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American Academy of Otolaryngology—Head and Neck Surgery

July 2013—Vol.32 No.07

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American Academy of Otolaryngology—Head and Neck Surgery

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Research and Quality Improvement Accomplishments

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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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ENTs Respond to Boston Marathon Tragedy

Several healing months have passed since the sad events of April 15, in Boston during its annual marathon and celebration of Patriots' Day. We are proud of all of our members who responded with compassion and professionalism, demonstrating strength and grace in the middle of tragedy.

Like many of us, **Daniel J. Lee, MD**, neurotologist, Massachusetts Eye and Ear, and director, Pediatric Ear, Hearing and Balance Center, is used to long days. He has a busy surgical practice and sees a variety of pediatric and adult patients primarily with ear and skull base disorders. **Gregory W. Randolph, MD**, let the Academy know of the involvement of Dr. Lee and some residents, including **Alicia M. Quesnel, MD**, in the treatment of the injured that day.

Dr. Lee kindly shared a glimpse of that experience with the *Bulletin*. He prefaced his account saying that neither he nor any of the staff members had personally experienced an emergency situation of this level before.

Dr. Lee: We saw a few patients on the evening of the Marathon Monday bombing at Mass. Eye and Ear in our subspecialty emergency department, but our otolaryngology residents saw a number of victims as inpatient consults that evening and during the ensuing days.

These patients were initially stabilized in several large general hospitals in Boston affiliated with the Harvard Medical School—Mass General Hospital, Brigham and Women's Hospital, Beth Israel-Deaconess Hospital, and Children's Hospital. As a group we have seen more than 60 patients since the events of April 15.

Bulletin: What injuries were you treating, and what was the range of seriousness?

Dr. Lee: Most patients presented with mild conductive hearing loss and small tympanic membrane perforations that we would predict should heal spontaneously with hearing recovery to baseline.

Read more online exclusive coverage of the Boston Bombing by Alicia Quesnel, MD, and Aaron K. Remenschneider, MD, at www.entnet.org/Bulletin (member login required).

Link to a CBS report of Drs. Lee and Member, Jo Shapiro, MD, Chief, Division of Otolaryngology, and Director, Center for Professionalism and Peer Support Brigham and Women's Hospital.

A few patients had larger tympanic membrane perforations and moderate conductive hearing loss. In some, a sensorineural hearing loss component was found in the ear closest to the blast.

We recommended steroids for many of our patients seen early after the bombing to help reduce the risk of permanent damage to the inner ear given the intensity of the acoustic exposure. This came at the recommendation of our military otologic colleagues who use steroids to help blast injury victims in the field.

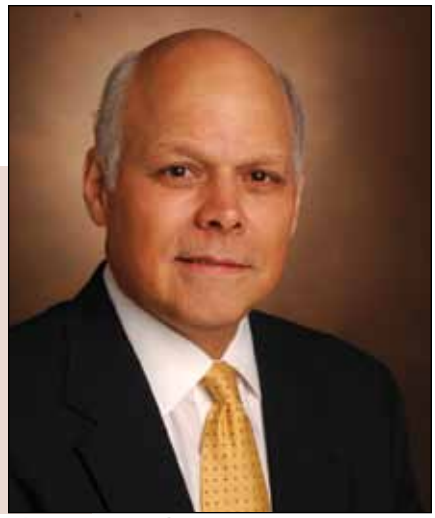
We also used a small paper patch over the tympanic membrane perforation when patients were seen in our otology clinic to help facilitate the healing process.

Bulletin: What about the patients who had other wounds, but needed otolaryngic care and could not be sent to you...did your hospital confer on them as well?

Dr. Lee: We have otologists and otolaryngology residents in all of the Harvard-affiliated hospitals, as well as the other teaching hospitals in Boston where victims were sent and so patients received specialty care at their respective institutions.

Bulletin: In an explosion like that, would some patients face permanent hearing damage or loss?

Dr. Lee: Most patients we have seen have a mild conductive hearing loss and small tympanic membrane perforations that will resolve spontaneously. Other patients presented with a sensorineural hearing loss with or without perforation and some of these patients will have a permanent threshold shift given the hair cell injury associated with acoustic trauma.



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

Bulletin: What other kinds of long-term issues would need ENT care? And, have you seen many patients since that day who have realized they have hearing loss or other injuries?

Dr. Lee: The patients needing long-term care are those with large tympanic membrane perforations that will not heal on their own and require tympanoplasty surgery. Other patients will have a permanent sensorineural hearing loss and will likely have interval testing to determine if the hearing loss remains stable or progresses. In most cases, the hearing will stabilize over time.

Bulletin: What was the biggest eye-opener into changes you will make at your clinic in emergency planning?

Dr. Lee: Thankfully none. Many otolaryngology and ophthalmology residents and staff volunteered their time to stay at the hospital to help care for these victims on Monday night. We are very fortunate to have a critical mass of specialists at MEEI and our affiliated institutions and importantly, our audiology colleagues are always on call after hours for any emergency consults requiring hearing testing or intraoperative monitoring.

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The Many Faces of Accountability

David R. Nielsen MD

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

The uncertainty faced by physicians today has many sources–new models for physician payment, employment options, use of electronic health records, documenting care, new coding and billing systems, and many more. Linking many of these issues is the concept of "accountability." While for some, the word "accountability" conjures up negative images of blame, assignment, reckoning, or finger-pointing, this arbitrary connotation is not functionally optimal. Just as we may argue about "quality" – what is it and who gets to define it – we could be equally baffled by whose definition of "accountability" we should use as demand for holding elements of the health care system "accountable" increase. Rather than focus on negative images, may I suggest that we as otolaryngologists adopt our own approach. As described by author and business consultant Susan Scott in her work on Fierce Accountability™, we would be better served to intentionally define our own accountability as a personal, private, non-negotiable choice to take responsibility for the results that we want to achieve. It is a bias toward action, motivation, and solution. It is the opposite of being a "victim."

Accountability is a key element in many of the aspects of health care delivery reform. Accountable Care Organizations (ACO) are defined as part of the Shared Savings Program in the Affordable Care Act (ACA).

They are one of the mechanisms by which improved structure, coordinated care, and shared health data and information are intended to reduce waste, duplicated effort, unnecessary care, and cost, while offering a part of the savings as a reward to the ACO participants. On behalf of the specialty, the AAO-HNS/F has designed its Research, Quality, and Health Policy Business Unit to coordinate health services research with basic and clinical research, as well as provide answers to questions of health policy and advocacy. We transfer basic science findings into useful clinical applications ("bench to bedside") through clinical research design and action. Using health services research we engage in integrating what works at the bedside for the individual into systems and populations as efficiently and effectively as possible. Systematically applying the best of what we learn through research, assessment of practice gaps, patient safety initiatives, or evidence-based guidelines and performance measures, we demonstrate our intentional assumption of accountability and responsibility for improving how we care for patients and for their individual and collective medical outcomes.

In this issue, you will read about examples of this critical aspect of accountability and professionalism – voluntary self-improvement and self-regulation. Our recent collaboration with the Society of Physician Assistants in Otolaryngology (SPAO-HNS) was again a success through the donation of space by the Weill-Cornell campus and the contributions of Academy and SPAO-HNS members to create excellent programming that qualifies for PA continuing education. We expect continued growth in such educational collaborative events that strengthen our team-based collaborative care model of quality improvement.

> "...we would be better served to intentionally define our own accountability as a personal, private, non-negotiable choice to take responsibility for the results that we want to achieve."

A few weeks ago it was my privilege to be part of a large group of otolaryngologists who assembled to recognize one of our colleagues whose lifetime contributions to the specialty are truly unique and touch nearly every one of us. After 57 years in the United States as a resident, practicing surgeon, and professor and teacher, **Eiji Yanagisawa, MD,** is retiring. In addition to a rich legacy of personal mentoring, Dr. Yanagisawa has studiously and meticulously documented, through still and video images, a lifetime of clinical care. Many years ago, these images were donated to the AAO-HNS/F to be utilized for the development of educational programming and for the use of our members. Most of us have used or seen Dr. Yanagisawa's images in Academy educational materials without even knowing where they came from. Most of our online learning products, e-books, COOL cases, and our ENT Exam Video Series rely heavily on his contributions. And our digital image library, originally founded by the Yanagisawa collection, has now been augmented by many other contributors who have followed in his footsteps and added even greater content.

The membership of the Academy has a culture of volunteerism and contributing that has been a hallmark of the success of our Annual Meeting, educational programming, and advocacy efforts for decades. This is the model of "accountability" that demonstrates the personal, private choice that each of you make to fashion the future that you envision. I salute all of you for your dedication to principle and your unflagging efforts to demonstrate your accountability through action and solution.

Quality, Research, and Accountable Care, Oh My!

Stacey L. Ishman, MD, MPH
BOG, Member-at-Large

The Affordable Care Act (ACA) has become the four-letter word of the medical world, and yet the tenets of the ACA are based on improved patient access, supporting preventative care, and a greater emphasis on the provision and measurement of quality care. Tenets, I hope, we can all support and aspire to achieve. And while the current legislation may not satisfy many (or any) of us, I think we can all endeavor to improve the medical world around us.

As the science of quality and performance improvement rapidly grows, we all need to focus on our practices, our patients, and the systems within our purview. Measurement, whether of our outcomes or the systems in which we work, is the key to more effective and cost-efficient patient care. These kinds of endeavors do not require large medical system programs, but the determination of individuals or groups to investigate the effectiveness of our current care systems. Understanding our surgical and medical outcomes remains the ultimate goal of these efforts in order to optimize patient care.

While research may support the broad establishment of quality systems, the ability to gauge our care outcomes starts with an individual mandate to measure something: tonsil bleeds, fistula rates, hospital readmissions, or post-operative pneumonias. Many of us may have existing systems based on tracking with an Excel spreadsheet of cases or piles of operating room and clinic schedules (I have used both), but the advantage of the electronic medical record (EMR) is the ability to track and measure without all the manual effort. If we can trade all the pain, time, and money we are investing in EMRs for some substantial, useful data that can support or improve our practices, maybe there is a silver lining.

Every system has failures, and medicine has been in the forefront of analyzing these while reviewing methods to improve individual care through the morbidity and mortality conference. While the airline industry is commonly touted for its failure analysis and safety culture, physicians have been evaluating our negative outcomes since before air travel even existed. This commitment has long served as a fantastic communal basis for quality improvement, and preserved a culture of accountability. In addition, it forms the basis for our current efforts to move to the next stage and implement system-wide changes based on these observations.

While individual efforts prove critical here, the establishment of research protocols and programs remains fundamental to outcomes improvement. Toward this end, the ACA resulted in the creation of the Patient-Centered Outcomes Research Institute (PCORI), which focuses on assessment of treatment, diagnosis, and prevention, system-wide improvements, and disparities. While these national programs are important and will hopefully provide funding that directly improves otolaryngologic care, the Academy itself has joined forces with subspecialty societies, foundations, and industry sponsors to broaden research opportunities through the Centralized Otolaryngology Research Efforts (CORE). Since 1985, CORE has awarded more than 500 grants and more than $9 million for research projects, research training, and career development to further the specialty of otolaryngology, with grants ranging from $5,000 to $80,000.

The Academy's committee system has also been dedicated to these efforts, and primary efforts have been highlighted through the Patient Safety and Quality Improvement and the Outcomes Research and Evidence-Based Medicine committees. In addition, the Academy has been at the national forefront of evidence-based guidelines creation and has helped establish internationally recognized methodology for their construction.

As we embrace a focus on quality, outcomes, and the ACA, please join the Board of Governors at the Annual Meeting at 8:00 am on Tuesday, October 1 for a miniseminar titled, "Hot Topics in Otolaryngology: ACOs." We will discuss accountable care organizations (ACOs), and the payment and care delivery model created through the ACA that ties reimbursement to performance and cost reduction.

At the end of the day, we all enjoy caring for patients and celebrating medical successes with them. Who wouldn't be proud when a child gets to leave the hospital after airway reconstruction or a patient can sleep through the night (and not in school or work) after amelioration of their severe sleep apnea? If embracing a system of constant evaluation and measurement is the way to make these outcomes happen more frequently, I am on board. I hope that you will join me in these efforts.

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Clinical Practice Guideline: Tympanostomy Tubes in Children

Richard M. Rosenfeld, MD, MPH; Seth R. Schwartz, MD, MPH; Melissa A. Pynnonen, MD, MSc; David E. Tunkel, MD; Heather M. Hussey, MPH; Jeffrey S. Fichera, PA-C; Alison M. Grimes, AuD; Jesse M. Hackell, MD; Melody F. Harrison, PhD; Helen Haskell, MA; David S. Haynes, MD; Tae W. Kim, MD; Denis C. Lafreniere, MD; Katie LeBlanc, MTS, MA; Wendy L. Mackey, APRN, BC; James L. Netterville, MD; Mary E. Pipan, MD; Nikhila P. Raol, MD; Kenneth G. Schellhase, MD, MPH

This month, the AAO-HNSF will publish its latest clinical practice guideline, "Tympanostomy Tubes in Children," as a supplement to *Otolaryngology–Head and Neck Surgery*. Recommendations developed address patient selection, as well as surgical indications for, and management of, tympanostomy tubes in children. The guideline was developed using the *a priori* protocol outlined in the *AAO-HNS Clinical Practice Guideline Development Manual*.[1] The complete guideline is available at http://oto.sagepub.com.

To assist in implementing the guideline recommendations, this article summarizes the rationale, purpose, and *key action statements*. Recommendations in a guideline can be implemented only if they are clear and identifiable. This goal is best achieved by structuring the guideline around a series of key action statements, which are supported by amplifying text and action statement profiles. For ease of reference only, the statements and profiles are included in this brief summary. Please refer to the complete guideline for the important information in the amplifying text that further explains the supporting evidence and details of implementation for each key action statement.

For more information about the AAO-HNSF's other quality knowledge products (clinical practice guidelines and clinical consensus statements), our guideline development methodology, or to submit a topic for future guideline development, please visit: http://www.entnet.org/guidelines.

Table 1. Abbreviations and definitions of common terms

Term	Definition
Otitis media with effusion (OME)	The presence of fluid in the middle ear without signs or symptoms of acute ear infection
Chronic OME	OME persisting for three months or longer from the date of onset (if known) or from the date of diagnosis (if known)
Acute otitis media (AOM)	The rapid onset of signs and symptoms of inflammation of the middle ear
Recurrent AOM	Three or more well-documented and separate AOM episodes in the last six months OR at least four well-documented and separate AOM episodes in the last 12 months with at least one in the last six months.[4]
Middle-ear effusion (MEE)	Fluid in the middle ear from any cause, but most often from OME and during, or after, an episode of AOM
Tympanostomy tube otorrhea (TTO)	Discharge from the middle ear through the tube, usually caused by AOM or external contamination of the middle ear from water entry (swimming, bathing, or hair washing)

Introduction

Insertion of tympanostomy tubes is the most common ambulatory surgery performed on children in the United States. Each year, 667,000 children younger than 15 years receive tympanostomy tubes, accounting for more than 20 percent of all ambulatory surgery in this group.[2] By age 3, nearly one of every 15 children (6.8 percent) will have tympanostomy tubes, increasing by more than two-fold with day care attendance.[3]

Tympanostomy tubes are most often inserted because of persistent middle ear fluid, frequent ear infections, or ear infections that persist after antibiotic therapy. All of these conditions are encompassed by the term otitis media (middle ear inflammation), which is second in frequency only to acute upper respiratory infection (URI) as the most common illness diagnosed in children by healthcare professionals.[5] Children younger than 7 years are at increased risk of otitis media because of their immature immune systems and poor function of the Eustachian tube, a slender connection between the middle ear and back of the nose that normally ventilates the middle ear space and equalizes pressure with the external environment.[6]

Despite the frequency of tympanostomy tube insertion, there are currently no clinical practice guidelines in the United States that address specific indications for surgery. When children require surgery for otitis media with effusion (OME), insertion of tympanostomy tubes is the preferred initial procedure, with candidacy dependent primarily upon hearing status, associated symptoms, and the child's developmental risk.[7] Placement of tympanostomy tubes significantly improves hearing, reduces effusion prevalence,[8] may reduce the incidence of recurrent acute otitis media (AOM), and provides a mechanism for drainage and administration of topical antibiotic therapy for persistent AOM. Additionally, research indicates tympanostomy tubes also can improve

disease-specific quality of life (QOL) for children with chronic OME, recurrent AOM, or both.[9]

Risks and potential adverse events of tympanostomy tube insertion are related to general anesthesia usually required for the procedure, and the effect of the tympanostomy tube on the tympanic membrane and middle ear.[10] Tympanostomy tube sequelae are common, but generally transient (otorrhea) or do not affect function (tympanosclerosis, focal atrophy, or shallow retraction pocket). Tympanic membrane perforations, which may require repair, are seen in about two percent of children after placement of short-term tympanostomy tubes.[10]

When making clinical decisions, the risks of tube insertion must be balanced against the risks of prolonged or recurrent otitis media, which include suppurative complications, damage to the tympanic membrane, adverse effects of antibiotics, and potential developmental sequelae of hearing loss. The frequency of tympanostomy tube insertion combined with variations in accepted indications for surgery create a pressing need for evidence-based guidelines to aid clinicians in identifying the best surgical candidates and optimizing subsequent care.

Purpose

The primary purpose of this clinical practice guideline is to provide clinicians with evidence-based recommendations on patient selection, as well as surgical indications for, and management of, tympanostomy tubes in children. This guideline is intended for any clinician involved in managing children, aged six months to 12 years, with tympanostomy tubes or being considered for tympanostomy tubes in any care setting, as an intervention for otitis media of any type. The target audience includes specialists, primary care clinicians, and allied health professionals, as represented by this multidisciplinary guideline development group.

Although children considered at risk for developmental delays or disorders are often excluded for ethical reasons from clinical research involving tympanostomy tubes, the guideline development group decided to include them in the scope because these patients may derive enhanced benefit from tympanostomy tubes.[11] This decision was based on clinical experience of the guideline development group and a recommendation from a multidisciplinary guideline on OME that, "Clinicians should distinguish the child with OME who is at risk for speech, language, or learning problems from other children with OME, and should more promptly evaluate hearing, speech, language, and need for intervention," including tympanostomy tubes.[7] Risk factors for developmental difficulties (delay or disorder) include: permanent hearing loss independent of OME, suspected or confirmed speech and language delay or disorder, Autism-spectrum disorder and other pervasive developmental disorders, syndromes (e.g., Down) or craniofacial disorders that include cognitive, speech, or language delays, blindness or uncorrectable visual impairment, cleft palate with or without associated syndrome, or developmental delay.

In planning the content of the guideline, the development group broadly discussed indications for tube placement, perioperative management, care of children with indwelling tubes, and outcomes of tympanostomy tube surgery. Given the lack of current published guidance on surgical indications, despite a substantial evidence base of randomized trials and systematic reviews on which to base such guidance, the group decided early in the development process to identify situations where tube insertion would be optional, recommended, or not recommended. Additional emphasis was placed on opportunities for quality improvement, particularly regarding shared decision-making and care of children with existing tubes.

Key Action Statements

STATEMENT 1. OME OF SHORT DURATION: Clinicians should not perform tympanostomy tube insertion in children with a single episode of OME of less than three months duration, from the date of onset (if known) or from the date of diagnosis (if onset is unknown). *Recommendation against based on systematic review of observational studies of natural history and an absence of any randomized controlled trials on efficacy of tubes for children with OME less than three months duration and a preponderance of benefit over harm.*

Action Statement Profile

- Aggregate evidence quality: Grade C, based on a systematic review of observational studies and control groups in RCTs on the natural history of OME and an absence of any RCTs on efficacy of tympanostomy tubes for children with OME less than two months duration
- Level of confidence in evidence: High
- Benefits: Avoidance of unnecessary surgery and its risks, avoidance of surgery in children for whom the benefits of tympanostomy tubes have not been studied and are uncertain, avoidance of surgery in children with a condition that has reasonable likelihood of spontaneous resolution, cost savings
- Risks, harms, costs: Delayed intervention in children who do not recover spontaneously and/or in children who develop recurrent episodes of MEE
- Benefit-harm assessment: Preponderance of benefit
- Value judgments: Exclusion of children with OME less than two months duration from all published RCTs of tube efficacy was considered compelling evidence to question the value of surgery in this population, especially considering the known risks of tympanostomy tube surgery
- Intentional vagueness: None
- Role of patient (caregiver) preferences: Limited, because of good evidence that otherwise healthy children with OME of short duration do not benefit from tympanostomy tube insertion
- Exceptions: At-risk children; see Statements 6 and 7 for explicit information on at risk children
- Policy level: Recommendation
- Differences of opinion: None

STATEMENT 2. HEARING TESTING: Clinicians should obtain an age-appropriate hearing test if

OME persists for three months or longer OR prior to surgery when a child becomes a candidate for tympanostomy tube insertion. *Recommendation based on observational and cross-sectional studies with a preponderance of benefit over harm.*

Action Statement Profile

- Aggregate evidence quality: Grade C, based on observational and cross-sectional studies assessing the prevalence of conductive hearing loss with OME
- Level of confidence in evidence: High
- Benefits: Documentation of hearing status, improved decision making regarding the need for surgery in chronic OME, establishment of baseline hearing prior to surgery, detection of coexisting sensorineural hearing loss
- Risks, harms, costs: Cost of the audiologic assessment
- Benefit-harm assessment: Preponderance of benefit
- Value judgments: None
- Intentional vagueness: The words "age-appropriate" audiologic testing are used to recognize that the specific methods will vary with the age of the child, but a full discussion of the specifics of testing is beyond the scope of this guideline.
- Role of patient (caregiver) preferences: Some, caregivers may decline testing
- Exceptions: None
- Policy level: Recommendation
- Differences of opinion: None

STATEMENT 3. CHRONIC BILATERAL OME WITH HEARING DIFFICULTY: Clinicians should offer tympanostomy bilateral tube insertion to children with bilateral OME for three months or longer AND documented hearing difficulties. *Recommendation based on randomized controlled trials and observational studies, with a preponderance of benefit over harm.*

Action Statement Profile

- Aggregate evidence quality: Grade B, based on well-designed RCTs showing reduced MEE prevalence and improved hearing after tympanostomy tube insertion; observational studies documenting improved quality of life; and extrapolation of research and basic science principles for optimizing auditory access.
- Level of confidence in the evidence: High.
- Benefits: Reduced prevalence of MEE, improved hearing, improved child and caregiver QOL, optimization of auditory access for speech and language acquisition, elimination of a potential barrier to focusing and attention in a learning environment
- Risks, harms, costs: Risk of anesthesia, sequelae of the indwelling tympanostomy tubes (e.g. otorrhea, granulation tissue, obstruction), complications after tube extrusion (myringosclerosis, retraction pocket, persistent perforation), failure of or premature tympanostomy tube extrusion, tympanostomy tube medialization, procedural anxiety and discomfort, and direct procedural costs
- Benefit-harm assessment: Preponderance of benefit over harm
- Value judgments: Assumption that optimizing auditory access would improve speech and language outcomes, despite inconclusive evidence regarding the impact of MEE on speech and language development
- Intentional vagueness: The term "hearing difficulty" is used instead of "hearing loss" to emphasize that a functional assessment of how a child uses hearing and engages in their environment is important, regardless of what specific threshold is used to define hearing loss based on audiologic criteria
- Role of patient (caregiver) preferences: Substantial role for shared decision-making regarding the decision to proceed with, or to decline, tympanostomy tube insertion
- Exceptions: None
- Policy level: Recommendation
- Difference of opinion: Minor differences regarding the role of caregiver report as a surrogate for audiologic assessment and whether the action taken by the clinician should be to "recommend" tubes (minority opinion) vs. to "offer" tubes (majority opinion)

STATEMENT 4. CHRONIC OME WITH SYMPTOMS: Clinicians may perform tympanostomy tube insertion in children with unilateral or bilateral OME for three months or longer (chronic OME) AND symptoms that are likely attributable to OME that include, but are not limited to, balance (vestibular) problems, poor school performance, behavioral problems, ear discomfort, or reduced quality of life. *Option based on randomized controlled trials and before-and-after studies with a balance between benefit and harm.*

Action Statement Profile

- Aggregate evidence quality: Grade C, based on before-and-after studies on vestibular function and QOL, RCTs on reduced MEE after tubes for chronic OME, and observational studies regarding the impact of MEE on children as related, but not limited to, school performance, behavioral issues, and speech delay
- Level of confidence in evidence: High for vestibular problems and QOL; medium for poor school performance, behavioral problems, and ear discomfort, because of study limitations and the multifactorial nature of these issues
- Benefits: Reduced prevalence of MEE, possible relief of symptoms attributed to chronic OME, elimination of MEE as a confounding factor from efforts to understand the reason or cause of a vestibular problem, poor school performance, behavioral problem, or ear discomfort
- Risks, harms, costs: None related to offering surgery, but if performed, tympanostomy tube insertion includes risks from anesthesia, sequelae of the indwelling tympanostomy tubes (otorrhea, granulation tissue, obstruction), complications after tube extrusion (myringosclerosis, retraction pocket, persistent perforation), premature tympanostomy tube extrusion, retained tympanostomy tube, tympanostomy tube medialization, procedural anxiety

and discomfort, and direct procedural costs
- Benefit-harm assessment: Equilibrium
- Value judgments: Chronic MEE has been associated with problems other than hearing loss; intervening when MEE is identified can reduce symptoms. The group's confidence in the evidence of a child benefitting from intervention was insufficient to conclude a preponderance of benefit over harm and instead found at equilibrium
- Intentional vagueness: The words "likely attributable" are used to reflect the understanding that the symptoms listed may have multifactorial causes, of which OME may be only one factor, and resolution of OME may not necessarily resolve the problem
- Role of patient (caregiver) preferences: Substantial role for shared decision-making regarding the decision to proceed with, or to decline, tympanostomy tube insertion
- Exceptions: None
- Policy level: Option
- Differences of opinion: None

STATEMENT 5. SURVEILLANCE OF CHRONIC OME: Clinicians should reevaluate, at three- to six-month intervals, children with chronic OME who do not receive tympanostomy tubes, until the effusion is no longer present, significant hearing loss is detected, or structural abnormalities of the tympanic membrane or middle ear are suspected. *Recommendation based on observational studies, with a preponderance of benefit over harm.*

Action Statement Profile
- Aggregate evidence quality: Grade C, based on observational studies
- Level of confidence in evidence: High
- Benefits: Detection of structural changes in the tympanic membrane that may require intervention, detection of new hearing difficulties or symptoms that would lead to reassessing the need for tympanostomy tube insertion, discussion of strategies for optimizing the listening-learning environment for children with OME, as well as ongoing counseling and education of parents/caregiver
- Risks, harms, costs: Cost of examination(s)
- Benefit-harm assessment: Preponderance of benefit over harm
- Value judgments: Although it is uncommon, untreated OME can cause progressive changes in the tympanic membrane that require surgical intervention. There was an implicit assumption that surveillance and early detection/intervention could prevent complications and would also provide opportunities for ongoing education and counseling of caregivers
- Intentional vagueness: The surveillance interval is broadly defined at three to six months to accommodate provider and patient preference; "significant" hearing loss is broadly defined as one that is noticed by the caregiver, reported by the child, or interferes in school performance or quality of life.
- Role of patient (caregiver) preferences: Opportunity for shared decision making regarding the surveillance interval
- Exceptions: None
- Policy level: Recommendation
- Difference of opinion: None

STATEMENT 6. RECURRENT AOM WITHOUT MEE: Clinicians should not perform tympanostomy tube insertion in children with recurrent acute otitis media who do not have middle ear effusion in either ear at the time of assessment for tube candidacy. *Recommendation against based on systematic reviews and randomized controlled trials with a preponderance of benefit over harm.*

Action Statement Profile
- Aggregate evidence quality: Grade A, based on a meta-analysis of RCTs, a systematic review of RCT control groups regarding the natural history of recurrent AOM, and other RCTs
- Level of confidence in evidence: High
- Benefits: Avoid unnecessary surgery and its risks, avoid surgery in children for whom RCTs have not demonstrated any benefit for reducing AOM incidence or in children with a condition that has reasonable likelihood of spontaneous resolution, cost savings
- Risks, harms, costs: Delay in intervention for children who eventually require tympanostomy tubes, need for systemic antibiotics among children who continue to have episodes of recurrent AOM
- Benefit-harm assessment: Preponderance of benefit over harm
- Value judgments: Implicit in this recommendation is the ability to reassess children who continue to have AOM despite observation and to perform tympanostomy tube insertion if MEE is present (Statement 7); risk of complications or poor outcomes from delayed tube insertion for children who continue to have recurrent AOM is minimal
- Intentional vagueness: The method of confirming the absence of middle ear effusion should be based on clinician experience and may include tympanometry, simple otoscopy, and/or pneumatic otoscopy
- Role of patient (caregiver) preferences: Limited, because of favorable natural history and good evidence that otherwise healthy children with recurrent AOM without MEE do not have a reduced incidence of AOM after tympanostomy tube insertion
- Exceptions: At-risk children, children with histories of severe or persistent AOM, immunosuppression; prior complication of otitis media (mastoiditis, meningitis, facial nerve paralysis); multiple antibiotic allergy or intolerance.
- Policy level: Recommendation
- Differences of opinion: None

STATEMENT 7. RECURRENT AOM WITH MEE: Clinicians should offer bilateral tympanostomy tube insertion in children with recurrent AOM who have unilateral or bilateral MEE at the time of assessment for tube candidacy. *Recommendation based on randomized controlled trials with minimal limitations and a preponderance of benefit over harm.*

Action Statement Profile
- Aggregate evidence quality: Grade B, based on RCTs with minor limitations
- Level of confidence in evidence: Medium; some uncertainty regarding the magnitude of clinical benefit and

importance, because of heterogeneity in the design and outcomes of clinical trials.
- Benefits: Mean decrease of approximately three episodes of AOM per year, ability to treat future episodes of AOM with topical antibiotics instead of systemic antibiotics, reduced pain with future AOM episodes, improved hearing during AOM episodes
- Risks, harms, costs: Risks from anesthesia, sequelae of the indwelling tympanostomy tubes (otorrhea, granulation tissue, obstruction), complications after tube extrusion (myringosclerosis, retraction pocket, persistent perforation), premature tympanostomy tube extrusion, retained tympanostomy tube tympanostomy tube medialization, procedural anxiety and discomfort, and direct procedural costs
- Benefit-harm assessment: Preponderance of benefit over harm
- Value judgments: In addition to the benefits seen in RCTs, the presence of effusion at the time of assessment served as a marker of diagnostic accuracy for AOM
- Intentional vagueness: The method of confirming the presence of middle ear effusion should be based on clinician experience and may include tympanometry, simple otoscopy, and/or pneumatic otoscopy.
- Role of patient (caregiver) preferences: Substantial role for shared decision-making regarding the decision to proceed with, or to decline, tympanostomy tube insertion.
- Exceptions: None
- Policy level: Recommendation
- Differences of opinion: None

STATEMENT 8. AT RISK CHILDREN: Clinicians should determine if a child with recurrent AOM or with OME of any duration is at increased risk for speech, language, or learning problems from otitis media because of baseline sensory, physical, cognitive, or behavioral factors. *Recommendation based on observational studies with a preponderance of benefit over harm.*

Action Statement Profile
- Aggregate evidence quality: Grade C, based on observational studies
- Level of confidence in evidence: High for Down syndrome, cleft palate, and permanent hearing loss; medium for other risk factors.
- Benefits: Facilitation of future decisions about tube candidacy, identification of children who might benefit from early intervention (including tympanostomy tubes), identification of children who might benefit from more active and accurate surveillance of middle ear status as well as those who require more prompt evaluation of hearing, speech, and language
- Risks, harms, costs: None
- Benefit-harm assessment: Preponderance of benefit over harm
- Value judgments: Despite the limited high quality evidence about the impact of tubes on this population (nearly all RCTs exclude children who are at risk) the panel considered it important to use at risk status as a factor in decision making about tube candidacy, building on recommendations made in the OME guideline.[5] The panel assumed that at risk children would be less likely to tolerate OME or recurrent AOM than would the otherwise healthy child.
- Intentional vagueness: None
- Role of patient (caregiver) preferences: None, since this recommendation deals only with acquiring information to assist in decision-making.
- Exceptions: None
- Policy level: Recommendation
- Differences of opinion: None

STATEMENT 9. TYMPANOSTOMY TUBES AND AT RISK CHILDREN: Clinicians may perform tympanostomy tube insertion in at risk children with unilateral or bilateral OME that is unlikely to resolve quickly as reflected by a type B (flat) tympanogram or persistence of effusion for three months or longer. Option based on a systematic review and observational studies with a balance between benefit and harm.

Action Statement Profile
- Aggregate evidence quality: Grade C based on a systematic review of cohort studies regarding natural history of type B tympanograms and observational studies examining the impact of MEE on at risk children
- Level of confidence in evidence: Moderate to low, because of methodologic concerns with the conduct, outcome reporting, and follow up of available observational studies.
- Benefits: Improved hearing, resolution of MEE in at risk children who would otherwise have a low probability of spontaneous resolution, mitigates a potential obstacle to child development
- Risks, harms, costs: Risk of anesthesia, sequelae of the indwelling tympanostomy tubes (otorrhea, granulation tissue, obstruction), complications after tube extrusion (myringosclerosis, retraction pocket, persistent perforation), failure of or premature tympanostomy tube extrusion, tympanostomy tube medialization, procedural anxiety and discomfort, and direct procedural costs
- Benefit-harm assessment: Equilibrium
- Value judgments: Despite the absence of controlled trials identifying benefits of tympanostomy tube placement in at-risk children (such children were excluded from the reviews cited), the panel agreed that tympanostomy tubes were a reasonable intervention for reducing the prevalence of MEE that would otherwise have a low likelihood of prompt spontaneous resolution. Untreated persistent MEE would place the child at high risk for hearing loss from suboptimal conduction of sound through the middle ear, which could interfere with subsequent speech and language progress
- Intentional vagueness: None
- Role of patient (caregiver) preferences: Substantial role for shared decision-making with caregivers regarding whether or not to proceed with tympanostomy tube insertion
- Exclusions: None
- Policy level: Option
- Differences of opinion: None regarding the action statement; a minor difference of opinion about whether children with Down syndrome or cleft palate should be considered

independently of children with speech and language delays/disorders

STATEMENT 10. PERIOPERATIVE EDUCATION: In the perioperative period, clinicians should educate caregivers of children with tympanostomy tubes regarding the expected duration of tube function, recommended follow up schedule, and detection of complications. *Recommendation based on observational studies, with a preponderance of benefit over harm.*

Action Statement Profile

- Aggregate evidence quality: Grade C, based on observational studies with limitations
- Level of confidence in evidence: Medium; there is good evidence and strong consensus on the value of patient education and counseling, in general, but evidence on how this education and counseling impacts outcomes of children with tympanostomy tubes is limited.
- Benefits: Define appropriate caregiver expectations after surgery, enable caregivers to recognize complications early, and improve caregiver understanding of the importance of follow-up.
- Risks, harms, costs: None
- Benefit-harm assessment: Preponderance of benefit over harm
- Value judgments: Importance of patient education in promoting optimal outcomes
- Intentional vagueness: None
- Role of patient (caregiver) preferences: None, since this recommendation deals only with providing information for proper management.
- Exceptions: None
- Policy level: Recommendation
- Differences of opinion: None

STATEMENT 11. ACUTE TYMPANOSTOMY TUBE OTORRHEA: Clinicians should prescribe topical antibiotic eardrops only, without oral antibiotics, for children with uncomplicated acute tympanostomy tube otorrhea. *Strong recommendation based on randomized controlled trials with a preponderance of benefit over harm.*

Action Statement Profile

- Aggregate evidence quality: Grade B, based on RCTs demonstrating equal efficacy of topical versus oral antibiotic therapy for otorrhea and improved outcomes with topical antibiotic therapy when different topical preparations are compared
- Level of confidence in evidence: High
- Benefits: Increased efficacy by providing appropriate coverage of otorrhea pathogens, including Pseudomonas aeruginosa and methicillin-resistant S. aureus (MRSA), avoidance of unnecessary overuse and adverse effects of systemic antibiotics, including bacterial resistance
- Risks, harms, costs: Additional expense of topical otic antibiotics compared to oral antibiotics, potential difficulties in drug delivery to the middle ear if presence of obstructing debris or purulence in the ear canal
- Benefit-harm assessment: Preponderance of benefit over harm
- Value judgments: Emphasis on avoiding systemic antibiotics due to known adverse events and potential for induced bacterial resistance
- Intentional vagueness: None
- Role of patient (caregiver) preferences: Limited, because there is good evidence that topical antibiotic eardrops are safer than oral antibiotics and have equal efficacy.
- Exceptions: Children with complicated otorrhea, cellulitis of adjacent skin, concurrent bacterial infection requiring antibiotics (e.g., bacterial sinusitis, group A strep throat), or those children who are immunocompromised
- Policy level: Strong recommendation
- Difference of opinion: None

STATEMENT 12. WATER PRECAUTIONS: Clinicians should not encourage routine, prophylactic water precautions (use of earplugs or headbands; avoidance of swimming or water sports) for children with tympanostomy tubes. *Recommendation against based on randomized controlled trials with limitations, observational studies with consistent effects, and a preponderance of benefit over harm.*

Action Statement Profile

- Aggregate evidence quality: Grade B, based on one randomized controlled trial and multiple observational studies with consistent effects
- Level of confidence in evidence: High
- Benefits: Allows for normal activity and swimming, reduced anxiety, cost savings
- Risk, harm, cost: Potential for slight increase in otorrhea rates in some children
- Benefit-harm assessment: Preponderance of benefit over harm
- Value Judgments: Importance of not restricting or limiting children's water activity in the absence of proven, clinically significant benefits of routine water precautions
- Intentional vagueness: The word "routine" is used to soften the recommendation since individual children may benefit from water precautions in specific situations (e.g., lake swimming, deep diving, recurrent otorrhea, head dunking in the bathtub, or otalgia from water entry into the ear canal).
- Role of patient (caregiver) preferences: Significant role in deciding whether or not to use water precautions based on the child's specific needs, comfort level, and tolerance of water exposure.
- Exceptions: Children with tympanostomy tubes and 1) an active episode of otorrhea, or 2) recurrent or prolonged otorrhea episodes, and those with a history of problems with prior water exposure
- Policy level: Recommendation
- Differences of opinion: None

Disclaimer

The clinical practice guideline is provided for information and educational purposes only. It is not intended as a sole source of guidance in managing children with tympanostomy tubes or being considered for tympanostomy tubes. Rather, it is designed to assist clinicians by providing an evidence-based framework for decision-making strategies. The guideline is not intended to replace clinical judgment or establish a protocol for all individuals with this condition and may not provide the only appropriate approach to diagnosing and managing

this program of care. As medical knowledge expands and technology advances, clinical indicators and guidelines are promoted as conditional and provisional proposals of what is recommended under specific conditions, but are not absolute. Guidelines are not mandates; these do not and should not purport to be a legal standard of care. The responsible physician, in light of all circumstances presented by the individual patient, must determine the appropriate treatment. Adherence to these guidelines will not ensure successful patient outcomes in every situation. The AAO-HNS, Inc. emphasizes that these clinical guidelines should not be deemed to include all proper treatment decisions or methods of care, or to exclude other treatment decisions or methods of care reasonably directed to obtaining the same results.

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'Give Every Man Thy Ear But Few Thy Voice' Or Collecting Medical Books and Apparatus in the 21st Century

Allan J. Stypeck,
Owner, Second Story Books
Washington, DC

On September 10, 2012, I was privileged to speak to the Otolaryngology Historical Society (OHS) on collecting in the medical field. The premise of my talk was to present facts, values, and suggestions about the current market in the collectable field of the history of medicine, and to provide suggestions on building both primary and collateral collections.

My title, taken from Shakespeare's *Hamlet*, was tongue in cheek (sorry for the ENT pun)—and an observation on the depth of potential collecting and the value in the current market place. An excellent copy of Shakespeare's First Folio, for example, runs about $5 million to $7 million.

My objective was to stimulate interest in recognizing and potentially developing collections in the medical field, and applying the guidelines of one's professional knowledge and imagination.

Giulio Casserio, *De vocis auditusque organis historia anatomica singulari fide methodo ac industria concinnata tractatibus duobus explicata ac variis iconibus aere excusis illustrata.* Ferrara: Excudebat Victorius Baldinus, 1601 (Colophon, part I); Excudebat Victorius Baldinus, Sumptibus Unitorum Patavii, 1600 (Colophon, part II). No. 24 in Grolier Society's "The 100 Most Influential Books in the History of Medicine."

I identified such key historical figures in the fields of phonetics and otolaryngology as Alexander Melville Bell, Alexander Graham Bell, Helen Keller, and Wilhelm Meyer, MD, plus lesser known 20th century otolaryngologists, such as Inokichi Kubo, MD, (1874-1939) a highly respected haiku poet, and Heinrich Neumann von Hethars, MD, (1873-1939) who refused to treat Adolf Hitler and suffered the consequences.

Giving an overview of the current collecting landscape, I discussed the future of collections in the 21st century as reliable investments and appropriate donations to academic and professional institutions.

I illustrated the current status of value with specific examples from the Grolier Society's list of "The 100 Most Influential Books in the History of Medicine" and their market prices shown in current auction sales records and catalogue entries from ABAA bookseller Howard Rootenberg, specializing in the history of medicine.

Examples and values ranged from Paul Ehrlich's *Die Experimentelle Chemotherapy*, published in 1910 and currently valued at $1,250, to Andreas Vesalius' first edition of *De Humani Corporis Fabrica* printed in 1543 and currently valued at $450,000. Of particular interest to the OHS audience was Casserio's 1600 printing of *De Vocis (The Throat)*, valued at $20,000.

There followed an active discussion on the future of collecting in a primarily digitized information environment, including the use of books and artifacts as tactile history and the inevitable generational changes in access to information.

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Research and Quality Improvement Accomplishments

John S. Rhee, MD, MPH

As you can tell from reading through these pages, there is an abundance of work being done on behalf of our members in the areas of quality and research. It is imperative, given all of the focus from external organizations including the government, private payers, and certifying boards (ABOto and the umbrella ABMS organization), that we are involved in initiatives that demonstrate the specialty's continued focus on improving performance in practice. I want to highlight several of these initiatives in this column.

The Patient Safety and Quality Improvement (PSQI) Committee (led by **David W. Roberson, MD**, and **Rahul K. Shah, MD**) agreed to spearhead the AAO-HNS Foundation's participation with the American Board of Internal Medicine (ABIM) Foundation's *Choosing Wisely*® campaign last year. The main focus of the campaign was to identify tests and/or procedures that should be questioned and to engage patients in discussions about appropriateness of care. This was a great example of the specialties working together toward a common goal. The PSQI engaged other academy and foundation committees, the Specialty Society Advisory Council (SSAC) and the Guideline Task Force (GTF), in the development of an AAO-HNS list, and many of the suggestions came from AAO-HNS clinical practice guideline action statements. (Further information on *Choosing Wisely* appears in the PSQI summary on p. 32.) As the first surgical specialty to join the campaign, we were invited to participate in the Washington press conference in February at the Kaiser Family Foundation headquarters to roll out our list with other specialty societies. A commentary article on the campaign appeared in the April 2013 edition of *Otolaryngology–Head and Neck Surgery*.

The PSQI committee was also instrumental in working with the FDA on our members' behalf when the FDA contacted us about its plans to issue a directive regarding the use of codeine post tonsillectomy and/or adenoidectomy. The PSQI Committee proactively emailed members once it was informed that the FDA was moving in this direction. The committee then kept in touch with the FDA as it came out with an alert in August warning of the risk of possible fatality when codeine is used in this clinical setting and when it ultimately issued a black box warning and contraindication in February. The FDA agreed to co-author a commentary with PSQI Committee co-chair, Dr. Roberson, and our Executive Vice President and CEO, **David R. Nielsen, MD**, which was published in the *New England Journal of Medicine* (http://bit.ly/NEJMdrug).

This year, Research and Quality Improvement has partnered even more effectively with the Physician Payment Policy (3P) Workgroup to address many of the tenets of healthcare reform relating to quality, including public reporting of physician data initiatives, Medicare incentive programs, and alternative payment models. In April, physician leaders from the 3P Workgroup and the PSQI Committee, along with staff from both business units, met with officials at the Centers for Medicare & Medicaid Services (CMS) to receive feedback and discuss not only the Academy's significant accomplishments in the area of quality, but also some of the hurdles our specialty faces as we strive toward greater participation in the CMS

quality incentive programs. **Richard M. Rosenfeld, MD, MPH**, several other volunteers associated with research and quality improvement, and I have joined our socioeconomic colleagues on the Ad Hoc Payment Workgroup (led by **James C. Denneny III, MD**) to discuss ways we can use our combined knowledge of research, quality, payment, and policy to address future models of payment being discussed at the highest levels of government and by the private payer community. The group just reviewed all of the different Academy guidance products as one of the first steps in this process and shared this information at the Board meeting in May.

In terms of research, this year's Centralized Otolaryngology Research Efforts (CORE) grants program was again a great success. For our members who are not as familiar with this program, the Academy deploys an extensive administrative effort with CORE. This allows for a streamlined, efficient process from advertising the program to our members, to providing a software solution for enhancing the grant review process, to assisting grantees with uploading applications, and in identifying reviewers for each specialty area. The Academy organizes and funds an intense, but gratifying two-day, one-night NIH-modeled study section meeting in Dallas during a weekend every March. This year a total of 41 grants were awarded $848,730 in funds dispersed through the academy and our sister societies. CORE Grantees will be recognized at the AAO-HNSF Annual Research Awards Ceremony, which will take place 10:30 am–11:50 am on Tuesday, October 1 at the AAO-HNSF Annual Meeting & OTO EXPO℠ in Vancouver, Canada.

Beginning as an idea discussed among a visionary group of thought leaders at a quality conference in 2006, our clinical practice guidelines development process has evolved to become "best in practice" as identified by the Agency for Healthcare Research and Quality and the Institute of Medicine. The Guidelines Task Force (led by **Seth R. Schwartz, MD, MPH**) has become another model of what can be accomplished when the Academy and specialty societies work together for the betterment of the specialty. As this article goes to press, we have 10 guideline products published and several more in press. These clinical knowledge products have become increasingly important as we broaden our efforts of demonstrating our commitment to quality in the practice of otolaryngology-head and neck surgery, including building our expertise in quality measure development and exploring registry methods that could assist the specialty in several ways. These could include helping members to participate in quality incentive programs set by the government and private payers.

I hope you have time to read in detail about all of the projects that are underway as outlined in this month's *Bulletin*. The expertise and passion of our committee and taskforce volunteer members certainly have helped us complete some exciting projects as we work to meet and exceed our strategic priorities for research and quality. Finally, I wish to shine light on our extraordinary academy staff members, led by Jean Brereton, MBA, who have been instrumental in the vision and operationalization of these important projects for our specialty. Please join me in thanking them and our volunteer Academy members for their tireless efforts and unparalleled commitment.

Put Your Money Where Your Mouth Is: Directing Research Toward Targeted Evidence Gaps

Scott E. Brietzke, MD, MPH
Chair, OREBM

As the saying goes, "putting your money where your mouth is" is the best way to prove you are serious about something. Members of the AAO-HNS/F can rest assured that the Academy is serious about improving the evidence base of our specialty and is offering its financial resources to prove it. As the AAO-HNS continues creating rigorous, high-quality, evidence-based clinical practice guidelines (CPG), the Outcomes Research and Evidence-Based Medicine (OREBM) Committee, in conjunction with Academy research leadership, has been working on a parallel effort to enhance the quality and evidence base of our specialty. Identifying evidence gaps within our specialty for which there is insufficient evidence to guide clinical decision-making is an important component of advancing research and improving outcomes. In a perfect world, a significant proportion of active research would be directed toward targeted gaps where the lack of evidence negatively affects patient care. However, as everyone knows, serious research costs serious money.

> "Members of the AAO-HNS/F can rest assured that the Academy is serious about improving the evidence base of our specialty and is offering its financial resources to prove it."

The Maureen Hannley Research Grant is offered each year as part of the AAO-HNSF's Centralized Otolaryngology Research Efforts (CORE) grant program. Named in honor of former AAO-HNSF chief research officer Maureen T. Hannley, PhD, the grant was created in 2007. Under direction of the Research Advisory Board (RAB) and **John S. Rhee, MD, MPH**, coordinator for Research & Quality Improvement, the OREBM Committee worked closely with a group of the CORE grant program leaders during the last year to revise the Maureen Hannley Research Grant criteria, which now offer special consideration to investigators who target known evidence gaps within their project proposals. It also provides investigators the opportunity to utilize the Creating Healthcare Excellence through Education and Research (CHEER) network to engage both academic and community sites in their proposed study. These components were included in new Funding Opportunity Announcement (FOA) released during the 2013 grant cycle.

We are pleased to announce this year's grant awardee has taken advantage of this opportunity. Special congratulations are extended to **Milan R. Amin, MD**, of New York University, who is this year's Maureen Hannley Research Grant award recipient. Dr. Amin's successful application proposes a Level 1 study that will address the evaluation and treatment of patients with hoarseness. Dr. Amin references the recent Hoarseness (Dysphonia) Clinical Practice Guideline in his grant application abstract. "The recent Clinical Practice Guidelines (CPG) for Hoarseness put forward by the AAO-HNSF pointed out several major deficiencies in the evidence base related to the evaluation and treatment of patients complaining of hoarseness. One of these deficiencies is regarding the use of steroids for the treatment of patients with these complaints…In this study, we propose to study the comparative effectiveness of steroids in speeding and enhancing the recovery of non-surgically treated vocal fold lesions. To do this, we propose a randomized clinical trial comparing patients who undergo traditional voice therapy for the treatment of phonotraumatic vocal fold lesions and those who undergo combined modality therapy incorporating the use of steroids prior to the initiation of voice therapy. We hypothesize that the use of pre-therapy steroids will hasten and enhance the efficacy of traditional voice therapy and that steroid treatment alone will have a positive effect on voice outcomes."

Dr. Amin will receive a $50,000 award (with a possible extension to receive another $50,000) to conduct his study, which will expectantly provide high-level, definitive data to address the evidence gap. Dr. Amin's vision and commitment to evidence-based practice is applauded and will hopefully be the first of a long succession of awarded Maureen Hannley Research Grant proposals addressing important evidence gaps within our specialty. Congratulations again to Dr. Amin! We encourage AAO-HNS members, particularly junior faculty members who have completed their residency or fellowship within the last seven years, to apply for this wonderful opportunity. The Maureen Hannley Research Grant is awarded to one recipient each year, so next year could be your opportunity to design a proposal that will address another important evidence gap and improve outcomes in our specialty. In return, the Academy will gladly put its money where its mouth is.

Web Reporting Portal

Rahul K. Shah, M.D., George Washington University School of Medicine, Children's National Medical Center, Washington, D.C.

We all experience near misses, adverse events, and unfortunately medical errors; we see this with patients in the hospital and sometimes our own patients are affected. Our tendency is to internalize these issues. This is partly because there is not a safe nonjudgmental venue for us to discuss the case that is both cathartic and potentially actionable.[1*]

The Aviation Safety Reporting System[2*] is perhaps the world's most robust and well-known incident reporting system. The platform has lead to significant improvements in the aviation industry to the extent that it is safer to fly than receive medical care. How can it be safer for me to fly half-way across the world for fifteen hours than it is to enter my local hospital and have an hour surgery?[3*] It is the system. As Academy members, **Gerald B. Healy, MD**, and **David W. Roberson, MD**, described in what is one of my favorite articles—it is the system that we practice in that helps put the care we deliver and our zones of risk in perspective.

To improve the system, we must know our vulnerabilities—not only as physicians and surgeons, but specifically in our realms of practice. To this end, studies looking at marco-level trends for errors in otolaryngology become paramount.[5*] However, the data from such studies are often times antiquated and not really actionable by the time the research methodology and peer review publication is complete. Rather, like the airline industry, real time data is actionable. After a series of high-profile incidents with a beautiful new jetliner, the fleet was grounded due to a faulty battery connection that was resulting in overheating and smoke in the cabin.[6*]

I cannot recall in the past decade when surgeries were stopped because of adverse incident reporting. The reason is that one-off events do not permit the ability for us to cluster these events into meaningful trends. For example, if I have a near-miss with a patient, I may assume that it was due to my fault rather than the system. However, if we had a marco-level data set that would show me that in case "x" there were thirteen near misses, then I immediately consider the possibility of a latent systems defect rather than this near miss being an isolated event.

Once we realize the value of aggregate data in affecting change, then we must be able to provide such a secure, confidential, easy to use reporting tool.

The New Portal

The Academy's Patient Safety and Quality Improvement (PSQI) Committee is thrilled to finally be unveiling such a platform. The Patient Safety Event Web Portal (http://www.entnet.org/patientsafety) was developed with broad engagement from various stakeholders. We are excited that this secure, confidential, web-based reporting tool allows Academy members to report on near misses, adverse events, and medical errors in real-time. There are safeguards to ensure the confidentiality of reporting. Once users sign-in to the Academy's website they are able to access the platform. However, despite signing in, no identifiable data about the user is submitted with the report. Nor is the computer's IP address from the submitting computer captured with the report. We have gone to extraordinary lengths to preserve the confidentiality of the reporter. Further, each report is immediately reviewed by a non-clinician at the Academy and if there is identifiable information (hospital name, location, practice name, etc.) the report is immediately discarded.

The PSQI Committee will then aggregate the reports and look for trends. We hope that this voluntary and confidential platform will result in our membership being able to report their patient safety events in a secure manner. The data which will come from this safety event portal will provide macro-level trends and hopefully result in interventions to improve the quality of the care we deliver and enhance the safety of the otolaryngology patient.

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 to engage us in a patient safety and quality discussion that is pertinent to your practice.

**see references in online version of this article*

Visit us ONLINE

www.entnet.org/bulletin

CORE Grants Program Breaks Record

The Centralized Otolaryngology Research Efforts (CORE) grants program plays a critical role in advancing the field of otolaryngology by providing support to research projects, research training, and career development. CORE aims to unify the research application and review process; encourage young investigators to pursue research in otolaryngology; and serve as an interim step that may ultimately channel efforts for important NIH funding opportunities. The CORE grant program societies, foundations, sponsors, and partners have awarded more than 500 grants totaling more than $9 million since the program's inception in 1985. In conjunction with the American Academy of Otolaryngology—Head and Neck Surgery Foundation (AAO-HNSF), societies, foundations, and sponsors are involved in funding one- to two-year non-renewable grants ranging from $5,000 to $80,000. The leadership of each participating subspecialty society is ultimately responsible for determining who is selected to receive funding each year. The scores and critiques provided by the CORE Study Section are simply recommendations to help in the decision process. The AAO-HNSF leadership determines the recipients of the grants sponsored by Alcon, Cook Medical, Oticon, and The Doctors Company.

This year the CORE Study Section reviewed a record 196 applications. Applicants were seeking a total of $3,501,900 in research funding.

The 2013 CORE Study Section subcommittees included: Head and Neck Surgery, chaired by **Jay O. Boyle, MD**, and chair-elect **Christine G. Gourin, MD**; Otology, chaired by **David R. Friedland, MD, PhD**; and General Otolaryngology, chaired by **Rodney J. Schlosser, MD**.

The 2013 CORE leadership, including the boards and councils of all participating societies, has approved a portfolio of 41 grants totaling $848,730 (up 13 percent from 2012). A record 28 percent of those selected to receive funding were resubmitted applications.

Congratulations to the 2013 CORE Grantees

The Alcon Foundation

AAO-HNSF Resident Research Grant sponsored by The Alcon Foundation

Britni H. Jacobs, MD
Vanderbilt University Medical Center, Nashville, TN
Project: The role of vascular endothelial growth factor in palate development ($10,000)

American Academy of Otolaryngic Allergy (AAOA) Foundation

AAOA Foundation Research Grant

Charles S. Ebert, Jr, MD, MPH
The University of North Carolina, Chapel Hill, NC
Project: Protease-activated receptors in allergic fungal rhinosinusitis ($47,687)

Amber Luong, MD, PhD
The University of Texas Health Science Center, Houston, TX
Project: TLR4 signaling in the pathophysiology of allergic fungal rhinosinusitis ($44,900)

American Academy of Otolaryngology—Head and Neck Surgery Foundation (AAO-HNSF)

AAO-HNSF Health Services Research Grant

Sydney C. Butts, MD
SUNY Downstate Medical Center, Brooklyn, NY
Project: Perceptual assessment of velopharyngeal dysfunction by otolaryngology residents ($10,000)

AAO-HNSF Resident Research Grant

Randall A. Bly, MD
University of Washington, Seattle, WA
Project: Computer modeled multiportal approaches to the skull base ($9,735)

Samuel Hahn, MD
University of Pennsylvania, Philadelphia, PA
Project: Genetic variations in bitter taste receptors and sinonasal infection ($8,000)

Kyle M. Hatten, MD
University of Pennsylvania, Philadelphia, PA
Project: Bitter and sweet taste receptor regulation of upper respiratory immunity ($9,955)

Candace M. Hrelec, MD
The Ohio State University, Columbus, OH
Project: Prevention of cisplatin-induced ototoxicity by intratympanic dexamethasone ($10,000)

Jinwei Hu, MD
Loma Linda Veterans Association for Research and Education
Project: Vitamin C deficiency-induced middle ear and inner ear dysfunction in mice ($7,500)

Funding Organization	2013 Dollars Awarded
AAO-HNSF	$270,189
Triological	$200,000
AAOA	$92,587
AHNS	$80,000
ARS	$41,000
ASPO	$39,990
Knowles Hearing Center	$30,000
AHRF	$25,000
AAFPRS	$19,964
ALA	$10,000
Alcon	$10,000
Cook Medical	$10,000
Oticon	$10,000
The Doctors Company	$10,000
HHF	$0
TOTALS	**$848,730**

In addition to providing >$200,000 to operate the CORE grant program and sponsor the annual CORE Study Section, the AAO-HNSF is also the largest individual donor.

Elliott D. Kozin, MD
Massachusetts Eye and Ear Infirmary, Boston, MA
Project: Optogenetic control of auditory neurons using a new generation opsin ($10,000)

Jonathan H. Law, MD
Washington University, St. Louis, MO
Project: The contribution of HOXB7 to oral cavity squamous cell carcinoma metastasis ($10,000)

Matthew K. Lee, MD
University of California, Los Angeles, CA
Project: Regeneration of mandibular defects using adipose-derived stem cells ($9,999)

Lauren Luk, MD
Oregon Health & Science University, Portland, OR
Project: Gentamicin entry into hair cells and toxicity ($10,000)

Brendan P. O'Connell, MD
Medical University of South Carolina, Charleston, SC
Project: Impact of oral steroids on local dendritic cells in chronic rhinosinusitis ($10,000)

Andrea M. Park, MD
Washington University, St. Louis, MO
Project: Evaluating the efficacy of post-operative voice rest: a pilot study ($10,000)

Seiji Shibata, MD, PhD
The University of Iowa, Iowa City, IA
Project: Using RNA-interference to rescue progressive hearing loss in the Tmc1 mouse ($10,000)

AAO-HNSF Maureen Hannley Research Award

Milan R. Amin, MD
New York University School of Medicine, New York, NY
Project: Investigation of the role of steroids in enhancing voice therapy outcomes ($50,000)

AAO-HNSF Percy Memorial Research Award

Richard Kollmar, PhD
SUNY Downstate Medical Center, Brooklyn, NY
Project: Restoration of recurrent-laryngeal-nerve function after injury in a rat model ($25,000)

AAO-HNSF Saidee Keller Memorial Research Grant

Mathew N. Geltzeiler, MD
Oregon Health & Science University, Portland, OR
Project: Personalized cancer care for head and neck malignancy ($10,000)

American Head and Neck Society (AHNS)

AHNS Alando J. Ballantyne Resident Research Pilot Grant

Michael Sim, MD
University of Michigan, Ann Arbor, MI
Project: Effects of carrier-based intralymphatic cisplatin on cancer stem cells ($10,000)

AHNS Pilot Grant

Matthew Hedberg, BA
University of Pittsburgh, Pittsburgh, PA
Project: PI3K signaling and PIK3CA; critical mitogenic drivers in HNSCC ($10,000)

AHNS/AAO-HNSF Translational Innovator Combined Award

Luc G. Morris, MD
Memorial Sloan-Kettering Cancer Center, New York, NY
Project: The EGFR phosphatase PTPRS as a modulator of cetuximab resistance in HNSCC ($80,000)

AHNS/AAO-HNSF Young Investigator Combined Award

Nicole C. Schmitt, MD
University of Pittsburgh, Pittsburgh, PA
Project: Effects of STAT1 on cisplatin and cetuximab sensitivity in HNSCC patients ($40,000)

American Hearing Research Foundation (AHRF)

AHRF Wiley H. Harrison Memorial Research Award

Yen-fu Cheng, MD
Massachusetts Eye and Ear Infirmary, Boston, MA
Project: Manipulation of ubiquitin-proteasome pathway leads to inner ear regeneration ($25,000)

American Laryngological Association (ALA)

ALA-ALVRE Award

Jacob Pieter Noordzij, MD
Boston Medical Center Corporation, Boston, MA
Project: Treatment of chronic laryngopharyngeal irritability with amitriptyline ($10,000)

The American Laryngological, Rhinological and Otological Society, Inc., aka The Triological Society

The Triological Career Development Awards

Alexander T. Hillel, MD
Johns Hopkins University School of Medicine, Baltimore, MD
Project: Role of inflammation in the development of laryngotracheal fibrosis ($40,000)

Amy Anne D. Lassig, MD
University of Minnesota - Twin Cities, Minneapolis, MN

2013 Research Awards Ceremony

The 2013 Research Awards Ceremony recognizing the 2013 CORE Grantees will take place 10:30 am–11:50 am on Tuesday, October 1, at the AAO-HNS Annual Meeting & OTO EXPO℠ in Vancouver, Canada.

Project: The effect of smoking on wound healing in head and neck surgery ($40,000)

Amber Luong, MD, PhD
University of Texas Health Science Center, Houston, TX
Project: Dissecting Fungal Induced IL-33 Production in Respiratory Epithelial Cells ($40,000)

Andrew McCall, MD
University of Pittsburgh, Pittsburgh, PA
Project: Influences of Limb Afferents on Central Vestibular Processing ($40,000)

Albert Park, MD
University of Utah, Salt Lake City, UT
Project: Congenital Cytomegalovirus Induced Hearing Loss in a Murine Model ($40,000)

American Rhinologic Society (ARS)

ARS New Investigator Award

Nithin Adappa, MD
University of Pennsylvania, Philadelphia, PA
Project: T2R38 polymorphisms as a disease modifier of CF chronic rhinosinusitis ($25,000)

ARS Resident Research Grants

Adam J. Kimple, MD, PhD
The University of North Carolina, Chapel Hill, NC
Project: Regulator of G-protein signaling-22: a putative regulator of motile cilia ($8,000)

Sarah Novis, MD
University of Michigan, Ann Arbor, MI
Project: Variations in antibiotic usage for the treatment of acute sinusitis ($8,000)

American Society of Pediatric Otolaryngology (ASPO)

ASPO Research Grant

Erin Kirkham, MD
Seattle Children's Hospital, Seattle, WA
Project: Assessment and validation of lymphatic malformation functional assessment ($20,000)

Jordan M. Virbalas, MD
Albert Einstein College of Medicine of Yeshiva University, Bronx, NY
Project: Evaluation of the CYP2D6 gene in a diverse urban population ($19,990)

Cook Medical

AAO-HNSF Resident Research Grant sponsored by Cook Medical

Andrea M. Park, MD
Washington University, St. Louis, MO
Project: Low dose colchicine and paclitaxel inhibit post-traumatic nerve regrowth ($10,000)

The Doctors Company Foundation

AAO-HNSF Resident Research Grant sponsored by The Doctors Company Foundation

Carrie L. Nieman, MD, MPH
Johns Hopkins University School of Medicine, Baltimore, MD
Project: Hearing healthcare among minority and low-income older adults ($10,000)

The Education and Research Foundation for the American Academy of Facial Plastic and Reconstructive Surgery (AAFPRS)

AAFPRS Leslie Bernstein Grant

No meritorious applications received.

AAFPRS Leslie Bernstein Investigator Development Grant

Preston D. Ward, MD
University of Utah, Salt Lake City, UT
Project: Investigation of an implantable neuroprosthesis for facial reanimation ($14,964)

AAFPRS Leslie Bernstein Resident Research Grant

Meir Hershcovitch, MD
University Ear, Nose, Throat Specialists, Inc. Cincinnati, OH
Project: Enhancing peripheral nerve repair with a bioresorbable metal ($5,000)

Hearing Health Foundation Centurion Clinical Research Award

No meritorious applications received.

The Knowles Hearing Center at Northwestern University

Knowles Hearing Center Collaborative Grant

David Kohrman, PhD
University of Michigan, Ann Arbor, MI
Project: Genetic analysis of formin proteins in progressive hearing loss ($30,000)

The Oticon Foundation

AAO-HNSF Resident Research Grant sponsored by The Oticon Foundation

Dunia Abdul-Aziz, MD
Massachusetts Eye and Ear Infirmary, Boston, MA
Project: Epigenetic regulation of hair cell differentiation ($10,000)

The Plastic Surgery Foundation (PSF)

PSF/AAO-HNSF Combined Grant

No meritorious applications received.

Thank You to the 2013 CORE Study Section

The AAO-HNS/F, CORE societies, foundations, sponsors, and partners would like to formally thank the 2013 CORE Study Section for its commitment to ensuring that research grants are awarded to the most meritorious grant applications. They provide written critiques to each applicant to assist our young investigators with strengthening their grant-writing skills and encouraging them to continue to pursue their research careers in otolaryngology–head and neck surgery.

Dunia Abdul-Aziz, MD
Waleed M. Abuzeid, MD
Oliver F. Adunka, MD
Yuri Agrawal, MD
Nishant Agrawal, MD
Sun Mi Ahn, MD
Henry P. Barham, MD
Carol M. Bier-Laning, MD
Benjamin Saul Bleier, MD
Jonathan M. Bock, MD
Emily F. Boss, MD, MPH
Jay O. Boyle, MD
Michael J. Brenner, MD
Trinita Y. Cannon, MD
Dylan K. Chan, MD
Teresa V. Chan, MD
Steven S. Chang, MD
Alan G. Cheng, MD
Dinesh Chhetri, MD
Steven B. Chinn, MD, MPH
John J. Christophel, MD
Marion E. Couch, MD, PhD, MBA
Adam DeConde, MD
Raj C. Dedhia, MD, MS
Gregory R. Dion, MD
Jayme R. Dowdall, MD
Carole Fakhry, MD
Robert L. Ferris, MD, PhD
David O. Francis, MD
David R. Friedland, MD, PhD
Jonathan R. George, MD, MPH
Nira A. Goldstein, MD
Christine G. Gourin, MD
John H. Greinwald, Jr, MD
Samuel P. Gubbels, MD
Rebecca Hammon, MD
Ronna Hertzano, MD, PhD
Alexander T. Hillel, MD
Michael E. Hoffer, MD
Eric H. Holbrook, MD
Monica Hoy, MD
Timothy E. Hullar, MD
Clifford R. Hume, MD, PhD
Lisa Ishii, MD, MHS
Stacey L. Ishman, MD, MPH
Mark J. Jameson, MD, PhD
Nancy P. Judd, MD
Benjamin L. Judson, MD
Alexandra Kejner, MD
Adam J. Kimple, MD, PhD
Stephen Y. Lai, MD, PhD
Andrew Lane, MD
Jonathan H. Law, MD
Timothy S. Lian, MD
Jeffrey C. Liu, MD
Brenda L. Lonsbury-Martin, PhD
Tomoko Makishima, MD, PhD
Stephen Maturo, Maj, USAF, MC, FS
I-Fan Theodore Mau, MD, PhD
Bryan R. McRae, MD
Eduardo Mendez, MD
Stephanie Misono, MD, MPH
Luc G. Morris, MD
Jeffrey S. Moyer, MD
Rick F. Nelson, MD, PhD
Robert C. O'Reilly, MD
Henry C. Ou, MD
Thomas J. Ow, MD
Albert H. Park, MD
Jayant Pinto, MD
Karen T. Pitman, MD
Diego Preciado, MD, PhD
Liana Puscas, MD
Vijay R. Ramakrishnan, MD
Murugappan Ramanathan, MD
Aaron K. Remenschneider, MD, MPH
Vicente A. Resto, MD, PhD
Claus-Peter Richter, MD, PhD
Pamela C. Roehm, MD, PhD
Peter S. Roland, MD
Rodney J. Schlosser, MD
Cecelia E. Schmalbach, MD
Nicole C. Schmitt, MD
Nathan M. Schularick, MD
Carol G. Shores, MD, PhD
Andrew Shuman, MD
Andrew Sikora, MD, PhD
Bhuvanesh Singh, MD, PhD
Zachary M. Soler, MD
Matthew E. Spector, MD
Michael E. Stadler, MD
Amar C. Suryadevara, MD
Bruce Tan, MD
Richard M. Tempero, MD, PhD
Travis T. Tollefson, MD
Michael P. Underbrink, MD, MPH
Ravindra Uppaluri, MD, PhD
Steven J. Wang, MD
Eric W. Wang, MD
Edward M. Weaver, MD, MPH
Debra G. Weinberger, MD
Heather M. Weinreich, MD, MPH
Sarah K. Wise, MD
Bradford A. Woodworth, MD
Adam Mikial Zanation, MD
Jing Zheng, PhD

Thanks to the AAO-HNSF CORE Grant Supporters

AAO-HNSF and its members are grateful for the generous support of the donors, foundations, and corporate partners that have made significant commitments to ensuring advances in the specialty through innovative research.

The ANS/AAO-HNSF Herbert Silverstein, MD, Otology and Neurotology Research Award

The AAO-HNSF Percy Memorial Research Award

AAO-HNSF Resident Research Grants Supported by:

- The Alcon Foundation
- Cook Medical
- The Doctors Company Foundation
- The Oticon Foundation

To learn more about how you can get involved please email David Buckner, Manager, Corporate Relations, at dbuckner@entnet.org or call (703) 535-3718.

Looking Back and Forward at PQRS and eRx Participation

The Centers for Medicare & Medicaid Services (CMS) released its annual experience report for the Physician Quality Reporting System (PQRS) and E-prescribing (eRx) earlier this year. A summary of some of the report's highlights are described below. A copy of the full report is available at http://go.cms.gov/12ZSwil.

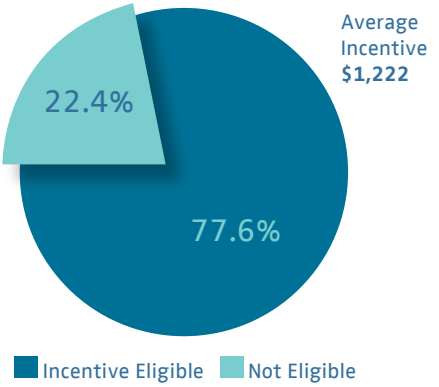
PQRS in 2011

An estimated 320,422 eligible professionals participated in PQRS during 2011. Through successful participation in the 2011 PQRS program, physicians and other eligible professionals received a 1 percent incentive payment on their total estimated Part B Medicare Physician Fee Schedule (MPFS) allowed charges provided during the reporting period. Of those who participated, nearly 83 percent earned a 2011 incentive payment; the average incentive was $1,059 per individual eligible professional.

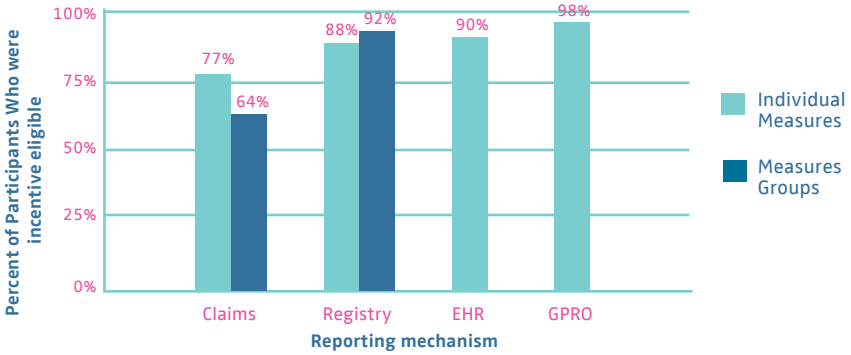
Which Reporting Method was Most Successful?

As with prior years, claims-based reporting was the least successful reporting method—only 64 percent of participants reporting measures groups were eligible for an incentive. For individual participants, registry and electronic health records (EHR) reporting had an average success rate of 90 percent. As a reminder, the AAO-HNS continues to make PQRI*wizard*, a CMS-certified registry product tailored to otolaryngology, available for PQRS reporting. More details about the reporting options and PQRI*wizard* are available at http://www.entnet.org/pqrs.

1,852 Otolaryngologists Participated in PQRS



2011 PQRS Incentive Eligibility by Reporting Mechanism



How Did Otolaryngologists Fare?

A record number of otolaryngologists (1,852) participated in the PQRS program during 2011, representing 21.4 percent of those eligible to participate. In total, otolaryngologists earned more than $1.7 million in incentive payments during 2011 with 77.6 percent of participating otolaryngologists earning an incentive. While the maximum incentive payment paid was $7,848, otolaryngologists earned an average incentive payment of $1,222.

What Measures Were Reported?

One of the most common questions regarding PQRS participation relates to which measures otolaryngologists report. In 2011, the top five measures reported within otolaryngology were:

- 124 – Health Information Technology (HIT): Adoption/Use of EHR*
- 130 – Documentation of Current Medications in the Medical Record
- 226 – Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- 91 – Acute Otitis Externa (AOE): Topical Therapy
- 92 – Acute Otitis Externa (AOE): Pain Assessment*

*Note: Measures 124 and 92 are not available for PQRS reporting in 2013

E-Prescribing in 2011

An estimated 282,382 eligible professionals participated in eRx during 2011, the vast majority (97 percent) participating via the claims-based reporting mechanism. A total of 38 percent of those eligible for the program participated in 2011, an increase from 16 percent in 2010. Professionals who successfully reported in the eRx program were eligible for a 1 percent incentive payment on their Part B MPFS services. Nearly 62 percent of program participants were eligible for an incentive payment in 2011.

How Did Otolaryngologists Fare?

Again, a record number of otolaryngologists participated in the eRx program during 2011. Almost 50 percent of otolaryngologists (4,142 individuals) eligible for the program participated, with 2,364 earning an incentive payment. In total, otolaryngology received more than $3.8 million in incentive payments in 2011 with the average payment within the specialty being $1,617 and a maximum incentive payment of $13,312.

PQRS and eRx in 2013

CMS continues to emphasize the importance of participation in both the PQRS and eRx programs. This year is of particular importance as participation is now tied to future penalties (payment adjustments).

The AAO-HNS has developed a variety of resources to help members and their practices participate in these programs. You may have noticed in recent editions of the *Bulletin* factsheets regarding these programs (May *Bulletin*) and a participation reporting timeline (June *Bulletin*). The AAO-HNS Health Policy and Quality staff members are happy to answer any questions you may have about these programs; they can be contacted at qualityimprovement@entnet.org. AAO-HNS resources related to PQRS and eRx are available at http://bit.ly/CMSQI.

AAO-HNSF Quality Knowledge Products

This year witnessed continued growth and maturation of the AAO-HNSF's efforts at guideline development. The clinical practice guidelines (CPGs) are the most read articles in our journal (representing nine of the top 10 articles in 2012) and provide a strong basis for improving clinical outcomes for patients with the conditions that have been addressed so far based on the best available evidence. The demand for more products is ever increasing and the Guidelines Task Force has been working to grow the leadership group to be able to meet these demands. Our quality products have been used to develop quality measures and to support reimbursement for care by our members. They continue to be adopted by primary care and pediatric clinicians as evidenced by the recent endorsement by the AAFP of the tonsillectomy guideline. The following summary of our efforts highlights the critical and expanding role that CPGs will likely play in the evolving healthcare landscape.

Seth R. Schwartz, MD, MPH
Guidelines Task Force Chair
Director, The Listen for Life Center at Virginia Mason®

Since 2006, the AAO-HNSF has developed quality knowledge products (QKPs) including clinical practice guidelines (CPGs) and clinical consensus statements (CCSs) to support evidence-based decisions in patient care for its members, the wider clinical community, and the general public.

Since we reported last July, the AAO-HNSF has published four new QKPs:

- CCS: CT Imaging Indications for Paranasal Sinus Disease (November 2012)
- CCS: Tracheostomy Care (January 2013)
- CPG: Improving Voice Outcomes after Thyroid Surgery (June 2013)
- CPG: Tympanostomy Tubes (July 2013)

Three new CPGs (Bell's Palsy, Tinnitus, and Allergic Rhinitis), and two CPG updates (Acute Otitis Externa and Adult Sinusitis) are currently in development.

Oversight: Guideline Task Force (GTF)

The GTF oversees the development, dissemination, implementation, and prioritization of topics for AAO-HNSF CPGs and CCSs. **Seth R. Schwartz, MD, MPH**, chair, and **Richard M. Rosenfeld, MD, MPH**, past-chair and current AAO-HNSF senior advisor for quality and guidelines lead the GTF. The GTF includes subspecialty society representatives from the American Broncho-Esophagological Association, American Neurotology Society, American Rhinologic Society, American Head and Neck Society, American Laryngological Association, The American Laryngological, Rhinological and Otological Society, Inc. (The Triological Society), American Otological Society, American Academy of Facial Plastic and Reconstructive Surgery, American Academy of Otolaryngic Allergy, American Society of Pediatric Otolaryngology, and representatives from the AAO-HNS Board of Governors, Association of Otolaryngology Administrators, American Board of Otolaryngology, and Society of Otorhinolaryngology and Head-Neck Nurses. The AAO-HNS Physician, Payment, and Policy (3P) Workgroup also now has a representative on the GTF.

The group meets biannually at the Academy's headquarters and reviews guideline development methodology, progress, and prioritizes upcoming products. All AAO-HNS/F scientific and education committees are encouraged to submit topics to the GTF for consideration. Topics are presented and voted on at the second GTF meeting each year. Approved future CPG/CCS topics include Septoplasty and Rhinoplasty.

The GTF produces a newsletter that highlights the group's activities and provides updates on guideline and consensus statement development; recent editions of the GTF newsletter are available on the Academy's website.

The 2012 AAO-HNS/F Voice of the Member survey showed a 10 percent increase in AAO-HNS members indicating they were "very satisfied" with the AAO-HNSF's efforts to build quality guidelines and performance measures (from 28 percent in 2010 to 38 percent in 2012).

Get Involved with Guidelines

In an effort to foster involvement in guideline development and encourage participation in guideline development groups, the AAO-HNSF started the G-I-N Scholars program in 2012.

The 2012 G-I-N Scholars program offered four AAO-HNS members travel grants to attend the Guidelines International Network (G-I-N) North America (NA) Conference in New York. Each scholar has agreed to write a commentary for *Otolaryngology–Head and Neck Surgery* during 2013 related to one of the themes of the G-I-N NA meeting. This is part of our education effort to help bring awareness and understanding about the development of clinical practice guidelines to our members.

- *Closing the Clinical Gap: Translating Best Practice Knowledge to Performance with Guidelines Implementation* by **Lisa Ishii, MD, MHS** (e-published in *Otolaryngology–Head and Neck Surgery* March 5, 2013)
- *Conflict of Interest Reporting in Otolaryngology Clinical Practice Guidelines* by **Gordon H. Sun, MD, MS**
- *From bench to trench: How evidence and guidelines shape healthcare policy and practice* by **David O. Francis, MD**

- *Making clinical practice guidelines trustworthy* by **Melissa A. Pynnonen, MD**

In addition, all G-I-N Scholars agree to serve on an upcoming AAO-HNSF clinical practice guideline panel.

Congratulations to the 2013 G-I-N Scholars, who were awarded $2,500 travel grants to attend the 2013 G-I-N Conference in San Francisco, CA, August 18-21.

- **Scott E. Brietzke, MD, MPH**, Walter Reed Army Medical Center
- **Richard K. Gurgel, MD**, University of Utah
- **Benjamin R. Roman, MD**, University of Pennsylvania
- **Jennifer J. Shin, MD, SM**, Massachusetts Eye & Ear Infirmary

Sharing and Expanding our Knowledge

In addition to sponsoring members to attend the 2013 G-I-N Conference, we will also be presenting three posters: *Engaging consumers in the guideline development process—the U.S. perspective,* presented by Peter Robertson, MPA; *How cultural differences in treatment approach affect interpretation of literature and guideline recommendations,* presented by Caitlin Drumheller; and *Including the exclusion: the importance* of *addressing at risk populations in guidelines,* presented by Heather M. Hussey, MPH.

Payers Paying Attention to the CPGs and CCSs

- In October 2012, several members brought to our attention changes that were made to the Anthem/Empire Blue Cross Blue Shield Pediatric Tonsillectomy Medical Policy, which cited the *CPG: Tonsillectomy in Children* inappropriately. A call took place with the parent company WellPoint in November 2012. The Medical Policy and Technology Assessment Committee (MPTAC) reviewed the Academy's comments during its November meeting and on November 12, 2012, WellPoint revised the policy on Tonsillectomy for Children, incorporating many of the Academy's comments.

In August of 2012, the four Durable Medical Equipment Medicare Administrative Contractors (DME MACs) changed their Local Coverage Determinations (LCDs) such that providers can now only order replacement tracheostomy tubes every 90 days. Previously, providers were able to replace trach tubes every 30 days, which comports with what we believe is the most typical, and best, standard of care for patients with trach tubes. CMS has stated that this change was related to our CCS panel failing to reach consensus on the question of whether tubes should be changed weekly or bi-weekly. In response, the Academy submitted a letter to CMS in April 2013 requesting that CMS national, and the DME MACs, modify their LCDs and return to the prior 30 day policy, and attempted to clearly define "non-consensus" and how it should be interpreted by the Agency.

Guideline Usage

AAO-HNS Guidelines Usage Summary: The following table contains the cumulative number of page

CPG/CCS	Date published	National Guidelines Clearinghouse Page views from publication through March 2013	Citations through 4/8/2012 (Source: Google Scholar)
CPG: acute otitis externa	7/14/2006	70,430	94
CPG: adult sinusitis	8/22/2008	61,861	384
CPG: cerumen impaction	4/17/2009	32,376	40
CPG: benign paroxysmal positional vertigo	4/17/2009	40,706	164
CPG: hoarseness (dysphonia)	4/23/2010	22,216	60
CCS: nasal valve compromise	7/1/2010	N/A	10
CPG: tonsillectomy in children	5/13/2011	20,735	83
CPG: polysomnography for sleep-disordered breathing prior to tonsillectomy in children	12/16/2011	10,048	26
CPG: sudden hearing loss	4/26/2012	15,428	32
CCS: tracheotomy care	9/18/2012	N/A	3
CCS: CT for paranasal sinus disease	10/10/2012	N/A	1
TOTALS		**273,800**	**897**

views for each AAO-HNSF guideline listed on the National Guidelines Clearinghouse (NGC) website from the time the guideline was posted to the NGC through December 2012 (provided by NGC and the number of citations for each product collected from Google Scholar through January 2013).

Dissemination

- The AAO-HNSF is proud to have joined 16 other specialty groups—each of which released a list of "Five Things Physicians and Patients Should Question" on February 21, 2013, as part of the American Board of Internal Medicine (ABIM) Foundation *Choosing Wisely*® Campaign. The AAO-HNSF's list of recommendations was carefully selected after a review of the current evidence including AAO-HNSF clinical practice guidelines. Each list includes when a particular test or treatment may be appropriate based on the current clinical evidence. *Consumer Reports*, along with a coalition of consumer partner organizations, is also a part of the *Choosing Wisely*® effort and is working with many of the societies to help patients understand the tests and treatments that are right for them. For more information visit http://www.entnet.org/choosingwisely. See page 32 for the "List of Five Things."
- American Academy of Family Physicians (AAFP) Commission on Health of the Public and Science and AAFP Board of Directors has given qualified endorsement of the *AAO-HNSF Clinical Practice Guideline: Tonsillectomy in Children.*
- Voice Therapy: An administrative supplement to the CHEER Practice-based Research Network grant was awarded by the NIDCD in May 2012. This study focuses on usage of voice therapy and perceptions and barriers from both the patient and provider perspective. This will provide useful information for the eventual dissemination of all related guidelines including the *Clinical Practice Guideline: Improving Voice Outcomes after Thyroid Surgery*. This study has kicked off in 11 CHEER sites and as of March 1 was 20 percent of the way toward a recruitment goal of 500 patients.

Implementation

- With funding from AAO-HNSF, the CHEER Practice-based Research Network is exploring awareness of and barriers to implementation of the AAO-HNSF Sudden Hearing Loss Guideline. This study has a physician survey and a patient data collection component. The physician survey component was fielded in 2012 and preliminary results were presented in a miniseminar at the AAO-HNSF 2012 Annual Meeting & OTO EXPO℠. These results will be incorporated into the manuscript that is developed from the multi-site study, which kicked off in March. Twenty-seven CHEER sites are participating in this study, which has a primary observational study on treatment pathways and patterns in SHL patients and a sub-study (observational) on IT and oral steroid use (solo, combined, sequential).
- The Adult Sinusitis Performance Measurement Set was approved by the PCPI on July 2, 2012, and has been submitted by PCPI to the National Quality Forum for endorsement. The measures are also being submitted to CMS for inclusion in PQRS.

AAO-HNSF ANNUAL MEETING & OTO EXPO℠ 2013 CANADA
VANCOUVER BC
SEPTEMBER 29 - OCTOBER 2

Sunday, September 29

Title:	AAO-HNSF Clinical Practice Guideline: Bell's Palsy
Time:	10:30-11:50 am
Moderator:	Reginald F. Baugh, MD
Presenters:	Gregory J. Basura, MD, PhD; Lisa Ishii, MD, MHS; Seth R. Schwartz, MD, MPH
Room:	West 304-305

Monday, September 30

Title:	AAO-HNSF Clinical Practice Guideline: Tympanostomy Tubes
Time:	8:00-9:20 am
Moderator:	Richard M. Rosenfield, MD, MPH
Presenters:	Melissa A. Pynnonen, MD, MS; David E. Tunkel, MD; Seth R. Schwartz, MD, MPH
Room:	West 301

Wednesday, October 2

Title:	Understanding Clinical Practice Guidelines
Time:	1:45-2:45 pm
Instructors:	Richard M. Rosenfeld, MD, MH
Room:	West Ballroom A

Highlights from the PSQI Committee 2013

The Patient Safety Quality Improvement Committee (PSQI) has been involved in several prominent projects that have elevated our visibility despite the small size of our specialty. We received positive feedback on our quality focus and the work we have done throughout the years from officials at Centers for Medicare & Medicaid Services (CMS) including Patrick Conway, MD, chief medical officer, who congratulated us for the numerous quality improvement initiatives in otolaryngology-head and neck surgery. In addition, we were publically recognized as a joint American Medical Association/CMS meeting by Nancy Nielsen, MD, senior advisor for stakeholder engagement at the Department of Health and Human Services (HHS), for our work nationally and internationally on clinical practice guidelines and our participation as the first surgical specialty in the *Choosing Wisely*® campaign. There is ongoing work by PSQI on behalf of the specialty including issues affecting safety of patients, representing the specialty at national quality organizations, developing survey and database studies to identify issues for improvement in safety, and publishing studies in peer reviewed journals.

During the past year, PSQI focused on the following projects, and a few of these are highlighted in more detail below.

1. *Choosing Wisely* campaign
2. FDA alert on utilization of codeine post tonsillectomy
3. Annual meeting programming
4. Publications
5. Safety Web portal
6. National quality organization representation

Choosing Wisely® Campaign

In the spring of 2012, we were made aware of the *Choosing Wisely* campaign through some of our members. *Choosing Wisely* was gaining momentum since the release of the lists of the initial group of organizations during phase one of the campaign in February 2012. PSQI volunteered to spearhead AAO-HNSF's efforts in compiling a list of five treatments and/or procedures that should be questioned. The Committee reached out to academy committees, the Specialty Society Advisory Council (SSAC), and the Guidelines Task Force (GTF), so this was an inclusive process. Our list of recommendations was carefully selected after a review of the current evidence including AAO-HNSF clinical practice guidelines and was approved by our Board in December 2012. Each list includes when a particular test or treatment may be appropriate based on the current clinical evidence. *Consumer Reports*, along with a coalition of consumer partner organizations, is also a part of the *Choosing Wisely* effort and is working with many of the societies including AAO-HNSF to help patients understand the tests and treatments that are right for them. For more information visit http://www.entnet.org/choosingwisely.

The AAO-HNSF's List of Five Things Physicians and Patients Should Question

1. Don't order computed tomography (CT) scan of the head/brain for sudden hearing loss.
2. Don't prescribe oral antibiotics for uncomplicated acute tympanostomy tube otorrhea.
3. Don't prescribe oral antibiotics for uncomplicated acute external otitis.
4. Don't routinely obtain radiographic imaging for patients who meet diagnostic criteria for uncomplicated acute rhinosinusitis.
5. Don't obtain computed tomography (CT) or magnetic resonance imaging (MRI) in patients with a primary complaint of hoarseness prior to examining the larynx.

FDA Alert on Utilization of Codeine Post Tonsillectomy

The FDA approached the PSQI Committee last summer regarding concerns with utilization of codeine post tonsillectomy and/or adenoidectomy. PSQI developed a message including the FDA alert, which was delivered by an email blast to all Academy members. The Committee and representatives from the BOG and the Pediatric Otolaryngology Committee participated in a conference call with FDA officials to ensure that they were aware of the impact of their ruling on our specialty and to provide feedback as the FDA developed its communication plan. As mentioned in this month's Research and Quality Improvement column by John S. Rhee, MD, MPH, these efforts resulted in a joint commentary in the *New England Journal of Medicine* in April.

"There is ongoing work by PSQI on behalf of the specialty including issues affecting safety of patients, representing the specialty at national quality organizations, developing survey and database studies to identify issues for improvement in safety, and publishing studies in peer reviewed journals."

National Quality Organization Representation

The Committee continues to represent our specialty at the following forums: the National Quality Forum (NQF); the American College of Surgeons Surgical Quality Alliance (SQA); the American Medical Association's (AMA) Physician Consortium for Performance Improvement (PCPI); and the Ambulatory Quality Alliance (AQA). These groups are consistently queried to provide feedback at the highest levels of government (the White House, CMS, Congress, etc.) as national quality programs are developed and implemented.

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SUBMISSION OPENS JULY 1ST at www.triological.org

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January 10-12, 2014 | Loews Miami Beach | Miami Beach, FL

Abstract Submission July 1 - August 1, 2013

117th Annual Meeting at COSM

May 14-18, 2014 | Caesar's Palace | Las Vegas, NV

Abstract Submission July 1 - October 15, 2013

The Laryngoscope
FOUNDED IN 1890

All abstracts accepted for oral or poster presentation are the property of the Triological Society. Manuscript submission to the Triological Society's journal, *The Laryngoscope*, is required prior to oral presentation.

The material in all abstracts may not be submitted for publication, published or presented previously at another national or international meeting and may not be under consideration for presentation at another national or international meeting. The penalty for duplicate presentation/publication will prohibit all authors from presenting at a Triological Society meeting or at COSM for three years.

All Abstracts Must Be Submitted On-Line
www.triological.org

Administrative Office - 402-346-5500

CHEER Network Brings Meaningful Research to the Community

Creating Healthcare Excellence through Education and Research (CHEER) is your research network. The drive for investigators committing time and energy to CHEER is to make a difference in healthcare, see changes from their participation in our lifetimes, and leave a legacy.

Studies and Projects Underway

As you read through our updates, think about CHEER being your network. These studies will contribute to our understanding of the often baffling and challenging conditions that we treat all of the time. Our participating CHEER sites helps to make a difference for all of us and the patients we treat.

1. **The Sudden Hearing Loss (SHL) Study** is enrolling patients. From this study we will be able to learn about the degree of infusion of the SHL clinical practice guideline in practice and answer important questions such as:

   What was the patient's treatment pathway after onset of hearing loss? How long did it take them to get to the otolaryngologist? What treatments did the patient receive prior to and at the current otolaryngology visit? Is there more improvement in audiologic findings after steroids and is it different for oral, IT, combined, or sequential delivery?
2. **The Voice Therapy Study** is halfway to our enrollment goal of 500 patients. This study will help us determine use of and perceptions about voice therapy from the patient, otolaryngologist, and speech language pathologist's perspectives. We will also learn more about the personality-based characteristics of patients who are effectively treated with this approach.
3. **The Retrospective Data Collection Project** is two-thirds to completion. The database has more than a half-million patients and represents more than 1.5 million visits. This de-identified patient level data includes age, gender, race, visit date, and diagnosis and procedure codes. Its primary purpose is to match sites to study opportunities and determine sample size and enrollment feasibility tables for grants.

Development and Support of Clinical Investigators

4. **Expert Panel Awards.** CHEER accepts applications for grant research concepts and funds two Expert Panels each year. The funding provides support for travel and meeting costs. The awardee uses the panel to develop and vet research concepts prior to grant submission. **Walter T. Lee, MD**, of Duke University Medical Center, and **Jennifer J. Shin, MD**, of Brigham and Women's Hospital, were awarded expert panels for their research concepts this year.
5. **Task Force on Practice-based Research.** This is a new Task Force currently accepting nominations with the ultimate goal of becoming an official Academy committee. Practice-based research is a challenge and requires the development of strong relationships and leadership across busy, geographically dispersed practitioners. This task force will conduct its first meeting during the AAO-HNSF 2013 Annual Meeting & OTO EXPO℠ and will meet throughout the year via web conferencing.
6. **CORE Grant.** CHEER was added as an additional incentive and resource this year to the Maureen Hannley Research Grant, an AAO-HNSF CORE Grant. This new component allows applicants to use the infrastructure and support of CHEER for practice-based studies.
7. **Training Research Coordinators.** We have the following opportunities for training your coordinators:

   CHEER holds a two-day Annual Research Coordinator's Conference each August at the Academy headquarters. This conference is an excellent training and networking opportunity for all levels of coordinators. The conference is free and travel and lodgings are covered for all CHEER site coordinators. Non-CHEER site Academy members may cover travel costs, but otherwise have their coordinators attend the conference free of charge. Investigators new to CHEER or interested in CHEER are also welcome to attend. The 2013 Research Coordinator's Conference will take place August 8-10.

   Leadership opportunities: Coordinators have the opportunity to apply for the **CHEER Coordinator Advisory Board (CAB)**. The CAB drives the agenda development for the Annual Coordinator's Conference, and selects articles and hosts Quarterly Journal Club Calls on key topics in research process, regulations, case studies, etc.

If you want to learn more about CHEER, visit us at www.cheerresearch.org or email Kris Schulz at Kristine.schulz@duke.edu.

In our second five years of funding through NIH/NIDCD, we have a strong network of 28 sites throughout the country, half of which are community-based. Across our sites, we have more than 200 otolaryngologist-head and neck surgeons, 100 audiologists, 50 speech language pathologists, and many other office and professional staff dedicated to our mission of being the "nation's resource for practice-based clinical research in disorders of the ear, nose, and throat; translate the latest evidence into practice efficiently and expeditiously; and ultimately improve patient care."

2013 BOG Spring Meeting & OTO Advocacy Summit Highlights

This year's BOG Spring Meeting & OTO Advocacy Summit was a great success! The combined meetings provided a unique opportunity for attendees—including more than 30 residents—to network and engage in peer-to-peer interactions with eminent leaders in the field. Future, current, and past AAO-HNS presidents were in attendance, along with other members of the AAO-HNS/F Boards of Directors and key BOG and state society leaders.

For the first time this year, Summit activities were "live tweeted" throughout the various events. AAO-HNS members embraced this new use of social media and provided many of the photographs used on our platforms. You can view the photos online @AAOHNSGovtAffrs and at our Government Affairs Facebook page.

Sunday, May 5—Cruising on the Potomac

The OTO Advocacy Summit activities began Sunday evening with an ENT PAC Leadership Club reception aboard the *Capital Elite* for a scenic cruise on the Potomac River. Reception attendees had the opportunity to mingle with colleagues and admire the views of Alexandria, VA, and Washington, DC, from a private yacht. The ENT PAC reception had 58 PAC contributors and surpassed its fundraising goal by collecting more than $18,000 in donations!

Monday, May 6—Learning the 'Asks'

On Monday afternoon, the OTO Advocacy Summit officially kicked off with a legislative briefing from AAO-HNS Government Affairs staff. Attendees were educated on the key legislative issues facing the specialty, with a focus on the specific "asks" for Tuesday's Capitol Hill meetings.

U.S. Rep. Aaron Schock with Michael Brenner, MD, and Nikhil Bhatt, MD, during the AAO-HNS 2013 OTO Advocacy Summit.

Next, attendees observed a mock Congressional visit demonstrating common advocacy "Do's and Don'ts"

2013 AAO-HNS OTO Advocacy Summit Group.

to help prepare Summit participants for their upcoming Capitol Hill meetings. **Lawrence M. Simon, MD, Ayesha N. Khalid, MD**, and **Jerry M. Schreibstein, MD**, reenacted a "typical" Congressional visit, providing strategies for communicating with Members of Congress and their staff (along with a few laughs).

The afternoon continued with presentations from U.S. Representative Phil Roe, MD, (TN-1), the lead sponsor of a bill (H.R. 351) to repeal the Independent Payment Advisory Board (IPAB), and U.S. Representative Michael Burgess, MD (TX-26), a key champion of efforts to repeal the flawed Sustainable Growth Rate (SGR) formula. Attendees also learned about a new legislative threat—an ill-advised "non-discrimination in healthcare" provision included in the Affordable Care Act—from Ronald Szabat, JD, leader of the Coalition for Fair Participation and Coverage. The day's activities concluded with members of the ENT PAC Board of Advisors discussing current ENT PAC initiatives and answering questions about how attendees can become more involved in the Academy's political programs.

Tuesday, May 7—Making a Difference

On Tuesday, the conference culminated with a full day of pre-scheduled meetings with Members of Congress and/or their staffs on Capitol Hill. More than 70 AAO-HNS members traveled to Capitol Hill to meet with nearly 125 Congressional offices representing 26 states and the District of Columbia. In addition, AAO-HNS leaders met with staff from key Congressional committees—namely, the House Committee on Ways and Means, the House Committee on Energy Commerce, and the Senate Committee on Finance.

During their meetings, attendees spoke to legislators and staff regarding several issues of importance to the specialty, including: finding a long-term solution to the flawed SGR formula; repeal of the IPAB; truth and transparency in healthcare advertisements; and patient safety/scope-of-practice concerns relating to the medical specialty. Attendees were invited to the AAO-HNS Capitol Hill office "war room" to re-fuel on Georgetown cupcakes, provide feedback to Academy staff on their meetings, and draft "thank you" notes prior to their departure from Washington, DC.

AAO-HNS Advocacy—Keeping the Drumbeat Going

The AAO-HNS Government Affairs team appreciates the Academy members who took time from their demanding schedules to attend this year's BOG Spring Meeting & OTO Advocacy Summit. Speaking with a unified voice for the specialty will help make a difference!

Advocating on behalf of the specialty does not stop here. We must continue to build relationships with our elected officials and discuss the important legislative issues affecting our practices and our patients. Even if you were unable to attend this year's Summit, consider meeting with your legislators locally during the July 4th holiday or the August recess. Your AAO-HNS Government Affairs team can help schedule the appointments. Simply email us at govtaffairs@entnet.org. For more information on the combined meeting, please visit http://www.entnet.org/conferencesandevents/.

Stay Informed: Follow the Government Affairs Twitter Account

Do you want to be one of the first to know the status of healthcare bills moving through Congress or your state? Follow the Government Affairs Twitter account @AAOHNSGovtAffrs. By following us, you can learn more about the issues impacting the specialty, including repeal of the flawed Sustainable Growth Rate (SGR) formula, medical liability reform, scope-of-practice battles, Graduate Medical Education (GME) funding, truth-in-advertising initiatives, and efforts to repeal the Independent Payment Advisory Board (IPAB). Not a fan of Twitter? You can also check the Government Affairs webpage for updates at http://www.entnet.org/Advocacy.

ENT PAC

ENT PAC, the political action committee of the AAO-HNS, financially supports federal Congressional candidates and incumbents who advance the issues important to otolaryngology–head and neck surgery. ENT PAC is a non-partisan, issue-driven entity that serves as your collective voice on Capitol Hill to increase the visibility of the specialty with key policymakers. To learn more about ENT PAC, visit our new PAC website at www.entpac.org (log-in with your AAO-HNS ID and password).

Register online @ www.entnet.org/hsc

Hsc
Home Study Course

2013 HOME STUDY COURSE

Registration deadline September 6, 2013

Sign up before August 5 to SAVE

For more Home Study Course information: www.entnet.org/hsc

Early registration savings up to 40% available until August 5, 2013

Registration fee is based on AAO-HNS membership status at the time form is received.

Payment must be received by September 6, 2013, to receive 2013–2014 courses. First packet begins mailing in late August.

PRACTICING PHYSICIANS & ALLIED HEALTH PROFESSIONALS

Order 2 YEARS and SAVE!	Member Early (By Aug.5)	Member Regular	Nonmember Early (By Aug.5)	Nonmember Regular	Total
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Two Years	❑ $585	❑ $820	❑ $820	❑ $1145	$
Best Buy!			Airmail fee*		$
			TOTAL		$

*Registrants outside U.S. add **AIRMAIL FEE** of **$120 for one year and $240 for two years.**

Mail or fax your order with full payment to:

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Boston, MA 02241-8546
Fax credit card orders: 1-703-519-1570
For more information, call: 1-703-535-3776
or email: LLee@entnet.org

AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY FOUNDATION

Empowering physicians to deliver the best patient care

Address Information

❑ New address for HSC ONLY

❑ New address for ALL Academy correspondence

Your Home Study Course (HSC) and all other AAO-HNS/F publications will be mailed to the same address.

First Name _____ Family/Last Name _____ Degree (MD, DO, PhD) _____

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Address _____

Address (No P. O. boxes, please) Suite/Room _____

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ZIP+4/Postal Code _____ Country _____

Phone/Extension _____ Fax _____ Email _____

Online Exam (Choose One)

❑ Paper version ❑ Online: (email required) _____

Present Position

❑ Resident in Otolaryngology–HNS
(Copies of your examination profiles will be sent to your program director)

Institution _____ Program Year _____ Program Director _____

❑ Practicing Otolaryngologist

❑ Other (specify) _____

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Enclose your check or complete credit card information below. Checks must be in U.S. dollars drawn on a U.S. bank. Credit card orders only can be faxed to 1-703-519-1570.

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To receive the first section on time, registration with payment must be RECEIVED by August 5, 2013. Registration closes September 6, 2013. A $200 late registration penalty will be applied to all registrations **RECEIVED** after September 6, 2013.

You Asked, We Delivered: Academy Achieves Modification to NCCI Edit for CPT 69424

In early 2013, several members and coding experts approached the Academy regarding frequent denials by Medicare Administrative Contractors (MACs) for claims that listed CPT 69424 *Ventilating tube removal requiring general anesthesia* with a modifier. In response, the Academy researched the issue and found that the current National Correct Coding Institute (NCCI) edit in place for 69424 was an edit of "0," which means that there are no circumstances for which a modifier would be appropriate to be reported in conjunction with 69424. In fact, the parenthetical in the CPT book under 69424 states: *(Do not report code 69424 in conjunction with 69205, 69210, 69420, 69421, 69433-69676, 69710-69745, 69801-69930).*

Upon review of this information, the Academy agreed with members that the parenthetical, and associated NCCI edit of "0," were inappropriate given that these code combinations could be provided contralaterally (i.e., separate services performed on opposite ears) in some clinical scenarios, and in those instances, these services should be separately reported and reimbursed. As such, the Academy crafted a letter to NCCI's medical director that was delivered on February 11, 2013, requesting that the CCI edit for CPT 69424 be modified from a "0" to a "1," which would allow the use of modifiers when 69424 is performed on one side and an exclusionary code in the CPT parenthetical (listed previously) is performed on the other side.

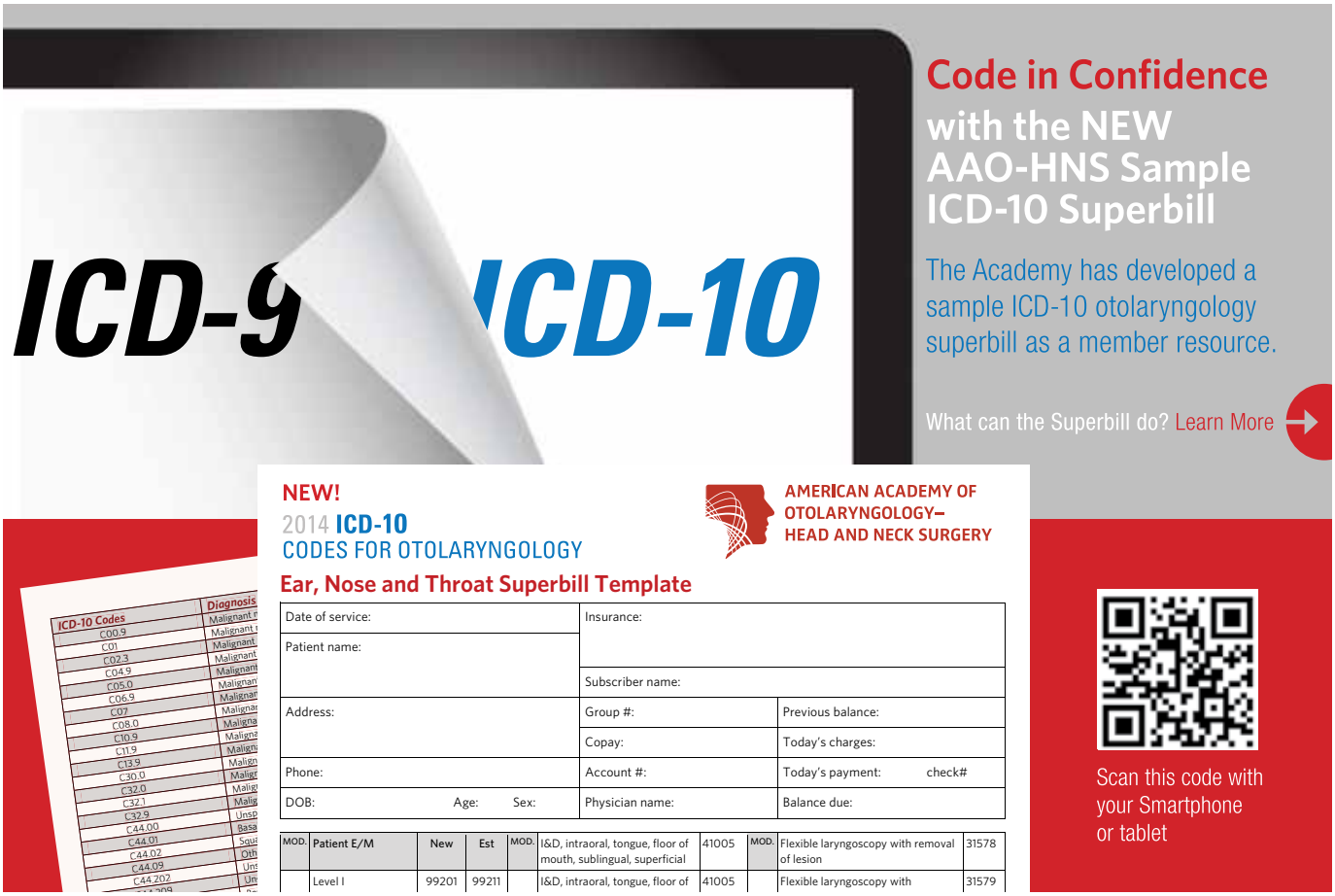
The NCCI medical director responded to our request expeditiously, and on February 21 the Academy was informed that our requested modification from a CCI edit of "0" to "1" was approved and would become effective July 1, 2013. This modification will allow surgeons to correctly code for uncommon, but medically appropriate, clinical scenarios where 69424 and one of the following codes *(69205, 69210, 69420, 69421, 69433-69676, 69710-69745, 69801-69930)* are **performed on opposite ears**.

The Academy is pleased that CMS and the NCCI have agreed to implement this change. To access the full response from NCCI, visit http://bit.ly/NCCIMUE. We encourage members to keep health policy staff abreast of any similar coding issues they encounter in the future, and urge you to email us at healthpolicy@entnet.org with any questions related to this issue or other coding and reimbursement matters.

Academy Releases Sample ENT Superbill to Assist Members in the ICD-9 to ICD-10 Conversion

Note the postcard in the polybag of this month's *Bulletin*. By accessing the link on it, members will find a new resource, developed by the Academy. The tool is aimed at assisting members and ENT practices with their transition from ICD-9 to ICD-10 coding by the October 2014 deadline. This sample ICD-10 superbill is designed to assist otolaryngology practices in quickly completing and submitting procedure(s) and diagnosis(s) codes from a patient visit for reimbursement. It is generally customized for an otolaryngology office and contains fields for patient information, the most common CPT (procedure), and ICD-10-CM (diagnostic) codes used by otolaryngologists. Access this Microsoft Word version of the superbill on the Academy's ICD-10 webpage at http://bit.ly/entICD10, which is designed to be customizable by users to include the most frequently billed procedures and associated diagnostic codes used in their office.

Members should note that this superbill is designed solely as an exercise in demonstrating the process of transitioning to the new ICD-10-CM coding system, and does not represent an endorsement by the Academy of the use of superbills or this particular superbill format. For more information on the transition to ICD-10, please email the health policy team at healthpolicy@entnet.org.



Continuing Medical Education at the Foundation: What It Means for Our Members

The AAO-HNS Foundation just completed its *Accreditation Council for Continuing Medical Education (ACCME) 2012 Annual Report* of its continuing medical education (CME) activities. It was another successful year and we wanted to share the good news with our members.

As you may know, the Foundation has been a CME provider for more than 30 years. We have successfully reaccredited with the ACCME every four years during that time. Our relationship with the ACCME connects us to a nationwide network of CME providers whose mission is to provide lifelong learning for physicians.

The ACCME's mission is to accredit physician education that promotes the following three principles.

Education Activities that Provide CME Credit

Annual Meeting & OTO EXPO℠ 27.5 credits

Online Courses and Lectures 0.5 – 1.5 credits per course

Home Study Course 40 credits per issue/160 credits per year

Coding and Reimbursement Workshops 6 credits per workshop

Patient Management Perspectives in Otolaryngology 8 credits per issue/64 credits per year

Manuscript Review 3 credits per review/15 credits per year

Learner-Centered and Practice-Based

Accredited CME is based on a learner-centered, continuous improvement model. Accredited providers facilitate self-directed, practice-based education that supports physicians' commitment to lifelong learning.

Safeguard Independence

ACCME standards and policies aim to facilitate the appropriate free flow of new information and scientific exchange, while preserving accredited CME's independence and freedom from commercial influence.

Support Professional Requirements

Accredited CME aligns with continuing professional development systems such as the American Medical Association Physician's Recognition Award credit system, the American Board of Medical Specialties Maintenance of Certification® and the Federation of State Medical Boards Maintenance of Licensure initiatives.

The Foundation's CME Mission strives to influence healthcare provider professional development through lifelong learning by identifying and addressing the education needs that underlie practice gaps in otolaryngology-head and neck surgery.

The total number of physician participants in 2012 was 15,000 with nearly 6,000 being unique physician participants. In addition, close to 600 nonphysicians participated in our accredited activities. All told, the Foundation provided nearly 270,000 *AMA PRA Category 1 credits*™ last year.

Many physicians receive credit from more than one of the Foundation's education activities. The 2012 CME accredited activities included the Annual Meeting & OTO EXPO℠, more than 100 online courses and lectures, three volumes and 24 issues of Patient Management Perspectives in Otolaryngology, four Home Study Course sections, eight Coding and Reimbursement Workshops, and journal manuscript review.

The Foundation's next ACCME reaccreditation date will be July 2015. At that time the Foundation plans to submit an application for Accreditation with Commendation. This accreditation status is the highest available and it is accompanied by a six-year term of accreditation.

"The Foundation leadership and staff feel very strongly that our continuing professional development efforts meet and exceed the expectations for accreditation with commendation," said Mary Pat Cornett, CAE, CMP, senior director, education, with the Academy. "I am confident that through the hard work and dedication of our education committees and leaders, Accreditation with Commendation will be achieved in our next reaccreditation cycle."

What this means for you as an Academy member is an ongoing commitment to provide you with high quality, need-based education opportunities that will enhance your ability to provide effective patient care.

As always, to access all of the education activities available through the Foundation that offer CME credit go to www.entnet.org/acacdemyu.

For more information about CME and the work of the ACCME visit www.accme.org.

Meet Us in Vancouver!

If you are a senior resident, fellow or practicing otolaryngologist interested in joining the Faculty or Staff of the world-famous New York Eye and Ear Infirmary, you may need to travel no further than mere blocks from the convention hall at the AAO-HNS annual meeting in Vancouver.

The New York Eye and Ear Infirmary is hosting two informal evenings in which to meet and network with its medical leaders and senior management as well as potential professional colleagues.

Monday, September 30 and Tuesday, October 1, 2013

5:30 – 7:30 PM each evening

Cocktails and hors d'oeuvres in one of the city's premiere facilities.

To learn more about any of the positions described below, and to RSVP to the NYEE Hospitality Evenings, please contact: Dan Mui at 212-979-4225 or email dmui@nyee.edu.

Seeking board certified, fellowship trained Pediatric Otolaryngologist

The Department of Otolaryngology/Head & Neck Surgery at The New York Eye and Ear Infirmary has a faculty position available for fellowship trained pediatric otolaryngologist. Build tertiary level pediatric practice in state-of-the-art settings at NYEE as well as physician satellite offices in multiple geographic areas throughout the New York metro area.

Joseph M. Bernstein, MD, Director
Division of Pediatric Otolaryngology
The New York Eye and Ear Infirmary
Continuum Otolaryngology Service Line
Phone: 212-979-4071
Email: jbernstein@nyee.edu

Opportunities for Otolaryngologists

The New York Eye and Ear Infirmary Department of Otolaryngology/Head & Neck Surgery has ongoing positions for US Board Certified or Board Eligible General Otolaryngologists in state-of-the-art practice settings at multiple locations throughout New York City and the New York-New Jersey metropolitan area.

Send CV to:
Dan Mui, Department Administrator
The New York Eye and Ear Infirmary
310 East 14th Street
New York, NY 10003
Phone: 212-979-4225
Email: dmui@nyee.edu

NY Eye & Ear Infirmary

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AAO-HNSF 2013 Annual Meeting & OTO EXPO℠

Orals to Offer Accelerated Format and Miniseminars and Instruction Courses to also Target Topics

The AAO-HNSF 2013 Annual Meeting & OTO EXPO℠ Scientific Program will offer new enhancements this year. The 300-plus oral presentations will be given in either five-minute or eight-minute increments. According to Eben L. Rosenthal, MD, who chairs the Scientific Sessions, the Board of Directors and the Program Advisory Committee are committed to promoting innovation within the Annual Meeting that will improve the value of the meeting for attendees. The traditional format will offer 50-minute presentations scheduled from 9:30 to 10:20 am each day and will be presented in eight-minute increments. The new accelerated presentation format is scheduled during the 80-minute time slots each day from 8:00 to 9:20 am and 10:30 to 11:50 am. These presentations will be given as five-minute presentations followed by a question-and-answer period.

Continuing the popular track offerings of this meeting, the scientific oral presentations will be offered in nine topic areas. These are: Business of Medicine/Practice Management; Facial Plastic and Reconstructive Surgery; General Otolaryngology; Head and Neck Surgery; Laryngology/Broncho-Esophagology; Otology/Neurotology; Pediatric Otolaryngology; Rhinology/Allergy; and Sleep Medicine. Abstracts, presenters, and time-slots are fully available to view and search at **www.entnet.org/annual_meeting**.

Once at this web spot, you can also plan your schedule using the itinerary planner to plan your time at the meeting effectively. While planning, insert time in your schedule to view the scientific posters that will be on display Sunday, September 29, until noon Wednesday, October 2, in Hall C of the Vancouver Convention Centre. Coming soon, a smart phone App will let you browse and plan on the go.

Miniseminars and Instruction Courses Previewed

Miniseminars and Instruction Courses follow the nine tracks to allow you to target content areas you need as do the scientific orals. In this issue and in August and September we will update three of the nine tracks consecutively. So below see the first group of miniseminars and instruction course presentations for The Business of Medicine/Practice Management, Facial Plastics and Reconstructive Surgery, and General Otolaryngology.

Business of Medicine/Practice Management

Miniseminars

Alternative Payment Models and Academy Advocacy
Supported by the Physician Payment Policy (3P) Workgroup and the BOG Executive Committee
Michael Setzen, MD (Moderator); James C. Denneny III, MD; Richard W. Waguespack, MD; Charles F. Koopmann Jr., MD, MHSA; Robert R. Lorenz, MD; Emily F. Boss, MD, MPH; Denis C. Lafreniere, MD

Avenues to Leadership: Opportunities at Every Level
Supported by the Young Physicians Committee and Women in Otolaryngology Section
Marita S. Teng, MD (Moderator); Marion E. Couch, MD, PhD; Lauren S. Zaretsky, MD; Stacey Tutt Gray, MD; Craig S. Derkay, MD; Sukgi S. Choi, MD

Cutaneous Carcinoma: Beyond Mohs Surgery
Supported by the Head and Neck Surgery and the Oncology Committee
Gregory J. Renner, MD (Moderator); Randal Scott Weber, MS; Sue S. Yom, MD; Cecelia E. Schmalbach, MD; Michael R. Migden, MD; Nicholas Golda, MD

Detailed Analysis on Selecting/Installing/Using an ENT EMR
Supported by the Medical Informatics Committee
K. J. Lee, MD (Moderator); Subinoy Das, MD; Edward B. Ermini, MD; Lawrence J. Gordon, MD; David R. Nielsen, MD; David T. Upchurch, MD

Hot Topics in Otolaryngology 2013: ACOs
Supported by the BOG Executive Committee and the BOG Socioeconomic and Grassroots Committee
Wendy B. Stern, MD (Moderator); Raymund C. King, MD, JD; James C. Denneny, MD; Denis C. LaFreniere, MD

Pearls on How to Transition to ICD-10 Coding by 2014
Supported by the Physician Payment Policy (3P) Workgroup
Richard W. Waguespack, MD, and Michael Setzen, MD
(Moderators); Rhonda Buckholtz; Robert R. Lorenz, MD; Annie Boynton

Practical Guide to MOC: Who, What, When, Why, and How
Marita S. Teng, MD (Moderator); Sonya Malekzadeh, MD; Robert H. Miller, MD; Sukgi S. Choi, MD; Derrick T. Lin, MD; Randal Scott Weber, MD; Shane Smith, MD

The Top 10 Business Mistakes I Have Made in Practice
Seth M. Brown, MD, MBA (Moderator); Winston C. Vaughan, MD; Donald C. Lanza, MD; Michael Setzen, MD

Using Social Media in Medicine
Supported by the Section for Residents and Fellows and the Media and Public Relations Committee
Wendy B. Stern, MD (Moderator); Christopher Y. Chang, MD; Lee D. Eisenberg, MD, MPH; Lawrence M. Simon, MD; Julie L. Wei, MD

Instruction Courses

The 2013 Primer for the Otolaryngology Program Director Brian B. Burkey, MD; Terance Tsue, MD

ACGME Next Accreditation System in your Residency Program Ⓜ
Terance Tsue, MD; Sukgi S. Choi, MD; Pamela L. Derstine, PhD, MHPE

✋ = Hands-on ($70/hour)

ⓜ = Mini-course ($50/hour)

❖ = Audience Response ($50/hour)

② = Two-hour course

Regular = $50/hour
Rates increase August 23

Become an Expert in Rhinology Coding ②
Seth M. Brown, MD, MBA; Winston C. Vaughan, MD

Building a Referral Network in Medicine's Changing Times
Douglas D. Backous, MD; Kris Barlow, RN, MBA

Clinical Fundamentals: Clinical Outcome Measures/Evidence-Based Medicine
Michael G. Stewart, MD, MPH

Clinical Fundamentals: Management of the Addicted Surgeon
Peter Sargent Roland, MD

Clinical Fundamentals: Universal Precautions for the Otolaryngologist
Peggy E. Kelley, MD

Coding for Residents and New Practitioners ②
Marc G. Dubin, MD; Brian A Kaplan, MD; Kenneth C. Fletcher, MD

Developing a Quality Control Program for Surgeons
Carl H. Snyderman, MD, MBA; Erin M. McKean, MD

Developing a Compliance Program for Your Practice
Charles F. Koopmann, MD, MHSA

Development of a Physician Assistant Fellowship in OTO/HNS
Michael L. Hinni, MD; Richard E. Hayden, MD; Carlene B. Donald, PA-C

Disclosure of Medical Errors for the Otolaryngologist
John R Houck, MD

E&M Coding and Documentation for Proper Reimbursement
Richard W. Waguespack, MD; Lawrence M. Simon, MD

Evidence-Based Approach to Endoscopic Skull Base Surgery
Rodney J. Schlosser, MD; Bradford A. Woodworth, MD

Financial Planning for Young Physicians
John E. Buenting, MD, MPH

General Otolaryngology Review Course ②
Karen T. Pitman, MD

Healthcare 2014
Alvin B. Ko, MD

Healthcare Reform: A Brief Summary
Jerome Walter Thompson, MD, MBA; Rose Mary S. Stocks, MD, PharmD

Health Insurance 101
Kathleen L. Yaremchuk, MD

Hearing Aids: A Medical Prospective
Herbert Silverstein, MD; Vicki Alexander, LPN

Introduction to Reimbursement: A Crash Course! ❖ ②
Gregory A. Grillone, MD

Measuring the Productivity/Success of Your Practice
Kimberley J. Pollock, RN, MBA, CPC; Michael Setzen, MD

Medicare Audit Risk Identification and Prevention Prescription
Mary S. Legrand, RN, MA; Michael Setzen, MD

Medical Ethic Decision Making: Why, When, and How
Charles F. Koopmann, MD, MHSA

Office-Based Ultrasonography of the Neck ✋ ②
Hans J. Welkoborsky, MD, DDS, PhD; Lisa A. Orloff, MD

Office Practice Quality Improvement: A Hands-on Approach ✋ ②
Daniel H. Morrison, MD, MS; Giri Venkatraman, MD, MBA

Social Media for the Otolaryngologist ②
Steven Y. Park, MD

Surviving/Thriving: Practice Management 2013 ②
Steven F. Isenberg, MD

Techniques of Evidence-Based Medicine in Otolaryngology ✋
Sanford M. Archer, MD; Michael G. Stewart, MD, MPH

Ten Essentials to Negotiating Employment Contracts
Nadim B. Bikhazi, MD; Michael Scheuller, MD

Using M & M Conference to Promote Safety and Quality Improvement ❖
Brian Nussenbaum, MD; Rahul K. Shah, MD

Facial Plastic and Reconstructive Surgery

Miniseminars

❖= Audience Response

Coding and Precertification Strategies for Nasal Surgery ❖
Supported by the Plastic and Reconstructive Surgery Committee
John S. Rhee, MD, MPH (Moderator); Travis T. Tollefson, MD, MPH; Preston D. Ward, MD; Krishna G. Patel, MD, PhD

Functional Rhinoplasty
Supported by the Education Committee and the Facial Plastic and Reconstructive Surgery Committee
James R. Jordan, MD (Moderator); Benjamin W. Cilento, MD; Jose E. Barrera, MD; Edmund A. Pribitkin, MD

Parotidectomy Defect: To Reconstruct or Not
Supported by the American Head and Neck Society (AHNS)
Oleg N. Militsakh, MD (Moderator); Douglas A. Girod, MD;
Matthew M. Hanasono, MD; Derrick T. Lin, MD

Reconstruction of Mohs Defects
Supported by the Education Committee and the Facial Plastic and Reconstructive Surgery Committee
James R. Jordan, MD (Moderator); Ivan Wayne, MD; John B. Lazor, MD

Surgical Management of the Patient with Facial Paralysis
Supported by the Program Advisory Committee, the American Academy of Facial Plastic and Reconstructive Surgery (AAFPRS), and the American Head and Neck Society (AHNS)
Mark K. Wax, MD (Moderator); Eben L. Rosenthal, MD; Fred G. Fedok, MD; Tom D. Wang, MD

Instruction Courses

Advances in Traumatic and Oncologic Orbital Reconstruction
Kris S. Moe, MD

Botox and Fillers for Facial Lines and Wrinkles
Andrew Blitzer, MD, DDS

Cleft Lip and Palate Surgery for Residents ②
Tom D. Wang, MD

Defect-Based Approach to Reconstruction of Cutaneous Defects ②
Jeffrey S. Moyer, MD; Jennifer C. Kim, MD

Does My Patient Need a Free Flap? ⓜ
Douglas B. Chepeha, MD; K.M. Malloy, MD; Samir S. Kharuvala, MD

Essentials of Rib Cartilage Harvest for Septorhinoplasty
Marcus W. Moody, MD

Facial Injuries: Zygoma, Midface, Skull Base Reconstruction ②
Kurt Laedrach, MD

Functional Reconstruction of the Oral Cavity and Oropharynx
Gregory K. Hartig, MD; Ara A. Chalian, MD

Incisionless Otoplasty
Michael H. Fritsch, MD

Introduction to Craniofacial Surgery
Sherard A. Tatum, MD

Management of Septal Perforations
Stephen Francis Bansberg, MD

Open Rhinoplasty: Arming Novices for Success
Edmund A. Pribitkin, MD

Optimal Surgical Strategies for Treating Facial Paralysis ⓜ ②
David B. Hom, MD; Ravi N. Samy, MD; Patrick Shumrick, BS, MHS

= Hands-on ($70/hour)

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Orbital Trauma: Comprehensive Diagnosis and Treatment
E. Bradley Strong, MD

Otolaryngologists as Cleft Surgeons ⓜ ②
Lisa Buckmiller, MD; Larry Hartzell, MD

Reconstruction and Reanimation Spectrum: Parotidectomy Defects
Steven J. Wang, MD; Jennifer C. Kim, MD; Kevin Fung, MD, FRCS

Reconstruction of Partial Auricular Defects
Gregory J. Renner, MD; C. W. David Chang, MD

Scar Wars: Treating the Elusive Scar ②
David B. Hom, MD; J. Regan Thomas, MD

Surgical Rejuvenation of the Aging Forehead and Brow
Tom D. Wang, MD

Update in Minimally Invasive Cosmetic Injectible Treatments
Lisa Danielle Grunebaum, MD; Ryan Heffelfinger, MD

General Otolaryngology

Miniseminars

❖= Audience Response

7th Annual Academic Bowl ❖
Mark K. Wax, MD (Moderator); Sonya Malekzadeh, MD

Big Patients, Big Worries
Supported by the Patient Safety and Quality Improvement Committee
Margaret L. Skinner, MD (Moderator); Daniel L. Wohl, MD

Challenging Cough Cases: A New Frontier in Otolaryngology
Supported by the American Laryngological Association (ALA)
Kenneth W. Altman, MD, PhD (Moderator); John H. Krouse, MD, PhD; Amber U. Luong, MD, PhD; Thomas L. Carroll, MD; Albert L. Merati, MD

Clinical Practice Guideline: Bell's Palsy
Reginald F. Baugh, MD (Moderator); Gregory J. Basura, MD, PhD; Lisa Ishii, MD, MHS; Seth R. Schwartz, MD, MPH

Efficacy of Surgical Simulators for Otolaryngology Training
Supported by the Medical Devices and Drugs Committee
Kenneth H. Lee, MD, PhD (Moderator); Gregory J. Wiet, MD;
Marvin P. Fried, MD; Noel Jabbour, MD; Kaalan E. Johnson, MD

Exercises in Futility: Ethical Challenges in Otolaryngology ❖
Supported by the Ethics Committee
Andrew G. Shuman, MD, and Susan D. McCammon, MD (Moderators); Roger D. Cole, MD

From Simulation to Surgery: Making It Real!
Supported by the Education Committee
Michael D. Seidman, MD (Moderator); Marvin P. Fried, MD;

Gregory J. Wiet, MD; Milan R. Amin, MD; Sonya Malekzadeh, MD; Stacey L. Ishman, MD; Carl H. Snyderman, MD, MBA

Getting Published: Letters, Commentaries, and Social Media
Richard M. Rosenfeld, MD, MPH (Moderator); Nikhila Pinnapureddy Raol, MD; Jeffrey C. Liu, MD; Eileen Cavanagh, MPS; Courtney Pugh

Global Health 2013: Academy around the World
Supported by the International Steering Committee
Gregory W. Randolph, MD (Moderator); James L. Netterville, MD; Susan R. Cordes, MD; Terry A. Day, MD; Nikhil J. Bhatt, MD; Ramon A. Franco, MD; Bernard Gil Fraysse, MD; G. Richard Holt, MD, MPH, MSE; Chung-Hwan Baek, MD, PhD; Mark E. Zafereo, MD; James E. Saunders, MD

Grant Writing Pearls and Pitfalls: Maximizing your Funding
Supported by the CORE Study Section, and the Section for Residents and Fellows
Cecelia E. Schmalbach, MD (Moderator); Marion E. Couch, MD, PhD; Eben L. Rosenthal, MD; Melissa Pynnonen, MD, MS; Jeffrey Liu, MD

High-Anxiety Head and Neck Trauma Cases: Lessons Learned
Supported by the Trauma Committee
Joseph Brennan, MD (Moderator); Jose E. Barrera, MD; Joseph Sniezek, MD; Christopher Klem, MD; G. Richard Holt, MD, MPH; Paul J. Donald, MD

Hot Topics for the General Otolaryngology ✋
J. Pablo Stolovitzky, MD; David W. Kennedy, MD; Dennis S. Poe, MD; Michael Friedman, MD

Improving Outcomes in Septal Surgery
Grant Gillman, MD

In Office Safety: Are You Putting Your Patient at Risk?
Supported by the Patient Safety and Quality Improvement Committee
Robert J. Stachler, MD (Moderator); Berrylin J. Ferguson, MD; Jonathan C. Kopelovich, MD; Patrick T. Hennessey, MD

Integrative Approach to Atypical Facial Pain and Headache
Supported by the Complementary/ Integrative Medicine Committee, and the Rhinology and Allergy Education Committee
Marilene B. Wang, MD (Moderator); Brent A. Senior, MD; Chau T. Nguyen, MD; Malcolm B. Taw, MD

Management of CPAP Failure for the Otolaryngologist
John R. Houck, MD

Multi-Resistant Bacterial Infections in 2013
Supported by the Infectious Disease Committee and the Patient Safety and Quality Improvement Committee
Tulio A. Valdez, MD (Moderator); Steven E. Sobol, MD, MSc;
James C. Post, MD, PhD; Lee D. Eisenberg, MD, MPH

Neurological Disease of the Larynx
Andrew Blitzer, MD; Lucian Sulica, MD

Off Label Uses of Drugs and Technology: What's the Stigma?
Supported by the Ethics Committee
Karen B. Zur, MD (Moderator); Craig S. Derkay, MD; Steven D. Handler, MD; Bert W. O'Malley, MD; Michael J. Rutter, MD

Optimize Patient Education for Patient Satisfaction ❖
Maya G. Sardesai, MD, MEd (Moderator); Mark Whipple, MD; Edward M. Weaver, MD, MPH; Ellen S. Deutsch, MD; Sara Kim, PhD

Practical Management of Complications in Otolaryngology
Sunil P. Verma, MD (Moderator); Pete S. Batra, MD; Eric P. Wilkinson, MD; Timothy M. McCulloch, MD; Alfred A. Simental, MD

Scary Cases 2013 ❖
Michael P. Platt, MD (Moderator); Gavin Setzen, MD; Gregory A. Grillone, MD; Elie E. Rebeiz, MD; Phillip Song, MD; Cathy D. Chong, MD; David E. Tunkel, MD

To Operate or Not to: How to Approach the Older Patient
Supported by the Geriatric Otolaryngology Committee
Ozlem E. Tulunay-Ugur, MD (Moderator); David E. Eibling, MD; Robert T. Sataloff, MD, DMA; Brian J. McKinnon, MD; David R. Edelstein, MD; Gregory K. Hartig, MD; Karen M. Kost, MD

Instruction Courses

The ABCs of Hearing Aid Dispensing from A to Z
William M. Luxford, MD; Brad Volkmer, MD

Acupuncture for the Otolaryngologist: An Introduction
Anthony F. Jahn, MD

Advanced Ultrasonography Techniques for the ORL Office ✋ ②
Urban W. Geisthoff, MD; Hans J. Welkoborsky, MD, DDS, PhD; Jens Eduard Meyer, MD; Lisa A. Orloff, MD

Angioedema: Review for the Otolaryngologist
Marcus W. Moody, MD

Be All You Can Be: Simulation Boot Camps to Prepare Residents ✋ ②
Sonya Malekzadeh, MD; Ellen S. Deutsch, MD; Kelly M. Malloy, MD

Bedside Tracheotomy: From Program to Practice
Bradley A. Schiff, MD; Andrew Tassler, MD

Botulinum Toxin for Headache and Pain
Andrew Blitzer, MD, DDS; William J. Binder, MD

Can You Fly with That? Your Flying Patients and the FAA
David G. Schall, MD, MPH

Chronic Cough and Other Sensory Disturbances
Robert W. Bastian, MD

Clinical Fundamentals: Anesthesia Related Topics for Otolaryngologists
Murali Sivarajan, MD

Clinical Fundamentals: DVT: How, When, Why in Otolaryngology
Amy Clark Hessel, MD

✋ = Hands-on ($70/hour)

ⓜ = Mini-course ($50/hour)

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Rates increase August 23

Clinical Fundamentals: Ethics & Professionalism
Roger D. Cole, MD; Susan R. Cordes, MD; Susan D. McCammon, MD

Clinical Fundamentals: HIPAA: Updates and What It Means for You
Kathleen L. Yaremchuk, MD

Clinical Fundamentals: Integration of Quality and Safety into Otolaryngology
Amy Clark Hessel, MD; Randal S. Weber, MD

Clinical Fundamentals: Pain Management in Head and Neck Surgery
Christopher Oliver, MD; John Sok, MD

Complementary and Integrative Medicine (CIM)
Michael D. Seidman, MD

Corticosteroids: Know the Risks!
David T. Poetker; Todd T. Kingdom, MD

Crystal Clear BPPV
Michael T. Teixido, MD

Dysgeusia: Leaving a Bad Taste in the Doctor's Mouth
Allen Mark Seiden, MD

Errors in Otolaryngology: Where Can We Go Wrong
Rahul K. Shah, MD; Brian Nussenbaum, MD

Evaluation and Management of Oral Malodor 2013
Yosef P. Krespi, MD; Victor Z. Kizhner, MD

Head and Neck Surgical Pathology Pearls and Pitfalls
Yash J. Patil, MD; Qihui Zhai, MD

Head and Neck Trauma: Lessons of War and Mass Casualties
Joseph Brennan, MD; Jose E. Barrera, MD

Hearing Aids: From the Otolaryngologist Perspective
Stacey D. Watson, MS

Herbal Therapy: A Guide for Otolaryngologists
Edmund A. Pribitkin, MD

Histology, Histopathology, and Radiology of the Ear ②
Sujana S. Chandrasekhar, MD; Hosakere Chandrasekhar, MD

How to Interpret and Prepare a High Quality Systematic Review
Martin J. Burton, MD; Richard M. Rosenfeld, MD, MPH

How to Review a Journal Manuscript
Richard M. Rosenfeld, MD, MPH

HPV: What the Practicing Clinician Should Know
Eric M. Genden, MD

Improving Outcomes in Septal Surgery
Grant Gillman, MD

Lies, Damned Lies, and Statistics ⓜ
Bevan Yueh, MD, MPH; Edward M. Weaver, MD, MPH

Managing Mucus: Examining the Evidence
C. Blake Simpson, MD; Kevin C. McMains, MD

Medicolegal Issues for ENTs: Top Ten Concerns ❖
Winston C. Vaughan, MD; Ankit Patel, MD

More than a Headache: Migraine for the Otolaryngologist
Michael T. Teixido, MD; John P. Carey, MD

The Nasal Valve Primer: Everything You Need to Know
Grant Gillman, MD

Pains in the Neck: Treating Globus Pharyngeus
Lee M. Akst, MD; Seth H. Dailey, MD

Pearls of Dysphagia Management in the Older Patient
Ozlem E. Tulunay-Ugur, MD; Michael J. Pitman, MD

PET in Otolaryngology: When, Where, Why, and How
D. Gregory Farwell, MD; Quang C. Luu, MD

Red, White, and Ulcerative Lesions of the Oral Cavity ②
Susan Muller, DMD, MS

Sialendoscopy for Gland Preservation: A Case-Based Approach
M. Boyd Gillespie, MD, MSc; Johannes Zenk, MD

Steroids in ORL: Indications, Efficacy, and Safety
Stacey Tutt Gray, MD; Eric H. Holbrook, MD

Understanding and Managing Career ❖ ②
Julie Lien Wei, MD; Robert H. Orsoff, DMD, MD; Douglas A. Girod, MD

Understanding Clinical Practice Guidelines
Richard M. Rosenfeld, MD, MPH;

Understanding Audiology Assessment for the Otolaryngologist
Stacey D. Watson, MS

Worldwide Otolaryngology Humanitarian Missions
Drew M. Horlbeck, MD

Congratulations to the 2013 International Travel Grant Winners

Gregory W. Randolph, MD, Coordinator for International Affairs, and **Nikhil J. Bhatt, MD**, Chair, International Otolaryngology Committee, congratulate the six winners of the 2013 International Travel Grants to attend the Annual Meeting & OTO EXPO℠ in Vancouver, BC, Canada.

The winners are studying in post-residency fellowships in U.S. and Canadian otolaryngology departments.

- Ahmed Hussein, MD, Vanderbilt University (Egypt)
- Hideaki Moteki, MD, PhD, University of Iowa (Japan)
- Lalenthra Naidoo, MBBCh, MMed (ORL), DCH (SA), University of British Columbia (South Africa)
- Marianella Paz Silva, MD, University of Chicago (Venezuela)
- Duo Duo Tao, MD, House Ear Institute (China)
- Hongquan Wei, MD, University of Pittsburgh (China)

The travel grant awardees will be recognized at the Opening Ceremony. Dr. Bhatt invites them as guests to the International Otolaryngology Committee meeting from 1 to 2 pm Saturday, September 28, and the International Assembly from 2 to 4 pm Tuesday, October 1.

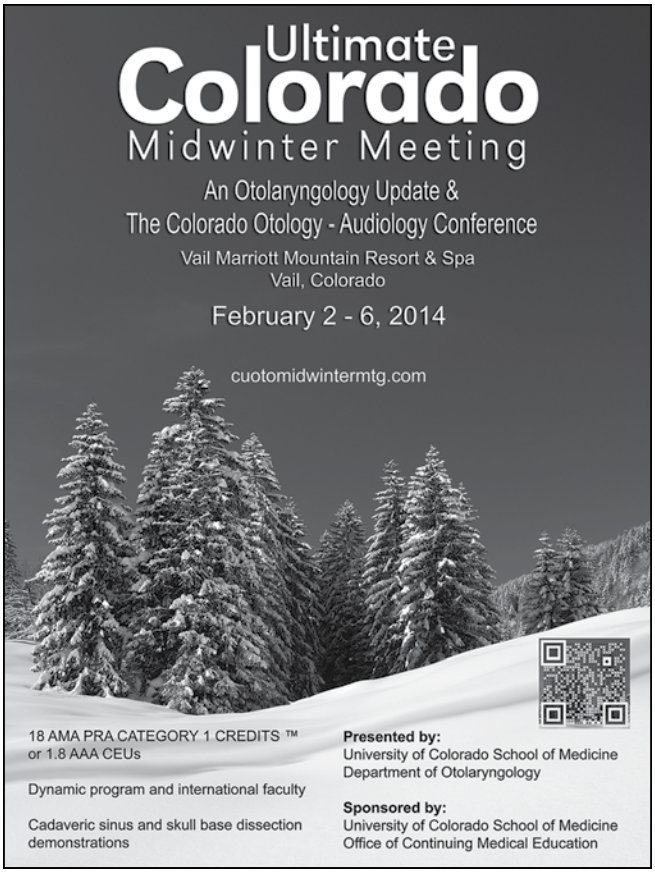
2013 Annual Dinner Meeting of the Otolaryngologists of Indian Heritage

The 36th Annual Meeting of the American Association of Otolaryngologists of Indian Heritage (AAOIH) will take place from 6:45 to 11 pm Monday, September 30, at Maurya Indian Cuisine, 1643 West Broadway, Vancouver, BC, V6J 1W9, Canada.

Residents of Indian heritage are encouraged to present original research at the meeting. Three prizes will be announced. Attendance is anticipated to be large and RSVP is strongly encouraged.

For charges and to learn more, contact Pete Batra, MD, secretary: pete.batra@utsouthwestern.edu or Arun K. Gadre, MD, president: Arungadre@Yahoo.com; Satish Govindaraj, MD, president-elect: Ameet Singh, MD, membership secretary; or visit www.theaaoi.org.

In addition, the AAOIH Executive Board will meet from 4:30 to 6:00 pm Sunday, September 29, in the Vancouver Convention Centre, ICS room. Please RSVP to Dr. Gadre at Arungadre@Yahoo.com.



South Florida ENT Associates, P.A.

South Florida ENT Associates, a forty five Otolaryngology group practice in Miami-Dade, Broward and Palm Beach has immediate openings for full- time ENT Physician's. South Florida ENT provides full service ENT practices with Audiology, Hearing Aid Sales, Allergy, and Facial Plastics.

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Requirements:
Must be board certified within 24 months of commencing employment
MD/DO from approved medical/osteopathy school and graduation from accredited residency program in ENT
Current Florida license
Bilingual (English/Spanish) preferred
Excellent communication and interpersonal skills.
ENT Experience a must
F/T - M-F plus call

Contact Information:
Contact name: Stacey Citrin, CEO
Phone: (305)558-3724
E-mail: scitrin@southfloridaent.com
Cellular: (954)803-9511

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That's why each and every year, ENT and Allergy Associates, LLP® reaches out to young men and women confronting the same choices you now consider, and offers them the insight and experience of those who recently faced those same difficult options, and selected ENT and Allergy as the place to successfully build their future. In fact, those insights are gathered in our PDF booklet 'Answers to Recruitment Questions'© (www.entandallergy.com/enta_arq.pdf). We invite you to download and review them.

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Dr. Douglas Leventhal, who practices out of our Oradell, NJ office, joined ENTA in 2012 after completing a residency in Otolaryngology-Head & Neck Surgery at Thomas Jefferson University Hospital in Philadelphia, PA and a fellowship in Facial Plastic & Reconstructive Surgery at New York University in New York, NY.

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Ear Nose and Throat Assoc.

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South Florida Associates, P.A.

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Jorge Helo, M.D.
Paul K. Foster, M.D.

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- Competitive Salary Base plus percentage.
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Must be BC/BE.

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Well-established private practice group (4 board-certified Oto/HNS in beautiful, Seaside Santa Monica, California. Practice includes all aspects of the specialty excepting neurotology. All partners academically affiliated @ UCLA or USC.

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Head and Neck Oncology
Surgeon/Scientist

University of Utah Otolaryngology—Head & Neck Surgery seeks BC/BE faculty with fellowship training in head and neck oncology. This is a full-time tenure track position at the Assistant or Associate Professor level. The successful candidate should be able to lead an extramurally-funded research effort and also participate in clinical care and resident education. Position available immediately.

The University of Utah is an Equal Opportunity/ Affirmative Action employer and educator. Minorities, women, and persons with disabilities are strongly encouraged to apply. Veterans preference. Reasonable accommodations provided. For additional information: http://www.regulations.utah.edu/humanResources/5-106.html.

Applicants must apply at:
http://utah.peopleadmin.com/postings/19713
For additional information, contact:
Clough Shelton, MD, FACS, Professor and Chief
University of Utah School of Medicine
50 North Medical Drive 3C120
Salt Lake City, Utah 84132
Phone: (801) 585-1626
Fax: (801) 585-5744
E-mail: inga.journey@hsc.utah.edu

KU UNIVERSITY of KANSAS
DEPARTMENT OF
OTOLARYNGOLOGY-
HEAD & NECK SURGERY

Head and Neck Surgeon *Position Number M0203642*

The University of Kansas Department of Otolaryngology-Head & Neck Surgery is seeking a head and neck surgeon who is interested in a full-time academic position to join the head and neck surgical oncology division.

The successful candidate will have fellowship training in microvascular surgery or surgical oncology and an interest in oncologic research is preferred. The candidate will be BC/BE and join as an Assistant or Associate Professor and will be involved with resident and medical student education while developing a strong clinical practice and research interests.

Head and Neck Fellowship

Clinical Focus: Head and neck surgical oncology, skull base surgery, endoscopic laser surgery, minimally invasive endocrine surgery, microvascular reconstructive surgery and robotic surgery

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

To view position online, go to **http://jobs.kumc.edu** and search by position number.

Letters of inquiry and CV may be mailed or emailed to:
Dan Bruegger, MD, Associate Professor and Interim Chairman
The University of Kansas School of Medicine
Department of Otolaryngology-Head & Neck Surgery
3901 Rainbow Blvd, MS 3010, Kansas City, KS 66160
Email: **dbruegge@kumc.edu**

THE UNIVERSITY OF NEW MEXICO
Department of Surgery, Division of Pediatric Otolaryngology

The Department of Surgery, Division of Otolaryngology, at the University of New Mexico, is seeking applications for a pediatric otolaryngologist trained in all aspects of Pediatric Otolaryngology surgery. This position will be recruited at the Assistant/ Associate Professor level. Research opportunities are available if desired, and clinical research opportunities are readily available. Appointment and salary will be commensurate with level of experience.

The successful candidate will participate in an active Pediatric Otolaryngology practice, as well as provide resident teaching rounds, medical student teaching and participation at local and national conferences. It is an excellent opportunity for a pediatric otolaryngologist interested in academic achievements and good clinical experience. An excellent compensation package is provided.

Minimum Qualifications: Medical doctor who is board certified/eligible in Otolaryngology-Head and Neck Surgery, eligible for licensure in New Mexico, and eligible to work in the U.S.
Preferred Qualifications: Academic/clinical experience and completed fellowship in Pediatric Otolaryngology, or completing a fellowship in the next twelve months.

Interested applicants must apply for this position via UNMJobs website, https://unmjobs.unm.edu/applicants/jsp/shared/frameset/Frameset.jsp?time=1345672123192, Posting # (to be provided). Please attach electronic copies of the CV, letter of interest, and three professional references to your application:

This position will remain open until filled; however, for best consideration, application materials should be received by August 1, 2013. For further information, interested applicants should contact Erica Bennett, M.D., at EBennett@salud.unm.edu.

The UNM School of Medicine is an Equal Opportunity/ Affirmative Action Employer and Educator. This position may be subject to criminal records screening in accordance with New Mexico state law. J1 Visas are not eligible for this opportunity. UNM's confidentiality policy ("Disclosure of Information about Candidates for Employment," UNM Board of Regents' Policy Manual 6.7), which includes information about public disclosure of documents submitted by applicants, is located at http://www.unm.edu/~brpm/r67.htm

Froedtert & Medical College of Wisconsin

Children's Hospital of Wisconsin

The Department of Otolaryngology and Communication Sciences at the Medical College of Wisconsin

Is currently seeking to hire the following full-time positions:

NEURO-OTOLOGIST / OTOLOGIST

MCW is seeking a full time Board eligible or certified neuro-otologist / otologist with special interest in clinical outcomes research and/or clinical quality. Academic rank will be commensurate with experience. Position will be based at the adult teaching hospital, Froedtert Hospital but will also have responsibilities at The Zablocki Veterans Affairs Medical Center and The Children's Hospital of Wisconsin. The successful candidate must be eligible for licensure in the State of Wisconsin.

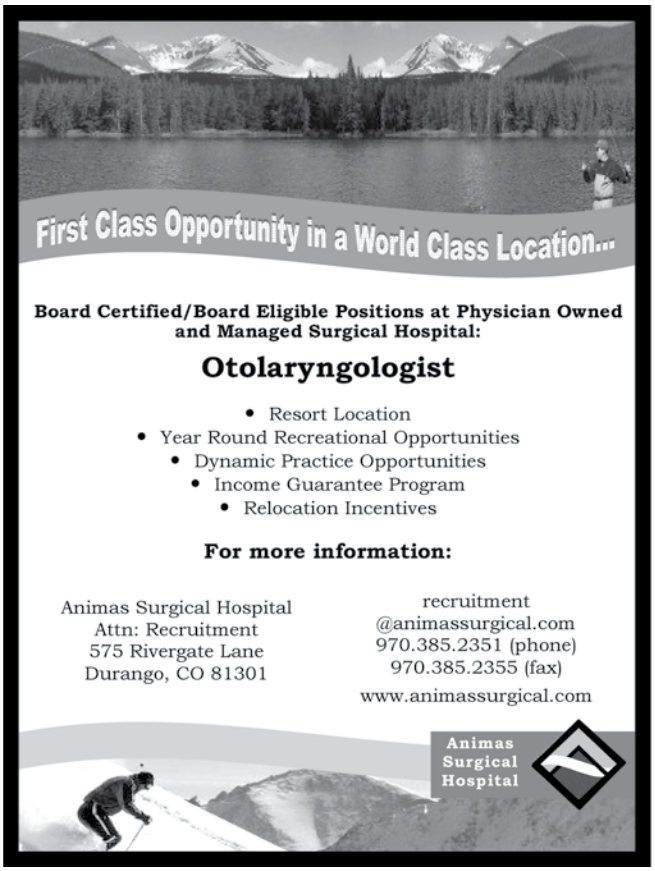
GENERAL OTOLARYNGOLOGIST

MCW is seeking a full time Board eligible or certified general otolaryngologist at the Assistant or Associate Professor level. Interest in sleep medicine/surgery will be given special consideration. The successful candidate must be eligible for Wisconsin licensure and will practice at Froedtert Hospital, Children's Hospital of Wisconsin and affiliated off campus sites.

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

John S. Rhee, MD, MPH
Professor and Chair
Department of Otolaryngology and Communication Sciences
Medical College of Wisconsin
9200 W Wisconsin Ave
Milwaukee, WI 53226
(414) 805-5227 (office)
jrhee@mcw.edu

MCW is an Equal Opportunity/Affirmative Action Employer.



THE UNIVERSITY OF UTAH

Pediatric Otolaryngology Surgeon/Scientist

University of Utah Otolaryngology–Head & Neck Surgery seeks BC/BE faculty with fellowship training in Pediatric Otolaryngology. This is a full-time tenure track position at the Assistant or Associate Professor level. The successful candidate should be able to lead an extramurally-funded research effort and also participate in clinical care and resident education. Position available July 2014.

The University of Utah is an Equal Opportunity/ Affirmative Action employer and educator. Minorities, women, and persons with disabilities are strongly encouraged to apply. Veterans preference. Reasonable accommodations provided. For additional information: http://www.regulations.utah.edu/humanResources/5-106.html.

Applicants must apply at:
http://utah.peopleadmin.com/postings/20311
For additional information, contact:
Clough Shelton, MD, FACS, Professor and Chief
University of Utah School of Medicine
50 North Medical Drive 3C120
Salt Lake City, Utah 84132
Phone: (801) 585-1626
Fax: (801) 585-5744
E-mail: inga.journey@hsc.utah.edu

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Relocation packages and signing bonuses are available to qualified candidates interested in practicing in Albuquerque, Raleigh or Rochester, NY.

For more information, call **866.601.5438.**

WAYNE STATE UNIVERSITY
SCHOOL OF MEDICINE

Faculty Positions

THE DEPARTMENT OF OTOLARYNGOLOGY - HEAD & NECK SURGERY
is currently seeking to hire

ACADEMIC OTOLARYNGOLOGISTS

With training and/or interest in either microlaryngology or pediatric surgery

The successful candidates must demonstrate experience and capability. Academic appointment and compensation commensurate with training and experience. Practice income available to augment negotiated salary.

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

Wayne State University is an Equal Opportunity/Affirmative Action Employer

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

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

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

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

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

WestVirginiaUniversity.

The Department of Otolaryngology/Head & Neck Surgery at West Virginia University is seeking a general otolaryngologist to join a thriving academic practice in the summer of 2014 or sooner. Applicants must be board certified/eligible by the American Board of Otolaryngology. Responsibilities include teaching of residents and medical students, patient care and clinical/basic research.

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

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

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

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

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

THE UNIVERSITY OF UTAH

General Otolaryngologist

University of Utah Otolaryngology—Head & Neck Surgery seeks a BC/BE faculty with an interest in general otolaryngology. This is a full-time clinical track position at the Assistant Professor level. Responsibilities will include teaching, research and clinical care in our community clinics. Position available July 2014.

The University of Utah is an Equal Opportunity/ Affirmative Action employer and educator. Minorities, women, and persons with disabilities are strongly encouraged to apply. Veterans preference. Reasonable accommodations provided. For additional information: http://www.regulations.utah.edu/humanResources/5-106.html.

Applicants must apply at:
http://utah.peopleadmin.com/postings/18379
For additional information, contact:
Clough Shelton, MD, FACS, Professor and Chief
University of Utah School of Medicine
50 North Medical Drive 3C120
Salt Lake City, Utah 84132
Phone: (801) 585-1626
Fax: (801) 585-5744
E-mail: inga.journey@hsc.utah.edu

HARVARD MEDICAL SCHOOL

MASSACHUSETTS GENERAL HOSPITAL

3 CLINICAL AND 1 RESEARCH FELLOWSHIP POSITIONS IN LARYNGEAL SURGERY AND VOICE DISORDERS

Massachusetts General Hospital

The Division of Laryngeal Surgery is seeking applicants for clinical and research fellowships. The 3 clinical fellowship positions cover all aspects of laryngeal surgery, voice disorders, and management of the professional voice. The curriculum will provide a wide range of experiences for benign and malignant disease, including phonomicrosurgery (cold instruments and lasers), laryngeal framework surgery, novel operating-room and office-based laser (Pulsed-KTP, Thulium) treatment, complex laryngeal stenosis with aortic homograft transplantation, and the use of botulinum toxin injections for spasmodic dysphonia. The fellow will participate in the management of voice disorders and clinical research as a member of a multidisciplinary team (voice scientists and speech pathologists) that has access to state-of-the-art voice clinic and surgical engineering laboratory facilities. The research fellowship provides numerous opportunities to focus on grant-funded (NIH and private foundations) clinical and basic science research projects in collaboration with interdisciplinary teams of scientists and clinicians at the Massachusetts Institute of Technology and the Wellman Laboratories of Photomedicine at the Massachusetts General Hospital. The option to collaborate with local music conservatories is also available. The research fellowship can possibly be followed by the clinical fellowship. Qualified minority and female candidates are encouraged to apply. Send curriculum vitae and three letters of recommendation. The Massachusetts General Hospital is a teaching affiliate of Harvard Medical School.

ACADEMIC LARYNGEAL SURGEON

Massachusetts General Hospital
Harvard Medical School

The Center for Laryngeal Surgery and Voice Rehabilitation in the Department of Surgery at the Massachusetts General Hospital, a major teaching hospital of Harvard Medical School and Partners HealthCare System, Inc, seeks qualified individuals to apply for the full-time position of laryngeal surgeon. The individual will join an expanding multidisciplinary group of surgeons, scientists, and speech pathologists managing all aspects of laryngeal surgery (benign, malignant, neurogenic, trauma, and stenosis) and voice disorders. He/she will have access to state-of-the-art clinic and operating room facilities, as well as clinical, basic science, and surgical engineering laboratories. We are seeking candidates who are board-certified/eligible by the American Board of Otolaryngology and appropriate for appointment at the Instructor, Assistant Professor, or Associate Professor level. As part of developing an academic career, he/she will participate in grant-funded (NIH and private foundations) clinical and basic science research projects underway in collaboration with interdisciplinary teams of scientists at the Massachusetts Institute of Technology and the Wellman Laboratories of Photomedicine at the Massachusetts General Hospital. The appointee will also participate in the training of clinical and research fellows, as well as teaching medical students of Harvard Medical School.

Massachusetts General Hospital is an equal opportunity employer and is committed to increasing the diversity of its faculty. Qualified minority and female candidates are encouraged to apply.

Send curriculum vitae and three letters of recommendation to:

Steven M. Zeitels, MD, FACS
Eugene B. Casey Professor of Laryngeal Surgery, Harvard Medical School
Director, MGH Center for Laryngeal Surgery & Voice Rehabilitation
One Bowdoin Square, 11th Floor
Boston, MA 02114
Telephone: (617) 726-0218 Fax: (617) 726-0222
zeitels.steven@mgh.harvard.edu

A246

MIDVALLEY ENT & ALLERGY HEARING & BALANCE CENTER FULL OR PART TIME (locums possible)

Beautiful Oregon location with nearby State University and Medical School. Lots of outdoor and cultural amenities within short distances. Busy practice looking to expand. We are looking for a part-time and/or full-time MD/DO ENT to serve a community of over 200,000 population with a referral base from a five-hospital system. Diverse practice includes general ENT with full allergy testing, audiology, vestibular testing, sinus CT machine,and ultrasound. Candidate would be busy from day one. Excellent pay.

Please contact:
Kelly Robertson, Practice Administrator
950 29th Ave SW
Albany, OR 97321
541-967-0404
kdrobertson66@yahoo.com

West Virginia University

The Department of Otolaryngology/Head & Neck Surgery at West Virginia University is seeking a general otolaryngologist to join a thriving academic practice in the summer of 2014 or sooner. Applicants must be board certified/eligible by the American Board of Otolaryngology. Responsibilities include teaching of residents and medical students, patient care and clinical/basic research.

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

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

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

THE UNIVERSITY OF UTAH

Research Scientist

University of Utah Otolaryngology–Head & Neck Surgery seeks candidates for a full-time faculty position in the tenure track. Applicants must have a PhD or equivalent degree and a past record of scholarly publication and extramural funding. Must have active R01 Funding. Research interests in the areas of neurobiology, genetics of inner ear development, hearing or voice preferred. Will also be responsible for education of residents regarding research design, basic statistics and ethics of research. Rank commensurate with experience. Position available immediately.

The University of Utah is an Equal Opportunity/ Affirmative Action employer and educator. Minorities, women, and persons with disabilities are strongly encouraged to apply. Veterans preference. Reasonable accommodations provided. For additional information: http://www.regulations.utah.edu/humanResources/5-106.html.

Applicants must apply at:
http://utah.peopleadmin.com/postings/18375
For additional information, contact:
Clough Shelton, MD, FACS, Professor and Chief
University of Utah School of Medicine
50 North Medical Drive 3C120
Salt Lake City, Utah 84132
Phone: (801) 585-1626
Fax: (801) 585-5744
E-mail: inga.journey@hsc.utah.edu

Southern New England Connecticut

Otolaryngologist/Subspecialty Interests Welcome

ProHealth Physicians is currently seeking an Otolaryngologist to join an established ENT practice in Bristol, Connecticut. Bristol is the home to ESPN and is a suburban community conveniently located 30 minutes from the cities of Hartford/New Haven CT and halfway between New York City and Boston Massachusetts (*2 hours to either city*). The surrounding area has excellent school systems and ample recreational opportunities.

Currently the group has 4 ENT physicians including subspecialists in rhinology and otology. Interest is in a comprehensive otolaryngologist, but complementary subspecialty interests are welcomed. Excellent compensation and benefits package offerings.

Forward CV to Debra Colaci
ProHealth Physician Recruiting
860-284-5333 (Fax)
dcolaci@prohealthmd.com

ProHealth PHYSICIANS

KU MEDICAL CENTER
The University of Kansas

Russell E. Bridwell, MD, Endowed Chair of Otolaryngology
University of Kansas School of Medicine

The Department of Otolaryngology-Head and Neck Surgery at the University of Kansas Medical Center is a top ranked US News and World Report department that has developed a national reputation for educational innovation and has seen an ongoing increase in the number and clinical expertise of its faculty. The University is looking for a dynamic leader who will continue to develop the department's national reputation as a leader in clinical care, the education of students and residents, and clinical and translational research.

The chair of the Department of Otolaryngology-Head and Neck Surgery reports directly to the executive dean of the University of Kansas School of Medicine.

The chair will demonstrate the highest level of personal and professional commitment, enthusiasm, integrity and pride in the university and the department and its values; aligns the vision for the department with the values of the campus and strives to achieve excellence in all aspects of the department's operation. The chair provides leadership, supervision and is accountable to fulfill the education, research, clinical and administrative service missions and values of the department and the school. The chair is responsible for providing a vision and strategic direction for the department, maintains an academically successful, clinically excellent and fiscally sound department.

A complete position description is available at http://www.kumc.edu/kumc-leadership/leadership-searches.html.
The University of Kansas is an EOO employer.

LSUHealthShreveport

Louisiana State University Health Sciences Center in Shreveport is seeking a **Rhinologist/ Skull Base Surgeon** and a **General Otolaryngologist** interested in joining a thriving academic practice within the Department of Otolaryngology/ Head & Neck Surgery. Applicants must be BE/ BC. Responsibilities include teaching of residents/medical students and direct patient care. Clinical and basic science research opportunities are available.

Rhinologist/ Skull Base Surgeon
A unique opportunity to develop a robust practice in rhinology/ skull base surgery in conjunction with our neurosurgery department as there is no fellowship trained rhinologist in northwest LA.

General Otolaryngologist
An excellent opportunity exists for a general otolaryngologist to join our team and participate in all areas of ENT with a particular interest in the areas of allergy and sleep.

Please contact or send CV to:
Cherie- Ann Nathan, M.D., FACS
Professor and Chairman
1501 Kings Highway
Shreveport, LA 71103
cnatha@lsuhsc.edu
318-675-6262
LSUHSC is an AA/EO employer.

UNIVERSITY of VIRGINIA
HEALTH SYSTEM

2 FACULTY POSITIONS
Rhinology and Laryngology
Department of Otolarygology - Head and Neck Surgery

RHINOLOGY - TENURED OR TENURE-ELIGIBLE

This position will be responsible for teaching medical students and residents, participating in rhinology clinical research and providing clinical services in both outpatient and OR settings. Salary, rank and tenure status will be dependent on qualifications and experience. Candidates must have an MD and be board-eligible or board-certified in Otolaryngology as well as have completed a fellowship in rhinology. For consideration for the tenure-eligible position, candidates must have strong clinical skills, as well as documented excellence in patient care, teaching or research. To be considered for the tenured position, candidates must demonstrate scholarship and excellence in two domains consistent with the requirements for tenure in the School of Medicine.

To apply for the tenure-eligible position, visit **https://jobs.virginia.edu** and search on **Posting Number 0610427**. To apply for the tenured position, visit **https://jobs.virginia.edu** and search on **Posting Number 0610468**.

LARYNGOLOGY - TENURE-ELIGIBLE

This tenure eligible position will be responsible for teaching medical students and residents, participating in laryngologic and swallowing disorders research, and providing clinical services in both outpatient and OR settings. This position will also take a lead role in the development of a multi-disciplinary swallowing center. Rank will be dependent on qualifications and experience. Candidates must have an MD and be board-eligible or board-certified in Otolaryngology, as well as have completed a fellowship in laryngology.

To apply, visit **https://jobs.virginia.edu** and search on **Posting Number 0609465**.

For both positions, complete a Candidate Profile online, attach a cover letter, curriculum vitae and contact information for three references. Please also attach a copy of your surgical case log from residency, fellowship or last three years of practice.

Positions will remain open until filled. For further information regarding the application process, please contact: Jennifer Oliver, via e-mail **jmo8n@virginia.edu** or telephone **434-243-3697**.

The University of Virginia is an Equal Opportunity/ Affirmative Action Employer strongly committed to achieving excellence through cultural diversity. The University actively encourages applications and nominations from women, minorities, veterans and persons with disabilities.

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The most advanced, complete earwax removal system from the #1 Doctor Recommended earplug brand.

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HEALTH BEAUTY COSMETICS

TOPS
Friendly Markets

www.macksearplugs.com