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American Academy of Otolaryngology—Head and Neck Surgery

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(1) Rosen, Clark A., et al. Vocal Fold Augmentation with Calcium Hydroxylapatite (RADIESSE Voice), Otolaryngology – Head and Neck Surgery (February 2007), 136(2): 198-204

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# bulletin

American Academy of Otolaryngology—Head and Neck Surgery

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## Advances in Head and Neck Surgery

From preemptive strikes against pharyngeal cancers to advances in robotic surgery, otolaryngology—head and neck surgery is riding a wave of trends and technological discoveries toward significant breakthroughs.

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AMERICAN ACADEMY OF  
OTOLARYNGOLOGY—  
HEAD AND NECK SURGERY

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

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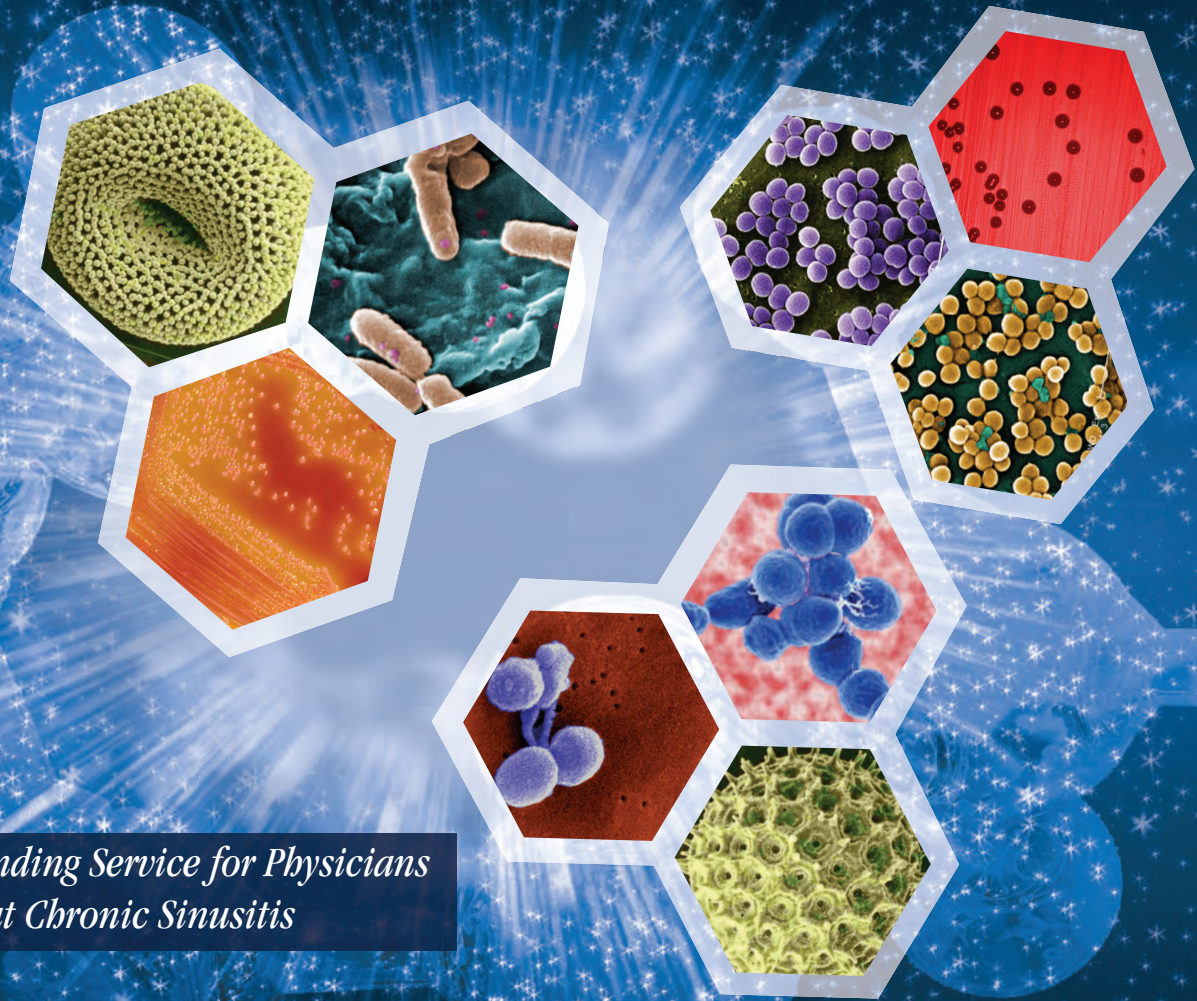
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## Planning for 2012 and Beyond

As the New Year begins, the AAO-HNS/F is getting ready for the challenges of 2012.

The Boards, with “key leaders,” have just completed their yearly strategic planning with a focus on the viability and sustainability of our organizations. In early December, two days are set aside to focus on what priorities should guide us through the upcoming year and advance our stated Mission and Vision:

**MISSION** – *We help our members achieve excellence and provide the best ear, nose, and throat care through professional and public education, research, and health policy advocacy.*

**VISION** – *Empowering otolaryngologist-head and neck surgeons to deliver the best patient care.*

As many of you know, strategic plans are often developed with considerable effort and energy, then placed on the shelf and not referred to until the next year’s strategic plan. This is not the case with your Academy. We do not have unlimited resources and personnel; therefore our efforts have to be guided and targeted towards specific goals. The Boards’ function is to oversee the viability of the Academy by developing a vision for the future, identifying problems and framing the desired outcome or goal. The Boards then charge the Academy staff to work out the details of implementation and hold the Academy staff accountable for the outcome.

The AAO-HNS/F leaders and staff have been working to structure these strategic planning sessions so that the problems and solutions have concrete measures to assess their effectiveness. This process involves the input of all Board members and guests through written comments and breakout discussions which further define the problems and desired results. It is understood that the visible outcome of our efforts will be a revised strategic document which guides the activities for 2012 and 2013.

### Hearing leaderships’ voice

The Boards and our specialty society leaders prepared for this year’s strategic

planning meeting by responding to a questionnaire built upon a SWOT (Strengths, Weaknesses, Opportunities, and Threats) analysis. Each member provided a written assessment of AAO-HNS/F’s Internal Strengths with an eye on our mission and vision, what are we doing well, what should we keep doing and, are we meeting the needs of our members and patients? We were also assessing our Weaknesses. Where are we not meeting membership expectations, what areas need improvement, alternative approach, or complete change?

AAO-HNS/F leaders and staff are working to structure these strategic planning sessions so there are concrete measures to guide success.

We then assessed the AAO-HNS/F’s external and internal Opportunities. Looking at our strengths and weaknesses, where can we have our greatest impact, and how can we better serve the membership? Where do we think we could add value? How can we work together to strengthen our impact and value for our patients and members?

We looked at both internal and external Threats. What are the legislative or political trends that affect the Academy and its members? What competition and societal changes may affect our sustainability?

The survey responses were organized into distinct categories and when we arrived in Alexandria on Thursday for the planning session, the Boards were briefed on the results of the SWOT analysis.

To further prepare the Boards for this year’s planning, staff leaders gave presentations highlighting their business unit functions and how those linked to



*Rodney Lusk*

**Rodney P. Lusk, MD**  
**AAO-HNS/F President**


the strategic plan approved by last year’s Boards.

The survey and staff presentations provided a good foundation for developing this year’s strategic plan. Using the survey results, four areas of focus were identified for further discussion on how we:

- Enhance knowledge/data access for our patients and membership
- Strengthen the value of membership in the Academy
- Improve communication with our membership and other organizations
- Ensure sustainability of the Academy

Along with key staff members, Board members and invited guests spent the day detailing and assessing what success would look like in these four areas.

### Working Forward

As January begins, the staff will finalize plans to conform to the new strategic plan. These plans will go to the Executive Committees and the Boards for approval. The approved plan will be shared in forthcoming issues of the *Bulletin*. No doubt, there will be unforeseen issues which will arise over the next year. Rest assured that your Boards, the Academy staff, and I are working strategically to meet the challenges ahead. 



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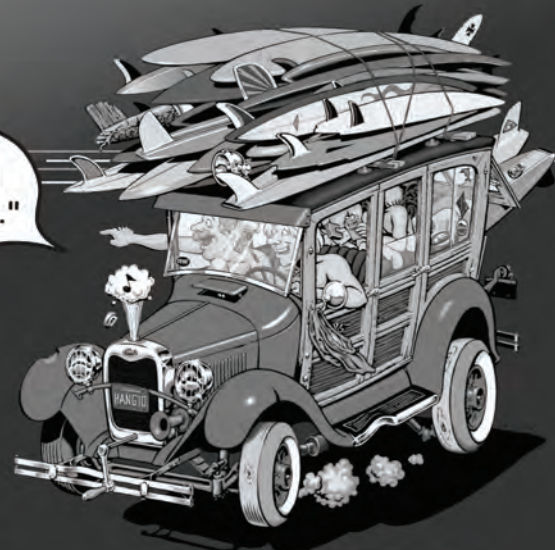
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"I can rock the crowd without harming my ears."





## Seasons of Renewal

**F**requently throughout our personal lives are seasons of renewal and introspection of our progress and growth. This phenomenon also occurs with institutions, and the AAO-HNS/F is no exception. In fact, it seems to have even more frequent formal milestones that suggest it's time to raise the bar again. Our fiscal year begins July 1; our Annual Meeting & OTO EXPO in September/October; and of course, our calendar year January 1. Additionally, each of us who serves you here at AAO-HNS/F headquarters in Alexandria, VA, and in our Washington, DC, office participates in personal annual evaluations of our performance. Each of these events provides an opportunity to start fresh, to adjust our sights, and to raise our performance.

Recently we strengthened the process of our staff's personal evaluations to create greater integration and closer alignment with our annual AAO-HNS/F performance cycle. This ensures more synergy, accountability, and effectiveness on your behalf. The process that each staff member goes through with supervisors annually actually begins before the year starts to set SMART (Specific, Measurable, Attributable, Realistic, and Timely) goals. Monitoring progress is not a "report card" at the end of the year, but a dynamic activity that continues throughout the year.

One of the improvement tools that we use to train all our staff we call the "Gradually, Then Suddenly" principle. It comes from *Fierce Conversations* by Susan Scott. This principle states that our efforts, our employment, our education, our relationships, and even our very lives succeed or fail *gradually, then suddenly*, one conversation, one action, or one day at a time. We are often surprised to *suddenly* find that something unexpected (often undesired) has evolved in our work, relationships, or our lives. But with careful consideration and scrutiny, we can often see in retrospect that what suddenly seemed to hit out of the blue was building up over time. If we are wise,

we can learn to notice the change that is taking place in the *gradually* phase, when there is time to do something about it. When project milestones are not met, or when progress lags, or when dependent actions are not taken, we can assume that project failure is pending.

As you read this column, our annual strategic planning process with our AAO-HNS/F and Boards of Directors will have already taken place. Now, our staff are working hard to update actions and deliverables, with the required budget proposals, which, when completed by the Boards, will define success this and next year. I ask you to join me in thanking the very many volunteers who sacrifice their time and energy to represent all of us in this critical process. In addition to our officers and Boards of Directors, we

“One of the improvement tools that we use to train all our staff we call the “Gradually, Then Suddenly” principle.


routinely invite specific board “guests” to provide essential expertise and perspective. These guests include leaders from our Residents and Fellows Section, Young Physicians Committee, Women in Otolaryngology Section, Diversity Committee, Nominating Committee, Research Advisory Board, Physician Payment Policy Workgroup, and AMA Delegation. When you add the skilled coordinators, at-large board members, and those expert representatives from our Board of Governors, Specialty Society Advisory Council, our journal, *Otolaryngology–Head and Neck Surgery*, and our professional staff, we have tremendous power and knowledge to address the challenges we face.



*David R. Nielsen MD*

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

In the next two years, you will be seeing more emphasis on agility in responding to challenges; more rapid delivery of education, research and quality, and member services products; a more useful and robust website; and more value from enhanced product and service integration. This will not only be demonstrated within AAO-HNS/F structure, but in our collegial relations with ABOto, SUO, OPDO, our dynamic specialty societies, and other entities of great importance to you.

As you engage in your own personal and professional introspection and craft your goals and resolutions for 2012 and beyond, I thank you, along with our many leaders and volunteers. Further, I solicit your increased support and personal engagement in the AAO-HNS/F and its programs as we strengthen our position as the best resource for your career. Whether your interests are primarily educational, research oriented, health policy, legislation, or regulatory, or all the above, there are many ways for you to become and stay involved in the Academy. See the new Engagement Brochure along with this *Bulletin* to find many opportunities to make the “whole become greater than the sum of its parts.” I wish you all a happy and prosperous 2012! 

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## Delivering the Best Care to Difficult Patients

**Joseph E. Hart, MD, MS**  
*Chair, Board of Governors Rules & Regulations Committee Waterloo, Iowa*

One of my favorite courses at the 2011 AAO-HNSF Annual Meeting & OTO EXPO was “The Difficult Patient,” which presented a project out of Henry Ford Health System, Detroit, MI. A young head and neck surgeon on staff, named **Tamer Abdul-Hamlin Ghanem, MD, PhD**, had some challenging patients in clinic. One young patient had kept his heavy drinking a secret from his immediate family, and denied the problem with the otolaryngology clinic staff. He had successful cancer surgery, yet had complications and an extended hospital stay due to delirium tremens treatment. Instead of having the departmental chair, **Kathleen Yaremchuk, MD**, and administrators chastise the patient, the care team approached the significant problem of identifying risk factors as an opportunity. They suggested a support staff position to share some of the immense burden of gleaning the real picture in their patients. Their attitude toward the problem was part of the solution.

The otolaryngology team created a staff position for a psychologist, Michael Ryan, PhD, to meet with the patient and family to help determine the best plan of care. The psychologist routinely meets with the head and neck surgeon to discuss the possible treatment options, and then meets with the patient and family to evaluate their ability to partner with the plan of action.

Being able to identify areas of support can be challenging for all of us, no matter how well connected we are. Surgeons know that patients and families may have issues that are not talked about or dealt with effectively. The sequelae can be far-reaching, if the issues are not identified and dealt with properly from the outset. Clinical impact can be a significant drain on patients, family members, physicians, staff, the hospital system, and community.

Clarity and honesty can be lacking because patients may live in some degree

of denial of their psychosocial challenges. Their day-to-day living situations may allow malcoping based on denial of the problem. This is where we surgeons can ask for, and get, some much needed help. As needed, the psychologist on staff at Henry Ford Hospital enters to perform straightforward evaluations of cognitive, emotional, and supportive environments.

Several provided examples are eye-opening and relevant.

One patient was estranged from his family and had to re-establish some support before surgery could be scheduled. Anger issues were identified and limits were set. All this is much easier to work out ahead of time, rather than after surgery.

Clarity and honesty can be lacking because patients may live in some degree of denial of their psychosocial challenges.

Another example was a patient who, due to some neurologic problems, was actually much lower functioning than his wife would allow anyone to see. The identification of that problem helped establish what the patient could tolerate for treatment. Without the psychologist's evaluation, he may have been offered something more complex than he could emotionally and physically tolerate.

A third example was a patient, spouse, and friend (advocate) who showed mistrust in all interactions with the physicians, nurses, and staff. The healthcare team dealt with it in an open way that did not deny the challenge but moved forward, with the patient always at the forefront.

Identifying these concerns can help ease the burden on the surgeon and the




**Joseph E. Hart, MD, MS**  
*Chair, BOG Rules & Regulations Committee*

whole team. At Henry Ford, it helped identify the problems at hand. It did not make things perfect, but did demonstrate where effective help could be offered to that patient, at that particular time.

It raised the situation to something more clearly recognized as uplifting to all.

What is further amazing to me was that this was taken on by a hospital system in a community that is suffering economically in ways I can only imagine.

I had gotten to know some of the otolaryngology staff at Henry Ford through leadership in AAO-HNS. I had the privilege of going to their presentation, and I had the opportunity to meet them later. They were quite humble in their approach in dealing with the problems in their clinic. I felt their approach would help me in my practice. Likewise, I see many other otolaryngologists making headway on so many fronts. I wanted to point these people out.

I welcome my colleagues to point out other positive stories, or their successes, to our Academy. 



# Have You Visited Your Academy Benefits Package Lately?

**Eve Humphreys**

**AAO-HNS Sr. Director, Membership**

The AAO-HNS dues renewal campaign is in full swing, and we look forward to your continued involvement with the Academy in 2012. Each year, we (your Academy leadership and staff) take the opportunity to challenge the value we offer you, the member. During strategic planning, we review the value of Academy membership to make sure we are speaking to your needs as an otolaryngologist—head and neck surgeon; whether you practice in a community or an academic setting, you are a resident or a retired physician, practicing domestically or internationally.

The AAO-HNS vision, as an organization, is to empower our members to provide the best patient care.

Our organizational mission states we do this through physician and patient education, research, and advocacy.

To that end, we encourage you to revisit your AAO-HNS member benefits package to ensure you are taking advantage of all opportunities. We all lead extraordinarily busy lives, and the Academy is here to help. There are many ways the Academy can help you serve your patients, run your practice, and enhance your professional development. We invite you to fully participate in your Academy to get the most out of membership.

## Engagement Opportunities

The January *Bulletin* includes a brochure containing a comprehensive overview of ways members can become more involved in the Academy and Foundation. Opportunities are designed to meet all levels of participation for continued development as physicians and as leaders to further strengthen the specialty. Members can select opportunities based on schedules, interests, and priorities.

## Education and Lifelong Learning Maintenance of Certification (MOC)

The Foundation provides educational support for maintenance of licensure and certification. All education activities, including the AAO-HNSF Annual Meeting & OTO EXPO, are aligned

with the specialty areas defined by the American Board of Otolaryngology, making it easy for you to customize your education.

## AAO-HNSF Annual Meeting & OTO EXPO

The AAO-HNSF Annual Meeting & OTO EXPO is the world's largest gathering of otolaryngologists, together with the world's largest collection of products and services for the specialty. This four-day, premier educational program provides the latest in otolaryngology medicine through scientific oral and poster presentations, miniseminars, instruction courses, and more.

## AcademyU®

We offer our members highly relevant educational opportunities to increase their knowledge, competence, and patient care. AcademyU®, the Foundation's e-learning system, provides 24/7 access to hundreds of learning activities, one-stop access to your AAO-HNSF CME records, and tools to help you plan your future learning activities to prepare for licensure and re-certification. This member benefit, worth several hundred dollars, is available at no additional charge just by enrolling.

## Research

Academy membership and participation supports the development of evidence-based guidance that is updated and refined based on feedback from current practice data. We identify, promote, and address the key research questions and disseminate discoveries for advancement of our field and to fundamentally improve patient outcomes.

## Legislative and Political Advocacy

Your membership and participation supports the Academy's political and legislative advocacy efforts, strengthening the influence and visibility of the specialty on Capitol Hill and in state legislatures. The Academy's Government Affairs team advocates on behalf of its



members and the specialty, urging legislators to ensure fair payment, improve patient care and access, and prevent inappropriate scope-of-practice expansions by allied healthcare professionals.

## Health Policy and Business of Medicine

Academy membership allows otolaryngologists to gain access to coding and reimbursement resources including coding and reimbursement workshops, template letters, links to outside resources, and ENTcodingToday, our custom database designed to save members time and money when submitting services for reimbursement.

## Publications

### *Otolaryngology–Head and Neck Surgery*

Ranked first\*\* (Eigen Factor) among the journals in the specialty, it is packed with articles on scientific developments, cutting-edge research, guidelines, topical supplements, and systematic literature and evidence reviews. Members have access to the new AAO-HNSF online journal, *Otolaryngology–Head and Neck Surgery* ([www.otojournal.com](http://www.otojournal.com)), with robust features and functionality. Editor's Choice collections have been added to the electronic journal as well as popular monthly podcasts.

### *Bulletin*

Our highly ranked and valued monthly magazine, the *Bulletin*, brings you timely, trusted insights on clinical developments, safety and socioeconomic issues, managing your practice, and translational research. Visit the *Bulletin* now online.

### *The News*

*The News* helps members stay informed with Academy news and other timely issues affecting the whole specialty. It is delivered weekly by email.

## Improve Your Practice and Stay Connected to Colleagues

The Academy and its Foundation have gone far beyond traditional services for

members to help build their practices, and further their careers.

### ENT Careers

The AAO-HNS online career center, ENT Careers, includes all specialty areas within otolaryngology—head and neck surgery. ENT Careers is a single-source solution for recruitment and career searches, and offers job candidates increased access and exposure to thousands of employers. For employers, job postings are advertised to millions of qualified job applicants.

### AAO-HNS Member Network

All members are automatically included in our online directory, “Find an ENT,” one of the most-visited features of our website. Do not miss having your name listed on this valuable referral tool. In addition, members receive an updated Membership Directory, a personal worldwide address and phone book for otolaryngology professionals. Members can use the Directory, and the companion online database, when making referrals out of their areas.

### Patient Information

Members receive a discount when ordering our health information designed to educate patients on the diagnoses and treatments you provide most. Created and peer-reviewed by our member physicians, this information, in print or as content for a practice's website, provides a basic overview of diagnoses and treatment conditions to help answer your patients' questions.

We are always looking to improve the value of membership. We are here to answer your questions, concerns, or suggestions at [memberservices@entnet.org](mailto:memberservices@entnet.org). Many questions can be answered on our website at [www.entnet.org](http://www.entnet.org) as well. Our success as an organization is directly related to your membership and participation. Thank you for your continued loyalty and dedication. 

**\*\*Eigenfactor™ Score (EF):** A measure of the overall value provided by all of the articles published in a given journal in a year. **Article Influence™ Score (AI):** a measure of a journal's prestige based on per article citations and comparable to Impact Factor



## In Memoriam: AAO-HNS Acknowledges Member Deaths

Throughout the year, through family members and other sources, the Academy is notified of deaths of members. The list is updated as Member Services learns of members who have passed. The AAO-HNS acknowledges the following members for their years of service to the profession of otolaryngology—head and neck surgery. Our sympathies go out to their families.

**Richard P. Ariagno, MD;**  
Las Vegas; Fellow; McGaw Medical Center/Northwestern University, 1953.

**John J. Ballenger, MD;** Natick, MA;  
Fellow; Massachusetts Eye and Ear Infirmary/Harvard Medical School, 1943.

**Col. William H. Gernon, MD;**  
Lakewood, WA; Fellow; Walter Reed Army Medical Center, 1969.

**Helen F. Krause, MD;** Gibsonia, PA;  
Fellow; University Health Center of Pittsburgh, 1962.

**Duane Sewell, MD;** Baltimore, MD,  
Fellow; University of Pennsylvania; 1994.

**Jose Smoler, MD;** Mexico City,  
Mexico; Fellow, University of Illinois College of Medicine at Chicago, 1964.

## Dates to Remember

**Jan. 1** *Bulletin* Online available.

**Jan. 1** *Otolaryngology—Head and Neck Surgery* available online.

**Jan. 1** PR and media campaign member materials available online.

**Jan. 1** Join the 2012 Millennium Society.

**Jan. 16** CORE final application.

**Feb. 9** *April Bulletin*; features The Business of Medicine; content due to [bulletin@entnet.org](mailto:bulletin@entnet.org).

**Feb. 1** PR and media campaign member materials available online.

**Feb. 1** Nominations of Distinguished Humanitarian.

**Feb. 2** Committee member application due.

**Feb. 17-18** Coding Workshops, see [www.entnet.org/conferencesandevents](http://www.entnet.org/conferencesandevents).

**Feb. 20** Close of AAO-HNSF 2012 Annual Meeting & OTO EXPO Call for Oral and Poster Papers.

**March 8** *May Bulletin*; features the AAO-HNSF Annual Meeting & OTO EXPO; content due to [bulletin@entnet.org](mailto:bulletin@entnet.org).

### JANUARY 2012

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## Membership Renewal Reminder

**Y**our 2012 member dues payment was due December 31, 2011. To ensure that your benefits are not interrupted, renew your commitment now at [www.entnet.org/renew](http://www.entnet.org/renew). Renew your



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Boston, MA 02241-8538

## Your Academy in Action

The AAO-HNS embarks on a new initiative, Your Academy in Action, to engage with members and nonmembers alike by strategically identifying and participating in key state, local, and other society and specialty meetings. The goals of this initiative are to:

- Offer key staff experts as speakers/presenters on such topics as legislative advocacy, health policy, and public relations, to educate physicians on issues facing their practices, their patients, and the specialty, and provide insight into Academy policies and initiatives.
- Promote the value of Academy membership to members and nonmembers.
- Provide a venue for gathering feedback by initiating discussions with a wide variety of members and nonmembers on topics of mutual importance.

We would like to incorporate interested Academy members into these presentations, as we consider you subject matter experts. If you are interested in participating in Your Academy in Action, or would like to suggest a meeting for the group to attend, contact: [memberservices@entnet.org](mailto:memberservices@entnet.org). We look forward to hearing from you.



## The HEALing Community Center: Reaching Out to the Underserved in the U.S.A.

**Charles E. Moore, MD**  
for the Diversity Committee

The health of many Americans has improved during the past few decades and tremendous scientific advancements have been made. However, the reality is that many homeless, uninsured, and low-income minorities are not benefitting from these advancements, nor are they receiving important health screenings and preventative primary medical care. A critical issue is that a lack of financial resources often plays an important role in access to care.

African Americans are diagnosed with some form of cancer at 44

diagnoses per 100,000 individuals more than Caucasians. Additionally, the death rate is 33-percent higher for African Americans than it is for Caucasians. We know that for most disease processes early detection means a better chance of more effective treatment. We also know that early detection is less common among African Americans.

In Fulton County, GA the increasing health disparity between Caucasians and African-Americans has cost 28,022 years of potential life lost due to premature death in African-Americans. This number is more than double the number of years lost in neighboring DeKalb

County and is drastically higher than any of Georgia's 159 other counties.

When considering oral cavity and oropharyngeal cancers in particular, it is seen that it will destroy 14,000 to 15,000 lives annually ([www.nccn.org](http://www.nccn.org), [www.cancer.gov](http://www.cancer.gov)). Additionally, 50,000 people will develop head and neck cancer this year. Of those who develop cancer of the oral cavity, nearly 75 percent of the cases of squamous cell cancer of the oral cavity involve only 10 percent of the mucosal surfaces of the mouth. This is an area that can be easily identified and monitored by health professionals. Also, it can be easily taught to lay people to examine in the home or community setting for signs of abnormality.

In my current practice in the Department of Otolaryngology at Emory University at Grady Health System, I saw numerous patients who sought medical care only after their cancer had progressed to the point where they had limited treatment options. When I continued to see such patients on an almost daily basis, I decided I could do more to increase awareness of head and neck cancers. I identified the three zip codes that represented the highest percentages of head and neck cancers that I saw in my clinic. All three of these zip codes were in medically underserved areas. I later focused my attention on creating a facility in the area that had the highest percentage of head and neck cancers identified with outreach to the other areas. Poverty, high crime rates, limited access to healthcare and joblessness make this area a real-life study in the social determinants of health.

Accordingly, I decided to develop a strategic approach to care that encompasses not only design, but delivery. From a community needs assessment, it was determined that cancer education was of primary importance. I developed the concept



Charles E. Moore, MD with children after health education class. Dr. Moore is the 2011 Gold Foundation Award recipient for Humanism in Medicine. Photo courtesy of Jim and Tamie Lyles.



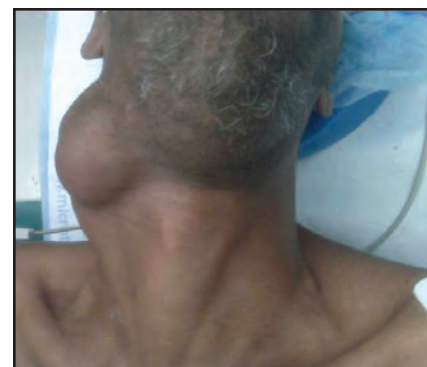
for the HEALing Community Center ([www.HEALingOurCommunities.org](http://www.HEALingOurCommunities.org)), a free medical facility that would provide health education and primary and specialty care in the zip codes that need them most. Through collaborations with multiple medical, faith-based, community, and academic organizations, the center provides direct services in a medically underserved inner-city area in Atlanta. The facility addresses

I later focused my attention on creating a facility in the area that had the highest percentage of head and neck cancers identified with outreach to the other areas.

the increasing health disparities among minorities and uninsured individuals in poverty.

In July of 2009, the Healing Community Center began providing primary care, cancer screenings and mental health services in three small rooms at a community-based organization. On June 25, 2011 the construction was completed on an 8,000-square foot facility that focuses on health education while providing comprehensive, integrated care. Since then, the need has increased exponentially necessitating the expansion to a larger facility to accommodate the requests of the community and other potential collaborators. The creation of this new facility will allow the center to further expand its services to provide comprehensive, integrated care to address the social determinants of health faced by people in poverty.

From the initial screenings, I saw firsthand the extent of medical issues that were not being addressed in the community. Education of the public is



Patients evaluated at Grady Health System, which provides care for indigent individuals in the metropolitan Atlanta area.

of paramount importance to empower our patients to address critical health issues. In this manner, together we can strive to decentralize the delivery of healthcare by providing critical information not only from bench to bedside, but from bench to bedside to curbside.

Donations to the HEALing Community Center can be addressed to HEAL Inc, PO Box 7522, Atlanta, Ga 30357 or completed online at [www.HEALingOurCommunities.org](http://www.HEALingOurCommunities.org).

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## Academy in Action Previewed at FSO-HNS 2011

On November 11, Academy and Foundation staff had the privilege of attending the Florida Society of Otolaryngology—Head and Neck Surgery (FSO-HNS) 2011 Annual Fall Meeting outside of Orlando, FL. Throughout the weekend, staff had the opportunity to meet with the more than 75 otolaryngologists—head and neck surgeons attending the meeting and to discuss the most pressing issues for otolaryngologists in that area of the country. **David R. Nielsen, MD**, executive vice president and CEO of the AAO-HNS/F, gave an informative, timely, and inspiring talk about “Healthcare in Transition.” His discussion provided attendees with a greater understanding of how the Academy and Foundation continue to work for you in the areas of healthcare reform, quality initiatives, and medical education.

Previewing the Your Academy in Action program, Foundation staff gave a presentation on becoming involved with the AAO-HNSF, focusing on how the Board of Governors (BOG) societies and the AAO-HNS/F can advance the specialty through individual society member involvement and advocacy efforts. From joining your local society and BOG, to participating in and joining the May OTO Advocacy Summit the ENT Advocacy Network or becoming a member of the Millennium Society, there is something for everyone willing to do more on behalf of the specialty.

AAO-HNS/F also hosted a booth in the exhibit hall to have one-on-one conversations with members and attendees. From the exhibit booth, attendees became new members, current members pledged Millennium Society gifts, and important conversations were had with

multiple groups about becoming more active through the AAO-HNS Partners for Progress program (a way for group practices to engage in our mission and provide vital annual funds to support it).

The AAO-HNS/F’s presence at the FSO-HNS 2011 Annual Meeting was a success, and we hope to continue to be a part of BOG meetings throughout the country. All of this would not have been possible without the help and support of key individuals from the FSO-HNS. We would like to thank **Tapan A. Padhya, MD**, FSO-HNS president; **Ari I. Wirtschafter, MD**, FSO-HNS president-elect and program chair; **Robin L. Wagner**, FSO-HNS executive director; and **Todd Blum, MHA, MBA**, FSO-HNS ad hoc administrator; for their facilitation of the Academy’s and Foundation’s participation in this important event. 



(Left to Right): Anurag Agarwal, MD; Tapan Padhya, MD; Ari I. Wirtschafter, MD (FSO-HNS Otolaryngologist of the Year); Michael Owens, MD; W. Mark Flintoff, Jr., MD; David R. Nielsen, MD; Todd Blum, MHA MBA CMPE; Michael S. Benninger, MD; Julie Wolfe, CFRE; and K. Paul Boyev, MD.

## Applications Open for 2012 BOG Model Society Award, Practitioner Excellence Award

The Model Society Award recognizes outstanding local, state, and regional societies that exhibit effective leadership, institute Academy and Foundation programs, and further Academy goals through active participation in the Board of Governors. The award is based on activities from February 1, 2011 through January 31, 2012.


Previous winners of the Model Society Award include: the Pennsylvania Academy of Otolaryngology-Head and Neck Surgery (2011), Massachusetts Society of Otolaryngology-Head and Neck Surgery (2008 and 2009).

Please consider applying for this prestigious award and letting the Academy know what great programs you are running in your region or state to improve the quality of care of our patients.

The Practitioner Excellence Award recognizes the prototypical clinical otolaryngologist one wishes to emulate. BOG representatives should nominate individuals who, within the past 10 years, have practiced medicine in an exemplary manner and are sought by other physicians because of their personal and effective care. The nominee must be an Academy member in good standing and should have, in addition to his or her clinical skills, one or more of the following attributes:

- Civic leadership
- Charitable activity
- Leadership involvement with local, state, or national medical organizations
- Community education
- Participation in local civic and/or community activities

Please consider applying for this prestigious award and letting the Academy know what great programs you are running in your region or state to improve the quality of care of our patients.

The applications deadline is March 19. Awards will be presented during the annual meeting in Washington, DC at the BOG General Assembly on Monday afternoon, September 10. Send questions to [bog@entnet.org](mailto:bog@entnet.org). 



*see you in*  
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**AAO-HNSF**  
**Annual Meeting**  
**& OTO EXPO**

**2012**  
**September**  
**9-12**  
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**Submissions: Closed**  
**Notifications: Late March 2012**

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**Submissions: Closed**  
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## PUT PATIENTS FIRST IMPROVE OUTCOMES, REDUCE COSTS

The term “complex care” in health care needs to take on new meaning in America. It will always speak to multidisciplinary collaboration among a team of highly trained specialists, but more and more, it should also define care that requires multifaceted clinical and social supports—before and after surgery.

The United States currently spends 17 percent of its gross domestic product on health care, and costs continuously rise. Most cost-cutting debates focus on reductions to Medicare, Medicaid, Graduate Medical Education financing, and reimbursements to doctors and hospitals. While these proposals may help contain costs in the short run, they would undoubtedly hurt patient care, and exacerbate spending, in the long term.

At The Mount Sinai Medical Center, we know that a focus on high-quality health care and optimal patient outcomes can improve the patient experience and reduce the overall cost of care. To that end, the Department of Otolaryngology developed the Patient First Program with the goal of improving a variety of clinical outcomes such as infection rates, wound complications, and length of stay.

The program is simple: Working in consultation with physicians, a dedicated patient coordinator performs a preoperative assessment to identify patients with complex medical comorbidities, malnutrition, a history of infection, or coagulation disorders. They also seek to understand any potential social barriers to discharge, including physical limitations, lack of family support, or assistance needed with specialized care such as tracheostomy or enteral nutrition. By identifying these patients, preoperative intervention can be introduced to limit the risk of perioperative complications, delays in hospital discharge, and hospital readmissions.

Consider, for example, J.M., one of 50 patients to receive Patient First care last year. He is a 63-year-old man with a

history of bleeding dyscrasia and chronic obstructive lung disease. A multidisciplinary team at Mount Sinai’s Head, Neck, and Thyroid Cancer Center evaluated him for a poorly differentiated thyroid cancer, and identified him as high risk for perioperative complications.

He was referred to the Patient First Program where his interventions included consultations with experts in hematology, social work, and nutrition. This coordination was instrumental in his uncomplicated inpatient experience and his timely discharge to a subacute facility near his home and family. By anticipating J.M.’s medical and social risks, the Patient First team optimized his inpatient experience and avoided costly medical expenses associated with surgical complications. Comparing J.M.’s case to a similar patient three years prior, when medical and social complications would have been managed symptomatically, \$24,000 was saved by avoiding postoperative pneumonia and attending to his social needs as much as his medical care.

Since the program’s implementation over a year ago, morbidity rates, infection rates, and length of stay have been reduced when compared to similar patients prior to the introduction of the program. When one considers the national average cost of treating common perioperative complications such as a urinary tract infection (\$13,000), a venous thromboembolism (\$8,500), or a surgical site infection (\$28,000), making patient care a priority is not only good for patients, it is good for the financial health of our hospitals and for the nation’s ailing health care system.

By broadening our view of complex care to include medical and social comorbidities, we can improve patient outcomes, reduce complications, shorten length of stay, and lower hospital readmission rates. Such outcomes are better for individuals, hospitals, and overall health care spending.

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*Eric M. Genden, MD, FACS, is Chairman of the Department of Otolaryngology and Director of the Head, Neck, and Thyroid Cancer Center at The Mount Sinai Medical Center in New York City.*

# Advances in Head and Neck Surgery

By *M. Steele Brown*  
*Special assignment to Bulletin*

From preemptive strikes against pharyngeal cancers to advances in robotic surgery, Otolaryngology—Head and Neck Surgery is riding a wave of trends and technological discoveries toward significant breakthroughs.

**Jay O. Boyle, MD**, chair of the Head and Neck Surgery section of the AAO—HNSF Centralized Otolaryngology Research Efforts (CORE) program, said one example of this is how the specialty is fighting head and neck squamous cell cancer on several fronts—and winning.

“Our knowledge is expanding, and with that in mind, researchers are continually able to generate new and more exciting hypotheses,” Dr. Boyle said. “In addition to the research in the lab, technology is beginning to allow us to answer questions more completely and faster than previously possible, due to the continuing advances in molecular biology and the discovery of high-throughput ways in which we can analyze many tumors in a short period of time.

In addition, the sequencing of the human genome—specifically the head and neck cancer genome, offers us quite a bit of insight into head and neck cancers, as well as a better understanding of other common issues, such as melanoma. We’ve also seen lots of good research in the area of salivary gland cancers.”

## Battling Cancer

Many of the most important surgical breakthroughs occur before surgery is even necessary. Nowhere is this more true than in the realm of oncology.

Head and neck cancer is the sixth-most common non-skin cancer in the world with more than half a million new cases each year. According to research from the National Cancer Institute (NCI), smokers, drinkers, and people infected with the human papillomavirus (HPV) have the highest risk of developing cancer in the oral cavity. Because of that, stopping these issues before they take root is an imperative.

Dr. Boyle, also an associate attending physician in Head and Neck Surgery at Memorial Sloan-Kettering Cancer

Center and associate professor of otolaryngology, Weill Medical College of Cornell University in New York, said the increased understanding of tobacco addiction is one key to fighting cancer.

“In addition, smoking cessation research is also advancing,” he said. “I think I speak for all head and neck surgeons when I say that I’m hoping that this research will help the effectiveness of the cessation programs that are out there right now. As awareness regarding the dangers of tobacco increases and smoking rates continue decreasing, this will have a positive influence on future head and neck cancer rates.”

**Marion E. Couch, MD, PhD**, associate professor in the Department of Otolaryngology/Head and Neck Surgery at Fletcher Allen Health Care, said that on the public health front, the recent recommendation from the Centers for Disease Control and Prevention (CDC)—that boys and young men up to the age of 21 be vaccinated against HPV—is “huge for the field.”

“From our point of view, this is a real victory because simply vaccinating young girls will not solve the problem,”





Dr. Couch said. “We are leaving the other half of the population at risk.

“While we are still looking for more and better data, there is evidence to suggest that HPV could be responsible for many cases of oral cancer—most of which occur in men. So I am greatly relieved that both boys and girls will now be vaccinated against HPV.”

While the latest expansion of the indications for the HPV vaccine is not for head and neck cancer, Dr. Couch believes that evidence will inevitably come to light.

“In the meantime, we will have to work to remove barriers in this regard,” she said. “But the news of the latest expansion is still welcome and will help us in our fight.”

Dr. Boyle said he concurred with Dr. Couch regarding HPV’s connection to head and neck cancer, and added that while the evidence of the connection is anecdotal, he believes it is a real concern.

“Some of the most important advances we have made are due to the fact that many of the cancers that we are finding in the pharynx now, we will

find are caused by HPV,” he said. “The good thing about that is these particular cancers have a high cure rate—higher than 90 percent—and are amenable to cancer prevention, so from a curative standpoint, this is all new and exciting territory for head and neck surgeons.”

### Further Research

In addition to the believed connection with HPV, Dr. Boyle said more encouraging advances exist in the realm of genomics.

“As the field (of genomics) evolves during the next five to 10 years, we will be able to individualize therapy for cancer,” he said. “And as we learn more about the molecular biology of tumors and tumor-host interactions, as well as how cancers are inherited, we will be able to better tailor treatment to the specific biology that is going on with the particular cancer. It is a good bet that this promising advance in head and neck oncology will be available to us in the next five to 10 years.”

As researchers make headway in understanding the process of carcinogenesis, Dr. Boyle said they are also

getting closer to identifying a way to reverse that process in the upper air tract using medications.

“For example, I am involved in ongoing randomized trials with a cancer prevention drug used to treat precancerous lesions of the mouth,” he said. “That study is open in nine institutions in the United States and one in Italy. That is an example of bench-to-bedside research where a hypothesis from the lab, and the subsequent animal studies, may create a drug that is useful in preventing oral cancer by targeting leukoplakia.”

Dr. Boyle was also quick to note that science should not be a substitute for cessation.

“We are not here to make smoking safer,” he said. “We need to stay focused on cessation and cessation research, but those patients who do quit still remain at moderate risk, and they are the ones we need to help with these therapies. We need to be able to halt and reverse cancer formation in patients who are successful in quitting.”

As the chair of CORE, Dr. Boyle said it is also important to note that new

research is constantly coming to the attention of the Academy.

"The number of head and neck oncology research proposals is increasing and the quality is improving as well," he said. "There are lots of exciting ideas and they are coming to our attention in many different areas of cancer biology."

### Educating on Robotic Surgery

Headway is also being made as the number of otolaryngologic surgeons training in robotic procedures continues to grow, Dr. Couch said.

"We could soon be looking at equivalent cure rates for robotic interventions and chemoradiation therapy," he said. "That said, I think we are seeing the pendulum swing back to the surgical approach for many of these diseases, and our patients are demanding outcomes using these innovative techniques."

Dr. Boyle echoed that idea and said that transoral robotic surgery (TORS)

has become a significant recent development. And while it is not yet proven to have the same cure rates as radiation therapy, it is likely to be proven in the next year or so. At this point, he said, the problem is with the number of trials.

"There are not any direct head-to-head random trials because we cannot randomize surgical patients," he said. "But the data we do have says the cure rates are good."

"So as TORS becomes more common in the coming five- to 10-year span, we can, and probably will, see a lowering in the intensity of radiation therapy necessary after surgery. That will be good for our patients."


**Dennis H. Kraus, MD**, the chair of Head and Neck Education for the Academy, added that robotic thyroidectomy is also helping head and neck surgeons advance the specialty.

"With robotic thyroidectomy, we can avoid making incisions in the neck," Dr.

Kraus said. "It really seems to be catching on and it offers a lot of advantages, such as an approach under the arm and one behind the ear, for example.

"I think there is a real focus on minimizing the effect of surgery on the patient right now. We are able to be just as effective, but in a way in which we do not hurt the patient, and that is an attractive path."

These developments, taken together, multiply the medical and surgical knowledge available exponentially, Dr. Couch said.

"All of this has allowed us to embrace innovation, which is exciting for our field," she said. "But it is also right in time because we are under pressure to treat patients who are getting younger because of HPV. Our patients used to be 60 to 80 years old, but now they are getting younger and are demanding excellent outcomes in terms of survival." 



Operating room model set up for robotic surgery. © 2012 Intuitive Surgical, Inc.



## Ultrasound Course Summary

**Robert A. Sofferman, MD,**  
Course Director, Ultrasound Course  
Director (Head and Neck)  
American College of Surgeons  
National Ultrasound Faculty

In both Boston in 2010 and San Francisco in 2011 on the day before the AAO-HNSF Annual Meeting & OTO EXPO, an Exported American College of Surgeons (ACS) Credentialing Course on Thyroid and Parathyroid Ultrasound has been available for interested otolaryngologists.

Although the course is defined by its title as emphasizing an endocrine orientation, it in fact allows the attendee to understand the application of ultrasound to virtually all areas of head and neck anatomy and disease. The course requires completing a preliminary online Basic Ultrasound CD ROM, attendance at the five didactic lectures, and a full afternoon hands-on skill session.

This skill session allows the course attendee to perform ultrasound examinations on volunteer patients, many with relevant pathologic conditions, under the watchful eye of an experienced ultrasound faculty. The course culminates in a multiple choice examination and practicum and ensures that the individual has properly absorbed and understood the process.

In each of the courses in Boston and San Francisco, 62 to 65 individuals have been credentialed, thanks the volunteer efforts of 14 unique faculty members. Each faculty member is an experienced endocrine surgeon with significant hands-on experience with ultrasound.

This course is the beginning of a clinical immersion in ultrasound. Once this exciting application becomes a part of




Robert A. Sofferman, MD

one's clinical armamentarium, it will be impossible to practice general otolaryngology and neck surgery without it at arm's length. Office-based ultrasound is convenient for the patient, the ideal means of understanding the condition under study at the time of presentation, and a means of obtaining appropriate,

focused cytology and culture

material when required. The natural progression of this tool from practice to education of residents in all training programs will place ultrasound in its proper clinical position.

To learn more about upcoming ultrasound courses at the 2012 Annual Meeting & OTO EXPO, check the Academy website [www.entnet.org](http://www.entnet.org) or contact [meetings@entnet.org](mailto:meetings@entnet.org). 

see you in  
Washington, DC



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## Head and Neck's Scope Include the Thyroid

**Lisa A. Orloff, MD**  
*Chair, Endocrine Surgery Committee,  
 AAO-HNS*

**A**lthough September is Thyroid Cancer Awareness Month, the AAO-HNSF encourages all of its members and affiliates to support thyroid cancer education all year. Since otolaryngologist—head and neck surgeons are concerned for, and pre-eminently qualified in, the management and treatment of disorders and diseases of the thyroid, this collaboration is intended to enhance early detection and care based on expert standards and guidelines, and research to achieve cures for all types of thyroid cancer.

Thyroid cancer is one of the few cancers continuing to increase in incidence, with a record high of more than 44,000 people newly diagnosed in the United States in 2010 and more than 200,000 people newly diagnosed worldwide. It is also a cancer that affects people of all ages, from young children to seniors. When detected early, most thyroid cancers are treatable. However, some thyroid cancers are aggressive and difficult to treat. These are some of the many reasons why the AAO-HNS is teaming up with ThyCa: Thyroid Cancer Survivors' Association, Inc. to raise thyroid cancer awareness.

Thyroid Cancer Awareness Month is a worldwide observance, sponsored and initiated by ThyCa: Thyroid Cancer Survivors' Association, Inc. (<http://www.thyca.org/september.htm>). It began in 2000 as Thyroid Awareness Week, and in 2003, expanded to the entire month of September. People and organizations in at least 55 countries around the world now take part. Thyroid Cancer Awareness Month is listed in official health events calendars and directories, including the American Hospital Association's Calendar of Health Observances & Recognition Days.

ThyCa is a national nonprofit organization of thyroid cancer survivors, family members, and healthcare

professionals dedicated to education, communication, support services, awareness for early detection, and thyroid cancer research fundraising and research grants. In addition to sponsoring Thyroid Cancer Awareness Month each September, ThyCa also sponsors free seminars, workshops, the annual International Thyroid Cancer Survivors' Conference, plus other year-round awareness campaigns. It also provides free educational materials upon request.

As partners, participating otolaryngologists are asked to help promote Thyroid Cancer Awareness Month, and to acknowledge ThyCa ([www.thyca.org](http://www.thyca.org)). Individual organizations



By Lisa A. Orloff, MD

will be recognized in ThyCa's newsletters and on ThyCa's website. Information about participants' organizations will also be included at the next annual International Thyroid Cancer Survivors' Conference, both on the resource tables and in the program booklet given to attendees. Large or small, local events are

also a great opportunity to raise awareness of thyroid cancer and acknowledge the contributions of everyone involved. Partnering otolaryngologists and organizations are encouraged to let ThyCa know the details of any event hosted, to receive recognition, to benefit from promotion, and to offer guidance to others who may wish to develop a similar event.



Volunteer faculty, Maisie L. Shindo, MD, instructs participants at the Ultrasound Course in San Francisco.



In addition to Thyroid Cancer Awareness Month, the AAO-HNSF is continually doing its part to raise awareness and expertise in the care of thyroid cancer and thyroid disorders, through resources that include:


- Online fact sheets such as:
  - Thyroid disorders and surgery <http://www.entnet.org/HealthInformation/Thyroid-Disorders.cfm>
  - Pediatric thyroid cancer <http://www.entnet.org/HealthInformation/Pediatric-Thyroid-Cancer.cfm>
  - Fine needle aspiration biopsy <http://www.entnet.org/HealthInformation/fineNeedleAspiration.cfm>
- Numerous miniseminars and instruction courses at the upcoming Annual Meeting of the AAO-HNSF in Washington, DC September 9-12
- Ongoing activities of the Endocrine Surgery Committee of the AAO-HNS, including:

Thyroid cancer is one of the few cancers continuing to increase in incidence, with a record high of more than 44,000 people newly diagnosed in the United States in 2010.

Public education campaigns about radiation exposure and health risks

- Professional campaigns including emphasizing the importance of baseline laryngoscopy in the evaluation of patients with thyroid disorders, and postoperative laryngoscopy in patients who undergo thyroid surgery

- Thyroid cancer research collaborations, database development, and outcomes studies
- Participation in humanitarian missions involving thyroid surgery in underserved parts of the world
- Review and endorsement of thyroid-related practice guidelines, most recently including the 2011 American Thyroid Association practice recommendations Radiation Safety in the Treatment of Patients with Thyroid Diseases by Radioiodine (131I) <http://www.thyca.org/ataradiation.pdf>.

The AAO-HNSF and ThyCa invite everyone interested to help with thyroid cancer awareness efforts in their communities. For free materials from ThyCa and tips on how to raise awareness, as well as more information about thyroid cancer, email [outreach@thyca.org](mailto:outreach@thyca.org), call 1-877-588-7904, fax to 1-630-604-6078, write to PO Box 1545, New York, NY 10159-1545, or visit [www.thyca.org](http://www.thyca.org). 

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## Apply Now to Serve on an AAO-HNS/F Committee

**Want to get more involved in your Academy and increase your opportunities to interact with your peers?**

The AAO-HNS/F has a committee for every interest. Get involved in one of the many clinical or education committees, or serve on a BOG committee to become more involved in the Academy's grassroots' efforts.

To learn more about the committee process and apply online visit [www.entnet.org/committees](http://www.entnet.org/committees). **The deadline for all applications is February 1.**

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## Pediatric Thyroid Cancer

The thyroid is a butterfly-shaped gland located at the base of the throat. It has two lobes joined in the middle by a strip of tissue (the isthmus). The thyroid secretes three main hormones: 1) Thyroxine, that contains iodine, needed for growth and metabolism; 2) Triiodothyronine, also contains iodine and similar in function to Thyroxine; and 3) Calcitonin, which decreases the concentration of calcium in the blood and increases calcium in the bones. All three of these hormones have an important role in your child's growth.

Thyroid cancer is the third most common solid tumor malignancy and the most common endocrine malignancy in children. It occurs four times more often in females than males and has similar characteristics as adult thyroid cancer. Surgery is the preferred treatment for this cancer. Although the procedure is often uncomplicated, risks of thyroid surgery include vocal cord paralysis and hypocalcemia (low blood calcium). Consequently, an otolaryngologist—head and neck surgeon, one experienced with head and neck issues, should be consulted.

### Types of Thyroid Cancer in Children:

**Papillary:** This form of thyroid cancer occurs in cells that produce thyroid hormones containing iodine. This type, the most common form of thyroid cancer in children, grows very slowly. This form can spread to the lymph nodes via lymphatics in the neck and occasionally spreads to more distant sites.

**Follicular:** This type of thyroid cancer also develops in cells that produce thyroid hormones containing iodine. The disease afflicts a slightly older age group and is less common in children. This type of thyroid cancer is more likely to spread to the neck via blood vessels, causing the cancer to spread to other parts of the body, making the disease more difficult to control.

**Medullary:** This rare form of thyroid cancer develops in cells that produce calcitonin, a hormone that does not contain iodine. This cancer tends to spread to other parts of the body and constitutes about 5 percent to 10 percent of all thyroid malignancies. Medullary thyroid carcinoma (MTC) in the pediatric population is usually associated with specific inherited genetic conditions, such as multiple endocrine neoplasia type 2 (MEN2A) or anaplastic. This is the fastest growing of the thyroid cancers, with abnormal cells that

grow and spread rapidly, especially locally in the neck. This form of cancer is not seen in children.

**Symptoms:** Symptoms of this disease vary. Your child may have a lump in the neck, persistent swollen lymph nodes, a tight or full feeling in the neck, trouble with breathing or swallowing, or hoarseness.

**Diagnosis:** If any of these symptoms occur, consult your child's physician for an evaluation. The evaluation should consist of a head and neck examination to determine if unusual lumps are present. A blood test may be ordered to determine how the thyroid is functioning. Ultrasonography uses sound waves and a computer to create an image of the thyroid gland and neck contents, such as lymph nodes. Other tests that may be warranted include a radioactive iodine scan, which provides information about the thyroid shape and function, identifying areas in the thyroid that do not absorb iodine in the normal way, or a fine needle biopsy of any abnormal lump in the thyroid or neck. Sometimes it is necessary to remove a part of the tumor or one of the lobes of the thyroid gland, known as a thyroid lobectomy, for analysis to help establish a diagnosis and plan for management.

### Treatments for Thyroid Cancer:

If the tumor is found to be malignant, then surgery is recommended. Surgery may consist of a lobectomy, subtotal thyroidectomy (removal of at least one lobe and up to near-total removal of the thyroid gland), or a total thyroidectomy. In children with papillary or follicular thyroid cancer, total or near-total thyroidectomy is currently the standard of practice, as children typically have more extensive disease at presentation, have higher rates of spread, and it reduces the risk of recurrence. In children, there is an increased need for repeat surgery when less than a total thyroidectomy is performed. Lymph nodes in the neck may need to be removed as part of the treatment for thyroid cancer if there is suspicion of spread of cancer to the lymph nodes.

Surgery may be followed by radioactive iodine therapy, to destroy cancer cells that are left after surgery. Thyroid hormone therapy may need to be administered throughout your child's life to replace normal hormones and slow the growth of any residual cancer cells.

If cancer has spread to other parts of the body, chemotherapy (treatment by chemical substances or drugs) may be given. This therapy interferes with the cancer cell's ability to grow or reproduce. Different groups of drugs work in different ways to fight cancer cells and shrink tumors. Radiation treatment may also be required for treatment of some forms of thyroid cancer.





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## Head and Neck Cancer

### Insight into recognizing symptoms for early detection

- Early detection of head and neck cancer
- Symptoms of head and neck cancer
- and more ...

This year, more than 55,000 Americans will develop cancer of the head and neck—most of which is preventable. Nearly 13,000 of them will die from it.

### Early Detection of Head and Neck Cancer

Tobacco use is the most preventable cause of these deaths. In the United States, up to 200,000 people die each year from smoking-related illnesses. The good news is this figure has decreased due to the increasing number of Americans who have quit smoking. The bad news is some of these smokers switched to smokeless or spit tobacco, assuming it is a safe alternative. This is untrue. By doing so, they are only changing the site of the cancer risk from their lungs to their mouths.

While lung cancer cases are decreasing, cancers in the head and neck appear to be increasing, but they are curable if caught early. Fortunately, most head and neck cancers produce early symptoms. You should know the potential warning signs so you can alert your doctor as soon as possible. Remember—successful treatment of head and neck cancer depends on early detection. Knowing and recognizing its signs can save your life.

### Symptoms of Head and Neck Cancer

A lump in the neck. Cancers that begin in the head or neck usually spread to lymph nodes in the neck before they spread elsewhere. A physician should see a lump in the neck that lasts more than two weeks as soon as possible. Of course, not all lumps are cancer. But a lump (or lumps) in the neck can be the first sign of cancer of the mouth, throat, voice box (larynx), thyroid gland, or of certain lymphomas and blood cancers. Such lumps are generally painless and continue to enlarge steadily.

**Change in the voice.** Most cancers in the larynx cause some changes in voice. An otolaryngologist is a head and neck specialist who can examine your vocal cords easily and painlessly. While most voice changes are not caused by cancer, you shouldn't take chances. If you are hoarse or notice voice changes for more than two weeks, see your doctor.



Tobacco use is the most preventable cause of these deaths.

**A growth in the mouth.** Most cancers of the mouth or tongue cause a sore or swelling that doesn't go away. These may be painless, which can be misleading. Bleeding may occur, but often not until late in the disease. If lumps in the neck accompany an ulcer or swelling, you should be concerned. In addition, any sore or swelling in the mouth that does not disappear after a week should be evaluated by a physician. Your dentist or doctor can determine if a biopsy (tissue sample test) is needed and can refer you to a head and neck surgeon who can perform this procedure.

**Bringing up blood.** This is often caused by something other than cancer. However, tumors in the nose, mouth, throat, or lungs can cause bleeding. If blood appears in your saliva or phlegm for more than a few days, you should see your physician.

## Head and Neck Cancer continued



**Swallowing problems.** Cancer of the throat or esophagus (swallowing tube) may make swallowing solid foods—and sometimes liquids—difficult. The food may “stick” at a certain point and then either go through to the stomach or come back up. If you have trouble almost every time you try to swallow something, a physician should examine you. Usually a barium swallow X-ray or an esophagoscopy (direct examination of the swallowing tube with a scope) will be performed to find the cause.

**Changes in the skin.** The most common head and neck cancer is basal cell cancer of the skin. Fortunately, this is rarely serious if treated early. Basal cell cancers appear most often on sun-exposed areas like the forehead, face, and ears, but can occur almost anywhere on the skin. Basal cell cancer often begins as a small, pale patch that enlarges slowly, producing a central “dimple” and eventually an ulcer. Parts of the ulcer may heal, but the major portion remains ulcerated. Some basal cell cancers show color changes. Other kinds of cancer, including squamous cell cancer and malignant melanoma,

also occur on the head and neck. Most squamous cell cancers occur on the lower lip and ear. They may look like basal cell cancers, and if caught early and properly treated, are usually not dangerous. If there is a sore on the lip, lower face, or ear that does not heal, consult a physician. Malignant melanoma typically produces a blue-black or black discoloration of the skin. However, any mole that changes size, color, or begins to bleed may mean trouble. A black or blue-black spot on the face or neck, particularly if it changes size or shape, should be seen as soon as possible by a dermatologist or other physician.

**Persistent earache.** Constant pain in or around the ear when you swallow can be a sign of infection or tumor growth in the throat. This is particularly serious if it is associated with difficulty in swallowing, hoarseness, or a lump in the neck. An otolaryngologist should evaluate these symptoms.

### Identifying High Risk of Head and Neck Cancer

As many as 90 percent of head and neck cancers arise after prolonged exposure to specific risk factors. Use of tobacco (cigarettes, cigars, chewing tobacco, or snuff) and alcoholic beverages are the most common cause of cancers of the mouth, throat, voice box, and tongue. In adults who do not smoke or drink, cancer of the throat can occur as a result of infection with the human papilloma virus (HPV). Prolonged exposure to sunlight is linked with cancer of the lip and is also established as a major cause of skin cancer.

**What you should do.** All of the symptoms and signs described here can occur with no cancer present. In fact, many times complaints of this type are due to some other condition. But you can't tell without an examination. So if they do occur, see your doctor to be sure.

Remember—when found early, most cancers in the head and neck can be cured with few side effects. Cure rates for these cancers could be greatly improved if people would seek medical advice as soon as possible. Play it safe. If you detect warning signs of head and neck cancer, see your doctor immediately. And practice health habits, which help prevent these diseases.





More Head and Neck resources to give to patients visit: To license this content and more for your website email: [hmcghee@entnet.org](mailto:hmcghee@entnet.org). Visit: [www.entnet.org/healthinformation/HeadandNeckSurgery.cfm](http://www.entnet.org/healthinformation/HeadandNeckSurgery.cfm) and [www.entnet.org/healthinformation/Cancer.cfm](http://www.entnet.org/healthinformation/Cancer.cfm) to access and print fact sheets (for educational use only).

## Thyroid Disorders and Surgery

### Insight into Complications and Treatment

- What is a thyroid disorder?
- What treatment may be recommended?
- What is thyroid surgery?
- and more ...

Your thyroid gland is one of the endocrine glands that makes hormones to regulate physiological functions in your body, like metabolism (heart rate, sweating, and energy consumed). Other endocrine glands include the pituitary, adrenal, and parathyroid glands and specialized cells within the pancreas. The thyroid gland is located in the middle of the lower neck, below the larynx (voice box) and wraps around the front half of the trachea (windpipe). It is shaped like a bow tie, just above the collarbones, having two halves (lobes) joined by a small tissue bar (isthmus). You can't always feel a normal thyroid gland.

### What is a Thyroid Disorder?

Diseases of the thyroid gland are common, affecting millions of Americans. The most common thyroid problems are:

- An overactive gland, called hyperthyroidism (e.g., Graves' disease, toxic adenoma or toxic nodular goiter)
- An underactive gland, called hypothyroidism (e.g., Hashimoto's thyroiditis)
- Thyroid enlargement due to overactivity (as in Graves' disease) or from under-activity (as in hypothyroidism). An enlarged thyroid gland is often called a "goiter."

Patients with a family history of thyroid cancer or who had radiation therapy to the head or neck as children for acne, adenoids, or other reasons are more prone to develop thyroid malignancy. If you develop significant swelling in your neck or difficulty breathing or swallowing, you should call your surgeon or be seen in the emergency room.

### What Treatment May be Recommended?

Depending on the nature of your condition, treatment may include the following:

**Hypothyroidism treatment:** Thyroid hormone replacement pills

**Hyperthyroidism treatment:**



Successful treatment of head and neck cancer depends on early detection.

- Medication to block the effects of excessive production of thyroid hormone
- Radioactive iodine to destroy the thyroid gland
- Surgical removal of the thyroid gland

### Goiters (lumps):

If you experience this condition, your doctor will propose a treatment plan based on the examination and your test results. He may recommend:

- An imaging study to determine the size, location, and characteristics of any nodules within the gland. Types of imaging studies include CT or CAT scans, ultrasound, or MRIs.
- A fine-needle aspiration biopsy—a safe, relatively painless procedure. With this procedure, a hypodermic needle is passed into the lump, and tissue fluid samples containing cells are taken. Several passes with the needle may be required. Sometimes ultrasound is used to guide the needle into the nodule. There is little pain afterward and very few complications from the procedure. This test gives the doctor more information on the nature of the lump in your thyroid gland and may help to differentiate a benign from a malignant or cancerous thyroid mass.

## Thyroid Disorders and Surgery continued

- Thyroid surgery may be required when:
  - the fine needle aspiration is reported as indeterminate, suspicious or suggestive of cancer
  - imaging shows that nodules have worrisome characteristics or that nodules are getting bigger
  - the trachea (windpipe) or esophagus are compressed because one or both lobes are abnormally large

Historically, some thyroid nodules, including some that are malignant, have shown a reduction in size with the administration of thyroid hormone. However, this treatment, known as medical “suppression” therapy, has proven to be an unreliable treatment method.

### What is Thyroid Surgery?

Thyroid surgery is an operation to remove part or all of the thyroid gland. It is performed in the hospital, and general anesthesia is usually required. Typically, the operation removes the lobe of the thyroid gland containing the lump and possibly the isthmus. A frozen section (immediate microscopic reading) may be used to determine if the rest of the thyroid gland should be removed during the same surgery. Sometimes, based on the result of the frozen section, the surgeon may decide not to remove any additional thyroid tissue, or proceed to remove the entire thyroid gland, and/or other tissue in the neck. This decision is usually made in the operating room by the surgeon, based on findings at the time of surgery. Your surgeon will discuss these options with you preoperatively. As an alternative, your surgeon may choose to remove only one lobe and await the final pathology report before deciding if the remaining lobe needs to be removed. There also may be times when the definite microscopic answer cannot be determined until several days after surgery. If a malignancy is identified in this way, your surgeon may recommend that the remaining lobe of the thyroid be removed at a second procedure. If you have specific questions about thyroid surgery, ask your otolaryngologist to answer them in detail. What happens after thyroid surgery?

### During the First 24 hours:

After surgery, you may have a drain (tiny piece of plastic tubing), which prevents fluid and blood from building up in the wound. This is removed after the fluid accumulation has stabilized, usually within 24 hours after surgery. Most patients are discharged later the same day or the next day. Complications are rare, but may include:

- Bleeding
- Bleeding under the skin that rarely can cause shortness of breath requiring immediate medical evaluation

- A hoarse voice
- Difficulty swallowing
- Numbness of the skin on the neck
- Vocal cord paralysis
- Low blood calcium

### At Home:

Following the procedure, if it is determined that you need to take any medication, your surgeon will discuss this with you prior to your discharge. Medications may include:

- Thyroid hormone replacement
- Calcium and/or vitamin D replacement

Some symptoms may not become evident for two or three days after surgery. If you experience any of the following, call your surgeon or seek medical attention:

- Numbness and tingling around the lips and hands
- Increasing pain
- Fever
- Swelling
- Wound discharge
- Shortness of breath

If a malignancy is identified, thyroid replacement medication may be withheld for several weeks. This allows a radioactive scan to better detect any remaining microscopic thyroid tissue, or spread of malignant cells to lymph nodes or other sites in the body.

### How is a Diagnosis Made?

The diagnosis of a thyroid function abnormality or a thyroid mass is made by taking a medical history and a physical examination. In addition, blood tests and imaging studies or fine-needle aspiration may be required. As part of the exam, your doctor will examine your neck and ask you to lift up your chin to make your thyroid gland more prominent. You may be asked to swallow during the examination, which helps to feel the thyroid and any mass in it. Tests your doctor may order include:

- Evaluation of the larynx/vocal cords with a mirror or a fiberoptic telescope
- An ultrasound examination of your neck and thyroid
- Blood tests of thyroid function
- A radioactive thyroid scan
- A fine-needle aspiration biopsy
- A chest X-ray
- A CT or MRI scan

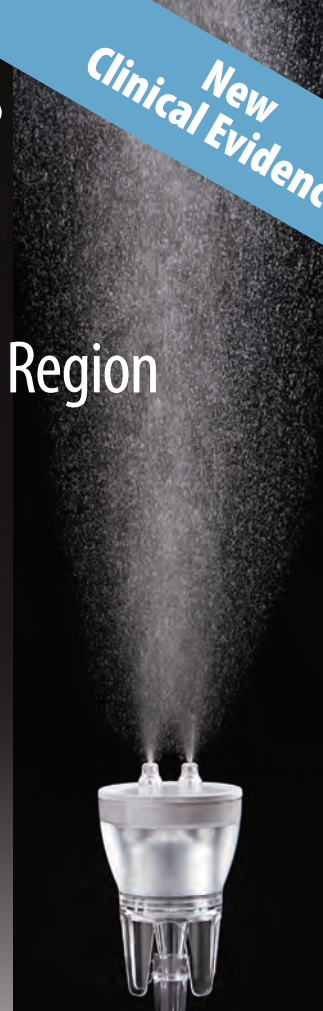


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1. Manes RP, Tong L, Batra PS.: "Prospective evaluation of aerosol delivery by a powered nasal nebulizer in the cadaver model" Int Forum Allergy Rhinol, 2011; 1:366-371

2. Yuri M. Gelfand, MD; Samer Fakhri, MD; Amber Luong, MD, PhD; Seth J. Isaacs, MD & Martin J. Citardi, MD: "A Comparative Study of the Distribution of Normal Saline Delivered by Large Particle Nebulizer vs. Large Volume/Low Pressure Squeeze Bottle" 56th Annual Meeting of the American Rhinologic Society, September 25, 2010, page 38

## ENT Advocacy: Raise Your Voice on Capitol Hill

**H**elp increase otolaryngology's visibility and influence on Capitol Hill by coming to Washington, DC, **May 7-8**. This year's advocacy conference is planned in conjunction with the spring meetings of the AAO-HNS/F Boards of Directors and the Board of Governors in an effort to ease the burden on our members' demanding schedules.

The OTO Advocacy Summit provides AAO-HNS members the ideal opportunity to directly lobby Congress on behalf of the specialty. Attendees will participate in legislative training sessions and pre-scheduled meetings with Members of Congress and/or their staff. There also will be ample

networking opportunities with your colleagues and an exclusive ENT PAC fundraising event at the historic George Washington Masonic Memorial in Alexandria, VA.


Advocacy activities will include an in-depth briefing with "insider" knowledge on all of the Academy's main legislative issues, including Medicare physician payment; truth in advertising; Medicare audiology direct access; graduate medical education (GME) funding; and comprehensive medical liability reform. AAO-HNS members also will be equipped with key talking points to fully brief Members of Congress and/or Congressional staff on important, specialty-related legislative

issues. Key strategies and "The Dos and Don'ts of Capitol Hill" will prepare attendees on how to communicate effectively in their Capitol Hill meetings.

Attendees also can expect to learn more about ENT PAC, the Academy's political action committee. ENT PAC is one of the main advocacy resources available to Academy members to help increase the visibility of the specialty with federal legislators and candidates. AAO-HNS members will be briefed on several recent ENT PAC initiatives that have carried over from 2011, including the State Fundraising and Membership Challenge and our Leadership Club giving levels.

Mark your calendar today, and don't miss the opportunity to raise your voice on Capitol Hill for the specialty.

### Top 10 Reasons to Attend the 2012 OTO Advocacy Summit

1. Learn to communicate effectively with federal legislators during advocacy training sessions.
2. Be informed of changes in the legislative landscape and political climate.
3. Attend an "insider's" briefing on key legislative priorities specific to otolaryngology.
4. Meet with your federal legislators and/or their staff.
5. Access numerous opportunities to network with your peers and other Academy leaders.
6. Learn effective advocacy tools to use back home.
7. Speak with a powerful, unified voice to Congress on key legislative issues.
8. Learn about the activities of ENT PAC, the AAO-HNS political action committee.
9. For 2012 ENT PAC Investors, attend an exclusive ENT PAC fundraising event.
10. Protect the future of your practice and ensure continued access to quality care for your patients. 





## Fasten Your Seatbelts for Another Busy Year in Politics

2011 was another whirlwind year on Capitol Hill and in the state-houses. If you need a refresher, don't miss the annual Legislative and Political Advocacy edition of the February *Bulletin*. Readers will learn more about:

- What to expect in the second session of the 112th Congress;
- Where Does Your State Rank? Find out which states won the inaugural ENT PAC State Fundraising and Membership Challenge and how to get your state ahead in 2012;
- 2011 ENT PAC Investors. See which of your peers is investing in their future ... today;
- AAO-HNS OTO Advocacy Summit, May 7-8, scheduled in conjunction with meetings of the Boards of Directors and Board of Governors (May 5-7). Advocacy activities will include Capitol Hill Meetings, advocacy training, and an exclusive ENT



Residents on the Hill in 2011.

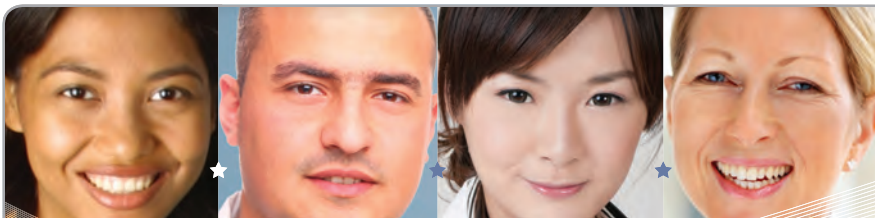
PAC event at the Masonic Temple in Alexandria, VA.

- AAO-HNS Election Central. 2012 is poised to be a crucial election year, and now is the time to become more involved.

The AAO-HNS Government Affairs team looks forward to another action-packed year. Do you want to be the first to know what's happening on Capitol Hill and in the states? Start the

year off right by joining ENT Advocacy Network—a free AAO-HNS member benefit.

Advocacy Network members receive the most timely updates straight to their email inboxes, including: “The ENT Advocate,” a bi-weekly email newsletter; legislative action alerts; and the latest news and updates regarding various ENT PAC programs. Join today by emailing [govtaffairs@entnet.org](mailto:govtaffairs@entnet.org). **b**



[www.entnet.org](http://www.entnet.org)

### Are You Interested in Politics and Public Policy?

Join the ENT Advocacy Network Today and Stay Informed!

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#### ENT Advocacy Network

Simply contact the AAO-HNS Government Affairs team at 1-703-535-3795 or [govtaffairs@entnet.org](mailto:govtaffairs@entnet.org).

The **ENT Advocacy Network** is a collaboration of AAO-HNS members who have an active interest in federal and state legislation impacting our specialty, our practices, and our patients.

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ENT Advocacy Network members receive exclusive “insider” information with the following benefits:

- A subscription to **The ENT Advocate**, a legislative e-newsletter delivered biweekly to your email inbox;
- Email alerts on federal and state legislative issues impacting our specialty; and
- Advocacy “Calls to Action” with easy instructions on contacting your legislators.



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## Update: BCBSA Balloon Sinus Ostial Dilation Reference Medical Policy

Since the beginning of 2011 members of the Physician Payment Policy (3P) workgroup and Academy staff have been in communication with staff from the Blue Cross Blue Shield Association (BCBSA) regarding its balloon sinus ostial dilation reference medical policy. (Catheter-based inflatable device is used as a synonymous term in the policy.) The Academy's Rhinology and Paranasal Sinus Committee provided valuable input during the process.

These communications included a letter from Academy Executive Vice President and CEO **David R. Nielsen**,

**MD**, responding to the draft reference medical policy and a conference call with members from 3P and Academy staff on the final reference policy. In all of these communications, the Academy expressed disagreement with the classification of balloon sinus ostial dilation as "Investigational/ Not Medically Necessary" and provided evidence supporting the safety and effectiveness of the procedure.

Despite these efforts, BCBSA decided to keep the "Investigational/ Not Medically Necessary" designation until future studies could meet the research

criteria necessary for the policy to be changed. One study submitted by the Academy (Plaza G, et al. Balloon dilation of the frontal recess: a randomized clinical trial. *Ann Otol Rhinol Laryngol.* 2011;120(8):511-8) was acknowledged to be the type of literature needed to revise coverage determinations but was, unfortunately, deemed insufficiently powered by BCBSA to change its policy.

Note that the BCBSA Reference Policies are available for use by each BCBS plan in making independent decisions about medical policy. Each plan may adopt the reference policy in whole or in part, may modify it, or may reject it. These reference policies are developed by BCBSA staff and then reviewed by a BCBSA Medical Policy Panel (MPP) comprised of senior medical plan directors.

The Academy has been, and remains, ready to cooperate with appropriate industry and other groups to develop requested prospective studies that could evaluate the efficacy and safety of devices and raise the level of evidence. The BCBSA Medical Director stated that there was no reference policy on denying payment for an entire surgical session when one portion or element was considered "Investigational/ Not Medically Necessary." The Academy will continue to work with BCBS plans, and any others with similar policies, to allow the balloon to be used as a tool to complement a procedure without the entire procedure being denied.

The 3P workgroup strongly believes the use of a balloon as a tool in a standard approach to a sinus ostial dilation is acceptable. Members may use a template appeal letter to appeal the denial of an entire surgical session where a balloon is used for sinus ostial dilation as a component of that session. It is available at <http://www.entnet.org/Practice/Appeal-Template-letters.cfm>.

If you receive this type of denial, forward information including an EOB/Explanation of Benefits (HIPAA

[Date]  
[Insurer Name]  
[Insurer Address]

Re: Patient: [Name]  
Policy Number:  
Group Number:  
Claim Number:  
Date of Service:

### Dear [Medical Director]:

Please consider this letter a formal request for reconsideration of a denial received for a septoplasty on [Patient's Name] on [Date of Service] by [Name of Physician].  
The [claim] [pre-certification] for the [septoplasty] was billed with CPT @code 30520 - Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft.

If the pre-certification or the claim was denied because the patient's condition was not chronic for more than 2 months or the patient did not have recurrent acute sinusitis, then you may include the bolded text below in your template letter:

I disagree with [insurer name]'s denial of the septoplasty based on your logic that the [Patient Name]'s condition was not chronic for over two months or that [s/he] did not have recurrent sinusitis. According to current medical practice, it is more clinically appropriate to document nasal obstruction that persists despite reasonable medical therapy (e.g. 4-8 weeks). As a result, I believe that [insurer name]'s denial of this procedure is not justifiable.

If the pre-certification or the claim was denied because you did not include a photograph of the external nose, then you may include the bolded text below in your template letter:

I disagree with [insurer name]'s denial of this septoplasty as medically unnecessary for [Patient Name] because I did not include a photograph of the patient's external nose. Photographs will often not show a clinically significant septal deviation; only caudal deviations will be evident and photos generally demonstrate external nasal deformities. As such, I believe that [insurer name]'s denial of this procedure is not justifiable.

If the pre-certification or the claim was denied because you noted that patient has a posterior septal deviation, which causes a physiologic functional impairment then you may include the bolded text below in your template letter:

Septoplasty corrects deformities of the partition between the two sides of the nose. I am enclosing the previously submitted claim [or pre-certification request], the Explanation of Benefits and operative notes.

Please reprocess this [claim] [pre-certification] for the payment of CPT code 30520. If you require additional information, please contact me at [Phone number].

Thank you for your prompt action.

Sincerely,

[Physician Name, MD]

Enclosures: [insert number of enclosures]  
cc: [Patient's Name]



information redacted), indicating whether the full session is being denied and in what setting the procedure is being denied to [healthpolicy@entnet.org](mailto:healthpolicy@entnet.org) so we can continue to track these. Also let us know if your local BCBSA plan is covering and paying for balloon sinuplasty.

### Advocacy Efforts So Far

- **January 1, 2011:** CPT approved new CPT codes for balloon sinus ostial dilation (31295-31297).
- **February 11, 2011:** AAO-HNS received request from WellPoint to provide input on draft reference medical policy for balloon sinus ostial dilation. Sends to Rhinology and Paranasal Sinus Committee (RPS) for review and comments, then sends to Academy's 3P workgroup for final review with final approval from the AAO-HNS Board.
- **May 17, 2011:** AAO-HNS sent comments to WellPoint, which forwards them to BCBSA for review.
- **May 2011:** BCBSA reviewed the draft medical policy for balloon sinus ostial dilation at its Medical Policy Panel meeting. AAO-HNS received reviewed comments.
- **July 29, 2011:** BCBSA reported that draft policy was final after May 2011 BCBSA medical policy panel review.
- **August 25, 2011:** Via "The News," sends request for members to inform the Academy of problems with third-party payer coverage of balloon sinus ostial dilation and opposition to outright denial of payment for any, including classic endoscopic sinus surgery, when balloons are used during a surgical session. The Academy's interpretation of extant literature led it to a different conclusion, and the Academy strongly opposed this action.
- **September 21, 2011:** AAO-HNS conducted conference call with BCBSA Technical Evaluation Committee Medical Chairman, 3P, and Academy staff. BCBSA indicated classification remains investigational/not medically necessary due to current insufficient evidence of comparative effectiveness. 3P provides the Plaza, et al., study. The Medical Chairman notes on September 24, 2011, in a written response that BCBSA determined that the study does not present a sufficient quality level and has serious limitations.
- **September 30, 2011:** AAO-HNS sent BCBSA a follow-up letter requesting what further study/information is required to eliminate "investigational" designation for balloon sinus ostial dilation going forward.
- **October 6, 2011:** Received response from BCBSA providing more information on types of trials needed to provide sufficient evidence for coverage, noting that for a treatment such as balloon sinus ostial dilation, they would expect high-quality clinical trials that compare this modality to alternatives, including a trial of sufficient size, analysis of the most clinically important outcome measures, and avoidance of major bias. The improvement in the outcome measure(s) should be both statistically and clinically significant. **b**

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## Event Reporting Web-based Portal

**Rahul K. Shah, MD**  
*George Washington University School  
 of Medicine*  
*Children's National Medical Center,*  
*Washington, DC*

The Academy, via the Patient Safety and Quality Improvement Committee, is eager to provide membership with quasi real-time reports on zones of risk within our specialty. To approach this in a secure and appropriate manner, we considered forming a Patient Safety Organization. Designation of such an organization affords specific legal rights, but also places specific requirements on such an entity. Our intense research of this potential designation yielded great insight. Currently, it is not in the Academy's best interest to

pursue designation as a Patient Safety Organization.

However, we do want to know what zones of risk exist for Academy members so they can ensure that the highest level of care is delivered to their patients. To this end, we can rely on articles published in peer-reviewed journals. However, it is difficult to have case reports on errors or sentinel events published in such journals. Furthermore, many ask if that is the appropriate forum for dissemination of such events. The study our group published in *Laryngoscope* in 2004 laid the foundation for many subsequent projects targeted at reducing harm and near-misses in our specialty.

We hope that by collecting data we can address issues that affect our patients on a macro level that may not

“We hope that by collecting data, we can address issues that affect our patients on a macro level that may not be identified in one-off reports or anecdotal vignettes.”

be identified in one-off reports or anecdotal vignettes. For example, if there is a device that has an issue at a frequency of 10-3, then that issue may never be evident to a single surgeon during a






couple of decades. However, if 7,000 surgeons use the device, then infrequent issues could become rapidly apparent.

The Food and Drug Administration has an excellent medication and device reporting system for adverse issues. However, when reviewing systemic defects with processes, some of these are not captured by such reporting mechanisms. An example of this would be the latent system defects in transitioning your office from a paper-based system to an electronic medical record process. This zone of risk (the potential for information technology to lead to adverse events) has only recently become evident in the patient safety and quality improvement world. However, a system that allows us to aggregate near-misses, adverse events, and errors would facilitate identification of this.


The Patient Safety and Quality Improvement Committee is working diligently with Academy staff to create a web-based portal that members could

access through the AAO-HNSF website. The portal would allow members to confidentially answer 10 brief questions on a near-miss, adverse event, or error. There would be no identifiable data, which is good and bad. The good we can all discern. The bad is that by having some potentially identifiable data, such as hospital characteristics, etc., we can learn more about the event and ways to minimize it. However, to ensure the confidentiality of the physician providing the report, it is absolutely imperative that only high-level information be obtained. We imagine you would submit a summary similar to this: "A 6-yo boy underwent a tonsillectomy and had a burn to the lip; I used xyz technique; I did the case, not a resident." If we were to obtain a dozen similar reports, it would indicate that this is a potential zone of risk. We could then leverage our Academy resources to help prevent this condition.

We are excited about the new web portal that will allow Academy members to input limited data about perceived or real safety issues; the end result would be an ability to see which issues affect Academy members and their patients and hopefully the most common sources of near misses, adverse events, and errors. 

We encourage members to write us with any topic of interest, and we will try to research and discuss the issue. Members' names are published only after they have been contacted directly by Academy staff and have given consent to the use of their names. Please email the Academy at [qualityimprovement@entnet.org](mailto:qualityimprovement@entnet.org) to engage us in a patient safety and quality discussion that is pertinent to your practice.

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*As of December 12, 2011*



## Update from the Physician Payment Policy Workgroup (3P)

**R**ichard W. Waguespack, MD, Coordinator for Socioeconomic Affairs, and **Michael Setzen, MD**, Coordinator for Practice Affairs, Co-chairs of 3P; Jean Brereton, MBA, senior director, Research, Quality Improvement and Health Policy; Jenna Kappel, MPH, MA, Director, Health Policy; Joe Cody, MA, Health Policy analyst; and Harrison Peery, Health Policy analyst.

The Physician Payment Policy Workgroup (3P), co-chaired by **Richard W. Waguespack, MD**, and **Michael Setzen, MD**, is the senior advisory body to Academy leadership and staff on issues related to socioeconomic advocacy, regulatory activity, coding, or reimbursement, and practice services or management. 3P and the Health Policy staff were busy in 2011 with a continued high level of activity, constant e-mails and monthly calls, working tirelessly on behalf of all members. Below, we have highlighted some advocacy efforts (For the latest health policy updates, visit the “what’s new” page at <http://www.entnet.org/Practice/CMS-News.cfm>).

### 3P’s Process for Private Payer Advocacy

3P developed a process for providing assistance to members dealing with private payers that may inappropriately deny or bundle a procedure or service you have furnished. The Academy cannot represent physician members individually on each issue with payers, so 3P recommends members contact their state otolaryngology society to resolve the issue at a state level. However, there are many resources available on the Academy’s website to assist members with individual issues, including appeal template letters, CPT for ENT articles, policy statements, and clinical indicators and guidelines.

If the issue cannot be resolved at the state level, contact the Academy’s health policy department at [healthpolicy@entnet.org](mailto:healthpolicy@entnet.org) and include all pertinent

information including, a copy of the denial, the EOB (with HIPAA information redacted), setting of the procedure, or anything else that could help). 3P and staff will research the issue and decide whether to pursue advocacy with the payer. For more information, see <http://www.entnet.org/Practice/Private-Payer-Resources.cfm>.

There are many resources available on the Academy’s website to assist members with individual issues, including appeal template letters, CPT for ENT articles, policy statements, and clinical indicators and guidelines.

Examples of recent efforts to advocate on members’ behalf with private payers on a national level include:

- Discussing the balloon sinus ostial dilation reference medical policy with Blue Cross and Blue Shield Association’s (BCBSA) national medical director; and
- Commenting on United Health Group’s (UHG) direct-to-consumer hearing tests and aids and entering into dialogue with United Healthcare’s national medical director to discuss concerns. Look for updates in The News and on the website as 3P and Academy staff continue to work with United Healthcare on these concerns.

(These issues are discussed in more detail in this issue on pages 33 for the BCBSA policy and 38 for UHG’s sale of hearing aids.)


3P would like to thank all of the committees and members who have provided input on these issues and others. We will continue to work on socioeconomic advocacy on behalf of the Academy and its members.

### Cahaba GBA Changes ‘Once in a Lifetime’ Policy

Cahaba Government Benefit Administrators®, LLC (Cahaba GBA) administers Medicare health insurance for the Centers for Medicare & Medicaid Services (CMS).

A major win for Academy members is Cahaba GBA removing procedures from their “once in a lifetime” procedure list. After learning about the inclusion of several procedures on the list, the Academy sent a letter to Cahaba GBA on September 30 explaining why they should be taken off the list. Shortly after receiving the letter, Cahaba removed the procedures from the list.

### Resources Available to You from 3P

3P has developed a number of resources available to members. During the annual meeting, 3P sponsored several miniseminars and presentations to educate members on issues that directly affect them. They included courses and seminars on the transition from ICD-9 to ICD-10 and how it affects you; the CMS Carrier Advisor Committee (CAC) and the Recovery Audit Contractor (RAC) process; and Academy Advocacy for Physician Payment. The sessions were highly successful and 3P looks forward to presenting them again in 2012. Along with the resources available during Annual Meeting, 3P also developed a webinar for AcademyU®, providing instruction on how to fill out a RUC survey to coincide with recent resurvey of CPT code 31231 Diagnostic nasal endoscopy. For more on these and other resources, see <http://www.entnet.org/Practice/regulatorySocioAdvocacy.cfm>. 

## UHG's Direct-to-Consumer Sale of Hearing Aids

On October 3, 2011, hi HealthInnovations, a UnitedHealth Group (UHG) subsidiary, announced the launch of an innovative and low-cost line of hearing aids available direct to consumer with a free, self-rendered online hearing test designed to work with most computers, tablets, or smartphones.

The devices are priced from \$749 to \$949, compared to the cost of a traditional hearing aid, which ranges from \$2,000 to \$4,000. Although the Academy supports innovation and lower costs for hearing aids for patients, the online hearing test is not clinically validated. UHG has yet to release any immediate research or details regarding verification of the test. Similar to many other clinical studies, a time-based analysis will be important for determining the clinical credibility of the hearing test. Further, the new methodology appears to potentially eliminate otolaryngologists and hearing professionals from the evaluative process, greatly increases the risk of misdiagnosis, and could drive up overall costs of hearing healthcare in the long-run.

Given the devices' low price range, UHG anticipates that the line of devices will drive down immediate out-of-pocket costs of hearing aids for the consumer. While the Academy appreciates UHG's intention to reduce costs, there are serious concerns regarding potential dangers, costs, and unforeseen consequences for patients with a self-rendered test.

Furthermore, the Academy strongly believes that an online hearing test is, at best, only an initial screening tool, and could provide misleading and false results. Instead of saving consumers money with a low-cost hearing aid, the potential misdiagnosis that may arise from a self-rendered hearing test could lead to increased costs for patient health and healthcare over time.


On October 6, the Academy was contacted by a reporter with *American*

the Academy strongly believes that an online hearing test is at best only an initial screening tool, and could provide misleading and false results. Instead of saving consumers money with a low-cost hearing aid, the potential misdiagnosis that may arise from a self-rendered hearing test could potentially lead to increased costs for patient health and healthcare over time.

*Medical News* (AMN), a print and online news publication published by the American Medical Association, with questions regarding the Academy's stance on UHG's new initiative. The Health Policy team collaborated with the Physician Payment Policy (3P) workgroup, the chair of the Hearing Committee, AAO-HNS Communications, and Government Affairs staff to carefully construct responses to the reporter's questions. The article quoted the Academy with the following statement: "Any changes in the paradigms by which hearing aids are evaluated and fitted must be shown to have equal or superior outcomes to those currently employed and not be based solely on cost." The article can be found in AMN's online October 24, 2011 issue.

Subsequently, the Health Policy team worked with Government Affairs staff to research and analyze state and federal law related to the issue. On November 2, 2011, the Academy submitted comments and concerns about the program to the national medical director at United Healthcare (UHC), a subsidiary of UHG, to request a conference call to collaborate on appropriately treating hearing loss in patients. AAO-HNS directed the letter to United Healthcare's national medical director after the Academy's recent open

dialogue and success in making positive changes to their rhinoplasty/septoplasty coverage guidelines. The Academy's fundamental message to UHC focuses on patient safety/quality and physician oversight when diagnosing patients with hearing loss. The AAO-HNS received an immediate response from the medical director at UHC and is currently working toward scheduling a meeting to further discuss the Academy's comments with UHC.

Academy Health Policy senior staff have been involved in communications with the American Academy of Audiology (AAA), the American Speech-Language-Hearing Association (ASHA), the Academy of Doctors of Audiology (ADA), and the International Hearing Society (IHS) to discuss collaborating on the response strategy. All groups are currently submitting or have submitted individual letters and are sharing comments with one another. The Academy plans to communicate with each group on future collaborations and will continue to share any new information received from UHG. To view a copy of the Academy letter to UHC, go to <http://www.entnet.org/Practice/News-and-Updates-from-Private-Payers.cfm>. Stay tuned for updates posted on the website and communicated via "The News." 





# Special Thanks To Our IRT Partners



We extend a special thank you to the partners of the AAO-HNSF Industry Round Table (IRT) program. Corporate support is critical to realizing the mission of the Academy, to help our members achieve excellence and provide the best ear, nose, and throat care through professional and public education and research. Our partnerships with these organizations who share this mission allow the Academy to continue to provide the programs and initiatives that are integral to our members providing the best patient care.

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Phone: 1-703-535-3714  
Email: [ptaylor@entnet.org](mailto:ptaylor@entnet.org)

## AAO-HNSF Shares Guideline Development Work internationally

The 8th Guidelines International Network (G-I-N) Conference took place August 28-31, 2011, at the Incheon Memorial Hall at Korea University in Seoul, South Korea. This year's theme was "linking evidence, policy, and practice." The scientific program committee was chaired by our own **Richard M. Rosenfeld, MD, MPH.**

The G-I-N Conference brings together many colleagues from around the world to develop collaborations and facilitate the dissemination and discussion of every aspect of guidelines, including evidence synthesis, guideline development, quality improvement, and health policy to improve patient outcomes. It is the premier venue for worldwide sharing of knowledge and experience about guideline development, dissemination, and implementation.

Presentations on guideline implementation made by Dave Davis, MD, were so thought-provoking for Dr. Rosenfeld and Stephanie Jones, director, Research and Quality Improvement, that they invited Dr. Davis to share his ideas and thoughts with the AAO-HNSF Guidelines Development Task Force at the October 31, 2011, meeting in Alexandria, VA. We are eager to learn from Dr. Davis' experience with clinical practice guideline development, adaptation, and implementation. His (and colleagues') 1995 *JAMA* systematic review of the effect of CME



Seoul, South Korea

interventions is widely cited as a seminal study in this field.

As the AAO-HNSF moves from developing guidelines to broader dissemination, implementation, and the development of educational tools, participation in G-I-N and networking with colleagues around the globe will be instrumental.

We are thrilled to announce the launch of G-I-N North America (G-I-N NA), which will enable us to network more frequently with our colleagues closer to home. G-I-N NA is the first regional initiative of G-I-N and was founded by Dr. Rosenfeld, who is also chair of the steering group.

Challenges faced by North American groups are not unique, but there are enough shared issues to justify a regional community. These include (a) heterogeneous guideline processes with minimal national oversight, (b) guideline development by diverse societies, groups, and organizations, (c) new standards from the Institute of Medicine that are likely to have broad implications for guideline

processes, including possible accreditation, (d) common concerns about funding and support, and (e) a regional desire to communicate and share best practices. To address these challenges, G-I-N NA will launch a webinar series in January 2012, leading up to a two-day conference and workshop meeting in New York City, December 2012.

### Cochrane Colloquium

The 19th Cochrane Colloquium took place October 19-22, 2011, in Madrid, Spain. The theme of this year's program was "Scientific evidence for healthcare quality and patient safety."

Four AAO-HNSF Cochrane Scholars were provided with travel grants, sponsored by Sage, to attend the meeting in exchange for developing a systematic review over the coming year for publication in the journal, *Otolaryngology—Head and Neck Surgery*. This year's scholars included: **Peter H. Hwang, MD**; **Melissa A. Pynnonen, MD**; **Sujana S. Chandrasekhar, MD**; and





**Seth M. Cohen, MD, MPH.** In addition, the meeting was attended by the AAO-HNSF Guidelines Development Task Force chair and chair-elect, **Richard M. Rosenfeld, MD, MPH,** and **Seth R. Schwartz, MD, MPH,** respectively and AAO-HNSF Guidelines staff Stephanie Jones and Peter Robertson, MPA.


The Cochrane Collaboration work is internationally recognized as the benchmark for high quality information about the effectiveness of healthcare and was recently recognized in the March 2011 report released by the Institute of Medicine titled *Finding What Works in Healthcare: Standards for Systematic Reviews*.

The AAO-HNS has a strong relationship with the Cochrane Collaboration and is actively involved with the U.S. Cochrane Center and the Ear, Nose and Throat Disorders Group. During the years, **Martin J. Burton, DM, FRCS,** joint coordinating editor for the Ear, Nose and Throat Disorders Group, and Dr. Rosenfeld have provided educational programming at the AAO-HNSF Annual Meeting & OTO EXPO. The Cochrane



Left to right: Seth R. Schwartz, MD, MPH; Seth M. Cohen, MD, MPH; Stephanie Jones, Martin J. Burton, DM, FRCS; Richard M. Rosenfeld, MD, MPH; Sujana S. Chandrasekhar, MD; Melissa A. Pynnonen, MD; and Peter H. Hwang, MD.

ENT Information Specialist/Trials Search coordinator, Gemma Sandberg, has played an invaluable role in supporting the AAO-HNSF clinical practice guidelines.

The call for applications for the 2012 Cochrane Scholars will be released soon. If you are interested in learning more, please contact Eileen Cavanagh [ecavanagh@entnet.org](mailto:ecavanagh@entnet.org). 

## Mission to El Salvador

**Derald E. Brackmann, MD**  
House Ear Clinic, Los Angeles, CA


I recently had the opportunity to travel away from the House Ear Clinic in Los Angeles, CA, and accompany **Richard Wagner, MD,** of Global ENT Outreach (GEO), to the hospital ISSS-Instituto Salvadoreño, San Salvador, El Salvador. This was GEO's 11th trip to El Salvador; it has an efficient system for visits well in place.

**Joni K. Doherty, MD, PhD,** otologist from California, and Jason Gilde, a fourth-year medical student from USC School of Medicine, joined us for the trip. We operated on 38 patients in four days. Half of them were for otosclerosis, the others were for chronic otitis media with the exception of one glomus tumor and one encephalocele with spinal fluid leak.



Dr. Brackmann (middle) performed 38 surgeries in four days.

The ENT director at the hospital was cooperative and had all the patients prepared for their surgeries. The hospital and operating room staffs were supportive. Most of all, the patients were extremely appreciative. All in all,

this was a very rewarding experience. I congratulate Dr. Wagner on all of his efforts. I look forward to doing this again. To learn more about Global ENT Outreach, contact [geoutreach@yahoo.com](mailto:geoutreach@yahoo.com) or visit [www.geoutreach.org](http://www.geoutreach.org). 

## Medals 4 Mettle

**M**edals 4 Mettle (M4M) is a non-profit organization founded by **Steven F. Isenberg, MD**, a head and neck surgeon in Indianapolis and an active member of the AAO-HNSF. He founded the organization to help recognize the difficult battle adults and children endure when diagnosed with a life-threatening illness.

Dr. Isenberg explained the impetus for M4M in *The Indianapolis Star*: “After I completed the Chicago Marathon in 2003, I came back to the hospital the morning after the race to see one of my colleagues, whom I had performed surgery on for cancer. I walked into his room, and it was dimly lit, very depressing. I had my medal in my briefcase. There wasn’t anything more I could do for him, so I just put it around his neck and said he deserved it more than me. I did that several times for other patients. In 2005, I got the idea that other people might feel the same way, so I set up Medals for Mettle.”<sup>1</sup> Since then Dr. Isenberg, and the staff and many M4M volunteers have awarded more than 20,000 medals to adults and children throughout the world.

My experience with M4M began the morning of October 29, 2011,



(left to right): Joe Burns, Laila, Dr. Steve Isenberg, Bill Preston

when I drove into Washington, DC, to the Georgetown University Hospital pediatric center to meet Dr. Isenberg and other M4M staff and volunteers. I entered the staff lounge to see two men conversing enthusiastically about the organization and their experience with M4M. I learned that, despite having worked to promote the mission of M4M

for several years, this was the first time Dr. Isenberg and Joe Burns, coordinator of the Detroit, MI, chapter, had met in person. Bill Preston, president of M4M, and Sharan Kaur, national coordinator of M4M, were also present to help award medals to each child.

Katie Foy, child life specialist for Georgetown Pediatrics, led us to the oncology and transplant units where we met 13 children. Although several were still sleeping, many of the kids were awake and happy to have visitors.

We first met Laila. It was her 8th birthday, and her room was filled with balloons and decorations. She came to the door to greet us dressed from head to toe as the little mermaid. Behind her, taped to the door was a full-size poster that read “Happy Birthday!” with messages and birthday wishes from staff and visitors. Her smile ran from ear to ear when Dr. Isenberg placed the medal around her neck as she posed for pictures.

We visited a 4-year-old girl named Ciara who was overwhelmed at first by everyone who entered the doorway, but slowly lit up when she realized the medal around her neck was hers to keep forever.



DJ and his mother enjoyed the acknowledgement of their own strength.





(left to right): Ciara with Bill Preston, president of M4M, responded slowly, but she soon lit up.

We then met a little boy named DJ and his mother. The nurses warned us he didn't like many things and probably wouldn't be excited about the medal. No one could have predicted how elated DJ became when Joe placed the medal

around his neck. He began moving around and shouting with excitement. You could see his mother was so pleased that something made her child so happy.

Although we were there for only an hour, it was an experience I won't soon forget.

To finish a marathon is a reward in itself, but to share that triumph by donating a medal to those fighting to finish their own personal race makes the feeling of that last step over the finish line that much sweeter. **b**

**If you would like to learn more about Medals 4 Mettle, how to volunteer your**



**time, or to donate a medal, please visit:**  
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Reference:

1. Rudavsky S. Marathon health battles are deserving of medals. *The Indianapolis Star*. December 24, 2009: Features- Healthy Living.



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# A History of United States Graduate Medical Education in Otolaryngology

Richard K. Gurgel, MD  
for the Otolaryngology Historical Society

Graduate medical education in otolaryngology has evolved dramatically in the United States during the past century. The establishment of training requirements and objective assessments paralleled the maturation of otolaryngology as a distinct specialty. Describing the many events that have shaped our modern training programs is beyond the scope of this brief summary. This report will therefore focus on some critical early developments that established graduate medical training in otolaryngology.

undergraduate and graduate medical education by calling for a standardized, university-based medical education and concomitant attrition of proprietary medical schools.

Amid this progressive background and influenced by European models, the American Laryngological, Rhinological, and Otological Society formed a committee in 1912 to guide the best methods of teaching otolaryngology in post-graduate schools. The committee acknowledged that “on this continent, there is no recognized portal to the specialty,” with the concern that otolaryngology would be, “dragged into the mire as a result of ignorance ... by the rank and file who style themselves specialists in diseases of

to protect its men, found it necessary to reject 70 percent of so-called otolaryngologists, what possible way exists at this time for the laity to protect themselves?”<sup>4</sup>

After many years of deliberation, a standardized curriculum was agreed upon and, in 1924, the American Board of Otolaryngology (ABOto) was organized. The ABOto certified graduates from approved training programs and functioned as the residency review committee for program accreditation until 1953.

This brief summary illustrates a cycle by which subspecialization occurs. New branches of medicine emerge from increased understanding of diseases and their management, technology, and innovation. As this process occurs, training in a specialty progresses from unstructured apprenticeships to developing standardized curricula on the subject matter.

This begets a need to formally assess those trainees through the formation of specialty boards and competency exams. Otolaryngology went through this process in the early 1900s and, as a specialty, we continue striving to improve the training experience of future otolaryngologists. [b](#)

In the mid- and late-1800s, physicians seeking specialization often spent time at dedicated eye and ear infirmaries, most of which were established in large cities such as Boston, New York, Philadelphia, Chicago, and New Orleans.

In the mid- and late-1800s, physicians seeking specialization often spent time at dedicated eye and ear infirmaries, most of which were established in large cities, such as Boston, Chicago, New Orleans, New York, and Philadelphia. More commonly, however, an aspiring specialist would travel to Europe to take courses in otology and laryngology at a university-based program, mainly in Germany and Austria.<sup>1</sup>

In the late 1800s, William Halsted pioneered the standardization of surgical training at Johns Hopkins University. By 1910, Abraham Flexner was charged by the Carnegie Foundation to assess the state of U.S. medical education. His report fundamentally changed

the ear, nose, and throat.”<sup>2</sup> The committee recommended six months of university-based basic science instruction, followed by at least 18 months of work as “resident assistants.” This training would then culminate with an examination for a formal degree.

However, implementation of these recommendations took many years, with the delay due in part to World War I. Some military data give insight into the state of otolaryngology at that time. The army rejected 70 percent of all alleged otolaryngologists, more than any other specialty, due to lack of sufficient expertise and training.<sup>3</sup> This staggering statistic caused L. W. Dean from the University of Iowa to comment, “If the army, in order

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## Shalom Foundation Mission to Guatemala

*David J. Archibald, MD, resident travel grantee*

Guatemala, a beautiful country with wonderful, humble people, is one of the poorest countries in our hemisphere. Guatemala's children suffer from the third-worst childhood growth rate in the world behind Bangladesh and Yemen.

In May 2011, a group from Vanderbilt University and the Mayo Clinic, including Shelagh A. Cofer, MD, partnered with the Shalom Foundation to travel to Guatemala City for a craniofacial surgery mission trip. In five days, we provided services at the Moore Pediatric Surgery Center for more than 60 children with craniofacial abnormalities. We primarily performed cleft lip and palate surgery.

The trip was extremely rewarding as we saw an immediate influence in these children's lives. Most memorable was a 10-week-old malnourished infant who could immediately bottle feed in the post-anesthesia recovery area after repair of his cleft lip.

Thanks to funding from Alcon Foundation, through the Humanitarian Efforts Committee, the trip was extremely successful, and I hope to take part in future trips of this nature.

## Former AAO-HNS/F President in the Media

Jonas T. Johnson, MD., professor and chair of the department of otolaryngology at the University of Pittsburgh School of Medicine and University of Pittsburgh Medical Center, and former AAO-HNS/F president, is the recipient of the 2011 Dr. Rodman E. Sheen and Thomas G. Sheen Award.

Since 1968, the award has been granted annually to a doctor or doctors for the purpose of furthering the study of medicine and the science of medicine and to compensate those who have each year done something outstanding in the medical profession. The \$25,000 award was presented by Bank of America on December 3 during the annual convention of the New Jersey Chapter of the American College of Surgeons.

"I am honored to be the recipient of this notable award," Dr. Johnson said. "The wonderful thing about healthcare, education, and research in our system has always been, and continues to be, a willingness to share ideas and train young people. This principle serves to provide access to high quality healthcare to as many Americans as possible."



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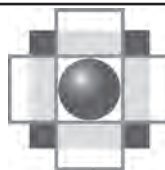
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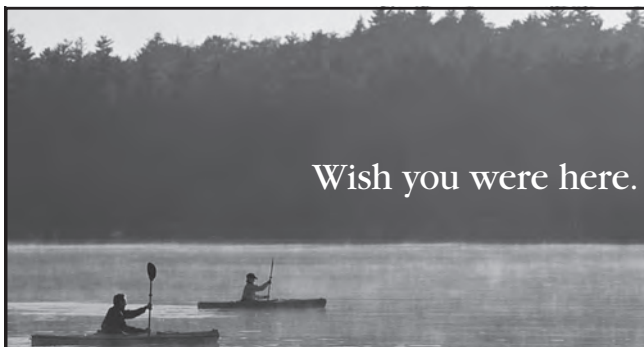
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Seeking an experienced, fellowship-trained otologist/neurotologist to replace a retiring senior partner at the world-renowned **Shea Ear Clinic** in Memphis, TN. The **Shea Ear Clinic** was founded in 1926 and is a tertiary referral otologic clinic that specializes in the treatment of all diseases of the hearing and balance system, including chronic otitis media, stapedectomy, cochlear implantation, and inner ear perfusion. We are an extremely successful and innovative four-physician private practice with our own outpatient surgery center and hearing aid center. We currently have three otologists and one general otolaryngologist. Our state of the art audiology department has three Aud's and one audiology tech. Clinical appointments are available at the University of Tennessee Department of Otolaryngology – Head and Neck Surgery and teaching of residents is encouraged. Major procedures such as acoustic neuromas are performed at one of several large local hospitals.

**Extremely competitive salary and benefits** plus fast track to partnership, generous signing bonus, and relocation package. Memphis is a major regional medical center that serves patients from the mid-south and beyond. Memphis offers a laid-back lifestyle with a low cost of living and small town southern hospitality, but big-city amenities, professional sports, good schools, and many cultural attractions.

Please reply ASAP to

**john.emmett@sheaclinic.com**

**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**. 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/](http://hrs.missouri.edu/find-a-job/academic/)

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UNIVERSITY OF NEBRASKA  
MEDICAL CENTER

**University of Nebraska Medical Center****Rhinology**

Fellowship trained or equivalent experience  
Rhinologist is sought to maintain and grow a developed Rhinology based practice.

**General Otolaryngology**

Excellent opportunity is available for a general Otolaryngologist. A combination of general ENT and subspecialty interest would be considered.

Applicants should be BC/BE, licensed to practice in Nebraska and have a strong interest in clinical care, teaching and scholarship. Salary is negotiable and commensurate with experience and training.

Daniel D. Lydiatt, DDS, MD, FACS

Department of Otolaryngology – Head & Neck Surgery

981225 Nebraska Medical Center

Omaha, NE 68198-1225

ent@unmc.edu

*An equal opportunity/affirmative action employer.  
Minorities and women are encouraged to apply.*



**Full Time Faculty Opportunities**  
**University of Rochester Medical Center**

**Laryngologist**

BC/BE, fellowship trained or equivalent experience laryngologist at any rank is sought to help build a nationally prominent laryngology and voice practice. Applicants should have a strong interest in clinical care and academic teaching. Protected research time and resources are available if candidate seeks a career as a clinician-scientist.

**Pediatric Otolaryngologist**

BC/BE, fellowship trained pediatric otolaryngologist at any rank is sought to practice at the Golisano Children's Hospital. This position offers excellent opportunities to practice the full range of the specialty in state of the art facilities. Resident teaching is expected and scholarly activities strongly encouraged. Protected research time and resources are available for candidates seeking a career as a clinician-scientist.

**General Otolaryngology**

BC/BE otolaryngologists with broad clinical interests are sought to develop a general otolaryngology practice in a community setting with full academic support. Protected research time and resources are available for clinician-scientists.

Our robust clinical practice and training program is affiliated with the University of Rochester Medical Center's Strong Memorial Hospital. The clinical office is located in a new facility opened in 2004. These are excellent opportunities to practice with an established group of academic faculty who already have practices in all Otolaryngology subspecialty areas, in a growing academic department.

The University of Rochester is an affirmative action/equal opportunity employer and strongly encourages applications from women and minorities.

*Interested candidates should send their curriculum vitae and letter of interest to:*

Shawn Newlands, M.D., Ph.D., M.B.A., F.A.C.S.  
 Professor and Chair  
 Department of Otolaryngology  
 Strong Memorial Hospital  
 601 Elmwood Avenue  
 Box 629  
 Rochester, NY 14642  
 (585) 758-5700  
 shawn\_newlands@urmc.rochester.edu



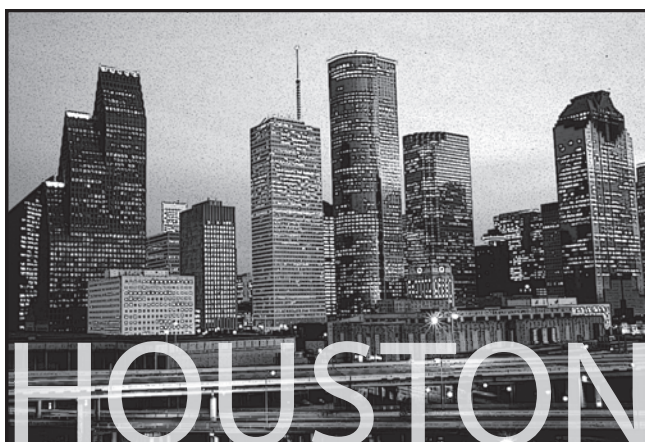
**Fellowship in Pediatric Otolaryngology**

*University of Utah  
 Primary Children's Medical Center*

Fellowship training is offered to develop an academic pediatric otolaryngologist with excellent clinical and research experience. This is a one year fellowship to begin July 2013. Experience will include advanced airway techniques, sinus surgery, cleft lip and palate, vascular malformations, otologic procedures, cochlear implant, and possible foreign surgical mission.

Over 4000 procedures are done in this division each year. We participate in the SFMatch.

Application Deadline is February 1, 2012. Please download the unified application form from the ASPO website.



**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



*UTMSH is an equal opportunity employer.*



**LARYNGOLOGY FELLOWSHIP**

A one-year fellowship in Laryngology is available at the University of Texas Voice Center for the 2013-2014 academic year (beginning July 2013). Training includes all aspects of laryngology, including professional voice care, phonosurgery, framework surgery, neurolaryngology, and endoscopic and open treatment of airway disorders. There is an emphasis on the development of skills in office-based procedures, including vocal fold injections and pulsed-KTP and CO2 laser treatment of vocal fold and tracheal lesions.

Salary is competitive. The applicant must be board eligible/certified and have Texas licensure.

*Interested applicants should send inquiries, CV and 3 to 5 references to:*

C. Blake Simpson, M.D., Professor  
 Director, The University of Texas Voice Center  
 Department of Otolaryngology-Head and Neck Surgery  
 University of Texas Health Science Center at San Antonio  
 8300 Floyd Curl Drive, MS 7777  
 San Antonio, TX 78229-3900  
 Email: simpsonc@uthscsa.edu

The University of Texas Health Science Center at San Antonio is an Equal Employment Opportunity/Affirmative Action Employer. All fellowship appointments are designated as security sensitive positions.



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[www.FauquierENT.net/job.htm](http://www.FauquierENT.net/job.htm)

## COASTAL NORTH CAROLINA PRACTICE OPPORTUNITY

Well established regional Otolaryngology practice is seeking a BC/BE Otolaryngologist. In its fourth decade, this four physician group has three office locations serving Eastern North Carolina.

Practice includes full audiology and allergy services with CT scanner, EMR, and operating/laser suite. Three audiologists and a strong support staff are in place to support further practice growth. All aspects of Otolaryngology are practiced and specialty interests in laryngology, head & neck oncology or facial plastics can be easily integrated into existing practice.

Coastal Eastern North Carolina is a beautiful region rich in history and offering abundant access to local rivers and sounds as well as various beach communities along North Carolina's Outer Banks.

*Interested applicants should contact:*

**T. Oma Hester, MD, FACS**  
Coastal Ear, Nose & Throat Associates, PLLC  
3110 Wellons Blvd.  
New Bern, NC 28562  
252-638-2515  
[ohester@coastalent.com](mailto:ohester@coastalent.com)



## ACADEMIC HEAD & NECK SURGEON West Virginia University

The Department of Otolaryngology at West Virginia University is seeking a fellowship-trained head and neck surgeon to expand our well established head and neck oncology service. Expertise with both ablative and microvascular reconstructive procedures is desired. 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 scientists.

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. Morgantown is located 80 miles south of Pittsburgh and three hours from Washington, DC. The position will become available in October 2011 and will remain open until filled. The WVU Health Sciences Center is a smoke free campus. West Virginia University is the recipient of an NSF ADVANCE award for gender equity.

*Contact:*

Hassan Ramadan, MD  
Department of Otolaryngology  
R.C. Byrd Health Sciences Center  
Morgantown, WV 26506-9200  
Telephone: (304) 293-3233; Fax: (304) 293-2902  
e-mail: [hramadan@hsc.wvu.edu](mailto:hramadan@hsc.wvu.edu)  
West Virginia University is an EOE/AA employer.



## Fellowship Trained Rhinologist and Pediatric Otolaryngologist

Albany ENT & Allergy is a well established and rapidly expanding ENT-HNS- Allergy practice with diverse ancillary services including audiology, allergy testing and immunotherapy, speech and swallowing therapy, CT imaging and sleep laboratory with convenient access to ambulatory and hospital based surgery centers.

Located in a newly constructed medical park, AENT is an innovative and progressively managed practice utilizing electronic health records and digitized file storage, a supportive clinical staff including three physician assistants, three audiologists, speech therapist and radiology technician as well as a large allergy staff.

A full patient schedule, excellent benefits and salary package (including 401k) as well as partnership potential await qualified candidates. No fellowship trained rhinologist in a region serving approximately one million patients.

*Please send confidential inquiries to:*

**Deborah Elia**  
Practice Manager  
518.701.2070  
[dellia@albanyentandallergy.com](mailto:dellia@albanyentandallergy.com)

Visit us on the web at  
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to learn more about our practice!





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## Division Chief, Pediatric Otolaryngology - Head and Neck Surgery

Nemours Children's Clinic, Jacksonville, FL

We are seeking candidates for this full-time position who possess strong leadership and interpersonal skills and who demonstrate collaborative communication. The candidate should have a strong record in pediatric clinical care and education, as well as the ability to shape annual divisional objectives and plans and to manage the support of these goals. The division currently consists of 6 full-time fellowship-trained physicians, 5 audiologists, 4 speech pathologists and 1 Ph.D. researcher within a 70+ physician pediatric subspecialty practice. Complete ancillary services are available on-site. The practice is 100% pediatric case mix and serves children from Southeast Georgia and Northeast Florida. An opportunity for an academic appointment to the Mayo Clinic College of Medicine is available. Nemours offers a competitive salary and a full array of benefits.

Jacksonville is on the northeast coast of Florida. It is bordered by the Atlantic Ocean, and the St. Johns River travels through the city, offering wonderful water views. We have wonderful weather all year-round, allowing outdoor activities and water sports to be enjoyed during personal time.

For further information, please contact: Gary D. Josephson, M.D., Office: 904-390-3690, Cell: 904-226-1231 or gjosephs@nemours.org. Nemours Children's Clinic, 807 Children's Way, Jacksonville, FL 32207

Nemours, an Equal Opportunity Employer, is one of the nation's largest pediatric subspecialty practices operating the Nemours Children's Clinics throughout Florida and Delaware and the Alfred I. duPont Hospital for Children in Wilmington, DE.

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## General Otolaryngologist

POSITION NUMBER: M0202609

The University of Kansas Otolaryngology-Head & Neck Surgery Department is seeking a General Otolaryngologist to join a faculty of 15 physicians. The successful candidate will develop a practice at The Kansas University Medical Center and affiliated hospital sites and teach residents & medical students.

## Head and Neck Surgeon

POSITION NUMBER: NOT ASSIGNED YET

The University of Kansas Otolaryngology-Head & Neck Surgery Department is seeking a BC/BE Head and Neck Surgeon for a full-time academic position. Fellowship training with expertise in microvascular surgery and an interest in oncologic research preferred.

Responsibilities include continued development of a strong clinical practice with three other members of the Head and Neck Team, resident and medical student education, and clinical or basic science research.

## Head and Neck Fellow

POSITION NUMBER: J0020146

### CLINICAL FOCUS

Head and Neck Surgical Oncology, Skull Base Surgery (anterior and lateral), Minimally Invasive Endoscopic Laser Surgery, Minimally Invasive Endocrine Surgery, Microvascular Reconstructive Surgery

Responsibilities will include clinical activities, clinical/basic science research, and resident and medical student teaching. Additional educational opportunities include a graduate level Clinical Research Training series, access to a microvascular laboratory, a craniomaxillofacial plating course and clinical research support personnel.

### APPLICANT REQUIREMENTS

Successful completion of an ACGME-accredited Otolaryngology-Head and Neck Surgery Residency training program, ABO board certified/eligible and Kansas and Missouri license eligible.

**KU** UNIVERSITY of KANSAS  
Department of  
Otolaryngology  
Head & Neck Surgery

## To view position online:

<http://jobs.kumc.edu>  
(Search by Position Number)

## For job information or to apply, contact:

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

Phone: 913-588-6719  
Email: dgirod@kumc.edu

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