bulletin

American Academy of Otolaryngology—Head and Neck Surgery March 2013—Vol.32 No.03

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See the World Voice Day Poster included in this mailing

New

DYMISTA™ for rapid and

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

Indication

Dymista Nasal Spray, containing an H_1-receptor antagonist and a corticosteroid, is indicated for the relief of symptoms of seasonal allergic rhinitis in patients 12 years of age and older who require treatment with both azelastine hydrochloride and fluticasone propionate for symptomatic relief.

Important Risk Information

- Patients may experience somnolence. Caution patients against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery
- Patients should avoid concurrent use of alcohol or other central nervous system (CNS) depressants because additional reductions in alertness and additional impairment of CNS performance may occur
- Because of the inhibitory effect of corticosteroids on wound healing, avoid use in patients with recent nasal ulcers, nasal surgery, or nasal trauma until healed
- Glaucoma, cataracts, and increased intraocular pressure may be associated with nasal corticosteroid use; therefore, close monitoring is warranted in patients with a change in vision and/or with a history of increased intraocular pressure, glaucoma, and/or cataracts
- Patients using corticosteroids may be susceptible to infections and may experience a more serious or even fatal course of chicken pox or measles. Dymista should be used with caution in patients with active or quiescent tuberculosis; fungal, bacterial, viral, or parasitic infections; or ocular herpes simplex
- Systemic corticosteroid effects, such as hypercorticism and adrenal suppression, may occur with very high dosages or at the regular dosage in susceptible individuals. If such changes occur, discontinue Dymista gradually, under medical supervision
- Potent inhibitors of cytochrome P450 (CYP) 3A4 may increase blood levels of fluticasone propionate
- Ritonavir: coadministration is not recommended
- Other potent CYP3A4 inhibitors, such as ketoconazole: use caution with coadministration
- Intranasal corticosteroids may cause a reduction in growth velocity when administered to pediatric patients. Monitor the growth routinely of pediatric patients receiving Dymista
- In clinical trials, the most common adverse reactions that occurred with Dymista Nasal Spray, azelastine hydrochloride nasal spray, fluticasone nasal spray, and vehicle placebo groups, respectively, were dysgeusia (4%, 5%, 1%, <1%), epistaxis (2% for each group), and headache (2%, 2%, 2%, and 1%)
- Pregnancy Category C: based on animal data; may cause fetal harm

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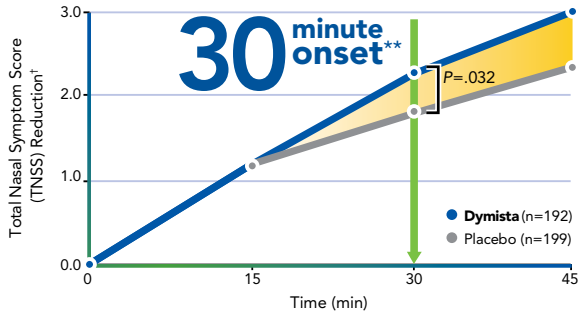
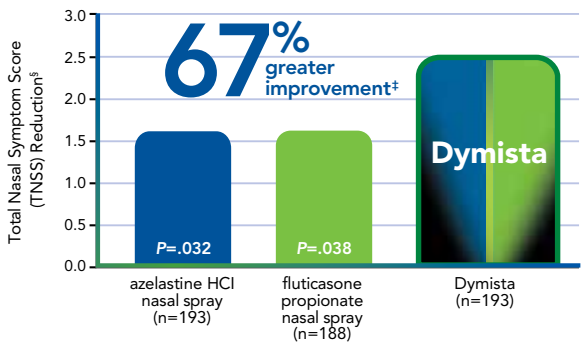
more complete *relief*

from seasonal allergy symptoms

Nasal Symptom Reduction: Statistically Superior at 30 Minutes*[1,2]



Magnitude of Nasal Symptom Relief Relative to azelastine HCl and to fluticasone propionate*[1,2]



Data shown are from study MP 4004. Across the 3 pivotal clinical trials, the improvement with Dymista ranged from 40% to 67% greater relative to the improvement achieved with either comparator.[1,2]

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

**Data shown are from study MP 4004. Onset of action was defined as the first timepoint at which Dymista was statistically superior to placebo in the mean change from baseline in instantaneous TNSS and was sustained thereafter.[1]

†Change from baseline in instantaneous TNSS following administration.[2]

‡Percent difference represents the improvement in TNSS with Dymista relative to azelastine HCl or fluticasone propionate comparator.[2]

§Change from baseline in the placebo-subtracted mean TNSS for each day (maximum score 24), averaged over the 14-day study period.[2]

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

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

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

www.Dymista.com

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

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

1 INDICATIONS AND USAGE

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

5 WARNINGS AND PRECAUTIONS

5.1 Somnolence

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

5.2 Local Nasal Effects

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

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

5.3 Glaucoma and Cataracts

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

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

5.4 Immunosuppression

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

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

5.5 Hypothalamic-Pituitary-Adrenal (HPA) Axis Effects

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

5.6 Use of Cytochrome P450 3A4 Inhibitors

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

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

5.7 Effect on Growth

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

6 ADVERSE REACTIONS

Systemic and local corticosteroid use may result in the following:

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

6.1 Clinical Trials Experience

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

Adults and Adolescents 12 Years of Age and Older

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

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

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

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

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

† Not commercially marketed

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

Long-Term (12-Month) Safety Trial:

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

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

7 DRUG INTERACTIONS

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

7.1 Central Nervous System Depressants

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

7.2 Cytochrome P450 3A4

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

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

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

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Dymista Nasal Spray: Teratogenic Effects: Pregnancy Category C:

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

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

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

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

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

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

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

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

8.3 Nursing Mothers

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

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

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

8.4 Pediatric Use

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

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

8.5 Geriatric Use

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

10 OVERDOSAGE

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

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

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

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

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American Academy of Otolaryngology—Head and Neck Surgery

March 2013—Vol.32 No.03

World Voice Day 2013: Connect with Your Voice

When you really need to connect with people, there is no substitute for the human voice. Connecting is about bringing people or things together and establishing relationships. Pause for a moment and think about how you personally connect with people.

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

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March 2013 | Vol.32 No.03

The *Bulletin* (ISSN 0731-8359) is published monthly by the American Academy of Otolaryngology—Head and Neck Surgery 1650 Diagonal Road, Alexandria, VA 22314-2857.

James L. Netterville, MD, President; David R. Nielsen, MD, Executive Vice President, CEO, Editor, the *Bulletin*; Jeanne McIntyre, CAE, Managing Editor (bulletin@entnet.org); Periodical postage paid at Alexandria, VA, and additional mailing offices. Yearly subscription included in dues of Academy Members: $27 U.S., and $52 International. Nonmembers: U.S. $55 per year; International $65 per year. Allied Health Personnel: $25 per year. Copy deadline: first of preceding month.

Changes of address must reach the Academy four weeks in advance of the next issue date.

POSTMASTER Send address changes to the American Academy of Otolaryngology—Head and Neck Surgery
1650 Diagonal Road, Alexandria, VA 22314-2857
Telephone: 1-703-836-4444.
Member Toll-Free Telephone: 1-877-722-6467.

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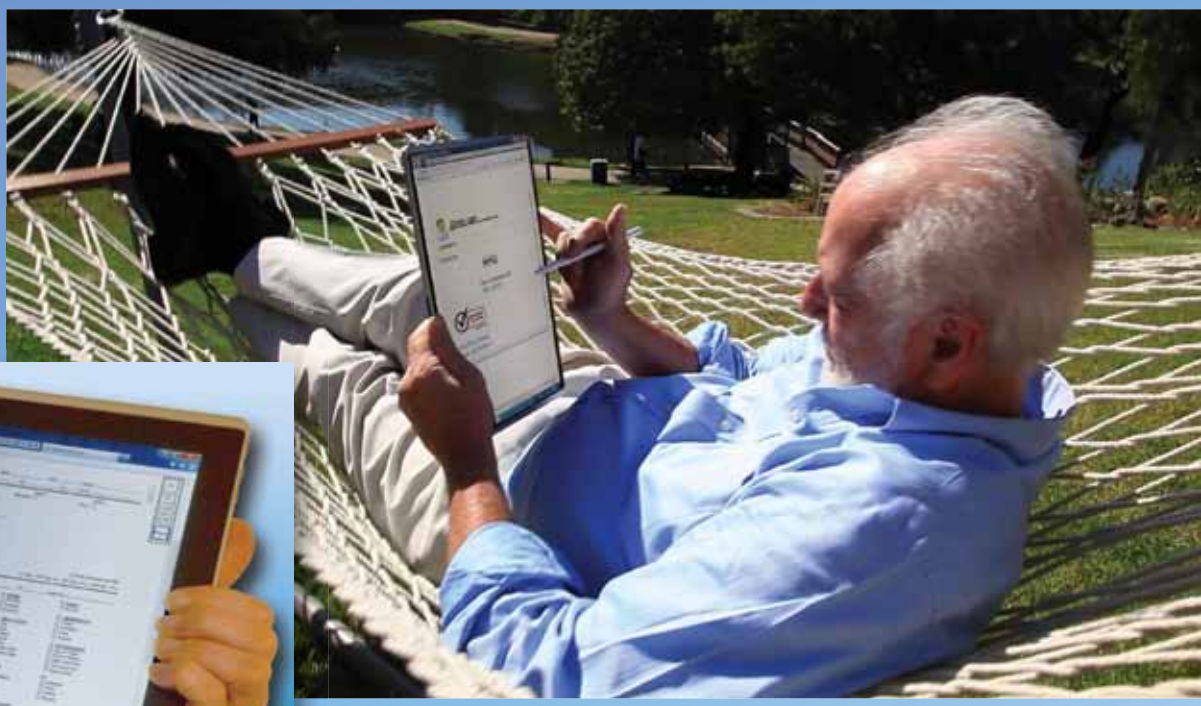

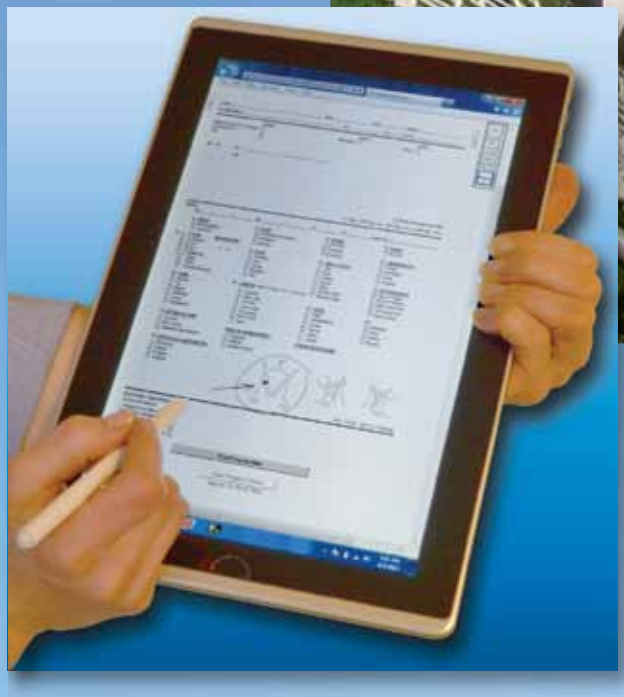

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World Voice Day: Our Efforts Connect Us to the Future

April 16 is coming. Aside from the fact that it is the day after our taxes are due, otolaryngologists should better know the day as World Voice Day. In a Google search of "World Voice Day," the Academy's 2012 campaign material comes up first and second, and our images for the campaign come up third. Following these entries are more than 20 pages of World Voice Day listings from organizations such as the University of Utah, Cleveland Clinic, WBAL News, Johns Hopkins, and the University of Cincinnati with the Cincinnati Opera, as well as international listings from the UK, Brazil, and other international observances. This day is no small deal.

Our Voice Committee, chaired by **Clark A. Rosen, MD**, with the help of **Michael M.E. Johns III, MD,** and **Norman D. Hogikyan, MD,** developed a task force to lead this international observation, and it met during our AAO-HNSF Annual Meeting 2012 & OTO EXPO℠ last September to plan the 2013 and 2014 campaigns. The task force heard about the highly successful observances in France and Belgium, (from **Marc J. Remacle, MD, PhD**) and the country where the observance originated (from **Mario Andrea, MD, PhD**). While it was noted that it is difficult to engage a renowned celebrity for our domestic campaigns due partially to privacy issues, attendees noted that a campaign featuring the importance of voice to all professions would be the approach to take and to build on. The committee then chose "Connect with Your Voice" as its theme this year.

In following that lead, I came upon a blog by Katie Peters, (http://katepeters.com/blog/) a professional speaker. Katie agreed to support World Voice Day 2013 in her blog as she did last year, and she offered this thought on our 2013 theme:

"As humans, we are passionately driven to communicate. We want to be heard. We want to be understood. But to be heard above all the noise of our culture, you must have a voice that others will listen to. There has never been a better time to develop and care for that voice. Resources for study and practice are abundant. Expertise is at an all-time high and instead of taking on less importance as our technology advances, the human voice is more important than ever, adding warmth and humanity to a digital world."

> "As humans, we are passionately driven to communicate. We want to be heard. We want to be understood. But to be heard above all the noise of our culture, you must have a voice that others will listen to."
>
> - Katie Peters

To help members support this observance and promote the special role otolaryngologists play in the treatment of voice disorders, this *Bulletin* offers you some starting tools. You'll find a message about the importance of a healthy voice from committee member **Norm D. Hogikyan, MD**, that may be offered to your patients and referral base prior to the observation. Also included in this issue is a fold-out poster to display in your offices that offers an Academy link (www.entnet.org/HealthInformation/WorldVoiceDay.cfm) for additional information about the campaign. Other materials for outreach have been developed by the Voice Committee and the Media and Public Relations Committee (**Wendy B. Stern, MD**, and **Ramon A. Franco Jr., MD**) and include a template letter to send to local media when you login as a Member.

In conclusion, I offer an example of the power of the voice to move human endeavor.

James Netterville, M.D.

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

The following "interplanetary voicemail" by NASA administrator Charles Bolden was returned to Earth via the Mars rover, Curiosity. The message, which had been sent to Mars and back, was played on Aug. 27, 2012, becoming the first voice transmission from Mars.

"Hello. This is Charlie Bolden, NASA administrator, speaking to you via the broadcast capabilities of the Curiosity rover, which is now on the surface of Mars. Since the beginning of time, humankind's curiosity has led us to constantly seek new life…new possibilities just beyond the horizon." (Hear the actual message at http://www.nasa.gov/mission_pages/msl/news/bolden20120827.html.)

While the message itself is simple, I was struck by the significance of the broadcast as explained by the NASA Curiosity program executive, Dave Lavery, "With this voice, another small step is taken in extending human presence beyond Earth…we hope these words will be an inspiration to someone alive today who will become the first to stand upon the surface of Mars. And like the great Neil Armstrong, they will speak aloud of that next giant leap in human exploration."

Surely, this is a "connection" to the future powered by the human voice.

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How Comparatively Effective Are We?

As everyone knows by now, embedded in the Patient Protection and Affordable Care Act of 2010 (ACA) is language designed to address the unsustainable cost of healthcare in the United States by reducing waste, eliminating unnecessary care, and dealing with the unwanted and unexplained variations in care. One specific method the ACA employs is support for comparative effectiveness research (CER)—defined by the Agency for Health Research and Quality (AHRQ) as research methods "designed to inform healthcare decisions by providing evidence on the effectiveness, benefits, and harms of different treatment options. The evidence is generated from research studies that compare drugs, medical devices, tests, surgeries, or ways to deliver healthcare." [http://effectivehealthcare.ahrq.gov/index.cfm/what-is-comparative-effectiveness-research1/]

The Patient-Centered Outcomes Research Institute (PCORI) was founded within the ACA language specifically for the purpose of providing direction and oversight for an entire spectrum of envisioned comparative effectiveness research that could dramatically and positively influence the decision making of professionals, bring consensus around the most efficient ways of providing high quality care for those conditions and interventions for which there is enough data to support a conclusion, and achieve the three aims of the National Quality Strategy: better individual health outcomes, better population health, and reduced cost of healthcare.

While using this approach to improve quality and resource use is a laudable goal and one that every physician and surgeon can support, the challenge of prioritizing clinical topics, designing relevant and meaningful studies, and acting on what is learned can be complex and daunting. The concept of CER is not new. The medical profession has many years of experience in this approach, but, to date, limited benefit to show from what we have learned. While there are many examples of how such research has improved quality and reduced cost, the promise of CER as envisioned by those who crafted the ACA language remains largely unfulfilled. What are the reasons for this?

A recent article in *Health Affairs* (October 30, 2012) is instructive. After careful study of the literature on many types of CER, the authors conclude that five root causes appear to be responsible for the failure of CER to be translated into positive changes in clinical practice. Misalignment of incentives, ambiguity of results, cognitive biases in interpreting the new information, failure to take into consideration the needs of end users of the data, and limited use of clinical decision support tools all impair the goal of changing clinical behavior. The cognitive biases alone reveal that physicians are not exempt from the powerful effect of traditional behavior and thought processes. As clinicians, the paper discovers, we demonstrate confirmation bias (the effect of believing and acting on that data that supports our pre-conceived notions of what is true); pro-intervention bias (that is, we tend to want to act, rather than to observe or wait, even when the evidence clearly shows that intervention has little or no benefit or may be harmful); and a pro-technology bias (more recent technological advances are superior to existing modalities).

The article concludes that PCORI has learned that multi-stakeholder involvement in CER from design to implementation is essential to minimize the negative effects of these five barriers and three biases to changing clinical practice for the better. The AAO-HNS/F agrees that collaboration is essential, and has made multi-disciplinary engagement in our Guidelines Task Force a hallmark of our published evidence-based guideline development process. Now in its third edition, if you have not read it, please take the time to review the supplement to the January issue of *Otolaryngology–Head and Neck Surgery*. Since learning to eliminate bias, carefully searching for and critically examining data, and being willing to change our clinical practice to achieve better results are all essential to improving quality, we each need to become familiar with relevant health services research and CER and master the ability to implement what we learn.

The particular approach championed by ARHQ and the ACA includes seven distinct steps for optimal implementation:

1. Identify new and emerging clinical interventions.
2. Review and synthesize current medical research.
3. Identify gaps between existing medical research and the needs of clinical practice.
4. Promote and generate new scientific evidence and analytic tools.
5. Train and develop clinical researchers.
6. Translate and disseminate research findings to diverse stakeholders.
7. Reach out to stakeholders via a citizens' forum.

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

Source:

Timbie JW, Fox DS, Van Busum K, Schneider EC. Health Aff (Millwood). Five reasons that many comparative effectiveness studies fail to change patient care and clinical practice. 2012 Oct;31(10):2168-75.

Using Our Voices to Connect on Grassroot Initiatives

Denis C. Lafreniere, MD
Chair, Board of Governors

To promote World Voice Day, April 16, many of our BOG state and local societies have successfully petitioned their state legislators to formally recognize the day. The voice is vitally important to our patients and ourselves as practitioners, allowing us all the ability to communicate, educate, and entertain.

The evolution of our ability to diagnose and treat voice disorders has certainly accelerated during the last several decades. Technological innovations have continually improved our ability to visualize the larynx and measure physiologic functions involved in voice production. Endoscope images with stroboscopic capabilities can now be seen in high definition, making the diagnosis of even the most subtle mucosal abnormality easier than before. Our ability to perform in-office diagnostic and therapeutic procedures has also improved with these technologic advances, and we routinely perform biopsies, laryngeal EMGs, medialization laryngoplasty injections, and laser treatment of laryngeal lesions under local anesthesia.

> "The evolution of our ability to diagnose and treat voice disorders has certainly accelerated during the last several decades."

Perhaps the most congenial development has been that the comprehensive care of the voice-disordered patient has led to a significant partnership between the otolaryngologist, the speech pathologist, and vocal pedagogues. Many voice centers can provide expert evaluation of the functional issues involved in many voice disorders and develop a team approach to the resolution of each patient's voice disorder. This successful collaboration between the otolaryngologist and the allied healthcare provider has required a complete understanding of the roles of each member of the voice care team, which has resulted in the best patient care experience. The ability to work together toward the goal of optimum vocal care ensures that voices will continue to be heard. This metaphor is one that now needs to be applied to the House of Medicine.

Affordable Care Act

As this column is being written, we have just postponed the "fiscal cliff," but still have no definitive answer to the many fiscal questions that desperately need answers such as the upcoming debt ceiling, underfunded entitlement programs, etc. The Affordable Care Act (ACA) is now in full swing with many states still trying to find their way in this new healthcare world. The meaningful use incentives are now in effect and many, if not most, of our practices have implemented electronic medical records as we work to meet the criteria for incentive payments. During the next several years, we will see these incentives turn into penalties for those not on board. The near future will also mean the introduction of quality metrics that will also result in penalties if these parameters are not measured and met. There are many aspects of the ACA that we as your BOG of the AAO-HNS are working to amend to allow us to maintain our ability to take outstanding care of our patients. The legislative arm of the AAO-HNS has been working with our colleagues from the House of Medicine to repeal the Independent Payment Advisory Board (IPAB) from the ACA as it allows payment decisions for medical expenditures to be influenced by non-elected officials. Many fellows of the AAO-HNS signed a "Declaration of Independence" from the flawed Sustainable Growth Rate Formula this past September in Washington, DC. In this document we collectively raised our voices on this particular issue, and we plan to continue this fight during this current legislative session. This is a battle that requires as many voices as we can muster. We, the BOG, are asking for your help!

Denis C. Lafreniere, MD

Spring Meeting and Advocacy Summit

The 2013 BOG Spring Meeting & OTO Advocacy Summit of the AAO-HNS will be taking place May 5-7 in Alexandria, VA. This meeting will immediately follow the Academy's Boards of Directors meeting on May 4. Visits with our individual Members of Congress' offices will take place nearby on Capitol Hill on May 7. I strongly encourage all Academy members, especially our new members and resident members in-training, to invest your time in these meetings. The BOG Spring Meeting will include useful practice information with talks on quality measures, and the changes scheduled to occur with ICD-10. The OTO Advocacy Summit will educate you on current issues being considered on Capitol Hill as we hear from several legislators. We will also discuss talking points for our meetings with our representatives. The stakes for our patients and us as practitioners has never been so high. We need our "voices," both as individuals and as a collective, to be heard loud and clear.

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Choosing Wisely®: Our List of Five Things Physicians and Patients Should Question

A Campaign to Improve the Nation's Healthcare Quality and Safety

On February 21, the American Academy of Otolaryngology—Head and Neck Surgery Foundation (AAO-HNSF) released its list of five things physicians and patients should question as part of the American Board of Internal Medicine (ABIM) Foundation's *Choosing Wisely*® campaign. To date, 25 specialty societies have developed and released lists as part of the initiative.

This month we highlight our five items and provide a set of questions and answers to stimulate discussion of the campaign in your practice and with your patients. Further information about the campaign is available at http://www.entnet.org/choosingwisely and http://www.choosingwisely.org/.

In releasing the list, the AAO-HNSF would like to thank everyone who provided leadership and input during the list's development. In particular, we would like to highlight the role of the Patient Safety and Quality Improvement Committee that spearheaded the AAO-HNSF list development process.

What Is the Choosing Wisely Campaign?

The campaign is an initiative of the ABIM Foundation to help physicians and patients engage in conversations about the overuse of tests and procedures and support physician efforts to help patients make smart and effective care choices. Recognizing the importance of physicians and patients working together, leading specialty societies, along with *Consumer Reports*, have joined the campaign to help improve the quality and safety of healthcare in America.

What Issues Stimulated the Campaign?

As the nation continues to tackle the rising costs of healthcare, it is important for physicians to take a leading role in ensuring patients receive the safest and highest quality of care. According to the ABIM Foundation, "The Congressional Budget Office estimates up to 30 percent of care delivered in the United States goes toward unnecessary tests, procedures, hospital stays, and other services that may not improve people's health—and in fact may actually cause harm." The campaign promotes physicians and patients working together and having conversations about wise treatment decisions.

> Recognizing the importance of physicians and patients working together, leading specialty societies, along with Consumer Reports, have joined the campaign to help improve the quality and safety of healthcare in America.

How Was the List Developed?

The AAO-HNSF's list was developed during a six-month period beginning in May 2012. The Academy's Patient Safety and Quality Improvement Committee spearheaded the list development process.

Choosing Wisely®

An initiative of the ABIM Foundation

Choosing Wisely®

An initiative of the ABIM Foundation

American Academy of Otolaryngology — Head and Neck Surgery Foundation

AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY FOUNDATION

Five Things Physicians and Patients Should Question

1 Don't order computed tomography (CT) scan of the head/brain for sudden hearing loss.

Computed tomography scanning is expensive, exposes the patient to radiation and offers no useful information that would improve initial management. CT scanning may be appropriate in patients with focal neurologic findings, a history of trauma or chronic ear disease.

2 Don't prescribe oral antibiotics for uncomplicated acute tympanostomy tube otorrhea.

Oral antibiotics have significant adverse effects and do not provide adequate coverage of the bacteria that cause most episodes; in contrast, topically administered products do provide coverage for these organisms. Avoidance of oral antibiotics can reduce the spread of antibiotic resistance and the risk of opportunistic infections.

3 Don't prescribe oral antibiotics for uncomplicated acute external otitis.

Oral antibiotics have significant adverse effects and do not provide adequate coverage of the bacteria that cause most episodes; in contrast, topically administered products do provide coverage for these organisms. Avoidance of oral antibiotics can reduce the spread of antibiotic resistance and the risk of opportunistic infections.

4 Don't routinely obtain radiographic imaging for patients who meet diagnostic criteria for uncomplicated acute rhinosinusitis.

Imaging of the paranasal sinuses, including plain film radiography, computed tomography (CT) and magnetic resonance imaging (MRI) is unnecessary in patients who meet the clinical diagnostic criteria for uncomplicated acute rhinosinusitis. Acute rhinosinusitis is defined as up to four weeks of purulent nasal drainage (anterior, posterior or both) accompanied by nasal obstruction, facial pain-pressure-fullness or both. Imaging is costly and exposes patients to radiation. Imaging may be appropriate in patients with a complication of acute rhinosinusitis, patients with comorbidities that predispose them to complications and patients in whom an alternative diagnosis is suspected.

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.

Examination of the larynx with mirror or fiberoptic scope is the primary method for evaluating patients with hoarseness. Imaging is unnecessary in most patients and is both costly and has potential for radiation exposure. After laryngoscopy, evidence supports the use of imaging to further evaluate 1) vocal fold paralysis, or 2) a mass or lesion of the larynx.

Input was sought from Academy and Foundation Committees, the Specialty Society Advisory Council (SSAC), and the Guidelines Task Force (GTF), previously known as the Guidelines Development Task Force. The AAO-HNSF's final list was based on support of the above groups, evidence supporting each of the items (such as clinical practice guidelines), and the current frequency/use of the test or treatment. A more detailed description of the list development process can be found in a commentary in April's edition of *Otolaryngology–Head and Neck Surgery*.

What Resources Are Available?

The ABIM Foundation has made each participating society's list available publicly. In addition, *Consumer Reports* has begun translating the lists into patient education materials. The AAO-HNSF plans to have patient materials available in the coming months. All AAO-HNSF resources related to the campaign can be found at http://www.entnet.org/choosingwisely.

Will the AAO-HNSF Develop Further lists?

Yes, the AAO-HNSF will continue to participate in the campaign and we hope to develop several more iterations of the list. A third phase of specialty societies have agreed to join the campaign and their lists will be released later this year.

Which Specialty Societies Have Participated?

Twenty five specialty societies have participated in the campaign and released lists of five items. The first phase included nine societies that released lists in April 2012, they included:

- American Academy of Allergy, Asthma, & Immunology
- American Academy of Family Physicians*
- American College of Cardiology
- American College of Physicians
- American College of Radiology
- American Gastroenterological Association
- American Society of Clinical Oncology
- American Society of Nephrology
- American Society of Nuclear Cardiology

** Released its second list on February 21, 2013.*

The second phase included 16 new societies, with the following societies releasing their lists alongside the AAO-HNSF:

- American Academy of Hospice and Palliative Medicine
- American Academy of Neurology
- American Academy of Ophthalmology
- American Academy of Pediatrics
- American College of Obstetricians and Gynecologists
- American College of Rheumatology
- American Geriatrics Society
- American Society for Clinical Pathology
- American Society of Echocardiography
- American Urological Association
- Society for Vascular Medicine
- Society of Cardiovascular Computed Tomography
- Society of Hospital Medicine
- Society of Nuclear Medicine and Molecular Imaging
- Society of Thoracic Surgeons

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Continue the *Choosing Wisely*® Conversation: Find AAO-HNSF Updates and Resources 24/7

To help continue to spread the word about *Choosing Wisely*®, visit **www.entnet.org/choosingwisely.cfm**. Here you can find the announcement and formal list of "Five Things Physicians and Patients Should Question." In addition to the list, you will find direct access to the sources from which the list was developed

You can also watch a brief video with AAO-HNSF EVP/CEO David R. Nielsen, MD, that explains the scope and purpose of the campaign and the AAO-HNSF commitment to the effort.

Follow the conversation about the campaign though the Academy's social media sites on Twitter, Facebook, and LinkedIn right from the page. Using the Twitter hashtag #ChoosingWisely will allow you to be part of what the medical community and consumers are saying about the campaign.

Continue the conversation with resources from www.entnet.org/choosingwisely.cfm. Additional resources can be found via the ABIM *Choosing Wisely*® campaign website at www.choosingwisely.org.

Laryngectomy and Laryngeal Cancer: A Fascinating and Inspiring Chapter in the Expansion of Otolaryngology

Valerie A. Fritsch, MD
Medical University of South Carolina, Charleston

Once a universally fatal diagnosis, "epithelioid" carcinoma of the larynx has evolved during the past 150 years into one of the most curable cancers. A historical overview of the diagnosis and surgical management of laryngeal carcinoma shows how this disease became the cornerstone of otolaryngology cancer care.

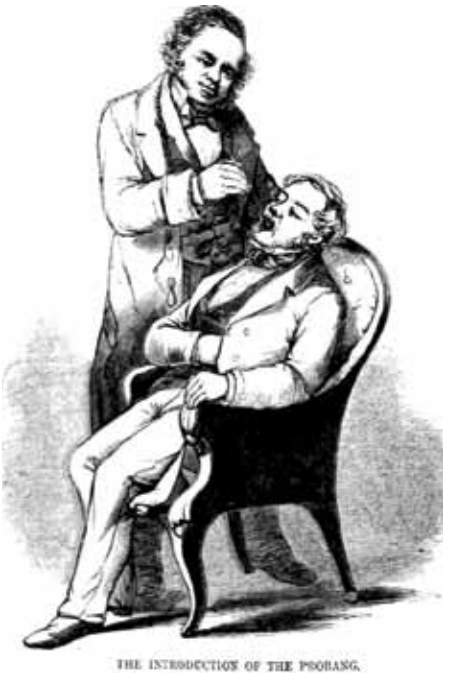
Highlights include important contributions, such as Billroth's first total laryngectomy in 1873, and Gluck and Cohen's modified version (1884), which involved completely separating the trachea and pharynx to reduce the risk of postoperative aspiration. Still, at the turn of the 19th century, operative and peri-operative mortality rates were reportedly as high as 50 percent and the procedure was nearly abandoned. Fortunately, rapid biomedical and technologic advances during that time eventually lifted many of the initial limitations. The evolution of laryngoscopy, tracheostomy, neck dissection, and reconstructive surgery, as well as the availability of antibiotics, endotracheal anesthesia, intravenous access, and blood replacement led to a resurgence of radical surgical extirpation in the 1940s.

The role of otolaryngologists in improving diagnostic techniques and surgical approaches and reconstruction was key. Since the latter half of the last century, efforts have focused on refining more advanced techniques to improve voice and swallowing outcomes, while maintaining or improving oncologic outcomes.

> Once a universally fatal diagnosis, "epithelioid" carcinoma of the larynx has evolved during the past 150 years into one of the most curable cancers.

In addition, an increased understanding of the molecular basis of cancer has catalyzed a significant interest in individualized, targeted therapies.

Although the prognosis of laryngeal carcinoma remains far from "favorable" by today's standards, the astoundingly rapid advances of knowledge and technology by our innovative predecessors illustrates the unbounded potential for future discoveries and improvements in our understanding and management of this complex disease.



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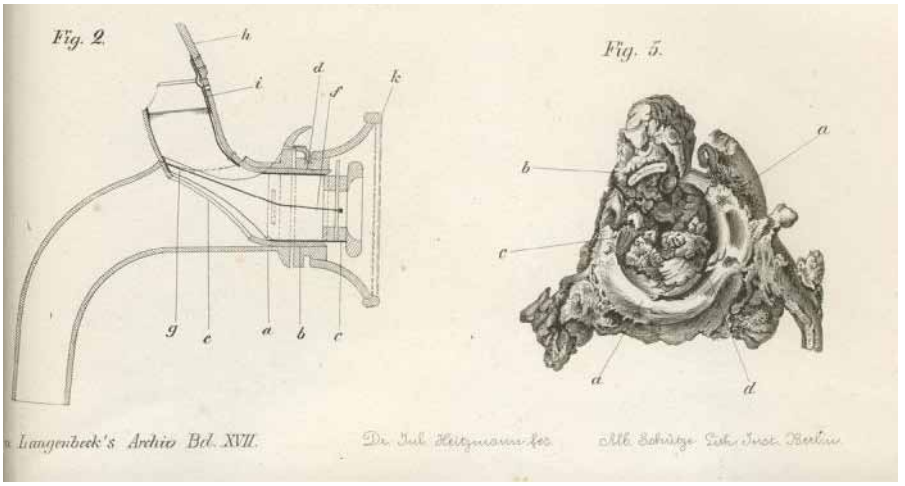

Otolaryngology Historical Society Call for Papers

If you are interested in presenting at the next OHS meeting, which will take place Sept. 30 in Vancouver, BC, Canada, email museum@entnet.org.

To join the society or renew your membership, please check the box on your Academy dues invoice or email Catherine R. Lincoln, CAE, MA (Oxon) at clincoln@entnet.org or call 1-703-535-3738.

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World Voice Day 2013: Connect with Your Voice

Norman D. Hogikyon, MD

When you really need to connect with people, there is no substitute for the human voice. Connecting is about bringing people or things together and establishing relationships. Pause for a moment and think about how you personally connect with people. Sure, you can send emails, texts, tweets, and photos in order to transfer information or data, but are you really making a connection? How often do these methods lead to misunderstandings or misinformation? Have you ever had the experience of needing to speak with someone in order to clarify what was sent in an email or to soothe angry emotions or hurt feelings from a charged message? For most of us, the answer to this question is a definite yes.

The voice conveys a rainbow of emotion and provides a window into an individual's personality and intentions. It is both the choice of words and how the voice sounds that convey

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their true meaning. This is true of the conversational speaking voice, and is elevated to a wondrous level when considering the singing voice. The profound connection and the range of possible emotions that can be elicited by singing are truly without equal. The singing voice is our natural instrument of artistic expression.

> "The voice conveys a rainbow of emotion and provides a window into an individual's personality and intentions. It is both the choice of words and how the voice sounds that convey their true meaning. This is true of the conversational speaking voice, and is elevated to a wondrous level when considering the singing voice."

For 2013 World Voice Day, you can connect with your own voice; establish a rapport with it. This can mean listening to yourself on a whole new level. How do you sound to yourself and to others? Confident or insecure? Kind or inconsiderate? Strong or meek? This can also mean gaining a better understanding of how voice is produced, how to care for it, and how to keep it in optimal shape. The sound-producing structures in your larynx are the vocal folds, or vocal cords. These remarkable little structures vibrate many times a second to generate sounds that are then shaped by other parts of the throat, mouth, and nose. Together they create the instrument that produces speech or song.

As you celebrate World Voice Day 2013, take some time to connect with your own voice and the voices of others and work to be at your vocal best. You can help maintain good vocal health by following a few simple vocal health tips.

Tips for Vocal Health

- Never smoke.
- Keep yourself well hydrated. Water is the best.
- Don't scream or shout. Use a microphone if you need to project your voice.
- Speak in an easy, unstrained voice.
- Rest your voice if you have laryngitis.
- Get evaluated by an otolaryngologist if you have hoarseness that lasts longer than two weeks.

Clip and copy these two pages to share in your community.

The Voice Committee Speaks about Voice

From the AAO-HNS Voice Committee

"I occasionally encounter difficulties with other people accepting my weak voice; sometimes it seems to border on overt discrimination. An example was the attitude I faced when I responded to an invitation to participate in a medical survey, (after repeated skepticism on the part of the survey organization) I completed this interview successfully. On being asked back again to respond to another one (survey), I did the same (completed it), but faced the same initial discrimination as the first time. This experience was an acute reminder that I may always face a harsh reality of potential discrimination based on the quality of my voice."

— Itzhak Brook, MD, MSc

Author, My Voice: A Physician's Personal Experience with Throat Cancer, and the John Conley Medical Ethics Guest Lecturer of the AAO-HNSF 2012 Annual Meeting & OTO EXPO℠ Opening Ceremony.

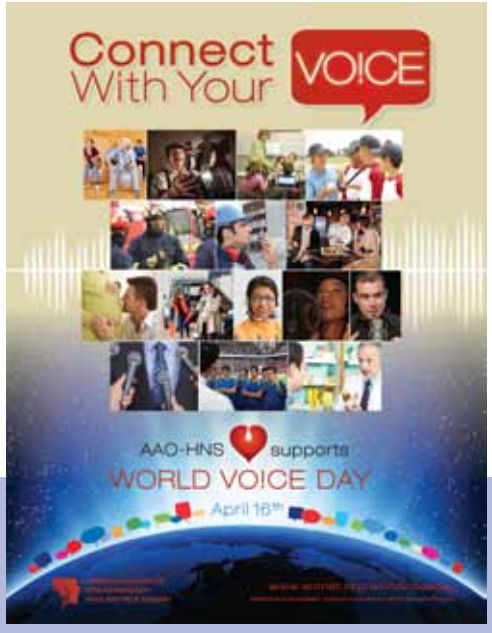
No one is more passionate about the power and frailty of the human voice than those who have lost this functionality, such as the amazing AAO-HNSF John Conley, MD, Guest Lecturer, Dr. Itzhak Brook.

Each year, aside from working to ensure that quality and appropriate patient care is available to all who need it, the 22 people who make up the Academy Voice Committee champion awareness of the importance of caring for the voice through the World Voice Day campaign on April 16.

The theme of this year's campaign, "Connect with Your Voice," is explained on previous pages.

A full-size poster is bound into this *Bulletin* as a member bonus to help you promote this year's campaign. Mount it in areas where patients can learn that otolaryngologists care for voice conditions and care about patients' voice health. The poster also offers access to more health information about the voice at www.entnet.org.

To assist the individual Academy members in outreach activities prior to the campaign in her/his community, several committee members discuss key points about the otolaryngologist's role in voice health by responding to some important questions. The seven committee members were asked to respond to several, but not all the questions. Their responses follow.



See this Member bonus informational poster polybagged with this *Bulletin*.

- **Lee M. Akst, MD**
  Director, Voice Center
  Assistant Professor of
  Otolaryngology-Head and Neck Surgery
  Johns Hopkins Medicine

- **Kenneth W. Altman, MD, PhD**
  Director, Eugen Grabscheid, MD, Voice Center
  Associate Professor of Otolaryngology
  Mount Sinai School of Medicine

- **Seth M. Cohen, MD, MPH**
  Associate Professor of Surgery, Division of
  Otolaryngology-Head and Neck Surgery
  Duke University Medical Center

- **Yolanda D. Heman-Ackah, MD**
  Associate Professor of Otolaryngology
  Drexel University College of Medicine
  Philadelphia Voice Center

- **Norman D. Hogikyan, MD**
  Professor and Director of Vocal Health Center
  Department of Otolaryngology-Head and Neck Surgery
  University of Michigan

- **Libby J. Smith, DO**
  Assistant Professor
  UPMC Voice Center
  University of Pittsburgh

- **VyVy N. Young, MD**
  Assistant Professor
  UPMC Voice Center
  University of Pittsburgh

What is the Role of the Otolaryngologist in Treating Voice Conditions?

Dr. Altman: The role of the otolaryngologist is the medical diagnosis, medical care, and to perform surgical interventions, if needed.

Dr. Akst: Based on history, physical examination, and laryngeal exam, the first role of the otolaryngologist is in accurately diagnosing the nature of the voice problem. Accurate diagnosis then leads to appropriate treatment planning, which might involve some combination of medication, surgery, and voice therapy. The otolaryngologist coordinates this treatment plan, making treatment decisions with the patient that take into account the nature and severity of the voice problem.

Dr. Cohen: The otolaryngologist is the physician with skills in examining the larynx, which is essential for accurately diagnosing voice conditions. The otolaryngologist has an essential role in treating voice conditions as treatment depends on diagnosing the cause.

Dr. Heman-Ackah: The otolaryngologist is a physician who diagnoses, directs, and coordinates treatment of voice problems. He or she works closely with the patient, voice therapists, and voice teachers to help an individual who is having problems with his or her voice to improve the voice.

Dr. Hogikyan: The otolaryngologist is the person who diagnoses and prescribes treatment for patients with voice disorders in order to set them on the path to vocal wellness. Treatment options commonly include medication, voice therapy, or surgery, and multiple approaches are sometimes employed for an individual patient.

Dr. Young: Hoarseness that lasts longer than two weeks is not normal, and a laryngeal examination should be performed to rule out more serious causes of persistent hoarseness. This type of examination, a laryngoscopy, is typically performed by otolaryngologists. More specialized care of voice conditions may be performed by fellowship-trained laryngologists (voice specialists).

Dr. Smith: The otolaryngologist diagnoses the condition for the voice problem. By discussing the cause of the problem, what is occurring functionally, and treatment options, the patient becomes a student of his or her own voice. The voice "team," including the patient, physician, and voice therapist, then works to improve the voice problem.

What New Resources are Available or on the Horizon for Physicians in the Treatment of Voice Problems?

Dr. Altman: We already see greater access to stroboscopy and other high-resolution diagnostic tools, and the advent of clinical practice guidelines defining standards of care (which enhances how we employ a standardized approach to medical and surgical management).

Dr. Heman-Ackah: The biggest resource available for physicians in the treatment of voice problems is laryngeal videostroboscopy. Videostroboscopy provides a magnified view of the vocal folds and allows the otolaryngologist to observe the motion of the vocal folds while they are vibrating. This is an invaluable tool in helping to delineate the cause of an individual's voice problems and is the key to directing treatment.

Dr. Hogikyan: We will more and more be able to translate knowledge acquired through research into active treatments for voice patients. This includes research related to tissue scarring, laryngeal paralysis, and new types of lasers. We also are training an increasing number of laryngologists, and this will make subspecialty voice care more broadly available to patients.

Dr. Akst: One relatively new technology, which helps otolaryngologists care for patients with voice problems, is digital imaging. This technology provides for high quality laryngeal exams. Laryngologists may use videostroboscopy to supplement laryngoscopy, allowing insight into vocal fold function and structure. A variety of new technologies and techniques have allowed for many beneficial procedures to be performed in the office rather than the operating room, including office-based laser therapy, vocal fold injection, transnasal esophagoscopy, and pH probe testing. Taken together, these resources are allowing for ever-greater quality of care to be provided to patients with voice complaints.

Dr. Young: The field of voice-related disorders is ever expanding. We are able to perform more surgical procedures in the office setting, thus avoiding general anesthesia and intubation. This is a significant benefit to patients, in terms of both time- and cost-savings. We are able to treat and improve more complex voice problems, and there are more laryngologists

(voice-specialists) available to treat people with complex voice issues.

Dr. Smith: Real-time imaging of vocal fold physiology is an area of constant improvement. With better visualization, and therefore improved characterization of what is occurring, the otolaryngologist becomes a better diagnostician.

What Would You Like the Healthcare Consumer With a Voice Problem to Know?

Dr. Altman: I would like to tell those with concerns not to delay proper evaluation, and to be aware of risk factors such as tobacco smoking, reflux, and HPV.

Dr. Cohen: Voice problems are common and may be caused by a variety of conditions from benign to neurologic to malignant. They can have a significant impact on patients' ability to communicate, work, function socially, and are treatable. Patients should seek evaluation if symptoms persist more than three weeks.

Dr. Heman-Ackah: As industry and technology require a greater use of the voice on a daily basis for working and communicating, more individuals are experiencing difficulties with their voices. Devices as commonplace as a Bluetooth headset present a unique demand on the vocal folds that most people never had to accommodate before, and many individuals are experiencing vocal problems in numbers that did not previously exist. Voice problems today are the 21st century version of carpel tunnel syndrome from the 1980s and 1990s. Many voice problems are the direct result of repetitive use of the vocal folds and occur from repetitive vocal fold injury.

Dr. Hogikyan: I feel that there are two key items here: 1. Hoarseness or voice change can be a sign of a serious problem and should be evaluated by an otolaryngologist if it is persistent (longer than about two weeks can be considered persistent), and 2. Most voice problems can be helped so don't just accept hoarseness without pursuing treatment by a specialist.

Dr. Akst:

- Voice quality is an important part of how we present ourselves to others and how we are perceived by others.
- Voice problems are a very common source of work-related difficulties, especially as more jobs depend on verbal communication.
- Voice disorders need not be "accepted as normal"—very often, there are things that can be done to diagnose and treat voice problems.
- Diagnosis and treatment for voice disorders should involve an otolaryngologist with experience in working with voice patients.

Dr. Young: Many voice disorders can be improved with proper treatment. Evaluation by an otolaryngologist (or laryngologist) is invaluable. Hoarseness does not need to be simply "tolerated." The most important message is that persistent hoarseness is not normal, and laryngeal examination should be performed to rule out more serious underlying causes, such as cancer.

Dr. Smith: There are dedicated otolaryngologists/laryngologists and voice therapists who want to help. We realize that voice is often a reflection of self, especially for the professional voice user (singer, preacher, teacher, etc). But, the quality of life related to voice is just as important for non-professional voice users, as it allows us to communicate with friends and family, conduct our jobs, and sing.

> "Each year, aside from working to ensure that quality and appropriate patient care is available to all who need it, the 22 people who make up the Academy Voice Committee champion awareness of the importance of caring for the voice through the World Voice Day campaign on April 16."

How Does the Observation of World Voice Day Benefit the Public?

Dr. Altman: It raises awareness for the working public, but also helps expand the limits of care we provide for voice professionals.

Dr. Cohen: By promoting awareness of how vital the voice is to our everyday life, awareness of resources if problems do arise, and discussing prevention in order to keep the voice healthy. The voice is often taken for granted until its function becomes compromised.

Dr. Heman-Ackah: Observation of World Voice Day helps to bring awareness of the fact that hoarseness and vocal fatigue are medical problems that can be treated medically and successfully. It helps the general public understand that there is something that can be done to help when one is experiencing difficulties with the voice, and it brings awareness to the fact that voice problems are occupational health issues that contribute to significant disability and absences from work.

Dr. Young: So many people use their voices extensively in their day-to-day life (work, home, etc.) and yet most people don't think about their voice or how to care for their voice properly. World Voice Day is a wonderful opportunity to bring awareness to this supremely important, but often overlooked, ability. Many people with voice problems or difficulties think that hoarseness should just be tolerated or that it will go away on its own. World Voice Day is a great time to remind people that persistent hoarseness is not normal and should be investigated further!

Dr. Smith: By placing a spotlight on the importance of voice in all realms of society, we hope that people with hoarseness will seek help. Whether hoarseness is caused by cancer or a non-cancerous process, voice does matter.

Dr. Akst: By increasing awareness that vocal difficulty is a medical condition that can be evaluated and treated, we help the public understand that they can be helped.

Dr. Hogikyan: It reminds us of the importance, power, and beauty of the human voice. Educational outreach efforts related to World Voice Day help educate the public about how to maintain good vocal health and when to seek an otolaryngology evaluation.

Can You Give an Example of How Use of Your Voice has Helped You to Connect With Others?

Dr. Altman: The voice is a window to the soul, and conveys emotion on top of the words that are communicated.

Dr. Cohen: I feel most connected when speaking with my patients, reading to my children.

Dr. Heman-Ackah: I use my voice on a daily basis to teach both patients and students. My voice is the essence of my ability to impart information to others.

Dr. Hogikyan: I think about this every day when I interact with patients. Particularly when people come to see me about a serious health problem, the voice I use in the clinic is vital to letting the patient know I care and that I will take care of them; the voice establishes our doctor-patient connection.

Dr. Young: As a physician, I spend all day talking to my patients. I am able to connect with them, communicate with them, and educate them. Every day, I describe to my patients the findings of their laryngeal exam, what it means, and what we will do next to address their voice problem. I absolutely could not do my job if I didn't have my voice.

And I know that there are many other jobs for which this is also true. Some of these are obvious (teachers, call center workers, lawyers, radio and television personnel) and some are less evident (cashiers, secretaries, nurses, flight attendants). For most people, if they stop to ask themselves if they could still do their job if they didn't have a voice, the answer would be "no."

Dr. Smith: As a laryngologist, I speak with patients all day. They know I care about their voice, much like they do. Through the connection of talking and singing with patients, their knowledge about voice improves. This allows them to "own" their voice. Together with the voice "team," their voices are heard.

Dates to Remember

March 15
Call for Editor in Chief. Contact ecavanagh@entnet.org.

April 15
International Travel Grant application deadline.
Email international@entnet.org.

April 16
World Voice Day

April 14-20
Oral Head and Neck Cancer Awareness Week

May 1
International Visiting Scholars application deadline.
Email international@entnet.org.

May 5-7
BOG Spring Meeting & OTO Advocacy Summit.
Learn more at www.entnet.org/bog&summit.

May 15
Otolaryngology Historical Society submissions deadline.
Email museum@entnet.org.

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AcademyU® Connects You to Online Learning Options for Voice Disorders

The Foundation's comprehensive otolaryngology education source, contains hundreds of learning options presented in a variety of formats to complement different learning styles. Developed by leading expert volunteers, the materials are designed to deliver relevant education that is meaningful to your practice.

In recognition of World Voice Day, a list of online lectures addressing issues related to voice disorders is included below:

- Phonomicrosurgery for Benign Pathology
  Steven M. Zeitels, MD
- Phonosurgery: What to Do and What to Avoid, Laser and Cold Instruments
  Jean Abitbol, MD
- Professional Singers: The Science and Art of Clinical Care
  Robert Thayer Sataloff, MD
- A Diagnostic Model for Voice Disorders
  Robert W. Bastian, MD
- Vocal Fold Injection: Fact, Fiction, and Material Selection
  Clark A. Rosen, MD
- New Lasers: Office and OR, Fiber Cutting and Pulsed Angiolysis
  Steven M. Zeitels, MD
- Vocal Nodules, Polyps, and Cysts: Diagnosis and Current Treatment
  Clark A. Rosen, MD
- Presbyphonia
  Michael M. E. Johns III, MD
  Edie Renee Hapner, PhD

Online Lectures are based on annual meeting instruction courses of the same name. Each lecture provides the highlights of these key sessions.

OCL
Online Courses and Lectures

The Foundation's complete library of online courses and lectures can be found at www.entnet.org/onlinecourses.

DRY NASAL ALLERGY SPRAYS
Return as a treatment option

Into the 1990's dry-formula intranasal steroid (INS) sprays comprised nearly 30% of the nasal allergy market.[1] And then, poof, they were gone. What happened? Many physicians had come to rely on them, including Eli Meltzer, MD, of the Allergy & Asthma Medical Group & Research Center in San Diego, California. "Many clinicians prescribed those corticosteroid nasal aerosol sprays more often than some other medications we had at that time."

The Montreal Protocol brought an end to the dry spray

The problem with the dry sprays was their propellant—chlorofluorocarbon (CFC). CFCs are known to be an ozone-depleting substance (ODS) and harmful to the environment.[2] The "Montreal Protocol on Substances that Deplete the Ozone Layer" is an important international environmental treaty under which the US agreed to phase out the production and importation of ODSs. An exception to this rule was medical products that were determined to be "medically essential."[3] Many asthma and chronic obstructive pulmonary disease (COPD) products fell into this category but nasal allergy sprays did not—and as of January 1, 1996, non-medically essential products could no longer be manufactured.[2,4]

Wet sprays attempted to fill the treatment void

With dry formula sprays no longer an option, doctors sought other solutions for their patients. "You can only use what you have available," said Dr. Meltzer. "On a personal level I preferred the aerosols, but they became less and less available, so we switched to the aqueous corticosteroid sprays, and they were effective." To this day, aqueous nasal sprays are a valuable treatment option for many patients. However, they are not without their issues.

> "On a personal level I preferred the (dry) aerosols, but they became less and less available..."
>
> ***ELI MELTZER, MD***

NASAL study revealed patient dissatisfaction

In 2010, a landmark survey of allergic rhinitis patients and their physicians was conducted to assess how well patients were being managed.[5] The National Allergy Survey Assessing Limitations (NASAL) revealed that many patients were dissatisfied with their current medication. Over 60% of surveyed patients who had used an INS spray in the past year reported that they experienced "medication drip back down the throat." Additionally, just over 18% of patients reported that they experienced "discomfort from spray." Nearly 1 in 5 nasal allergy sufferers asked their doctor to change their INS spray. Of those patients, 28% cited "bothersome side effects" as the cause of their dissatisfaction.

Dry sprays make a welcome return

In time, researchers developed a new, environmentally friendly aerosol propellant.[2] This was welcome news for physicians like Dr. Meltzer: "We were very pleased when HFA (hydrofluoroalkane) asthma inhalers became available and we encouraged the pharmaceutical companies to develop them for nasal allergy treatment. It's nice to say that we now have a couple of dry spray options. I liked them when they were first available, I preferred them when I had access to both the aqueous and the aerosol, and I still prefer them today." Many patients may also agree. "There are patients who prefer one over the other, and it's important to individualize treatment. I consider the dry sprays for patients who have a great amount of nasal drainage or blockage, or for patients who prefer something that doesn't have sensory attributes," said Dr. Meltzer.

References: 1. IMS Health Incorporated. Danbury CT. Monthly Rx data; 1996-2011. **2.** US Environmental Protection Agency. Metered dose inhalers: the transition to ozone-safe propellants. http://www.epa.gov/ozone/title6/downloads/mditransition.pdf. Updated September 28, 2011. Accessed December 20, 2012. **3.** US Environmental Protection Agency. Montreal Protocol: regulatory summary. http://www.epa.gov/ozone/downloads/MP20_Reg_Summary.pdf. Updated September 28, 2011. Accessed December 20, 2012. **4.** US Department of Health and Human Services, US Food and Drug Administration. Use of ozone-depleting substances; essential use determinations. In: *Federal Register.* 1999;64(169). Washington, DC: US Department of Health and Human Services. **5.** Fromer LM, Ortiz G, Ryan SF, Stoloff SW. Insights on allergic rhinitis from the patient perspective. *J Fam Pract.* 61(2)(suppl 1):S16-S22.

TEVA Respiratory

BOG & OTO

Board of Governors SPRING MEETING

Otolaryngology ADVOCACY SUMMIT

2013 Board of Governors Spring Meeting & OTO Advocacy Summit

May 5 – 7, 2013

Embassy Suites Alexandria – Old Town Hotel
1900 Diagonal Road, Alexandria, VA 22314

Online Registration at www.entnet.org/bog&summit

Contact information:

First Name (Please Print) _____ MI _____ Last Name _____ Member ID# _____

Home Address _____ Apt. _____ City/State/Zip _____

Daytime Phone _____ Mobile Phone (optional) _____ Fax _____ Email _____

Do you have any special physical, dietary (for example, vegetarian, kosher), or other needs? ☐ YES ☐ NO

If yes, please describe _____

Agenda *(tentative)*:

BOARD OF GOVERNORS SPRING MEETING

Sunday, May 5, 2013

Registration Opens	**9:00 AM – 4:30 PM**
☐ Ice-Breaker Event	**10:00 AM – 10:55 AM**
☐ BOG Rules & Regulations Committee Meeting	**11:00 AM – 12:00 PM**
☐ Luncheon/Media Training	**12:05 PM – 1:00 PM**
☐ BOG Socioeconomic & Grassroots Committee Meeting	**1:05 PM – 2:55 PM**
☐ BOG Legislative Representatives Committee Meeting	**3:05 PM – 4:20 PM**
☐ BOG Executive Committee (*by invitation only*)	**4:25 PM – 5:20 PM**

Monday, May 6, 2013

Registration Open	**7:00 AM – 12:00 PM**
☐ SRF Governing Council (*by invitation only*)	**7:00 AM – 8:00 AM**
☐ Society Information Sharing	**7:30 AM – 8:25 AM**
☐ Keynote Speaker, Dr. Rahul K. Shah	**8:30 AM – 9:30 AM**
☐ BOG General Assembly	**9:40 AM – 12:00 PM**
☐ BOG Luncheon Speaker, Wendy L. Kroll, JD	**12:00 PM – 1:00 PM**
☐ WIO Governing Council (*by invitation only*)	**5:40 PM – 6:30 PM**

OTO ADVOCACY SUMMIT

Sunday, May 5, 2013

☐ ENT PAC Reception (Ticket Required)	**6:00 PM – 8:00 PM**

Monday, May 6, 2013

☐ Advocacy Briefing	**1:15 PM – 2:30 PM**
☐ Congressional Speakers	**2:45 PM – 5:00 PM**

Tuesday, May 7, 2013

☐ Hill Visit Q&A	**7:00 AM – 8:00 AM**
☐ Pre-Scheduled Congressional Visits	**9:30 AM – 2:30 PM**
☐ De-Briefing/Lunch*	

*AAO-HNS Capitol Hill Office, Washington DC

IMPORTANT NOTES:

- **Attendance is a FREE AAO-HNS Member Benefit!**
- **AAO-HNS staff will schedule your Capitol Hill visits.**
- **Transportation provided to Capitol Hill.**
- **Please plan flight departures NO EARLIER than 4:00 PM on Tuesday, May 7, 2013.**

Hotel Accommodations:
Hotel Reservations can be made separately at the Embassy Suites Alexandria–Old Town Hotel in the group block named **AAO BOG Spring Meeting & OTO Advocacy Summit.** Our group has rooms available from May 3 - May 7, 2013. Reservations made in this block will receive a special rate of $189++single/double per night. Housing deadline is April 8, 2013. To make reservations, please visit www.entnet.org/bog&summit.

Send Completed Registration Form to: AAO-HNS Member Services 1650 Diagonal Rd, Alexandria, VA 22314 or Fax to 703-684-4288.

AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY

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Why You, Dr. OTO-HNS, Should Go to Washington in May

Kristina E. Hart, MD
Women in Otolaryngology Section Historian

For years, like many of you, I've been reading about the past JSAC meetings, the BOG Spring Meeting, and more recently, the combined BOG Spring Meeting & OTO Advocacy Summit. One only has to open the monthly *Bulletin* or read ones email to see that our Academy staff and an equally dedicated contingent of our membership are diligently working on our behalf to ensure that our specialty remains at the forefront of continuing education, innovation, policymaking, and reimbursement, and that our collective healthcare concerns as otolaryngologists-head and neck surgeons are being heard. So, why attend this meeting?

The informative, yet necessarily abbreviated, "sound bites" in our news media and our Academy's publications have long inspired me to gain a better understanding of the politics that affect how we practice medicine. The idea of being an advocate for our specialty did seem daunting, but curiosity and a desire to participate overcame intimidation and distance. I am so glad that I finally attended the 2012 BOG Spring Meeting & OTO Advocacy Summit, and I intend to make the trip again.

As with many things, being there was far more interesting than reading about it. It was highly energizing to be surrounded by fervent and knowledgeable AAO-HNS members including residents, who form the nucleus of the Academy's grassroots efforts. They, together with a broad network of ENT PAC supporters, put their money where their mouths are and work to change what we all find unacceptable for our practices and our patients. Our elected lawmakers could learn something about working together by watching our Academy members rally around common objectives regardless of personal political affiliation.

My initial concerns about preparedness for meetings with Congressional staffers quickly evaporated thanks to the well-organized advocacy preparation provided by our talented Government Affairs (GA) team. By reviewing and discussing our issue-specific talking points, we were quickly prepared to present a unified voice on Capitol Hill. Truly, who better than we—the constituents in the trenches—to advocate for our specialty?

You've heard terms like "individual mandate" and "severability," but do you really know what these mean? What does insurance have to do with the Commerce Clause of our Constitution? What does the 10th amendment have to do with healthcare reform? The answers to these questions were among many illuminating and relevant facts that were expounded upon during this meeting. We also learned about the Capitol Hill version of "TIA" among many other acronyms and definitions. "Truth in Advertising" or the "Healthcare Truth and Transparency Act," is legislation designed to help distinguish medical doctors from those who have doctorates in other health-related fields.

One of the primary talking points was the repeal of the Sustainable Growth Rate (SGR) formula. What does the SGR have to do with our practices and us? Though illogical, more than a decade ago, the SGR was tied to the Gross Domestic Product and incorporated in a formula to calculate physician payment for Medicare services. This formula fails to accurately estimate the actual present day cost of practicing medicine. It must be repealed and replaced with a more appropriate barometer of the "real time" cost of providing healthcare.

Why should we care what issues lurk behind the acronyms of today's healthcare realities? Because, as students, we've invested many years continually training in our profession to do what is best for our patients. We have an instinct for self-preservation; no one else is likely to be as interested in, or as informed about, developing policies favorable to our patients and our profession as we are. We work hard to be effective communicators and to support effective communication among our patients through prevention and treatment of hearing and phonatory disorders.

We're also educators. A staffer's questions regarding her niece's tympanostomy tubes during discussion of the Congressional Hearing Health Caucus afforded me both a teaching moment and a perfect segue to inviting this senator's team to seek me as a subject-matter expert on other specialty-specific topics. Our nation's leaders can only represent us effectively if we communicate with them on a regular basis.

We are citizens. In addition to having a responsibility to vote, we cannot complain about unfavorable outcomes if we are not part of the team that ensures implementation of sound policies. Freedom is not free. People from many nations are losing their lives for an opportunity to speak freely and choose their leadership. We are fortunate to already have a system in place that makes advocacy without fear of retribution possible.

Our efficient GA team works hard to identify issues that may or will impact the work we do every day. While we each have the freedom to independently meet with our legislators, attendance at the Spring BOG Meeting & OTO Advocacy Summit creates myriad opportunities to a.) collaborate with colleagues; b.) hear from passionate, knowledgeable "insiders;" c.) participate in lively conversations with the Board of Governors on issues that directly affect our specialty; and stand united with our colleagues on Capitol Hill.

I've barely scratched the surface of understanding all the intricacies of these policies and proposals, but I left Washington DC, more motivated than ever to continue my political education and advocate for our specialty. The meeting reaffirmed my conviction that as imperfect as our nation's political system is, our forefathers had an ingenious idea. We ought to take advantage of it. Please attend this year's meeting, Sunday, May 5 through Tuesday, May 7.

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AAO-HNS ACADEMY ADVANTAGE

As of March 1, 2013

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New Trend: Increased FTC Involvement in State Professional Boards

In recent months, the Federal Trade Commission (FTC) has become more involved in the states' rulemaking process by increasing its antitrust examination of state professional board actions, particularly board decisions and regulations, state legislation relating to scope of practice. These antitrust examinations by the FTC reportedly are to promote and protect competition by prohibiting agreements that unreasonably restrict trade. However, concerns about this increased involvement exist, and the American Medical Association (AMA) with the Scope of Practice Partnership (SOPP), which the AAO-HNS is a member of, are closely monitoring and addressing the FTC's inappropriate involvement as it arises.

The new trend by the FTC threatens patient safety and the structure of determining what is appropriate within a professional's scope of practice. Scope of practice guidelines are typically determined by the legislature and state professional boards. These methods help to ensure that unqualified practitioners are not rendering services they are not trained to perform. There is concern that the FTC's involvement will discourage state boards and state legislatures from engaging in defining appropriate scope of practice guidelines for fear of potential antitrust lawsuits.

The FTC recently has taken action in the form of letters and enforcement actions directed at state boards and state legislators. The FTC has issued several letters urging state boards to reject, or more thoroughly analyze, regulations that could potentially affect competition. One of the first examples of the FTC becoming more involved with state boards was a letter in 2010 that was sent to the Alabama State Board of Medical Examiners (ASBME). The FTC encouraged the board to reject a regulation that would prohibit non-physician professionals from providing advanced interventional pain management services, noting it would adversely affect competition. This letter was sent to the ASBME without any studies or evidence indicating this to be true. Although the FTC did not directly threaten to bring an antitrust action, the letter itself provided enough of a threat. The effect of the letter on the ASBME resulted in the board immediately ceasing activity on the proposed regulation. Since the letter to the ASBME in 2010, the FTC has reached out to legislators and state boards in Florida, Kentucky, Louisiana, Missouri, Tennessee, and Texas, where it commented on bills to regulate providers of interventional pain management procedures and proposed regulations to expand the scope of practice of nurses.

Some of the FTC's activity in the states has morphed into enforcement actions. In North Carolina, the State Board of Dental Examiners was attempting to approve a regulation that would prohibit non-dentists from providing teeth-whitening services, which the board had determined constituted the practice of dentistry. The FTC issued an order directing the board to stop regulating teeth-whitening, alleging that the board was harming competition by blocking non-dentists from providing the services. The case is currently awaiting consideration in the U.S. Court of Appeals.

The AMA and the SOPP have made progress toward working with the FTC to address the over-involvement of the FTC with state boards and state legislatures. The FTC letters that are now distributed no longer attempt to make clinical judgments. Instead, disclaimers have been added outlining that FTC staff members are not subject-matter experts on clinical or patient safety issues and are not offering advice on such issues. Furthermore, the FTC has now acknowledged that "certain professional licensure requirements are necessary to protect patients." The FTC has also agreed to work with the states by reaching out to state medical associations before drafting letters.

The AAO-HNS, the AMA, and others in the physician community are concerned that these actions by the FTC will prevent state legislatures, regulators, and medical boards from performing their duties and enacting legislation, proposing regulation, or other actions to protect patient safety for fear of reprisal and antitrust liability. The AAO-HNS will continue to work with the AMA and the SOPP as this issue progresses and advocate where necessary. For more information, email AAO-HNS State Legislative Affairs at legstate@entnet.org. In addition, to receive timely updates on state, federal, or grassroots initiatives, AAO-HNS members are encouraged to join the ENT Advocacy Network—a free member benefit. To join, email govtaffairs@entnet.org.

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

Long-Term 52-Week Safety Trial: In a 52-week placebo-controlled long-term safety trial in patients with PAR, 415 patients (128 males and 287 females, aged 12 to 74 years) were treated with QNASL Nasal Aerosol at a dose of 320 mcg once daily and 111 patients (44 males and 67 females, aged 12 to 67 years) were treated with placebo. Of the 415 patients treated with QNASL Nasal Aerosol, 219 patients were treated for 52 weeks and 196 patients were treated for 30 weeks. While most adverse events were similar in type and rate between the treatment groups, epistaxis occurred more frequently in patients who received QNASL Nasal Aerosol (45 out of 415, 11%) than in patients who received placebo (2 out of 111, 2%). Epistaxis also tended to be more severe in patients treated with QNASL Nasal Aerosol. In 45 reports of epistaxis in patients who received QNASL Nasal Aerosol, 27, 13, and 5 cases were of mild, moderate, and severe intensity, respectively, while the reports of epistaxis in patients who received placebo were of mild (1) and moderate (1) intensity. Seventeen patients treated with QNASL Nasal Aerosol experienced adverse reactions that led to withdrawal from the trial compared to 3 patients treated with placebo. There were 4 nasal erosions and 1 nasal septum ulceration which occurred in patients who received QNASL Nasal Aerosol, and no erosions or ulcerations noted in patients who received placebo. No patient experienced a nasal septum perforation during the trial.

6.2 Postmarketing Experience

In addition to adverse reactions reported from clinical trials for QNASL Nasal Aerosol, the following adverse events have been reported during use of other intranasal and inhaled formulations of beclomethasone dipropionate. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure. These events have been chosen for inclusion due to either their seriousness, frequency of reporting, or causal connection to beclomethasone dipropionate or a combination of these factors.

Intranasal beclomethasone dipropionate: Nasal septal perforation, glaucoma, cataracts, loss of taste and smell, and hypersensitivity reactions including anaphylaxis, angioedema, rash, and urticaria have been reported following intranasal administration of beclomethasone dipropionate.

Inhaled beclomethasone dipropionate: Hypersensitivity reactions, including anaphylaxis, angioedema, rash, urticaria, and bronchospasm have been reported following the oral inhalation of beclomethasone dipropionate.

7 DRUG INTERACTIONS

No drug interaction studies have been performed with QNASL Nasal Aerosol.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Teratogenic Effects: Pregnancy Category C

There are no adequate and well-controlled clinical trials in pregnant women treated with QNASL Nasal Aerosol. Beclomethasone dipropionate was teratogenic and embryocidal in the mouse and rabbit although these effects were not observed in rats. QNASL Nasal Aerosol should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Experience with oral corticosteroids since their introduction in pharmacologic, as opposed to physiologic, doses suggests that rodents are more prone to teratogenic effects from corticosteroids than humans.

Beclomethasone dipropionate administered subcutaneously was teratogenic and embryocidal in the mouse and rabbit at doses approximately twice the maximum recommended human daily intranasal dose (MRHDID) in adults (on a mg/m^2 basis at maternal doses of 0.1 and 0.025 mg/kg/day in mice and rabbits, respectively). No teratogenicity or embryocidal effects were seen in rats at approximately 460 times MRHDID (in adults on a mg/m^2 basis at a maternal inhalation dose of 15 mg/kg/day).

Non-teratogenic Effects: Hypoadrenalism may occur in infants born of mothers receiving corticosteroids during pregnancy. Such infants should be carefully monitored.

8.3 Nursing Mothers

It is not known whether beclomethasone dipropionate is excreted in human breast milk. However, other corticosteroids have been detected in human breast milk and thus caution should be exercised when QNASL Nasal Aerosol is administered to a nursing mother.

8.4 Pediatric Use

The safety and effectiveness for seasonal and perennial allergic rhinitis in children 12 years of age and older have been established. Controlled clinical trials with QNASL Nasal Aerosol included 188 adolescent patients 12 to 17 years of age *[see Clinical Studies (14)]*. The safety and effectiveness of QNASL Nasal Aerosol in children younger than 12 years of age have not been established.

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

A 12-month, randomized, controlled clinical trial evaluated the effects of QVAR®, an orally inhaled HFA beclomethasone dipropionate product, without spacer versus chlorofluorocarbon-propelled (CFC) beclomethasone dipropionate with large volume spacer on growth in children with asthma ages 5 to 11 years. A total of 520 patients were enrolled, of whom 394 received HFA-beclomethasone dipropionate (100 to 400 mcg/day ex-valve) and 126 received CFC-beclomethasone dipropionate (200 to 800 mcg/day ex-valve). When comparing results at month 12 to baseline, the mean growth velocity in children treated with HFA-beclomethasone dipropionate was approximately 0.5 cm/year less than that noted with children treated with CFC-beclomethasone dipropionate via large volume spacer. The potential growth effects of prolonged treatment should be weighed against the clinical benefits obtained and the risks/benefits of treatment alternatives.

The potential for QNASL Nasal Aerosol to cause reduction in growth velocity in susceptible patients or when given at higher than recommended dosages cannot be ruled out.

8.5 Geriatric Use

Clinical trials of QNASL Nasal Aerosol did not include sufficient numbers of subjects aged 65 years and older to determine whether they responded differently than younger subjects. Other reported clinical experience has not identified differences in responses between the elderly and younger patients. In general, administration to elderly patients should be cautious, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy.

10 OVERDOSAGE

Chronic overdosage may result in signs/symptoms of hypercorticism *[see Warnings and Precautions (5.5)]*. There are no data available on the effects of acute or chronic overdosage with QNASL Nasal Aerosol.

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What Are RUC Surveys and Why Should They Matter to Me?

As an Academy member, you've probably seen frequent requests distributed in "The News" asking for volunteers for upcoming AMA Relative Value Scale Update Committee (RUC) surveys of physician services. Many of you may have asked yourself, "what the RUC is and why are these surveys important?" During the last several years, the Academy has provided members with background on the RUC in an effort to educate and engage members in the annual RUC process. This year, we'd like to address the common questions that arise during the RUC survey process in hopes of outlining why member participation in these surveys is so critical.

What is the RUC and Who Participates?

The AMA RUC was developed in response to the transition to a physician payment system based on a Resource-Based Relative Value Scale (RBRVS). The RUC is a multispecialty committee that provides clinical expertise and input on the resources required to provide physician services. The RUC submits recommendations annually to the Centers for Medicare and Medicaid Services (CMS), which uses them to develop relative values for physician services provided to Medicare beneficiaries. The RUC, in conjunction with the Current Procedural Terminology (CPT®) Editorial Panel, has created a process where specialty societies can develop relative value recommendations for new and revised codes, and the RUC carefully reviews survey data presented by specialty societies to develop recommendations for consideration by CMS. CMS then issues final payment policies and values in the final Medicare Physician Fee Schedule rule, which is typically released around the first of November each year.

The RUC is intended to represent the entire medical profession and includes the following medical specialties: anesthesiology, cardiology, dermatology, emergency medicine, family medicine, general surgery, geriatrics, internal medicine, neurology, neurosurgery, obstetrics/gynecology, ophthalmology, orthopedic surgery, otolaryngology, pathology, pediatrics, plastic surgery, primary care (rotating seat), pulmonary medicine (rotating seat), psychiatry, radiology, rheumatology (rotating seat), thoracic surgery, urology, and vascular surgery (rotating seat). Four seats rotate on a two-year basis, with two reserved for an internal medicine subspecialty: one for a primary care representative, and one for any other specialty. The RUC chair, the co-chair of the RUC Health Care Professionals Advisory Committee Review Board, and representatives of the AMA, American Osteopathic Association, the chair of the Practice Expense Review Committee and CPT Editorial Panel hold the remaining six seats. The AMA Board of Trustees selects the RUC chair and the AMA representative to the RUC. The individual RUC members are nominated by the specialty societies and are approved by the AMA.

Who Represents the Academy at the RUC?

The Academy actively participates in the RUC process and surveys codes for nearly every RUC meeting. Meetings take place every winter, spring, and fall. The Academy's current RUC representatives are RUC panel member **Charles F. Koopmann Jr., MD, MSHA,** and panel member alternate, **Jane T. Dillon, MD**, as well as our RUC advisors **Wayne M. Koch, MD**, and advisor alternate **John T. Lanza, MD**. It is important to recognize that the RUC panel member representatives for each specialty are not advocates for their specialties, rather, they participate in an individual capacity and represent their own views and independent judgment while serving on the panel. In contrast, AAO-HNS' RUC advisors are responsible for working with the Physician Payment Policy Workgroup (3P) and Academy staff to develop relative value recommendations and practice expense direct inputs for otolaryngology services that are presented to the RUC on behalf of the Academy.

Why are RUC Surveys Conducted?

Surveys are used by the AMA RUC to allow medical specialty societies to have an active role in ensuring that relative values assigned to medical procedures and services are accurately and fairly presented to CMS. These surveys are critical because the values derived by member survey responses are used by our RUC advisors to make valuation recommendations to the AMA RUC. The goal of the surveys is to obtain time and complexity estimates required when performing a specific medical procedure. This information is then used to estimate a recommended physician work value.

How Does the Survey Generate a Recommended Value?

The surveys will ask physician members to compare the time, complexity, and work required to perform the procedure being surveyed as compared to another existing medical procedure. A list of possible comparator, or reference, procedures is provided to survey respondents as part of the survey.

What are the Key Components of the RUC Survey?

First, it is critical that members carefully review the code descriptor and vignette. This is critical because code

descriptors may have been modified and survey respondents will be asked if the descriptor and vignette match their typical (i.e., more than 50 percent of the time) patient. If the descriptor and vignette do not match the respondent's typical patient, the respondent will be asked to write a brief rationale for how their typical patient differs from the survey descriptor or vignette.

Next, surveyees will be asked to review and provide their basic contact information. They will then be asked to identify a reference procedure from the list of potential reference codes. Respondents should select the code from the list that is most similar in physician time and work to the new/revised CPT code descriptor and typical patient. The reference service does not have to be clinically similar to the procedure being surveyed, but must be similar in work required to perform the procedure. It is also important that respondents consider the global period of the service being reviewed. For CPT codes with 000, 010, or 090 day globals, physician services or visits provided within 24 hours prior are included and should be considered by respondents in their recommended value for the service. Likewise, for 010 and 090 globals, the post care following the procedure should be included in the estimate of physician work for a given procedure.

> "Surveys are used by the AMA RUC to allow medical specialty societies to have an active role in ensuring that relative values assigned to medical procedures and services are accurately and fairly presented to CMS."

Another key component to the RUC survey is estimating physician time. Respondents should base their recommendations of the time it takes them to perform the procedure under review on their own personal experience. It is important to note that time estimates provided should be based on the typical patient and not the most straightforward or most complex case the physician respondent has encountered.

There are three components to time estimates. First, the pre-service time, which begins the day prior to the procedure and lasts until the time of the operative procedure. Pre-service time is divided into three activities: evaluation; positioning; and scrub, dress, and wait time. Second, the intra-service time, which includes all "skin to skin" work that is a necessary part of the procedure. And last, the post-service time, which includes the physician services provided on the day of the procedure after the procedure has been performed.

One common source of confusion is the component of moderate sedation. Moderate sedation is a service provided by the operating physician or under the direct supervision of the physician performing the procedure. If anesthesia is provided separately by an anesthesiologist who is not performing the primary procedure, this work should not be included in the valuation of the procedure for the purposes of the RUC survey.

Finally, survey respondents will be asked to evaluate physician work and assign a recommended relative value unit for the work required to perform the procedure. Physician work includes the time it takes the physician to perform the procedure. Physician work should also include the mental effort and judgment necessary, as well as the technical skill required to perform the procedure. Note, time and work valuation should not include any work or service provided by clinical staff that are employed by the physician's practice and cannot bill separately. It is important to keep in mind that the survey methodology aims to set the work RVU for the procedure under review "relative" to the comparable reference procedure selected at the outset of the survey, and respondents may want to print out the reference service list to refresh them on the value of the comparator code selected.

What About the Practice Expense Portion of My Payment?

As part of its role in the RUC process, the Academy RUC team is asked to provide the AMA RUC and CMS with information regarding the direct practice expense inputs for all procedures that undergo RUC review. This includes recommendations on clinical staff time needed during the procedure, as well as equipment and supplies required for the procedure. These recommendations are reviewed by the Practice Expense Advisory Committee (PEAC) of the RUC and approved or modified prior to being submitted to CMS for acceptance in the final CY MPFS.

What About the Malpractice Portion of My Payment?

The AMA RUC sends recommendations to CMS on practice liability crosswalks for each procedure reviewed by the AMA RUC. This occurs in May of each year and, similar to the practice expense and physician work recommendations submitted by the AMA RUC, are approved or modified by CMS in the MPFS for that calendar year. All values finalized in the final rule then take effect the following January.

Still Have Questions?

For more background on the RUC survey process, members can access the following PowerPoint presentation on the Academy website: http://www.entnet.org/Practice/upload/2012-ruc-survey-presentation.pdf. Members can also email any questions to Jenna Minton at Jminton@entnet.org. We hope this information will assist members in better understanding the composition of the RUC surveys as well as the importance of your participation in future surveys and the valuation of otolaryngology-head and neck surgery procedures.

Physician Compare: What Is CMS Posting about Me?

You've probably heard about CMS' Physician Compare Website. You may even know that the development of this public website is a statutory mandate from the Affordable Care Act. Unfortunately, what many physicians and members are not aware of is the information that's available about them, and their practices, on this website.

The first thing members should know is that this program is updated and modified on an annual basis through federal rulemaking. This means that CMS will announce proposed revisions or additions to the Physician Compare Website in the notice of proposed rulemaking (NPRM) of the Medicare Physician Fee Schedule (MPFS) each calendar year. They then accept feedback on their proposals from the public during a 60-day comment period and finalize their policies in the final MPFS for that year, typically published on or around November 1 each year. The Website can be accessed at: http://www.medicare.gov/find-a-doctor/(X(1)S(0grwmc55y5poo245uxj5ifv5))/provider-search.aspx?AspxAutoDetectCookieSupport=1.

Background

The Physician Compare Website was launched in December 2010 and originally included data on those eligible professionals (EPs) who successfully reported on the Physician Quality Reporting System (PQRS) measures in CY 2009.

Today, the Website includes the following information on providers:

- The provider's primary, and any applicable secondary, specialty(ies);
- The provider's practice locations;
- The providers group practice or hospital affiliations, where applicable;
- The provider's education information, language skills, and gender;
- The names EPs who have successfully reported on quality programs, specifically e-prescribing and PQRS for CY 2011.

> "The first thing members should know is that this program is updated and modified on an annual basis through federal rulemaking. This means that CMS will announce proposed revisions or additions to the Physician Compare Website in the notice of proposed rulemaking (NPRM) of the Medicare Physician Fee Schedule (MPFS) each calendar year."

What to Expect in 2013

By January 2013, CMS is required to outline a plan for posting information on provider's quality performance, as well as patient experience data, on the Physician Compare Website. CMS is presently undertaking a full Website redesign project aimed at improving the usage and function of the site. In addition, CMS has finalized the following information for release in CY 2013:

- 2012 data on PQRS Group Practice Reporting Option (GPRO) measures for practices that meet the minimum sample size of 20 patients;
- Whether providers accept Medicare patients;
- Board certification information; and
- Improved information on language skills and hospital affiliations.

As part of the Website redesign project, CMS allowed the Academy

to view and comment on the proposed redesign. In the letter, the Academy addressed several issues included in the proposed redesign. Visit the Academy's "What's New" page at: http://www.entnet.org/Practice/CMS-News.cfm to access the full letter. Areas addressed by the Academy included:

- Data accuracy is paramount in the physician compare site and CMS proposes including claims based verification for physician information rather than just relying on PECOS;
- Concern regarding the small sample size used for posting information such as participation in PQRS GPRO;
- The posting of GPRO performance rates and the need for a review period to ensure the data posted is accurate; and
- The inclusion of CG-CAHPS survey data, as well as the S-CAHPS data, into the Physician Compare website.

What to Expect in 2014 and Beyond

For 2014, CMS anticipates posting information on provider performance rates on measures reported by physician groups or Accountable Care Organizations (ACOs) via the GRPO web interface system. These groups will have 30 days to review their information for accuracy before it becomes publicly available. CMS also hopes to post patient experience survey data gathers using the CG-CAHPS survey method for groups of 100 or more providers. Finally, CMS will post information on providers who obtain PQRS maintenance of certification incentives during CY 2014.

Other information CMS is considering for inclusion on the website in the future are performance on quality measures developed by specialty societies, continued efforts to align the PQRS and value based payment modifier (VBP) program measures, the release of provider performance in these programs, as well as individual EP performance measure data.

Data Accuracy

Currently, the website pulls physician information from the PECOS enrollment system. CMS plans to verify the accuracy of PECOS information via a claims based verification, which the Academy supports. Until these changes are implemented, the Academy encourages members to check their PECOS enrollment information, as well as what information is currently available about them on the Physician Compare website, and to contact CMS if they find the information is incorrect.

The Academy's health policy team will continue tracking the development of this important public website and will alert members to any key changes to the program in the future. Should you have any questions or concerns about the website, or your publicly available information, please contact us at healthpolicy@entnet.org.

Errors in Otolaryngology: Revisited

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

I was a resident almost a decade ago, working with **David W. Roberson, MD**, at Children's Hospital Boston when we both asked the question, "Where are we with errors in otolaryngology?" At that time, the study of patient safety and quality improvement was in a resurgence, which was in its relative infancy. To properly conduct studies, we were trained in the research methodology: ensuring a proper sample size and looking for statistical significance when comparing two groups. In an attempt to design a proper study of errors in otolaryngology, this methodology proved to be a stumbling block. There had been seminal work on a classification of errors in family medicine. That manuscript and methodology resonated with us as it elegantly provided a framework to assess, measure, quantify, and perhaps ameliorate errors in that specialty. Like good researchers, we emulated their methodology and it worked. In 2004, we published a classification of errors in otolaryngology along with the implications of those errors. When looking at zones of risk in our specialty, we would often revisit the data from that set to understand vulnerabilities in our realms of practice. We would then design a deeper dive study or approach to tackle a specific zone of risk. We have done that a few dozen times and hope we have made the practice of otolaryngology safer and more standardized.

In the past months, we have been struggling with the concept that our Academy Members' understanding, appreciation, and sophistication *vis-à-vis* patient safety and quality improvement have grown tremendously as a result of specific Academy initiatives, mandates from the government and payers, and personal interest from our dedicated Academy Members. To this end, we felt it compulsory to check the pulse of our members with regard to understanding errors in otolarygnology almost a decade after our initial survey study. We needed to ensure that we would be comparing apples to apples so we could make meaningful comparisons between the data from 2004 and the current data. Hence, we used a similar question set in an updated survey tool with some additional questions focusing on the nature of our practices and perceived zones of risk, attribution for the errors, culpability, and improvement processes implemented. After much consideration, we decided we should embrace technology (and keep costs low) and use an online survey tool to conduct the survey. The survey closed at the end of November after being open for fewer than 20 days.

> In fewer than 20 days, more than 677 Academy Members took time from their busy practices in the winter season to respond to a survey that was essentially self-reporting of errors in our specialty.

We have not sat down to properly classify and sort through the responses; we've only spent a few moments to ensure the integrity of the responses and confidential data capture of the online survey tool. We will, of course, properly classify the responses, write up the results in a peer-reviewed manuscript, and publish it for Academy members to continue to reference. However, we were shocked by the number of responses we received. In fewer than 20 days, more than 677 Academy Members took time from their busy practices in the winter season to respond to a survey that was essentially self-reporting of errors in our specialty.

The response rate is staggering and clearly shows the passion of Academy Members and sheer interest we each have in improving the quality of care we deliver. Members clearly understand that, collectively, we have the power to improve our own practices. The high response rate resonates with us because it implies that we are aware of the concept that we may proceed through our entire career and never experience an error such as mis-administration of concentrated epinephrine because it is so rare, however, if we collectively look at our practices, it is a problem that needs to be considered. The sheer volume of responses also validates the PSQI Committee's commitment to a secure, online patient safety event reporting portal, which will be available soon on the Academy website.

As this issue of *Bulletin* goes to press, we will be properly classifying and understanding the huge volume of responses we received from Academy members. We should all take a moment to pause and appreciate how collectively our specialty continues to move the needle toward improving the care and safety of patients with otolaryngology diseases because we are so passionate as a specialty and as Academy Members about ensuring that we deliver quality care.

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.

Get Involved with AAO-HNS/F

Learn More! Visit our website at www.entnet.org/getinvolved for a full list of opportunities.

Contact us any time Toll-free 1-877-722-6467 (U.S. and Canada); 1-703-836-4444 (international); or memberservices@entnet.org.

With membership comes many rewarding ways to engage with your colleagues through the Academy and its Foundation. Members can select opportunities based on schedules, interests, and priorities.

Involvement Levels: You Choose!

As an otolaryngologist—head and neck surgeon, you want to provide the best care to your patients. To help you succeed, the AAO-HNS/F has created opportunities for you to continue improving as a physician and as a leader.

We know your time is limited, so we have made it easy for you to Maximize Your Membership by getting involved in Academy and Foundation activities.

We encourage you to visit **www.entnet.org/getinvolved** to see which activities spark your interest and fit your schedule.

These activities are designed to fit any level of participation, from face-to-face networking opportunities to activities that do not require you to go any farther than your computer.

These opportunities are not only member benefits, but they also provide a valuable service to the specialty. Participation in these volunteer activities is based on your own personal schedule and interests.

AcademyU® Online Education Offers Hundreds of Learning Opportunities

AcademyU®, the Foundation's otolaryngology education source, offers five types of learning formats that include knowledge resources, subscriptions, live events, eBooks, and online education. Each one contains elements that make up the breadth of the education opportunities available through the Foundation. In this second article in the series, we explore the variety of activities that make up the online education component of AcademyU®; these include online courses and lectures and COOL cases.

AcademyU® Online Education (www.entnet.org/onlinecourse) is organized by the eight subspecialties within otolaryngology-head and neck surgery to make it easy for any otolaryngology specialist to find the courses that best fit his or her education needs. In addition, the online platform makes it easy for learners to take advantage of these education opportunities on their own schedules and at their own pace.

Online Courses and Lectures

Online Courses are learning activities developed by the Foundation education committees. These peer-reviewed courses provide in-depth study of otolaryngology head and neck surgery topics determined by an expert-driven analysis of learner education needs. These high-quality courses offer 45 to 60 minutes of detailed instruction on a particular topic. Each contains rich media elements such as detailed images and short video clips.

The online courses are:

- Preventing Operating Room Fires
- Optimal Safety in Otolaryngic Allergy Practice
- Chin Augmentation: Sliding Osteotomy and Alloplastic Implants
- Nasal Trauma
- Graves' Disease
- Alternative Medicine: Perioperative Management Issues of Herbal Supplements and Vitamins
- Basic Head and Neck Pathology
- Laser Safety
- Evaluation of an Adult Patient with a Benign Neck Mass
- Evaluation of an Adult Patient with a Malignant Neck Mass
- Loco-regional Recurrence in Head and Neck Squamous Cell Carcinoma
- Introducing the AAO-HNS Expert Witness Guidelines
- English-to-Spanish Ear Examination Phrases
- Gender Equity in the Workplace
- Hearing Assessment
- Understanding Stereotactic Radiation for Skull Base Tumors
- The Ten Minute Exam of the Dizzy Patient
- Office Otoscopy I: Normal Examination, Spectrum of Otitis Media, and Characteristic Appearances of Abnormal Pathologies
- Office Otoscopy II: Case Studies
- Office Otoscopy III: Clinical Case Studies Featuring Long-term Serial Examination and Anatomic Cross Section
- Risks of Steroids for Sudden Sensorineural Hearing Loss
- Cleft Lip and Palate Overview
- Introduction to Velopharyngeal Dysfunction
- Management of Sinonasal Cerebrospinal Fluid Leaks

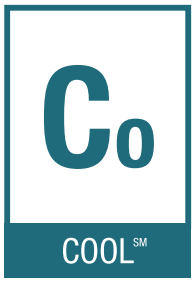
Online Lectures are based on the Annual Meeting & OTO EXPO℠ instruction courses of the same name. They are selected from the top abstracts submitted to the Annual Meeting; faculty are invited to record a condensed version of their presentation for publication to the AcademyU® website. Each lecture provides highlights of key sessions in short 20- to 40-minute segments using the speakers' slides and audio recordings. There are online lectures available, including more than 100 from the 2012 Annual Meeting & OTO EXPO.

The 2013 Online Lectures are:

- Worldwide Otolaryngology Humanitarian Missions
- Developing a Quality Control Program for Surgeons
- Rhinoplasty: Arming Novices for Success
- Facial Aesthetic Enhancements: Chemodenervation and Tissue Augmentation
- Current Management of Oropharyngeal Cancer
- The Management of Glottic Cancer in 2012
- Endoscopic and Robotic Thyroid Surgery
- Minimally Invasive Salivary Endoscopy
- Chronic Cough: Hacking Up a Treatment Algorithm
- Endoscopic Microsurgical Techniques for Laryngeal Disease
- Laryngopharyngeal Reflux (second edition)
- Tympanoplasty/Ossicular Reconstruction—Some Novel Ideas?
- Balance Problems in the Elderly
- Tinnitus: New Frontiers in Radiology and Brain Imaging
- Meniere's or Migraine: Similarities, Differences, Treatments
- Surgical Management of Eustachian Tube Disorders
- Pediatric Obstructive Sleep Apnea What to do after T and A?
- Chronic Rhinosinusitis in Children (second edition)
- Stertor, Stridor, and Babies that Squeak: A Practical Approach
- Up-to-Date Management of Recalcitrant Sinonasal Polyposis
- Five New Landmarks to Make You a Better Sinus Surgeon

Target audiences for both the online courses and online lectures are practicing otolaryngology-head and neck

physicians, surgeons, and residents. Most online courses and lectures offer continuing medical education credit.



Clinical Otolaryngology OnLine (COOL)

Clinical Otolaryngology OnLine, (COOL℠) cases are free, peer-reviewed, interactive case studies that lead the learner from patient presentation through diagnosis, treatment, and referral. COOL is an excellent instructive program for non-otolaryngologist physicians and other health professionals who regularly encounter otolaryngology-related problems.

The 34 COOL Cases are:

Ear

- Adult with Otitis Media due to MRSA
- Bloody Otorrhea
- Ear Canal Obstruction
- Dizziness in the Elderly
- Otalgia
- Otoscopy Cholesteatoma Part I
- Otoscopy Cholesteatoma Part II
- Sensorineural Hearing Loss
- Tinnitus

Mouth, Neck, and Throat

- An Approach to the Pediatric Patient with a Neck Mass
- Chronic Cough
- Dysphagia
- HPV and Head and Neck Cancer
- Indications for Tonsillectomy
- Management of the Thyroid Nodule
- Non-Melanoma Cutaneous Malignancies
- Oral Cavity Lesions
- Pediatric Aerodigestive Tract Foreign Bodies
- Pediatric Neck Abscess Due to MRSA
- Pediatric Stridor
- Pharyngitis
- Reflux
- Salivary Disease
- Upper Airway Obstruction—Obstructing Laryngeal Cancer

Nose and Sinus

- Allergy Emergency
- Chronic Rhinosinusitis
- Facial Soft Tissue Trauma
- General Exam of the Nose
- Management of Acute Rhinosinusitis
- Nasal Trauma
- Orbital Complications of Rhinosinusitis in Children

Target audiences for COOL include physician assistants and nurse practitioners, non-otolaryngologist health professionals, and medical students. COOL has been reviewed and approved for AAPA Category 1 Credit by the Physician Assistant Review Panel.

For a listing of all online education offerings be sure to refer to the *Education Opportunities* supplement to the January *Bulletin* and also online at www.entnet.org/onlinecourses.

Healing the Children: Ecuador

Jean-Paul Azzi, MD
New York Eye and Ear Infirmary

Dr. Azzi, preoperatively with a cleft-lip patient.

On Saturday, November 3, 2012, 29 other volunteers and I from Healing the Children Northeast flew from New York City to Guayaquil, Ecuador, on our way to Babahoyo. This would be a new site for us, and with this, we expected to face new challenges. As we discussed our concerns in the airport and on the flight to Ecuador, it was clear that despite this, our goal remained the same: to help these children and their families. Upon arrival we were greeted by our hosts Drs. Roxana Roman and Rafael Hernandez, as well as the local police force who escorted us to Babahoyo and our hotel.

The team included administrators, technicians, nurses, pediatricians, anesthesiologists, and surgeons. **Manoj T. Abraham, MD**, a facial plastic surgeon, led the surgical team, which included myself, **Augustine L. Moscatello, MD**, and **Craig H. Zalvan, MD**—all members of the American Academy of Otolaryngology—Head and Neck Surgery. John G. Bortz, MD, an oculoplastic surgeon, also joined us.

On Sunday, we evaluated 207 patients of which 91 were scheduled to have surgery during the next five days. Ages ranged from a few weeks old to adulthood, with most requiring either revision or repair of cleft lips and palates. Many of these children and their families traveled several hours across very difficult terrain. Some traveled by foot or on donkeys for days to reach our clinic, Fundacion Ceolinda Troya, where a tent with fans and cold water was erected the evening before.

> "I'm humbled by the impact I made even as just one part of a larger effort. It really puts things in perspective."

Healing the Children, with its goal of organizing humanitarian medical missions to perform surgeries on needy children around the globe, has made a lasting impact on the vulnerable and impoverished throughout the world. I feel fortunate to have contributed again this year. I'm humbled by the impact I made even as just one part of a larger effort. It really puts things in perspective. I know I speak for the entire team when I say we will continue to do everything we can to heal the children worldwide.

Drs. Moscatello and Azzi entertain a preoperative cleft lip patient.

2013 Humanitarian Travel Grants: Congratulations to the 15 Residents, Fellows-in-Training Awarded

Thanks to the generous support of Academy members who donated to our humanitarian efforts projects, 15 residents and fellows-in-training received grants of $1,000 each toward medical missions from January through July 2013.

For more than a decade, our AAO-HNS Foundation's Humanitarian Efforts Committee has selected senior residents and fellows-in-training for travel grants to accompany mission teams. While the grants of $1,000 each cannot cover the travel costs, they are an inspiration to the grantees, who return profoundly changed by their experiences. Feedback from returning residents has demonstrated how invaluable these encounters are for both their personal and professional development. Overwhelmingly, the awardees commit themselves to continuing to volunteer for missions throughout their lives.

The awardees will be recognized during the AAO-HNSF 2013 Annual Meeting and OTO EXPO℠, Vancouver Convention Centre in Vancouver, BC, during the Humanitarian Forum. Please join us in congratulating these dedicated residents and fellows-in-training.

1. **Sarah N. Bowe, MD**, Ohio State University Medical Center, Project EAR, Inc., Dominican Republic, Los Alcarrizos, April 13-21, 2013.
2. **Do-Yeon Cho, MD**, Stanford University, Myungsung Christian Foundation, Ethiopia, Addis Ababa, May 20-31, 2013.
3. **David J. Crockett, MD**, University of Utah, division of otolaryngology, Operation Restore Hope, Philippines, Cebu, February 15-24, 2013.
4. **Ethan B. Handler, MD**, Kaiser Permanente Oakland, Faces of Tomorrow, Ecuador, Quito, June 8-17, 2013.
5. **Andrew C. Heaford, MD**, University of Iowa Hospitals and Clinics; department of otolaryngology: head and neck surgery, Miles of Smiles in Guatemala; Iowa MOST mission, Guatemala, Huehuetenango, February 14-24, 2013.
6. **Evan R. McBeath, MD**, University Hospitals Case Medical Center, Case Western Reserve University, Concern for Children, El Salvador, San Salvador, January 9-19, 2013.
7. **Bryan R. McRae, MD**, Indiana University School of Medicine, department of otolaryngology-head & neck

Join KJ Lee, MD, for the 2013 China Tour

KJ Lee, MD, invites you to experience China, June 5-16, after the IFOS World Congress, Seoul, South Korea, and ending at the World Chinese ENT Academy Congress, Hong Kong.

Exchange ideas with Chinese otolaryngology leaders and enjoy Chinese cultural heritage, with such famous sights as:

- The Great Wall, Beijing's Summer Palace, Tiananmen Square, and Forbidden City
- Peking Opera and Peking duck banquet
- Xi'an's terra cotta warriors and the World Heritage Site, Fujian Tulou
- Hong Kong

To reserve, call 1-203-772-0060, 1-800-243-1806 or email donna.dalnekoff@atpi.com. Questions? Contact Dr. Lee, Academy past president, by calling 1-203-777-4005 or emailing kjleemd@aol.com.

surgery, IU-Kenya Program, Kenya, Eldoret, January 19-February 3, 2013.

8. **Sachin S. Pawar, MD**, Oregon Health & Science University, FACES Foundation, Peru, Lambayeque, January 25-February 3, 2013.
9. **Angela S. Peng, MD**, University of Minnesota, department of otolaryngology-head & neck surgery, Mayflower Medical Outreach, Nicaragua, Managua, February 16-24, 2013.
10. **Maria de Lourdes Quintanilla-Dieck, MD**, Oregon Health & Science University, FACES Foundation, Peru, Lambayeque, January 25-February 3, 2013.
11. **Joseph W. Rohrer, MD**, San Antonio Uniformed Services Health Education Consortium, Face the Future Mission Rwanda, Rwanda, Kigali, February 1-10, 2013.
12. **Dhave Setabutr, MD**, Penn State Hershey Medical Center, Faces of Tomorrow, Ecuador, Quito, June 7-16, 2013.
13. **Laura L. Shively, MD**, Dartmouth-Hitchcock Medical Center, Mayflower Medical Outreach, Nicaragua, Jinotega, Managua, February 17-25, 2013.
14. **Yi-Hsuan E. Wu, MD**, Tufts Medical Center, Medical Missions for Children, Rwanda, Gitwe, March 7-17, 2013.
15. **Estelle S. Yoo, MD**, Alfred I. DuPont Hospital for Children, department of surgery/division of otolaryngology, World Hearing Foundation, Honduras, Tegucigalpa, March 23-39, 2013.

Visit the Humanitarian Efforts Member Engagement Portal to help facilitate matching critical needs with medical specialty expertise: www.entnet.org/humanitarianportal.

To learn more about Humanitarian Resident Travel Grants visit http://www.entnet.org/HumanitarianTravel. May 31, 2013, is the deadline for grant applications for mission trips during July 1 through December 31, 2013.

SAVE THE DATE!

AAO-HNSF ANNUAL MEETING & OTO EXPO℠
SEPTEMBER 29–OCTOBER 2, 2013

VANCOUVER, BC, CANADA

IMPORTANT DATES TO REMEMBER:

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- Scientific Program (Orals and Posters) Faculty Confirmed: April 2013

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VANCOUVER BC
SEPTEMBER 29 - OCTOBER 2

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www.entnet.org/annual_meeting

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UNIVERSITY OF CALIFORNIA, LOS ANGELES
General Otolaryngologist
(full-time clinical, non-tenure track)

The Department of Head & Neck Surgery at the David Geffen School of Medicine at UCLA is seeking a general otolaryngologist to join its clinical faculty in the Santa Monica office. The position has both clinical and surgical responsibilities. Candidate should possess excellent communication skills and be a team player. Applicant must be Board certified (or eligible) and have a current California medical license.

Send letter of inquiry & curriculum vitae to:
Gerald S. Berke, M.D., Professor and Chair
UCLA Department of Head and Neck Surgery
10833 Le Conte Avenue, CHS 62-132
Los Angeles, CA 90095-1624

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

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

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

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

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

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

MEDICAL OTOLARYNGOLOGIST OPPORTUNITY

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

About the Position

- Join a team led by a specialist in head and neck surgery, thyroid/parathyroid surgery and sinus surgery
- Work with an experienced general otolaryngologist and a nurse practitioner
- Opportunity to develop new programs such as a dedicated allergy program
- State-of-the-art office with new Kay-Pentax videostroboscopy equipment
- One full-time and one part-time audiologist

Geisinger Health System serves nearly 3 million people in Northeastern and Central Pennsylvania and has been nationally recognized for innovative practices and quality care. A mature electronic health record connects a comprehensive network of 4 hospitals, 38 community practice sites and more than 900 Geisinger primary and specialty care physicians.

Geisinger fosters an atmosphere of clinical excellence while offering an excellent quality of life with good schools, safe neighborhoods with affordable housing and a wealth of cultural and recreational activities. The surrounding natural beauty provides opportunities for fishing, skiing, canoeing, hiking and mountain biking. Urban life is easily accessible, with New York, Baltimore, Philadelphia and Washington D.C. just an afternoon's drive away.

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

For more information, please visit Join-Geisinger.org or send your CV and cover letter to:

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

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If you are interested in walking into a busy practice from day one and becoming part of a forward-thinking organization, please consider this opportunity to join Central Maine Medical Group (CMMG). CMMG is part of Central Maine Healthcare, an integrated delivery system comprised of 350 physicians, three hospitals, and long term and residential care. We seek a BC/BE otolaryngologist for Central Maine ENT Head & Neck Surgery, a high volume practice located in the medical building attached to Central Maine Medical Center. CMMC is a 250 bed hospital and accredited Level II trauma center. A sophisticated EMR and strong support from a proactive administration make this an opportunity that you do not want to pass up.

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For more information, please contact:

Molly Alderson
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Seeking an ambitious Otolaryngologist for a small general ENT practice to replace a retiring member.

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Must be BC/BE.

Please Contact:
Dr. Paul K. Foster
4302 Alton Rd., Suite 650
Miami Beach, FL 33140
drpkfoster@gmail.com

Northern Dutchess ENT

The Center of Excellence for Sinus, Ear and Throat Care

Special Opportunity
Rhinebeck, New York

We are seeking a general BC/BE otolaryngologist to join our two physician practice. We are located in the beautiful mid- hudson river valley with offices in Rhinebeck and Kingston. The area offers great cultural and recreational opportunities with an excellent school system, New York city is one and a half hour by train.

We provide general ENT services with an in-office ct scanner and special emphasis on rhinology. We have a strong audiology and balance department including hearing aid dispensing. The practice is very successful and financially sound, it is well regarded by both the patients as well as the medical community.

The compensation and benefit package is excellent. The model for partnership is unique and flexible.

We have succeeded over the years in maintaining a healthy and a much needed balance between our personal and professional lives.

Contact:
Nader Kayal, MD, COPM
Managing partner
Northern Dutchess ENT, PLLC
845-518-7780
entdoc53@aol.com

South Florida Associates, P.A.

South Florida ENT Associates, a forty five Otolaryngology group practice in Miami Dade and Broward has immediate openings for full- time ENT Physician's. One location is a busy 2 physician, 2 office practice that is located in Broward County, in the Weston/Pembroke Pines area. Another location is a busy 4 physician, 4 office practice located in Dade County, in Aventura, Coral Gables and Miami. They are both full service ENT practice's with Audiology, Hearing Aid sales and Allergy.
We offer an excellent salary/bonus with partnership track, health insurance, paid vacation time, malpractice insurance and CME reimbursement, plus other benefits.
Candidate must have strong clinical knowledge, excellent communication skills, be highly motivated and hardworking.
This position will include both office and hospital setting.

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

Broward Location:
Jonathan Cooper, MD
(954)389-1414
jcooper@southfloridaent.com
Cellular: (954)816-1087

Dade Location:
Horacio Groisman, MD
Phone: (305)325-0900
horaciogroismanmd@gmail.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 2013. Applicants must be board certified/eligible by the American Board of Otolaryngology. Responsibilities include teaching of residents and medical students, patient care and clinical/basic research.

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

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

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

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

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

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

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

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

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

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

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

Laryngologist

Position Number M0204650

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

Head and Neck Surgeon

Position Number M0203642

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

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

Head and Neck Fellowship

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

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

KU UNIVERSITY of KANSAS
Department of
Otolaryngology
Head & Neck Surgery

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

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

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Pediatric Otolaryngology - Academic Position

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

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

UTHealth
The University of Texas Health Science Center at Houston
Medical School

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Purchase E.N.T.
Otolaryngology - Head & Neck Surgery

Purchase ENT, a well-established regional ENT practice in Western Kentucky, is actively searching for physicians to join our practice. Paducah, Kentucky offers everything from Broadway shows at the Carson Center to festivals like the annual BBQ on the River. Located a short 20 minute drive from Kentucky and Barkley Lakes, and the Land Between the Lakes National Recreation Area, where great recreational opportunities are offered, and also just a short two to three hour drive to larger cities like Nashville, Memphis, St. Louis and Louisville, Paducah is a great community. There is something for everyone in the region.

Purchase ENT is well respected in the medical community and is a very progressive practice offering in-office Allergy, Audiology, CT Scan, and Ultrasound. Additionally, there is an investment opportunity in a successful ambulatory surgery center. Although we are seeking candidates to practice general ENT, a fellowship in Otology or Head and Neck would be welcomed. For the successful candidate, the opportunity is a one year partnership track. For additional information about this great opportunity, contact Jim Wring, Practice Administrator at jwring@purchaseent.com or 270-408-3208.

OTOLARYNGOLOGIST OPPORTUNITY

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

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

About the Position

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

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

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

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

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

Learn more at Join-Geisinger.org

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Head and Neck Division Chief

The University of Mississippi Medical Center • Jackson

The Department of Otolaryngology and Communicative Sciences seeks a head and neck microvascular surgeon to build and lead our head and neck team. Responsibilities also include teaching, research and patient care at our University Hospital and the adjacent Veterans Affairs Medical Center.

The department also has divisions of otolaryngology, research, communicative sciences, dermatology and oral oncology and biobehavioral medicine. This creates a unique opportunity for multidisciplinary patient care and research within the department.

Rank, salary and tenure track will be commensurate with experience and training. Prior academic experience as a head and neck surgeon is required.

To apply for this opportunity, send a letter of interest, curriculum vitae and bibliography to:

Scott P. Stringer, M.D., M.S.
Department of Otolaryngology and
Communicative Sciences
The University of Mississippi Medical Center
2500 North State Street, Jackson, MS, 39216-4505
601-984-5167 (phone); 601-984-5085 (fax)
sstringer@umc.edu

For additional information about the Medical Center and the department, visit http://ent.umc.edu.

To learn more about the state of Mississippi, log on to www.mississippibelieveit.com.

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UNIVERSITY OF Cincinnati

COLLEGE OF MEDICINE
Department of Otolaryngology - Head & Neck Surgery

The Department of Otolaryngology – Head & Neck Surgery and Myles L. Pensak, MD, FACS, H.B. Broidy Professor and Chairman, are expanding its clinical/academic programs and have the following full-time openings:

- Board certified General Otolaryngologist
- Board certified fellowship-trained Laryngologist

Both positions require a strong interest and commitment to the education of residents, fellows and medical students. Academic appointment will be commensurate with experience/qualifications. MD/DO degree and the obtainment of a permanent Ohio medical licensure required.

Interested candidates should send a letter of interest, CV and a list of three references to: barbarag.huber@uc.edu

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OTOLARYNGOLOGY OPPORTUNITY

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Ken Sammut
888.372.9415 • ksammut@cejkasearch.com

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Children's Mercy HOSPITALS & CLINICS | Kansas City

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

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

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

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

University of Missouri
Department of Otolaryngology—
Head and Neck Surgery

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- 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.

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- Stil Kountakis, MD - Georgia Regents University
- Frederick Kuhn, MD - GA Nasal & Sinus Institute
- Rodney Schlossler, MD - Medical University of SC
- Brent Senior, MD - UNC School of Medicine
- Michael Sillers, MD - Alabama Nasal & Sinus Center

Scan the QR Code directly from your smartphone for full meeting details and Registration or visit www.southernstatesrhinology.org

13TH ANNUAL

Charleston Magnolia Conference

MAY 31 - JUNE 1, 2013

– Guest Speakers –

George T. Hashisaki, M.D.
Associate Professor
Department of Otolaryngology – HNS
University of Virginia Health Systems – Charlottesville, VA

Robert C. Kern, M.D.
Professor and Chairman
Department of Otolaryngology – HNS
Northwestern Feinberg School of Medicine – Chicago, IL

Gregory Postma, M.D.
Professor, Department of Otolaryngology
Director, MCG Center for Voice & Swallowing Disorders
Georgia Health Science Medical Center – Augusta, GA

– Topics –

• Endoscopic Sinus Surgery • Pediatric Sleep Apnea
• Endoscopic and Robotic Head and Neck Cancer Surgery
• Management of Cholesteatoma
• Management of Salivary Gland Disease
• Facial Reconstructive Surgery • Endocrine Surgery
• Vascular Anomalies in Children

– Recreation –

Beaches | Golf | Historic Charleston | Spoleto Arts Festival USA

MUSC MEDICAL UNIVERSITY of SOUTH CAROLINA

Otolaryngology – Head & Neck Surgery
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MAYO CLINIC

Mayo School of Continuous Professional Development

Endoscopic Sinus and Skull Base Surgery 2013

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

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

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

Course Director: Devyani Lal, MD

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

Endoscopic Sinus and Skull Base Surgery 2013 is our second state-of-the art course designed for otolaryngologists and endoscopic skull base surgeons. The curriculum will focus on inflammatory sinus disease on April 3-4, highlighting advanced, salvage and novel treatment strategies. Endoscopic skull base surgery will be the focus April 5-6. The curriculum is designed to introduce the novice surgeon to basic techniques, and provide advanced training for the more experienced surgeon. Hands-on dissection sessions will be conducted in our world-class laboratory with fresh frozen cadavers, powered instrumentation and image guidance.

Accommodations: Westin Kierland Resort • *www.kierlandresort.com* • (480) 924-1202 • Residence Inn Phoenix Desert View at Mayo Clinic • *www.marriott.com/phxmh* • (800) 331-3131

Meeting Location: Mayo Clinic's Phoenix and Scottsdale campuses

To Register, Contact MSCPD: *www.mayo.edu/cme/otorhinolaryngology* • email: *mca.cme@mayo.edu* • (480) 301-4580

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

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2013 Lone Star Rhinology Course

April 26-28, 2013
UT Southwestern Medical Center
Dallas, Texas

Cadaver Lab with Image Guidance
Program details and registration available at: sinuscourse.com

GUEST OF HONOR
Brent A. Senior, M.D., F.A.C.S., F.A.R.S.

COURSE DIRECTORS
Pete S. Batra, M.D., F.A.C.S.
Samer Fakhri, M.D., F.A.C.S.

PLANNING COMMITTEE
Martin J. Citardi, M.D., F.A.C.S.
Amber Luong, M.D., Ph.D.
Bradley F. Marple, M.D., F.A.A.O.A.
Matthew W. Ryan, M.D.

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