behalf of members, but the best advocate for the specialty is you. There is nothing more powerful than the voice of the physician who operates on and cares for patients, so we appreciate your efforts in getting involved in Academy advocacy and health policy efforts, including taking RUC surveys, reviewing private payer coverage policies, and reviewing AAO-HNS Clinical Indicators and Policy Statements to keep them updated. For more information on how you can help, read the weekly News, quarterly HP Updates, or contact the Health Policy staff at HealthPolicy@entnet.org.

CPT Changes for 2013: What ENTs Need to Know

As the medical community has come to expect, part of the annual rulemaking process conducted by the Centers for Medicare and Medicaid Services (CMS) includes the annual issuance of new and modified CPT codes, developed by the American Medical Association's (AMA) Current Procedural Terminology (CPT) Editorial Panel, for the coming year. In addition, CMS includes new, or updated, values—also known as relative value units (RVUs)—for medical services, which have undergone review by the American Medical Association's Relative Update Committee (AMA RUC). CMS has the discretion to accept the RUC's RVU recommendations for physician work, and their recommendations for direct practice expense inputs, or they may exercise their administrative authority and elect to assign a different value, or practice expense inputs, for medical procedures paid for by Medicare. The final value, as determined by CMS, is then publicly released in the final Medicare Physician Fee Schedule (MPFS) rule for the following calendar year.

The Academy is an active participant in both the AMA RUC valuation of otolaryngology-head and neck services, and the CMS annual rulemaking processes. As part of those efforts, we want to ensure members are informed and prepared for key changes to CPT codes and valuations related to otolaryngology-head and neck surgery serviced for CY 2013. The following outlines a list of coding changes, including new and revised CPT codes, and codes that were reviewed by the AMA RUC and could have modified Medicare reimbursement values for 2013:

New Codes

In CY 2013, several new CPT codes will be introduced, including:

- Two new codes to report pediatric polysomnography for children under the age of six. These services will be reported using new CPT codes 95782 and 95783.
- Two new codes to report intraoperative neurophysiology monitoring in the operating room. This also includes new introductory language in that section of the CPT book. These services will be reported using new CPT codes 95940 and 95941.

Codes Reviewed by the AMA RUC

The AMA RUC reviewed several codes relating to otolaryngology and their RUC-approved values were submitted to CMS for final determination for the CY 2013 final rule. Members should be prepared for modified relative value units for some, or all, of these procedures in CY 2013. It is critical to note that once the final MPFS is issued by CMS, typically on or about November 1 of each year. Academy health policy staff will summarize the final rule and alert members to any critical changes in reimbursement for any of the following medical procedures. Services that were reviewed include:

- **31231** Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)
- **40490** Biopsy of lip
- **69200** Removal foreign body from external auditory canal; without general anesthesia
- **69433** Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia
- **13132** Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm
- **13151** Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm
- **13152** Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm
- **New codes for pediatric polysomnography**
  - **95782** younger than six years, sleep staging with four or more additional parameters of sleep, attended by a technologist
  - **95783** younger than six years, sleep staging with four or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist
- **New add-on codes for intraoperative neurophysiology monitoring**

  - **+95940** Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes (List separately in addition to code for primary procedure.)
  - **+95941** Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour (List separately in addition to code for primary procedure.)

As noted above, health policy staff will provide members with a detailed summary of CMS approved values for the above services once they are issued in the 2013 final MPFS. Should members have any questions regarding the above information in the meantime, email healthpolicy@entnet.org.

Partners for Progress

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A Special Invitation for Your Practice or Academic Center

The AAO-HNS Partners for Progress are a special group of institutions and practices that believe so strongly in our work that they have elected to dedicate significant resources to support our mission.

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You can join this exclusive group of partners today by providing a generous gift of $10,000 or more to support the AAO-HNS. Contact Mary McMahon, 1-703-535-3717 or **mmcmahon@entnet.org** for details.

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As of November 1, 2012

AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY FOUNDATION

Global ENT Outreach Mission Trip: Phnom Penh, Cambodia

Anthony G. Del Signore, MD
Mount Sinai School of Medicine
Resident Travel Grantee

Ian M. Humphreys, DO
Michigan State University/Detroit Medical Center
Resident Travel Grantee

Anthony Del Signore, MD, examines a patient's ear during the screening clinic.

In July, we joined a medical missions trip led by Global ENT Outreach to Phnom Penh, Cambodia. This was the largest volunteer group to date for our host organization and included the following team members: **Shaheen M. Counts, MD; Anthony G. Del Signore, MD; Ian M. Humphreys, DO;** Marta Sandoval, MD; **Richard Wagner, MD;** and **Charles Z. Weingarten, MD.** We feel the experiences afforded to us by the AAO-HNSF Humanitarian Travel Grant were truly remarkable.

After nearly 20 hours of travel we reached the Cambodian capital of Phnom Penh. Our team of surgeons, nurses, medical students, and public health educators met for the first time in a tiny hotel. Our nationalities, ethnicities, and languages were diverse, but we shared a unified vision of providing otologic care and training to these people in need.

Only 30 years prior, an act of unspeakable genocide targeted the educated and professionals in this area; an entire generation of physicians, health educators, and nurses were eradicated. Today, a fractured healthcare system with poor infrastructure, limited resources, and inexperienced health professionals exists. Rehabilitative efforts, including a nascent otolaryngology residency-training program at the National Hospital Preah Ang Duong, are underway. However, otologic care in particular is poorly understood and under delivered.

The week began with a dedicated otologic clinic to further evaluate patients initially screened by Cambodian otolaryngologists. Many patients traveled great distances from the surrounding countryside to obtain long awaited care. In total, 120 patients were evaluated using either a teaching microscope or video endoscope. Forty-five surgeries were scheduled subsequently for the remainder of the week.

Ian Humphreys, DO, with a post-operative patient.

We saw a diverse spectrum of pathology, and patients including congenital malformations, chronic otorrhea, tympanic membrane perforations, cholesteatoma, and otosclerosis. Accordingly, surgical interventions focused on the management of chronic ear disease, with tympanoplasty and tympanomastoidectomy being the most frequent surgical procedures.

One goal reigned supreme: to create a dry, safe ear. Given the lack of readily available inhalational anesthesia, the majority of the procedures were performed under local anesthesia and intravenous sedation. All patients were admitted for overnight observation and subsequently discharged home with follow-up care to be provided by the Cambodian otolaryngologists.

Both in the clinic and operating room we had frequent opportunities to teach evaluative and diagnostic strategies, as well as surgical techniques. Despite obvious cultural and language barriers, we focused our collective efforts to achieve our mission. In the end, we provided high quality demonstrative surgery and instruction that serves as a model for continued development of the Cambodian otolaryngology training program.

Not only did we gain an appreciation for the difficulty of providing otologic care in a relatively impoverished part of the world with limited resources and a fractured health system, we also experienced the role of surgeon educator. In the end, our cultural awareness and sense of humanistic professionalism flourished throughout our Cambodian experience.

We are completely indebted to the support provided by the AAO-HNSF Humanitarian Efforts Committee and the Alcon Foundation for this wonderful experience and are confident that it has solidified our commitment to future mission endeavors.

Otolaryngology in Eretz-Israel: 1911-1948

Avishay Golz, MD
Rambam, Health Care Campus and
Bruce Rappaport Faculty of Medicine
The Technion Department
of Otolaryngology-Head
and Neck Surgery
Haifa, Israel

Until 1911, there was no Ear Nose and Throat (ENT) specialist in Eretz-Israel. Moshe Sherman, MD, an ENT specialist, disembarked at the port of Jaffa on August 4, 1911. He acquired his medical education in Odessa and Berlin, graduated from the University of Dorpat (now Tartu), Estonia, and pursued postgraduate studies in otolaryngology in Moscow, Russia.

Dr. Sherman was the first otolaryngologist in the country and remained the sole specialist for almost one year. He lived and worked in Jaffa and every six months he went to Jerusalem for two weeks to examine patients and perform small operations. In January 1912, Dr. Sherman, together with five other physicians, laid the foundation for the first doctors' organization in Israel—the Israel Medical Association of today.

Between 1911 and 1948, when the State of Israel was established, more than 100 otolaryngologists arrived in Israel and were dispersed throughout the country.

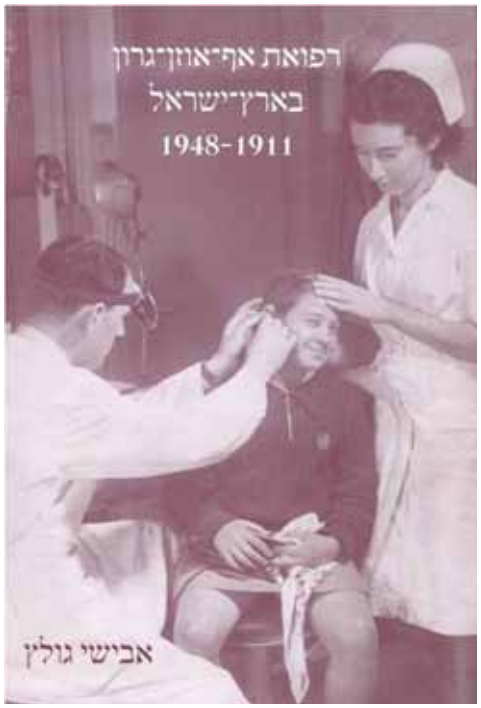
Karl Berenfeld, MD, opened the country's first ENT department in 1925 at Bikur Holim Hospital in Jerusalem. Dr. Berenfeld studied medicine in Vienna, and practiced otolaryngology, also in Vienna, under the famous professors Markus Hajek, Gustav Alexander, and Heinrich Neumann.

Dr. Sherman and Dr. Berenfeld, together with other otolaryngologists, brought modern and advanced European medicine to Israel. Many left their imprint on the development of ENT medicine in the country, laying the foundation of today's otolaryngologic services, both in clinical and academic spheres.

ENT medicine, like the other fields of medicine, evolved following the establishment of the State of Israel in 1948. Many departments were opened and equipped with the best modern instruments and technology. Department heads are the pupils of our pioneer physicians.

The book *Otolaryngology in Eretz-Israel: 1911-1948* is dedicated to the memory of these pioneer physicians, to their work and their achievements. They should be remembered and cherished by their successors and all physicians in Israel.

The book (in Hebrew) can be purchased through the publisher Itay Bahur: www.bahurbooks.com or contact: itay@bahurbooks.com



Otolaryngology in Eretz-Israel: 1911-1948 book cover.

Moshe Sherman, MD, the first otolaryngologist in Israel.

Otolaryngology Historical Society

Many thanks to Professor Golz, who donated a copy of *Otolaryngology in Eretz-Israel: 1911-1948* to the AAO-HNS Foundation's historical collection, managed by the History Factory, Chantilly, VA. For inquiries, email info@historyfactory.com or call 1-703-631-0500.

Reminder: If you have not yet renewed your OHS membership this year, email museum@entnet.org or call 1-703-535-3738. Not yet a member? Visit http://www.entnet.org/HealthInformation/otolaryngologyHistoricalSociety.cfm.

From Cancer to Cookbooks: The Story of Clementine Paddleford*

Andrew G. Shuman, MD
Head and Neck Service,
Department
of Surgery,
Memorial Sloan-Kettering
Cancer Center, New York, NY

The story of Clementine Paddleford, a laryngeal cancer survivor, who thereafter became the most famous culinary journalist of her time, would be remarkable in any era. The fact that she accomplished this feat 80 years ago makes it simply extraordinary.

Through archival research, the oft-forgotten tale of Clementine Paddleford may be shared with a new generation. An aspiring journalist from Kansas, Paddleford developed hoarseness shortly after arriving in New York in 1931; subsequent workup confirmed laryngeal cancer. Perhaps no individual better encapsulates the potential consequences of head and neck cancer than does a food writer; speech and swallowing are truly indispensable.

Clementine Paddleford, journalist and cookbook author. Photographs courtesy of Special Collections, Hale Library, Kansas State University.

In an era when vocal rehabilitation after total laryngectomy was severely limited and conservation laryngeal procedures were still being developed, Paddleford and her surgeon at New York Hospital agreed to proceed with partial laryngectomy.

Thereafter, she persevered, never accepting that she was disabled. Her permanent metal tracheotomy tube morphed into a fashion statement, and her distinctive dysphonia became her calling card.

Paddleford penned a column with a weekly readership measured in the millions, and served as the food editor for a major newspaper in Manhattan during a decades-long tenure. She would pilot an airplane across the country, writing about regional cuisine decades before the topic became popular.

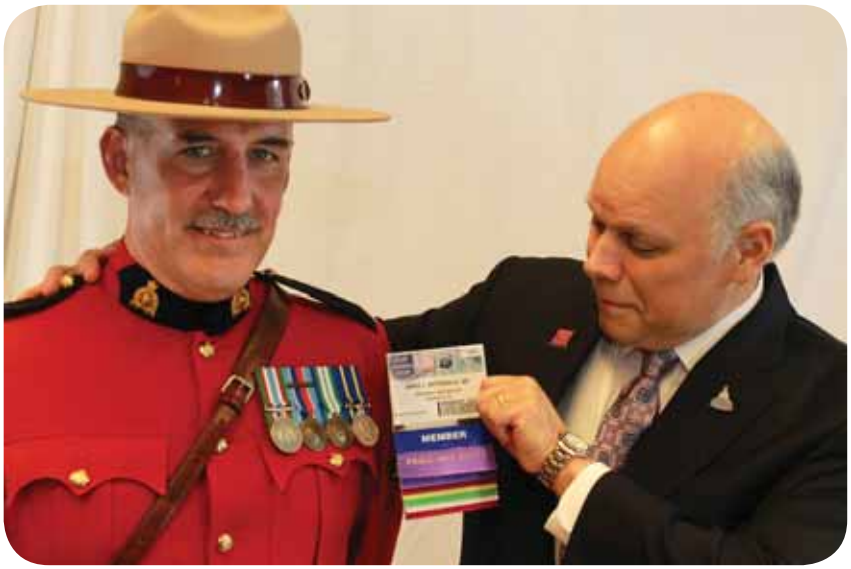
Paddleford's success reminds us that cancer survivorship is not only measured in months or years. Even in modern surgical oncology's infancy, functional outcomes were carefully considered, and quality of life was prized. As a testament to individual willpower and the ability of doctors and patients to forge partnerships with common goals, Paddleford's legacy lives on.

Eleanor Roosevelt (l) presents the New York Newspaper Women's Club Award to Clementine Paddleford (r). Paddleford won the award seven times.

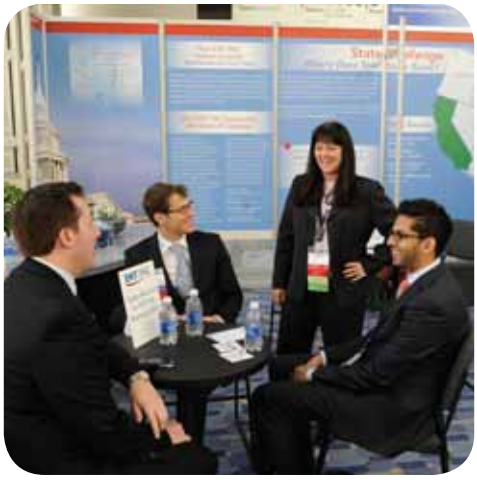
*Based on Dr Shuman's presentation at the Otolaryngology Historical Society's 2012 meeting at the Cosmos Club, Washington, DC, September 10, 2012.

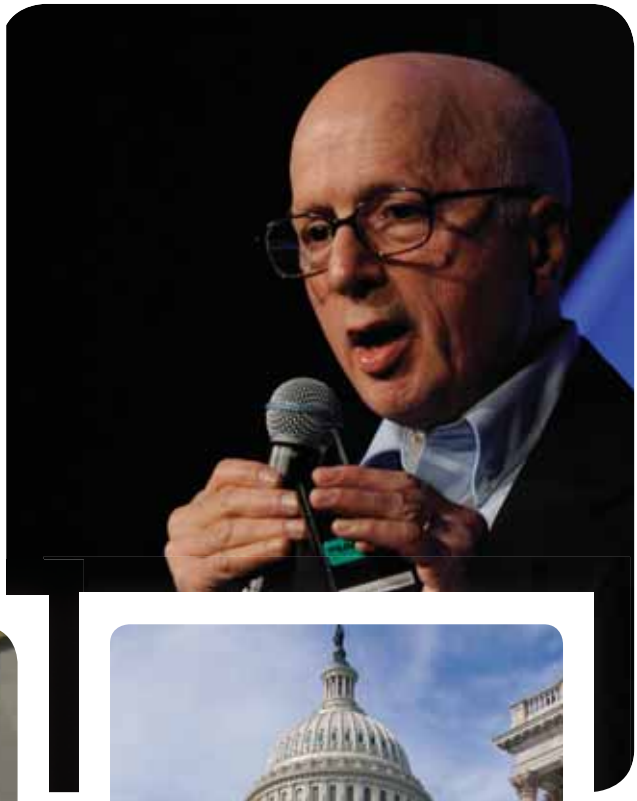
For a fuller description, please see the October issue of *Otolaryngology–Head and Neck Surgery*.

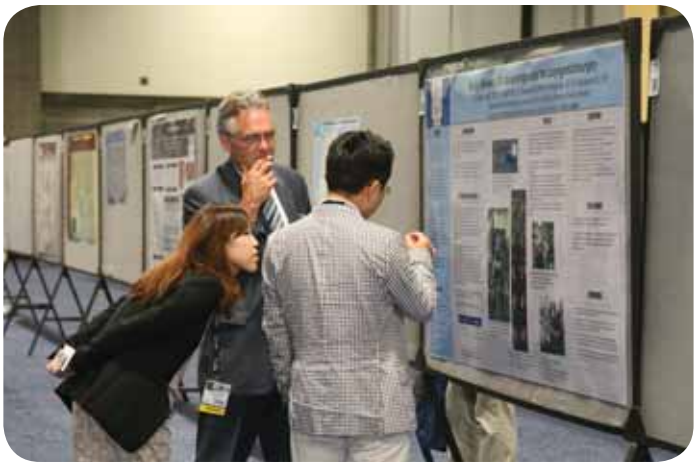
The following is a collection of pictures from various 2012 AAO-HNS events and milestones. What a great year it has been.



2012 Snapshots








COCLIA
PMP

Otolaryngologist-Head and Neck Surgeon
Tampa, Florida

The **James A. Haley VA Hospital**, seeks a board certified/board-eligible Otolaryngologist-Head and Neck Surgeon for a part-time position (0.375 FTE) on the attending staff in the Otolaryngology Section, Surgery Service.

Duties include outpatient, inpatient, and surgical care of a large and diverse population of veterans with diseases and disorders encompassing the full breadth of the specialty. Teaching responsibilities include didactic and clinical instruction of otolaryngology residents at all levels of training as well as medical students and residents from other specialties. Broad training and proficiency in the specialty, especially in the areas of general otolaryngology, head and neck surgical oncology, sleep disorders, and laryngology, are necessary. Specific expertise in head and neck oncologic and reconstructive surgery, surgery for sleep disorders, endoscopic sinus surgery, thyroid surgery, and laryngeal microsurgery is required. The successful candidate will join a group of 9 board certified Otolaryngologists on the hospital staff. The James A. Haley VA Hospital is a major teaching institution of the University of South Florida Morsani College of Medicine.

For questions regarding the position please contact Marion.Ridley@va.gov. For information on how to apply please see the Physician (Otolaryngologist) announcement on:

www.usajobs.opm.gov
James A. Haley VA in Tampa, FL

If additional information is needed, please contact Dr. Marion Ridley at (813) 972-2000 ext 6378. First preference will be given to a US Citizens.
EOE • DFWP • MFVD

Department of Veterans Affairs

James A. Haley Veterans' Hospital

MAYO CLINIC

Mayo School of Continuous Professional Development

Endoscopic Sinus and Skull Base Surgery 2013

Mayo Clinic • Scottsdale, Arizona • April 3-6, 2013

Guests of Honor:
Prof. Heinz Stammberger (Austria)
Prof. Piero Nicolai (Italy)

Honored National Faculty:
Anne E. Getz, MD
Peter H. Hwang, MD
Juan Fernandez-Miranda, MD
Carl H. Snyderman, MD
James A. Stankiewicz, MD

Course Director: Devyani Lal, MD

Mayo Clinic and Arizona Faculty:
Stephen F. Bansberg, MD
Timothy W. Haegan, MD
Joseph M. Hoxworth, MD
Erin K. O'Brien, MD
John F. Pallanch, MD
Naresh P. Patel, MD
Ryan M. Rehl, MD

Endoscopic Sinus and Skull Base Surgery 2013 is our second state-of-the art course designed for otolaryngologists and endoscopic skull base surgeons. The curriculum will focus on inflammatory sinus disease on April 3-4, highlighting advanced, salvage and novel treatment strategies. Endoscopic skull base surgery will be the focus April 5-6. The curriculum is designed to introduce the novice surgeon to basic techniques, and provide advanced training for the more experienced surgeon. Hands-on dissection sessions will be conducted in our world-class laboratory with fresh frozen cadavers, powered instrumentation and image guidance.
Accommodations: Westin Kierland Resort • *www.kierlandresort.com* • (480) 924-1202 • Residence Inn Phoenix Desert View at Mayo Clinic • *www.marriott.com/phxmh* • (800) 331-3131
Meeting Location: Mayo Clinic's Phoenix and Scottsdale campuses
To Register, Contact MSCPD: *www.mayo.edu/cme/otorhinolaryngology* • email: *mca.cme@mayo.edu* • (480) 301-4580

Featuring: Hands-on dissection, live prosection and endoscopic 3D anatomy

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PRESBYTERIAN HEALTHCARE SERVICES
Albuquerque, NM

Presbyterian Medical Group is seeking two BC/BE otolaryngologists to join our outstanding, well-established group of ENT providers. Have a satisfying full-spectrum ENT practice with a large built-in referral base while at the same time enjoying a great quality of life in the beautiful Southwest. ER call 4 days/month. Practice call shared equally among group. Our medical group employs more than 600 primary care and specialty providers and is the fastest growing employed physician group in New Mexico.

In addition to a competitive guaranteed base salary, plus productivity bonus, we offer a generous sign-on bonus, quality bonus, malpractice, relocation, house hunting trip, health, dental, vision, life ins, 403(b) w/contribution and match from employer, 457(b), short & long term disability, CME allowance, etc.

Albuquerque thrives as New Mexico's largest metropolitan center and has been listed as one of the best places to live in the United States by several major publications. A truly diverse and multicultural city, Albuquerque offers you and your family a wide variety of experiences, outdoor activities and entertainment. It is also home to the University of New Mexico, a world renowned institution.

Contact Michael Criddle, MD at mcriddle@phs.org or Kay Kernaghan, Physician Recruiter, kkernagh@phs.org or 505-823-8770 for more information or to forward CV. Please visit our website at www.phs.org

THE 2013 ALBERT C. MUSE PRIZE IN OTOLARYNGOLOGY
Awarded by the Eye & Ear Foundation of Pittsburgh

CALL FOR NOMINATIONS
We seek nominations for individuals who have made extraordinary contributions to the field of otolaryngology.

The Albert C. Muse Prize was established in 2001 by the Ear & Ear Foundation of Pittsburgh to honor world leaders in the fields of ophthalmology and otolaryngology. The Eye & Ear Foundation's mission is to support the Departments of Ophthalmology and Otolaryngology at the University of Pittsburgh, it's School of Medicine and the University of Pittsburgh Medical Center.

The Muse Prize alternates annually between Ophthalmology and Otolaryngology, carries a cash award of $5,000, and recognizes individuals who have made significant, progressive contributions to science and medicine in these specialties.

Presentation of the award will take place in the Fall of 2013. The prize is named for Albert C. Muse, who has served the Eye and Ear Institute and Foundation Board for more than three decades and has generously supported research into diseases affecting the eye, ear, nose and throat.

ELIGIBILITY:
The 2013 Albert C. Muse Prize in Otolaryngology is open to all individuals who have made extraordinary contributions within the field of otolaryngology.

There is no geographical restriction on candidates. Each nomination will be reviewed by a select panel of judges including otolaryngologists from the UPMC Department of Otolaryngology, a national leader in otolaryngology research and clinical innovation.

THE Eye & Ear Foundation OF PITTSBURGH

NOMINATION PROCESS
All nominations must be received by January 31, 2013 at the address below:

Please complete this form:

NOMINEE: _____

Institution: _____

Address: _____

_____

Telephone: _____

Fax: _____

Email: _____

NOMINATOR: _____

Institution: _____

Address: _____

_____

Telephone: _____

Fax: _____

Email: _____

Also submit:
- Brief biographical sketch of the nominee (no more than one page)
- Summary of important contributions made by the nominee to the field of otolaryngology (no more than two pages)
- List of three key publications by the nominee
- Up-to-date curriculum vitae for the nominee

Mail nomination form and supporting materials to:
Eye & Ear Foundation
Albert C. Muse Prize in Otolaryngology Committee
200 Lothrop Street
Eye and Ear Institute, Suite 251
Pittsburgh, PA 15213
412.383.8756
www.eyeandear.org

West Virginia University.

The Department of Otolaryngology/Head & Neck Surgery at West Virginia University is seeking a general otolaryngologist to join a thriving academic practice in the summer of 2013. Applicants must be board certified/eligible by the American Board of Otolaryngology. Responsibilities include teaching of residents and medical students, patient care and clinical/basic research.

The department currently has ten physician faculty members and fifteen residents and has an active NIH-funded research division with three PhD members.

With a metro area population of over 115,000, Morgantown, WV, is consistently rated as one of the best small cities in the U.S., with affordable housing, excellent schools, a picturesque countryside, many outdoor recreational activities, and close proximity to major cities, such as Pittsburgh, PA, and Washington, DC.

The position will remain opened until filled. For more information please contact:

Laura Blake
Director, Physician Recruitment
blakel@wvuhealthcare.com
Fax: 304.293.0230
http://www.hsc.wvu.edu/som/otolaryngology/

West Virginia University is an AA/EO Employer. WVU Health Sciences is a tobacco free campus. West Virginia University is the recipient of an NSF ADVANCE award for gender equity.

Charlotte Eye Ear Nose & Throat Associates, P.A.

CHARLOTTE EYE EAR NOSE AND THROAT
MONROE, NC
COMPREHENSIVE OTOLARYNGOLOGIST

Charlotte Eye Ear Nose and Throat Associates, PA, (headquartered in Charlotte, North Carolina) a physician-owned and operated dual specialty practice is seeking a BC/BE full time comprehensive otolaryngologist to practice all aspects of the field for 2013 in our Monroe facility located 20 miles from Charlotte. The largest provider of eye and ENT services in the Charlotte area, CEENTA offers a full range of services including general otolaryngology, pediatric otolaryngology, neurotology, laryngology subspecialty representation, voice center with 2 SLP, sleep medicine and facial plastic surgery.

The group, consisting of forty-seven ENT providers and sixteen locations has state of the art equipped offices including complete audiology services, allergy clinics, a CT scanner, an ambulatory surgery center, sleep lab and an in-house contract research organization.

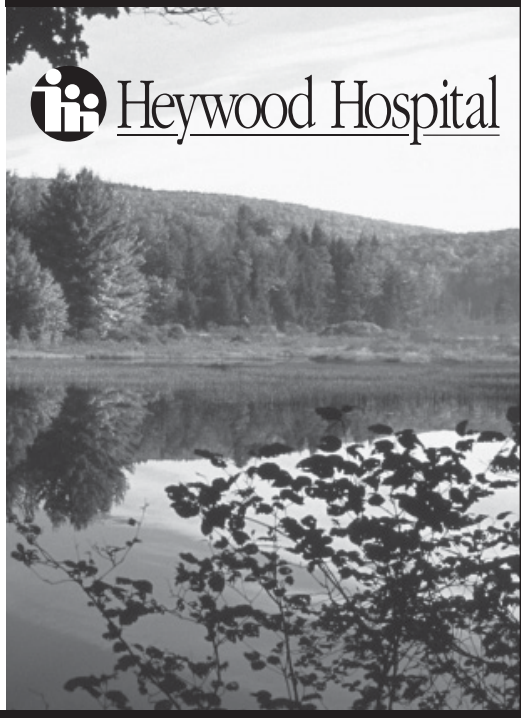
Charlotte, NC is two hours east of the Appalachian Mountains and 3 ½ hours west of the Atlantic Ocean. It is nationally recognized for combining academic rigor with rich opportunities in the arts and humanities as well as professional and collegiate athletics. It is also recognized as one of the leading cultural capitals of the south and spectators can cheer their home favorite in just about any sport.

Excellent salary with partnership anticipated, 401(k), professional liability insurance, health insurance, long term disability and life insurance.

Annette Potts, Director-Human Resources
Charlotte Eye Ear Nose and Throat Associates, PA
6035 Fairview Road Charlotte, North Carolina 28210
Email: apotts@ceenta.com
Fax: 704.295.3415
EOE

Tremendous ENT Practice Near Boston
NOW INTERVIEWING

Heywood Hospital



Come to the scenic area of North-central Massachusetts and experience an exquisite blend of a busy private practice and fulfilling personal lifestyle. Heywood Hospital and Health Alliance Hospital, located just a short drive from Boston, are collaborating in an effort to bring an additional ENT physician to join an existing practice within their service area. The combination of a manageable call arrangement and definitive need for additional general otolaryngology care for the area communities makes this a wonderful career choice for anyone seeking a practice opportunity in New England. No concern for sufficient patient volumes exists here!

This established practice, located between Gardner and Leominster, MA, has been in existence for over 10 years and is and poised and prepared for growth. Recent renovation and expansion of office space will accommodate this new ENT physician in a very comfortable layout. Both hospitals offer state-of-the-art OR suites, with Heywood Hospital unveiling a brand-new OR platform in 2014. This provides all surgeons on staff with the opportunity to provide input into final details of this new surgical facility.

A very competitive starting income and benefits package awaits you, as does an opportunity for an exceedingly successful practice, both financially and personally. If this is what you have been seeking as it relates to the future of your medical career, this opportunity in Massachusetts will not disappoint.

Central Massachusetts, located in the Heart of New England is a hidden gem of culture, arts, special events and wonder waiting to be discovered. New England is a dynamic area rich in culture and natural beauty. Central Massachusetts in particular, including the communities of Gardner and Leominster, is an area that fully exhibits the character of New England. Rolling hills and deep woodlands create a landscape that has been the centerpiece of countless works of art. Country towns with smiling locals and rising metropolitan areas come together to form the heart of New England. Few areas in the Northeast offer so much so close!

For more information, please contact:

Michelle Kraft
800-678-7858 x64457 | mkraft@cejkasearch.com

ID#145978AD

cejkasearch.com

Children's Hospital LOS ANGELES
DIVISION OF OTOLARYNGOLOGY HEAD AND NECK SURGERY

Division of Otolaryngology-Head and Neck Surgery Children's Hospital Los Angeles ***Department of Otolaryngology Keck School of Medicine University of Southern California***

Full-Time Pediatric Otolaryngologist at the Assistant/Associate Professor level.

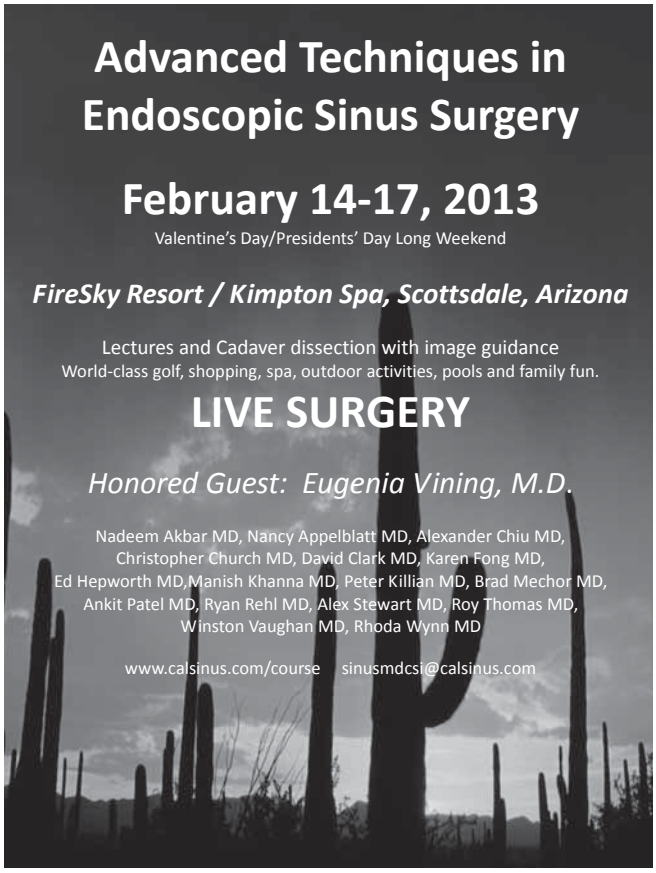
The candidate must be fellowship trained and either board eligible or certified. Specialty interest and/or training in otology or laryngology would be preferred. The candidate must obtain a California medical license.

CHLA is one of the largest tertiary care centers for children in Southern California. Our new "state-of-the-art" 317 bed hospital building with 85% private rooms opened July 2011. Our group has a nice mix of academic and private practice. Both clinical and basic science research opportunities are available and supported.

Excellent benefits available through USC.
USC values diversity and is committed to equal opportunity in employment. Women and men, and members of all racial and ethnic groups are encouraged to apply.

Please forward a current CV and three letters of recommendation to:
Jeffrey Koempel, MD, MBA
Chief, Division of Otolaryngology - Head and Neck Surgery
Children's Hospital Los Angeles
4650 Sunset Boulevard MS# 58
Los Angeles, CA 90027

jkoempel@chla.usc.edu
(323) 361-5959



OTOLARYNGOLOGIST OPPORTUNITY

Geisinger Wyoming Valley (GWV) Medical Center, Wilkes-Barre, Pa., is seeking a BC/BE Otolaryngologist.

Geisinger's otolaryngology specialists treat a wide range of conditions of the head and neck by providing the latest technologies in diagnostic, medical, surgical and rehabilitative techniques. We have board-certified and fellowship-trained specialists who collaborate to ensure the most comprehensive care.

About the Position

- Take part in the growth of this dynamic department
- Pursue research in your area of interest

Geisinger Wyoming Valley (GWV) Medical Center, Wilkes-Barre, Pa., is an acute care hospital that is licensed for 243 beds and houses the only Level II Trauma center in Luzerne County. The campus includes the Frank M. and Dorothea Henry Cancer Center, The Richard and Marion Pearsall Heart Hospital, the Janet Weis Children's Hospital Pediatric Unit, a transplant program and the Brain & Spine Tumor Institute. Geisinger South Wilkes-Barre (GSWB) is GWV's ambulatory campus.

Discover for yourself why Geisinger has been nationally recognized as a visionary model of integrated healthcare.

For more information or to apply for this position, please contact:

Autum Ellis, Department of Professional Staffing, at 1-800-845-7112 or amellis1@geisinger.edu

Learn more at Join-Geisinger.org

GEISINGER HEALTH SYSTEM
REDEFINING THE BOUNDARIES OF MEDICINE.

Children's Mercy HOSPITALS & CLINICS | Kansas City

Children's Mercy Hospitals and Clinics – Kansas City is seeking fellowship trained Pediatric Otolaryngologists to join our professional staff at the assistant or associate professor level. The position would entail clinical care, research, and teaching of medical students, and pediatric and otolaryngology residents.

Our active Pediatric Otolaryngology Section provides comprehensive tertiary patient care in a family-centered environment. There are currently 7 pediatric otolaryngologists on staff, as well as 3 neurotologists. In addition, our ACGME-accredited pediatric otolaryngology fellowship welcomed our 4th fellow this July, 2012. Children's Mercy Hospitals & Clinics is a large pediatric health care system that is affiliated with the University of Missouri-Kansas City School of Medicine. The main hospital is growing to nearly 400 beds this year with plans to expand to 41 PICU beds and 80 NICU beds.

Kansas City is a bi-state community with close to 2 million residents who enjoy an excellent quality of life. There is a robust offering of arts and entertainment, with a number of new venues having just opened within the past few years. The Kansas City metroplex contains a wide selection of highly rated public and private schools. We are also the regional home to several major colleges and universities. Salary and academic range are commensurate with experience. EOE/AAP

Robert A. Weatherly, MD
Section Chief, Ear, Nose, and Throat
rweatherly@cmh.edu
Phone: 866-CMH-IN-KC/866-264-4652
www.childrensmercy.org

University of Missouri

Department of Otolaryngology—
Head and Neck Surgery

Seeks clinicians, teachers, and researchers who are personable, energetic and innovative to join a rapidly growing and collaborative group of physicians. A Faculty opportunity at all academic levels (Assistant/Associate Professor or Professor or Clinical Assistant/ Associate Professor or Clinical Professor) is available in **Head and Neck Surgical Oncology with microvascular experience**. Title, track, and salary are commensurate with experience.

- Competitive production incentive
- Research interests encouraged and supported
- New outpatient clinic with state-of-the-art equipment and ancillary services
- Well established and expanding hospital system
- Live and work in Columbia, ranked by *Money* magazine and *Outside* magazine as one of the best cities in the U.S.

For additional information about the position, please contact:
Robert P. Zitsch III, M.D.
William E. Davis Professor and Chair
Department of Otolaryngology—Head and Neck Surgery
University of Missouri—School of Medicine
One Hospital Dr MA314 DC027.00
Columbia, MO 65212
zitschr@health.missouri.edu

To apply for this position, please visit the MU web site at hrs.missouri.edu/find-a-job/academic/

The University of Missouri is an Equal Opportunity/Affirmative Action Employer and complies with the guidelines of the Americans with Disabilities Act of 1990. To request ADA accommodations, please contact (573) 884-7282 (V/TTY). Diversity applicants are encouraged to apply.

The University of Kansas Department of Otolaryngology-Head & Neck Surgery is seeking a laryngologist, a head and neck surgeon, and a rhinologist/skull base surgeon who are interested in full-time academic positions.

The successful candidate will have fellowship training with expertise in their specialty and is BC/BE. The candidate will join as an Assistant or Associate Professor and will be involved with resident and medical student education while developing a strong clinical practice and research interests.

Laryngologist

Position Number M0204650

Join a busy voice and swallow team with a state-of-the-art laryngeal lab and experienced speech pathology support.

Head and Neck Surgeon

Position Number M0203642

Join a division of four head and neck surgeons. Fellowship in microvascular surgery, surgical oncology and an interest in oncologic research preferred.

Veterans Affair Clinician/Scientist

The Department is looking for a full-time VA position with potential for VA research funding. Ideally this position will allow 50% protected time for research.

Head and Neck Fellowship

Clinical Focus: Head and Neck Surgical Oncology, Skull Base Surgery, Endoscopic Laser Surgery, Minimally Invasive Endocrine Surgery, Microvascular Reconstructive Surgery and Robotic Surgery.

Applications are accepted through the American Head and Neck Society: **www.ahns.info**.

KU UNIVERSITY of KANSAS
Department of
Otolaryngology
Head & Neck Surgery

To view position online, go to http://jobs.kumc.edu
(Search by position number.)

Letters of inquiry and CV may be mailed to:
Douglas Girod, MD, FACS, Professor and Chairman
The University of Kansas School of Medicine
Department of Otolaryngology-Head & Neck Surgery
3901 Rainbow Blvd. MS 3010, Kansas City, KS 66160

The University of Kansas School of Medicine is an Equal Opportunity/Affirmative Action employer.

Otolaryngologist
Expanding Practice in York, PA

YORK ENT associates

A well established, busy four physician group in York, Pennsylvania is looking to add a fifth, full time Board Eligible/Board Certified Otolaryngologist. Our services include Allergy, Audiology and Hearing Aid Sales. Our office has been running on an EMR system since 2006. On-Call rotation with five physicians. Your first year includes an excellent salary and a production bonus. Partnership available after your first year with our practice.

York is a fast growing community with excellent schools and a very comfortable cost of living. It is convenient to Baltimore, Washington and Philadelphia.

Local inpatient hospital is well run and state-of-the-art. Surgical Center is well equipped, and partnership in the Surgical Center is available.

We are looking for a dynamic, motivated individual for partnership track. Income potential in the 90th percentile.

Contact Renee Gohn
Office- 717-843-9089
Email- yorkent@comcast.net

BERGER HENRY ENT SPECIALTY GROUP

Live the dream!

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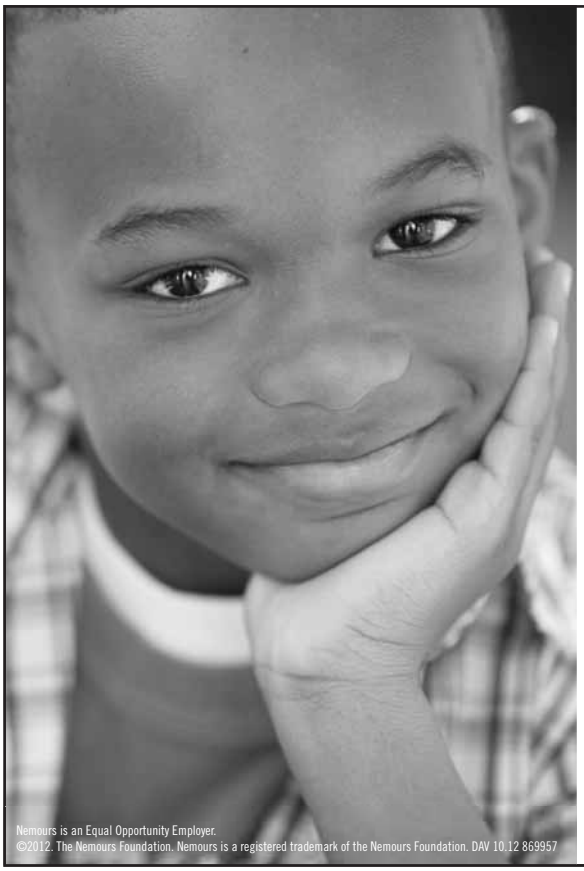

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As part of one of the premier pediatric health care systems in the nation, the Nemours Children's Clinic, Jacksonville is an 80+ physician pediatric subspecialty practice. Currently, we're looking for a full-time Pediatric Otolaryngologist to join our established 6-physician division with complete speech and audiology services. Ancillary services are available on site. Candidates must be fellowship-trained in Pediatric Otolaryngology, be BC/BE in Otolaryngology, and have a strong interest in clinical care, education and research.

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For information, contact:
Robert C. Sprecher, M.D., F.A.C.S., F.A.A.P., Chief, Division of Pediatric Otolaryngology, Office: 904-697-3690, Cell: 904-226-1748 or rspreche@nemours.org

Learn more at Nemours.org.

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West Virginia University.

The Department of Otolaryngology at West Virginia University is seeking a fellowship-trained head and neck surgeon to join a well established head and neck oncology service in the summer of 2013. Expertise with both ablative and reconstructive procedures is desired. Responsibilities include education of residents and medical students and patient care. Opportunities are available for those interested in clinical/basic research.

The department currently has ten physician faculty members and fifteen residents and has an active NIH-funded research division with three PhD members.

West Virginia University is located in beautiful Morgantown, which is rated one of the best small towns in America in regard to quality of life. Located 80 miles south of Pittsburgh and three hours from Washington, DC, Morgantown has an excellent public school system and offers culturally diverse, large-city amenities in a safe, family setting.

The position will remain opened until filled. Please send a CV with three professional references to:

Laura Blake
Director, Physician Recruitment
Fax: 304-293-0230
blakel@wvuhealthcare.com
http://www.hsc.wvu.edu/som/otolaryngology/

West Virginia University is an AA/EO Employer. WVU Health Sciences is a tobacco free campus. West Virginia University is the recipient of an NSF ADVANCE award for gender equity.

Pediatric Otolaryngology - Academic Position

The Department of Otorhinolaryngology is recruiting a third Pediatric Otolaryngologist to join a busy, tertiary Pediatric Otolaryngology practice. This is a unique opportunity to join a rapidly growing Department at a major University Children's Hospital with a large Level III NICU and a Level I Trauma Center. Excellent compensation and benefits. Academic appointment commensurate with experience. Strong interest in resident and medical student teaching and research is encouraged.

Applicants should forward a CV and statement of interest to:
Soham Roy, MD, FACS, FAAP
Director of Pediatric Otolaryngology
The University of Texas Medical School at Houston
Department of Otorhinolaryngology-Head & Neck Surgery
713-383-3727 (fax)
Soham.Roy@uth.tmc.edu
http://www.ut-ent.org

UTHealth
The University of Texas Health Science Center at Houston
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Assistant Professor or Associate Professor (full-time clinical, non-tenure track)
The Department of Otolaryngology-Head and Neck Surgery of LSU Health Sciences Center (New Orleans) is seeking a fellowship trained, BC/BE Laryngologist for a full-time faculty position at the rank of Assistant or Associate Professor (non-tenure track).

The selected candidate will practice primarily at the Our Lady of the Lake Medical Center Voice Center in Baton Rouge; this facility is a well established treatment resource for patients with voice, swallowing, and airway disorders serving Louisiana and the Gulf Coast. There is a collaborative clinical team established for patient evaluation and management, including laryngology, speech pathology and basic science support. The clinical practice encompasses all areas of laryngology with excellent departmental subspecialty coverage in neurotology, rhinology, head and neck oncology, facial plastic and reconstructive surgery and pediatric otolaryngology. Responsibilities include patient care, resident and medical student education, and the pursuit of clinical research. The candidate will assume a dedicated laryngology position in a busy clinical practice in a state of the art facility. Extensive collaborative research opportunities are available.

Reference PCN12-205

Assistant Professor, Associate Professor, or Professor (non-tenure, full-time clinical track)
The Department of Otolaryngology-Head and Neck Surgery of LSU Health Sciences Center is actively seeking a fellowship trained, BC/BE Pediatric Otolaryngologist for a full-time faculty position at the rank of Assistant Professor, Associate Professor or Professor (non-tenure track).

This is an excellent opportunity to join our growing practice. Responsibilities include patient care, resident and medical student education. Extensive collaborative research opportunities are also available. The candidate will assume a dedicated pediatric otolaryngologist position in a busy clinical practice in a state of the art, free standing Children's Hospital. An interest in airway reconstruction and/or sinus surgery is a plus.

Our Children's Hospital is a 247-bed, not-for-profit medical center offering the most advanced pediatric care for children from birth to 21 years. It is the only full-service hospital exclusively for children in Louisiana and the Gulf South. Critical care is provided in the hospital's 36-bed NICU, 24-bed PICU, and 20-bed CICU.

Our faculty team members enjoy liberal cross-coverage for weekend and holiday on-call responsibilities and share the benefit of subspecialty support in otology, laryngology, head and neck oncology, and plastic/reconstructive surgery.

We live in one of the most culturally diverse and fastest growing cities in the country, and residents can easily enjoy the outdoor and coastal lifestyle. New Orleans offers many of the amenities of larger cities but continues to maintain a small town family oriented atmosphere.

Reference Pediatric Otolaryngologist

LSUHealthNewOrleans
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Department of Otolaryngology

Head and Neck Surgery

Salary and rank will be commensurate with the knowledge, education and experience of the individual. Candidates interested in working within a dynamic and stimulating setting combined with a generous package of related benefits are encouraged to provide a cover letter with clinical and research interests and current Curriculum Vitae to ctorre@lsuhsc.edu; LSUHSC is an AA/EEO employer.

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For questions, contact Beth Faubel at (312) 202-5033 or visit www.cosm.md

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Send letter of interest and CV to:

Robert H. Mathog, M.D.
Professor and Chair
Department of Otolaryngology
540 E. Canfield, 5E-UHC
Detroit, MI 48201
(313) 577-0804

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