bulletin

American Academy of Otolaryngology—Head and Neck Surgery

May 2013—Vol.32 No.05

See the 2013 Annual Meeting & OTO EXPO℠ Preliminary Program Insert

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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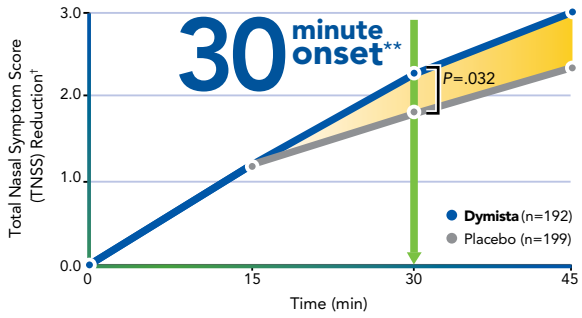
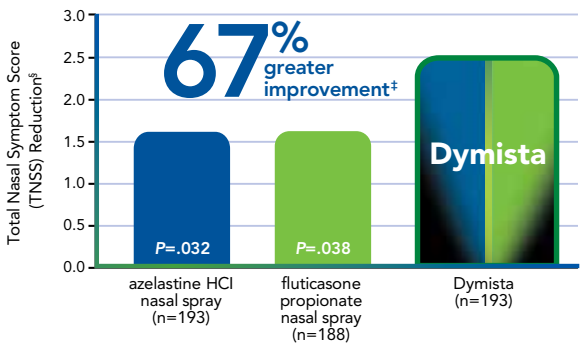
more complete relief

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.

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American Academy of Otolaryngology—Head and Neck Surgery

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Ad Hoc Payment Workgroup Evaluates Payment Models

The Ad Hoc Payment Workgroup was formed to provide an avenue for the Academy to evaluate current and future trends in healthcare payment reform and to develop methods for otolaryngologist-head and neck surgeons to actively participate in these new models.

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

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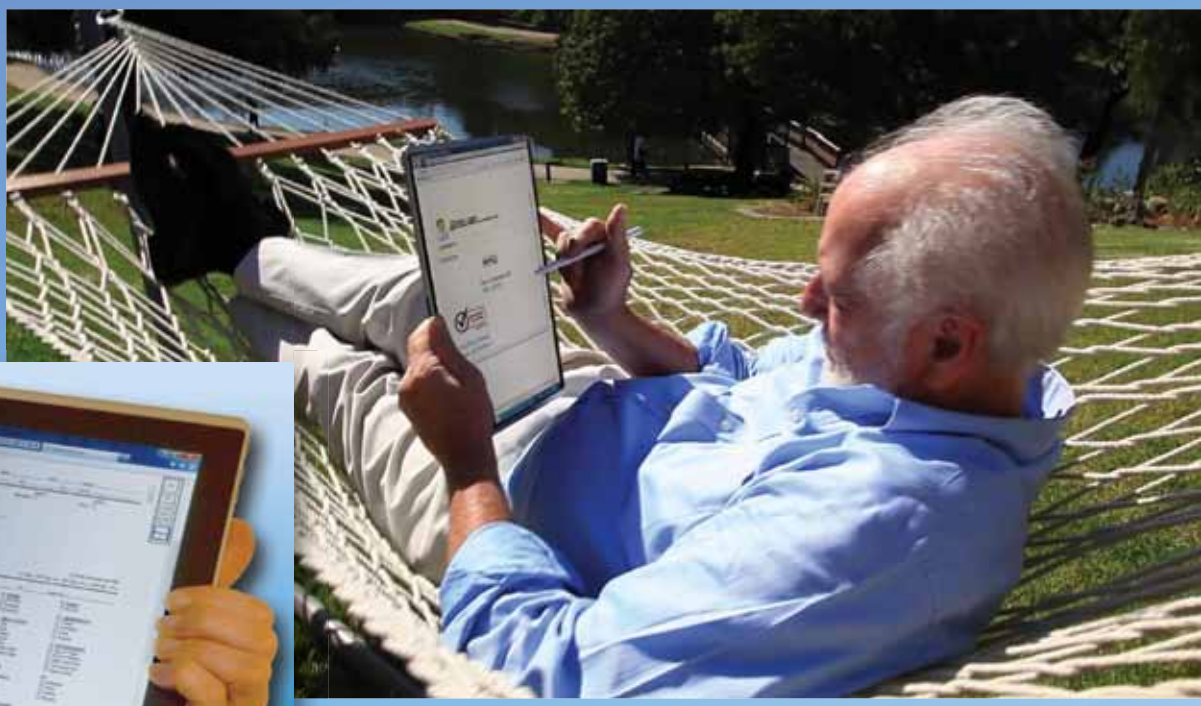

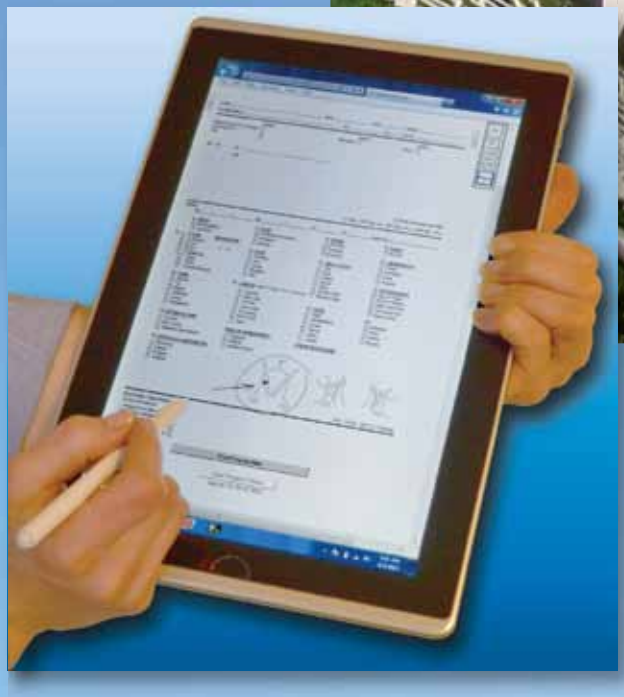

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An Introduction to the Ad Hoc Payment Workgroup

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

Dear Friends, I'd like to take the opportunity this month to tell you about the important work being undertaken by a group of volunteers on behalf of the Academy. As we begin to move away from a traditional fee-for-service model of payment currently used by our healthcare system today, the Academy has convened an Ad Hoc Payment Workgroup, which serves as a subgroup of the Physician Payment Policy Workgroup (3P), to review current and future payment trends in otolaryngology and other specialties. One of the Ad Hoc group's goals will be to recommend one new payment model to the executive committee and board of directors in 2013. This is an exciting time for the Academy, as the healthcare community strives to reform and improve, and this key group is led by a talented group of physicians working on your behalf.

The Ad Hoc Payment Workgroup comprises 3P Socioeconomic Coordinator, **James C. Denneny III, MD; Richard W. Waguespack, MD** (Academy President-Elect); **John S. Rhee, MD, MPH; Richard M. Rosenfeld, MD, MPH; Emily F. Boss, MD, MPH; Robert R. Lorenz, MD**; and **J. Pablo Stolovitzky, MD**, as well as staff from the Research and Quality and Health Policy teams. Additionally, the workgroup plans to collaborate with other members and Academy leadership who have specialized knowledge of payment models.

Focal Points

In 2013, the workgroup will focus on several areas that are particularly vital to you as otolaryngologist-head and neck surgeons and members of the Academy, including clarifying current guidance documents available, developing a Care Path for the treatment of sinusitis, and evaluating payment reform trends. This group has already been extremely active in the early months of 2013. For a more in-depth look at the Ad Hoc Payment Workgroup's specific projects, please read Ad Hoc Payment Workgroup Evaluates Payment Models on page 18.

Ad Hoc Payment Workgroup Coordinators

James C. Denneny III, MD

Richard W. Waguespack, MD, (Academy President-Elect)

John S. Rhee, MD, MPH

Richard M. Rosenfeld, MD, MPH

Emily F. Boss, MD, MPH

Robert R. Lorenz, MD

J. Pablo Stolovitzky, MD

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Integration Focuses Policy and Action

David R. Nielsen MD

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

At the time of this writing, we just completed an interesting week of having a couple of important spotlights on otolaryngology. First, the FDA announced its decision to issue a "box warning" for the use of codeine as an analgesic following tonsillectomy and adenoidectomy in children. Codeine is now contraindicated for this clinical scenario. While we had been communicating this issue to our members for some time, it became official only in February. Because tonsillectomy remains one of the most frequently performed surgeries in the United States, and often involves children, this is a significant announcement. It is beyond the scope of this column to share the details, but the specifics can be found at http://www.FDA.gov/Drugs/DrugSafety/ucm339112.htm.

During that same week, the national press conference by the *Choosing Wisely*® campaign, which included an announcement of the AAO-HNS Foundation's participation, took place at the Kaiser Family Foundation building in Washington, DC. Our "five things" or tests and treatments otolaryngologists and patients should question about overuse or effectiveness were released to the public. The event was well attended and many news outlets covered the campaign. We received several notices from members who heard the news in their local areas and complimented the Academy on its participation. You can read more at www.entnet.org/choosing_wisely.

While such events are not uncommon, this active week is a further reminder of the integration of the socioeconomic and the clinical. As advocates for our patients, we regard patient safety as paramount. Therefore, with regard to codeine, new data revealing a threat to patient safety is meaningful to us. However, it is challenging to have to abandon a well-established element of care on such short notice. The involvement of the FDA, the flurry of press coverage, and the need to notify doctors, hospitals, pharmacies, allied health providers, and the public demonstrate major advocacy, communications, and health policy challenges. The health policy issue arose from the published scientific and clinical literature combined with the FDA's own tracking mechanisms for adverse events.

Likewise, our participation in the *Choosing Wisely*® campaign arises from our members' clinical experience, contributions, and suggestions. A member brought the campaign to our attention. The recommendations were chosen through suggestions from our members, subspecialty societies, Foundation committees, Guidelines Task Force, Patient Safety and Quality Improvement Committee, and others. It is likely that future evidence-based guidelines' action statements will provide further tests, treatments, or interventions that should be questioned. As future payment models will inevitably be linked to quality improvement, we again see the intersection between advocacy and clinical care.

While the Academy/Foundation clinical committees are relatively well known to most of us, the health policy and socioeconomic structure is not. Most of us could sit in on a clinical committee, easily follow the dialogue and discussion, and contribute valued opinion, experience, or judgment. Few of us could attend a RUC (Relative Value Update Committee) or CPT (Current Procedural Terminology) meeting with the same comfort and ability to give relevant input without a lot of coaching, support, and assistance. Most of our members do not know to whom they are indebted for the outstanding manner in which our Physician Payment Policy Work Group (3P) members represent our interests and our specialty in these national venues. This group consists of appointed RUC and CPT representatives and alternates, our Coordinators for Socioeconomic and Practice Affairs, and other members who are engaged in policy in related areas or advancing their skills for future appointment opportunities.

Our current Academy structure is designed to better coordinate our efforts for seamless interaction between the socioeconomic and the clinical, research and education, and advocacy. With a single business unit responsible for Health Policy, Regulatory Advocacy, Research, and Quality, we are positioned to anticipate the effect of each element on the other, and to respond more quickly and effectively in advocating for our physician members and their patients' best interests. Please join me in thanking these tireless individuals who so expertly serve us.

CPT Team

- Bradley F. Marple, MD
  CPT Advisor
- Lawrence M. Simon, MD
  CPT Alternate Advisor

RUC Team

- Charles F. Koopmann, Jr., MD
  RUC Panel Member
- Jane T. Dillon, MD
  RUC Panel Alternate
- Wayne M. Koch, MD
  RUC Advisor
- John T. Lanza, MD
  RUC Alternate Advisor
- Pete S. Batra, MD
  RUC Team Trainee
- Peter Manes, MD
  RUC Team Trainee

EHR—Meaningful? Useful?

Every president of the United States since George H.W. Bush has touted the electronic health information record (EHR) as the entry point to a new age of healthcare delivery and patient care. The adoption of EHR had been phlegmatic until President Barack Obama initiated and signed into law the American Recovery and Reinvestment Act of 2009. It was this legislation that committed a $20 billion investment in the Health Information Technology for Economic and Clinical Health (HITECH) Act, with the goal of coordinating an informatics infrastructure that would help to eliminate waste and redundancy, enhance quality and safety, allow for improved data collection and analysis, leading to the development of best practices for defined disease entities, i.e., acceptable outcomes for most patients, the most number of times for the least cost. It would therefore result in improved patient care and lower cost, with an anticipated savings of $12 billion over 10 years. In 2010, only 20 percent of physicians and 10 percent of hospitals were using EHR systems.[1]

The Medicare and Medicaid EHR Incentive Program component of HITECH provided a financial incentive to physicians to buy into the process, with a federally funded "reimbursement" to offset some of the cost of EHR implementation. Of course these funds came with a quid pro quo; physicians had to meet certain criteria in data collection, services and information exchange (Meaningful Use-MU) as a prerequisite for payment. Also, payments to the physicians are staggered over five years, with the criteria for funding not fully developed. Impressively, physicians responded like lemmings jumping off the Norwegian cliffs. The U.S. Department of Health and Human Services boasts that physicians meeting at least five of the core Meaningful Use objectives has increased by at least 66 percent and currently, half of all physicians are meeting nine of the Meaningful Use objectives.[2] Two-thirds of physicians have received MU incentives. Now CMS is developing post payment MU audits, using outsourced recovery services, to expose any fraud and abuse. MU will enter Stage 2 in 2014, with a three-month reporting period. The added criteria for Stage 2 were decided upon by identifying the Clinical Quality Measures least reported by current users.

The Big Question

The biggest frustration of this program is finding the meaning and usefulness of much of the data being collected. Currently, there is no connectivity between practitioners and, other than improved report generation and computer initiated faxing or email, there is no ability to share data. Some federally funded state health information exchange initiatives are being developed, but have been limited to electronic access to laboratory and radiology studies. In the face of this failure to communicate, much of the data collected is moot, with no apparent utility. The next goal of the program is to add PQRS and ICD-10 to our EHR agenda, piling on more administrative strain and another potential roadblock for financial reimbursement from third party payers, including CMS.

Where have there been improvements from EHR to date? The ability to send a clinical visit summary to other providers is simplified and expedited. The patients can also be given a written summary of their visit as they exit. Patient healthcare information forms can be developed and personalized, including pre-and post-operative instructions, informed consent, specific disease educational material, and specific therapy material. The added capacity for medication interaction identification and e-prescribing through the Rx component of the EHR enhances patient safety and convenience by eliminating drug interactions and prescribing errors due to handwriting misreads. The next steps should include either a centralization of computer languages or, more likely, super software to allow interconnectivity of all EHR software. Additional services could also be developed.

Our Hopes, Our Needs

Thomas Goetz, editor of *Wired* magazine, sponsored and developed an improved clinical laboratory study patient data form, presented on the TEDMED Conference website. He presents a data form that summarizes all normal findings by system, e.g., thyroid, cardiac, and liver all normal. The program then presents abnormal values on a color-coded scale, which explains personal risk to the patient. The program then integrates the lab data with demographics and further develops actions that could be taken for the individual patient. This provides a basis for enhanced patient-doctor interaction, allowing for improved compliance and outcomes. This program costs all of $10,000 for *Wired* to develop.[3]

It is time for us, as end-users of EHR, to interact with software companies and the government to put the "meaning" and "useful" into Meaningful Use, put the "quality" into Physician Quality Reporting, and truly improve the quality of patient care.

For more information and key dates for CMS Quality Reporting Initiatives, see page 20.

Paul M. Imber, DO
Chair, BOG Legislative Representatives Committee

Sources

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2. US Department of Health and Human Services; "More doctors are adopting EHRs to improve patient care and safety," HHS.gov/news/press/12/201212b.html.
3. Goetz, Thomas; "It's time to redesign medical records," TEDMED, posted 10/11.

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

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

Diversity Committee Course Addresses Cultural Concerns

The Diversity Committee's ongoing endeavors to promote cultural competence and improve patient care across the spectrum of cultures and ethnic backgrounds has been furthered by the release of a recent Patient Management Perspectives in Otolaryngology (PMP) issue. The Volume 42 issue addresses the "Adult for Rhinoplasty Consultation: The Mixed Non-Caucasian Rhinoplasty." This is the first education activity developed by the Diversity Committee, and it is in the subspecialty of facial plastic surgery.

> "Further, the case challenges the surgeon to listen, accept, and act upon a patient's desires, even when these desires confuse..."

The case is a non-Caucasian woman seeking rhinoplasty, whose aesthetic characteristics show a mix of ethnic backgrounds. She is aware of her ethnic background, and she and her family share pride in this background. These feelings cause her to express specific preferences to the consulting surgeon about the desired result. The preferences expressed may likely result in some confusion on the part of the surgeon, as they may seem to restrict the surgeon from planning a rhinoplasty that he or she might understandably feel would yield an overall pleasing result. This tension is woven into the case that plays out as the case study is read and followed.

This course has a number of goals. As a basis, the case guides the participant in the approach to the aesthetic rhinoplasty patient, demonstrating an orderly progression from thoroughly listening to the patient, to formulating and carrying out a surgical plan, and through the postoperative care of the patient. Further, the case challenges the surgeon to listen, accept, and act upon a patient's desires, even when these desires confuse or even thwart the surgeon in his or her efforts to achieve a result that he or she feels would be reasonably favorable.

The case also demonstrates the concept that some patients of mixed ethnic heritage may be knowledgeable and sensitive about the specifics of that heritage, and may wish to preserve some, but not all, of the aesthetic characteristics of some components of that mixture. The influence the patient's family may have on the aesthetic surgery patient's feelings about his or her appearance is introduced. Even though it is axiomatic that the patient should be the primary beneficiary of surgical results, the surgeon who ignores the influence of significant surrounding persons on the patient's self image and acceptance of surgical change does so at his or her peril, particularly when appearance characteristics are clearly ethnic in nature.

The management of selected postoperative complications is explored. The concept of deciding against offering an operation to a patient who is clearly desirous of this operation is included, and an ethical manner that might be used to carry out this somewhat unusual decision is suggested. Finally, the course serves as a review of the characteristic rhinologic appearance of a specific non-Caucasian ethnic mix, the Mestizo nose.

This review of the approach to, and management of, the Mestizo nose seems itself to be important, because with the increase of Hispanic populations and the increasing mobility of populations in general, the chances of any rhinoplastic surgeon, in any location, encountering a patient with Mestizo characteristics, is growing. Also, because of the specific ethnic mix that comprises the Mestizo nose, it lends itself well to the discussion of the patient with atypical, unexpected, or confusing aesthetic desires, some or all of which may originate in the patient's ethnic self-image.

This exercise also shines a light on the emergence of differing aesthetic ideals other than the generally accepted, Euro-centric, Caucasian/Western ideal of beauty that has long been the norm in aesthetic endeavors. These differing ideals may well grow to take a place beside long-accepted Western ideals, coexisting with them rather than replacing them.

So, this course may be seen to address cultivation of the competencies of Patient Care, Medical Knowledge, Interpersonal and Communication Skills, Professionalism, and of course, Practice-Based Learning, in addition to stimulating the development of cultural competence. The interactive nature of the study promises to make it more interesting, and, we hope, more effective than simply presenting didactic material. Participants are invited to visualize themselves in their consulting rooms, actually discussing the patient's desires and possible management options.

The Diversity Committee hopes this PMP issue serves not only to educate participants in the specific aspects of this type of challenge in Facial Plastic Surgery, but also to increase awareness of the ever-broadening scope of patient self-perception, especially as it pertains to the non-Caucasian patient.

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A History of Otolaryngology through Artists' Eyes

Emma Cashman, MRCSI
for the Otolarynogology Historical Society

Art from the Renaissance through the 19th century provides some fascinating insights into historical perceptions of otolaryngology-related disease.

For instance, Michelangelo was a perfectionist in his art and enthralled by anatomy. In much of his middle life, he dissected corpses and at one point toyed with the idea of publishing a treatise on anatomy with eminent physician Realdo Colombo, who is credited with distinguishing the thyroid gland as a separate organ. The presence of a goiter in Michelangelo's *Separation of Light from Darkness* is well documented.

Additionally, the *Last Judgment*, a masterpiece of Michelangelo's later years, clearly depicts a woman with the classical signs of exophthalmos. Since the latest restoration in the 1990s, the presence of a small hemorrhage in the lower corner of her eyelid is now clearly visible.

Both Rembrandt's and Van Gogh's ears have long been the source of speculation. Several lesser known works of art, however, provide an interesting historical insight into medieval perceptions of head and neck pathology.

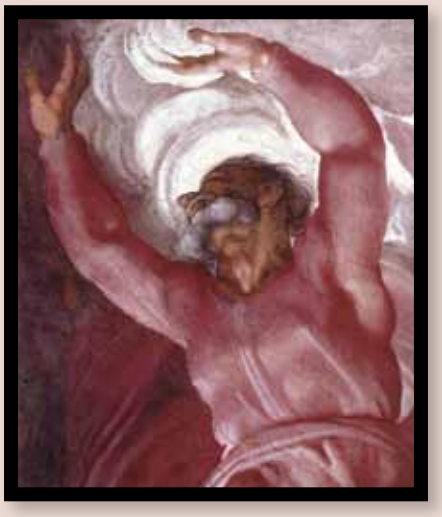
The central figure in Domenico Ghirlandaio's *An Old Man and His Grandson* is the gentleman's nose, which shows evidence of a rhinophyma. Does Piero di Cosimo's *A Satyr Mourning over a Nymph*, currently housed in the National Gallery, London, represent the 15th century approach to tracheotomy?

Sculpted depictions of facial trauma and, in particular, auricular hematomas, date back to antiquity. More recently, however, Rodin's bust of fellow-sculptor Jules Dalou in 1889 provides a remarkably accurate portrayal of his subject's deviated nasal anatomy.

Robert C. Hinckley's depiction of the first successful demonstration of anesthesia in 1846 (*The First Operation Under Ether*) commemorates an important landmark in surgical history. Hinckley purposely chose a large canvas to emphasize the importance of the event. The work depicts the patient sitting in a chair with his neck exposed for excision of a tumor of his jaw.

In this contrast in ages and faces, the sweet faced boy is not intimidated by his grandfather's rhinophyma in *An Old Man and His Grandson* by Domenico Ghirlandaio.

This scene of a wounded nymph lying on the grass could be linked to the death of Procris in Ovid's *Metamorphoses*. Despite the story that Procris was accidently stabbed by her husband, could Piero di Cosimo's *A Satyr Mourning over a Nymph* depict an early-day tracheotomy?



The Creator's throat exhibits a goiter in Michelangelo's *Separation of Light from Darkness.*

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Otolaryngology Historical Society Call for Papers

If you are interested in presenting at the next OHS meeting in Vancouver, BC, Canada, September 30, 2013, email museum@entnet.org.

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Ad Hoc Payment Workgroup Evaluates Payment Models

The Ad Hoc Payment Workgroup was formed to provide an avenue for the Academy to evaluate current and future trends in healthcare payment reform and to develop methods for otolaryngologist-head and neck surgeons to actively participate in these new models. The workgroup will supplement the work the Physician Payment Policy Workgroup (3P) and the Academy as a whole are already doing to position us for a future payment system based on quality and efficiency. This includes our work with national quality organizations, such as the American Medical Association convened Physician Consortium for Performance Improvement and the ABIM Foundation's *Choosing Wisely*® campaign, which focus on the development of quality metrics and the enhancement of quality care. In addition, we are working closely with our physician leadership to support our members' participation in quality programs such as Physician Quality Reporting System (PQRS) and the Electronic Health Record (EHR) incentive programs. To support this work, in 2011 we partnered with CECity® to offer *PQRIwizard*℠, a CMS qualified registry for PQRS reporting. This tool allows the Academy to offer a streamlined method of participation in PQRS to otolaryngologists and builds member participation in the PQRS program. The Academy also continues to develop resources to aid member participation in the EHR Incentive program.

The Ad Hoc Payment Workgroup plans to focus initially on three specific areas: 1) clarifying current quality guidance documents available to members, 2) developing a care path for members for the treatment of sinusitis, and 3) evaluation of payment reform trends.

Clarifying Academy Guidance Documents

Currently, the Academy produces a number of documents to aid members in achieving the highest standards of quality care, including Clinical Practice Guidelines (CPGs), Clinical Indicators (CIs), Clinical Consensus Statements (CCS) and Position Statements. In the last year, the Academy updated nine Clinical Indicators, reaffirmed nine position statements and revised 10, and drafted a new position statement on tongue suspension. Also last year, the AAO-HNSF published an update to our guideline development manual and two CCSs. Two new guidelines will be published this year, two CPGs are currently being updated, and development of a new CPG on tinnitus and a CCS on chronic and recurrent rhinosinusitis in children has begun.

Each of these guidance documents has proved valuable for the Academy's membership. However, the Ad Hoc Payment Workgroup plans to further evaluate the guidance documents and determine how they are best utilized and what differences exist among them. In doing this, they hope to better define each guidance document and improve its applicability to members.

Development of the Academy's First Care Path

The Ad Hoc workgroup will also work on the development of the first Care Path, focusing on the diagnosis and treatment of sinusitis. The

> This is an exciting time in healthcare and the Ad Hoc workgroup is led by a talented group of physicians at the forefront of payment reform and with the expertise needed to develop alternative models of payment.

Academy has developed several resources for our members on the treatment of sinusitis including a clinical practice guideline, performance measures, and a clinical indicator. Therefore, the workgroup will use these existing resources and work to develop a care path for this disease process focusing on the medical management of sinusitis, mapping out the physician decision-making process, treatment, and different options for patients. The workgroup hopes to create other Care Paths designed to help improve quality and efficiency for some of the most costly head and neck diseases with high variability in treatment.

Payer Reform Trends

Currently, the United States is undergoing a vast transformation of the healthcare system and the Ad Hoc workgroup is working with members, private payers, and patient advocacy groups to best understand, analyze, prepare, and help shape future payment models. Recently, the American Medical Association (AMA) asked the Ad Hoc workgroup to evaluate a draft tool being developed in conjunction with the AMA Federation to evaluate practice readiness for the value-based purchasing payment program. On behalf of the Academy, the Ad Hoc group provided input to assist the AMA and Federation in the development of a tool that is applicable to specialists and their practices.

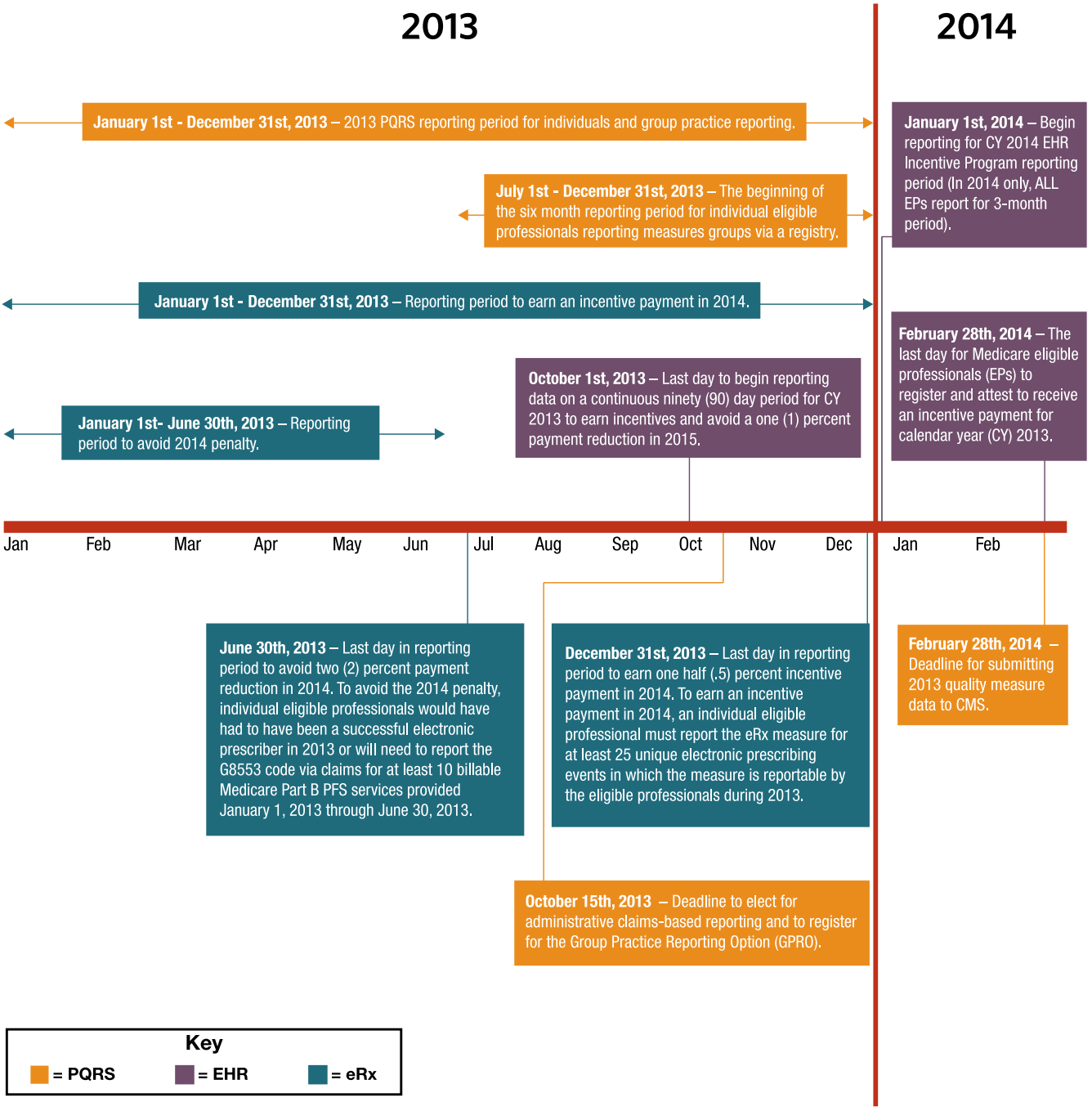
Recently, the Ad Hoc workgroup participated in the development of comments provided to the United States House of Representatives' Ways and Means Committee's proposal to replace the Sustainable Growth Rate (SGR). You can read more about this proposal and the Academy's comments on page 29. Along with this work, the workgroup plans to collaborate with other stakeholders, including the AMA and Surgical Coalition, on the development of new payment models. The Academy also plans to engage private payers to partner in the development of alternative payment methods for otolaryngologist-head and neck surgeons.

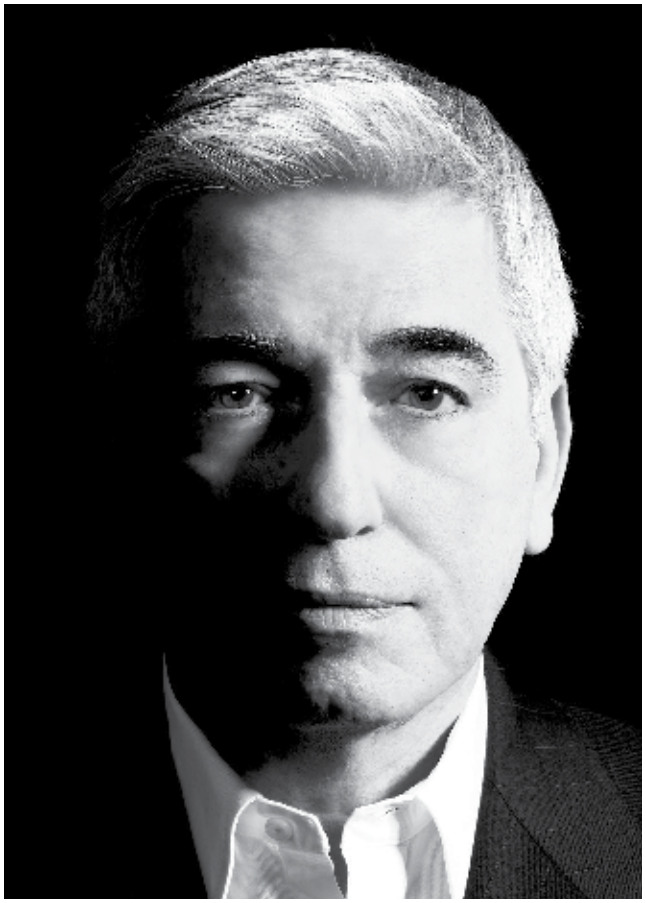
As **James L. Netterville, MD**, stated in his President's column, this is an exciting time in healthcare and the Ad Hoc workgroup is led by a talented group of physicians at the forefront of payment reform and with the expertise needed to develop alternative models of payment. The Academy will continue to work on ways to improve the quality of care for patients and advocate for otolaryngologists. For more information about the Ad Hoc workgroup, email the Health Policy team at healthpolicy@entnet.org.

Key Dates for CMS Quality Reporting Initiatives

Today, otolaryngologists are subject to multiple quality reporting initiatives that affect their bottom line. Through the Electronic Health Record (EHR) Meaningful Use Incentive Program, the Electronic Prescribing (eRx) Incentive Program, and the Physician Quality Reporting System (PQRS) Incentive Program, physicians may be subject to a nearly five percent payment reduction in 2015 if they do not begin to participate in these programs.

Because each of these programs is so complex and has different reporting criteria and timelines, the Academy has put together a timeline showing key dates for each program to help ensure you do not miss another deadline. For more details on the reporting criteria, incentive payments, and associated penalties, visit the Academy's newly redesigned CMS Quality Reporting initiatives webpage at www.entnet.org/qualityreporting.





Donald J. Palmisano, MD, JD, FACS
Board of Governors, The Doctors Company
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CPT for ENT: Coding for Intraoperative Neurophysiology Monitoring

Q: What Is Intraoperative Neurophysiology Monitoring and Can I Bill for it?

A: Intraoperative neurophysiology monitoring applies to performing nerve monitoring during complex surgical procedures involving cranial nerves. Another physician (usually a neurologist or physiatrist), or an electrodiagnostic technologist, prepares the patient prior to surgery by attaching fine wires and electrodes on designated areas, such as the face or neck, during a case of facial nerve monitoring. For recurrent nerve monitoring, the electrodes are integrated into the endotracheal tube. These electrodes are connected to electrodiagnostic equipment that monitors specific nerves either through automated monitoring (e.g., an audible alarm), or by the clinician's interpretation of the monitoring device's output.

Intraoperative neurophysiology monitoring is an "add-on" service, formerly reported with CPT 95920. For 2013, this code has been deleted and replaced with two new codes: CPT **+95940**: *Continuous intraoperative neurophysiology monitoring in the operating room, one-on-one monitoring requiring personal attendance, each 15 minutes (List separately in addition to code for primary procedures.);* and **+95941**: Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour.

Note that in the 2013 final Medicare Physician Fee Schedule, the Centers for Medicare & Medicaid Services (CMS) elected not to accept the CPT Editorial Panel's addition of CPT +95941, and, instead, created a G code to report monitoring that occurs outside the operating room. Providers should, therefore, report **G0453**: *Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby), per patient, (attention directed exclusively to one patient) each 15 minutes (List in addition to primary procedure.)* for monitoring occurring outside the operating room for Medicare beneficiaries. Members should note +95941 may be used for nonmedicare patients.

> "...to bill these codes... the service must be performed by a monitoring professional who is solely dedicated to performing the intraoperative neurophysiologic monitoring... The monitoring professional may not provide any other clinical activities during the same period of time."

The American Medical Association's Current Procedural Terminology (CPT®) does not limit CPT codes to any particular specialty. However, the CPT introductory language and AMA coding guidance is clear that in order **to bill these codes** (+95940, +95941, or G0453) **the service must be performed by a monitoring professional who is solely dedicated** to performing the intraoperative neurophysiologic monitoring and is available to intervene at all times during the service as necessary. The monitoring professional may not provide any other clinical activities during the same period of time. In the event the monitoring is performed by the surgeon or anesthesiologist, the professional services are **included** in the primary service code(s) and **should not be reported separately.** In addition, these codes should not be reported for automated monitoring devices that do not require continuous attendance by a professional qualified to interpret the testing and monitoring.

These codes, as with all add-ons, are not billable as standalone codes and are linked to the appropriate neurophysiologic monitoring code. For example, if facial nerve monitoring is performed during a parotidectomy, link CPT code +95940, +95941, or G0453 with the appropriate EMG CPT code (95867—*Needle electromyography; cranial nerve supplied muscle(s), unilateral)* instead of with the parotidectomy CPT code. If the physician performs only the interpretation and does not own the equipment, he or she should append modifier -26 (professional component) to the code.

The provider performing the monitoring must report both the intraoperative findings and record his or her precise level of involvement to obtain reimbursement. It is best to use CPT terminology in the dictation whenever possible. The provider who performs the nerve monitoring should have appropriate credentials to justify reimbursement. In addition, providers should note that there is not currently a code for reporting the use of surface electrode EMG monitoring performed for recurrent laryngeal nerve monitoring during thyroid surgery.

Members should also be aware that many carriers consider monitoring with an automated device integral to the surgery performed and will not reimburse for these services separately. Therefore, providers should familiarize themselves with their local Medicare Administrative Contractor (MAC), or private insurer's medical policies and coding guidelines for these CPT codes prior to reporting these services. Ultimately, it is the discretion of the surgeon to determine the mode and administration of these tests.

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The Transition to ICD-10: Will You Be Ready?

Robert R. Lorenz, MD
Lee D. Eisenberg, MD

After years of delay, the Centers for Medicare & Medicaid Services (CMS) has reiterated that on **October 1, 2014**, the ICD-9 code sets used to report medical diagnoses and inpatient procedures will be replaced by ICD-10 code sets. **This means providers should be preparing now** to meet the 2014 deadline for transition. The change does not affect CPT coding for physician services or outpatient procedures.

Why ICD-10?

The rationale for the transition is based on the fact that ICD-9 cannot be expanded to encompass necessary changes as it has only five numeric characters, whereas ICD-10 will have seven alphanumeric characters. Not only will the total number of diagnostic codes (ICD-10 clinical modification [CM]) be expanded from the current 14,000 to 68,000 codes, but the methodology of coding will be altered, too.

This mandated change will have a major effect on documentation and billing in the office and hospital. ICD-9 dates back to 1977, and many changes have occurred in technology and disease processes that are not reflected in the current code set. Due to the lack of detail and specificity in the current ICD-9 code sets, significantly different disease processes are being referred to by a single code, making it difficult to capture detailed diagnostic information and the specificity for accurate billing and reimbursement, especially as it relates to severity and complexity. As members are aware, one of CMS' primary goals in recent years has been to improve quality of care. Therefore, the lack of precision within the ICD-9 code set, which does not allow for the accurate measurement of quality, has been identified as an area requiring improvement by the agency. Further, since most developed countries converted to ICD-10 in the 1990s, international benchmarking of disease outside the U.S. will be facilitated by our domestic implementation of the ICD-10 code set.

In addition to the ICD-10-CM coding system changes, the transition to ICD-10-procedural coding system (PCS) will occur concurrently, but applies only to inpatient procedural coding and will largely affect facility-based coders. Physicians will be largely unaffected by ICD-10-PCS changes and will continue to use the CPT coding methodology to report their medical services.

Where Do I Stand?

When one examines the scope of changes that the ICD-9 to ICD-10 transformation entails, it is easy to become overwhelmed considering the effects on payers, suppliers, clearinghouses, administrators, schedulers, databases, quality measures, and research registries. By starting with your daily workflow as a physician, your focus should be concentrated on two areas: **documentation and provider-based coding.** Regarding documentation, we can summarize by stating that the increased level of granularity contained within the diagnosis code **will continue to need accurate and sufficient documentation to justify the use of that particular code.** The use of the diagnostic code should not be the first time an auditor comes into contact with data describing the pathophysiology, but rather, the detail should be contained within the documentation produced by the provider. Therefore, the specificity requirements in your documentation will be predicated on the new, more specific, diagnostic codes you will be entering.

More Specific?

In regard to provider-based coding, it is easy to state that the new ICD-10 code set will be more "specific," but many members have asked what that really means. The new code set contains increased granularity around diseases and will include new information such as, but not limited to, the following:

- Laterality
- Specific disease pathophysiology
- Combination codes
- Common clinical guidance scales and staging
- Timing of encounters
- Increased granularity of disease manifestations
- Alcohol and drug dependence effects of use
- Increase in injury codes
- Sequelae

What Does This Coding Change Mean for You?

The implication to your coding depends on how your practice is structured and what disease sets you commonly see. One place to start is determining whether you'll be using an electronic medical record (EMR) by October of 2014. Most EMRs are updating their disease-selection technology (pick-list) to conform to ICD-10 requirements. While this may not automatically convert the code from the ICD-9 to the ICD-10 version for existing patients, choosing a new, more specific ICD-10 code using this technology is not much more onerous than today's practice.

Providers who are using paper-based documentation and billing will experience a significantly more difficult conversion to the new coding system, especially if they are using the actual tabular, numerical code, rather than the alphabetic, disease description, as the new numerical system bears little resemblance to the previous methodology. The administrative burden for converting different categories of diseases will vary according to disease. Some codes will map from one ICD-9 code to merely two or three ICD-10 codes while others may map from one ICD-9 code to 12 ICD-10 codes. The most obvious examples of mapping "one-to-many" (in other words, one ICD-9 code being able to be converted to many potential ICD-10 codes) include orthopedics and obstetrics. But even for our standard "382.01: Acute suppurative otitis media with spontaneous rupture of ear drum" ICD-9 code, we will have to include a side and a timing when converting to "H66.014: Acute suppurative otitis media

with spontaneous rupture of eardrum, recurrent, right ear" in ICD-10.

To assist with the conversion, CMS has developed a tool called General Equivalence Mapping, or GEM, which aids in the conversion from a code in ICD-9 to ICD-10, and is available online. This can be a straightforward, one-to-one conversion, or a more complicated one-to-many mapping. GEMs have been created for both a forward mapping ICD-9 to ICD-10 conversion, or a backward mapping ICD-10 to ICD-9 conversion.

What Will This Cost My Practice?

Potential costs of the conversion can vary widely, depending on your IT and administrative support. Providers should plan for an initial decrement in their productivity of five percent to 10 percent during coding functions. If your coding is done for you in your office or the hospital, estimates suggest a decrease in coder efficiency of 20 to 50 percent initially, depending on the site. Most large EMR systems have a robust plan for administrating the ICD-10 conversion, but for providers with practice-specific technology, or worse yet, homegrown systems; a full IT overhaul may be required due to the dependencies with systems that interact with the EMR.

Training for physicians and staff will be costly and time consuming. The Medical Group Management Association (MGMA) estimates it will cost $84,000 for a three-physician practice to transition to ICD-10 and up to $3 million for large practices. There are multiple educational vendors with prepared materials for your office staff, billers, and us as providers, to review the changes that are specific to your area of expertise. Providers should plan on four to six hours of physician education in order to learn the content.

What Steps Should I Be Taking Now?

Providers should communicate with their office manager or financial support personnel to ask for a risk assessment of their practice. This should include questions such as: What will your coding process entail when you are utilizing ICD-10? How much additional documentation will be required, if any, to substantiate the use of the more granular code? Do you have preference lists that can be updated ahead of time to mitigate the disruption to your practice?

We also recommend that practices contact their payers and ask what type of infrastructure they are creating to assist with the conversion and whether there will be billing implications for the use of generic or unsubstantiated codes. Providers should also ask what percentage of their practice these codes and payers represent, and what they can do ahead of time to decrease revenue disruption. Remember, improving documentation accuracy to levels required for ICD-10 can begin now, even if your coding remains in the ICD-9 system. Other implementation and planning strategies could include the creation of a pilot with your office staff of dual coding to test the systems you've put into place or asking a payer to partner with you on a dual coding project ahead of the October 1, 2014, deadline in an effort to work out their own transition complications.

Academy Resources for Transition

In an ongoing effort to prepare and educate members regarding the looming transition to the use of ICD-10 diagnostic codes, the Academy has developed a series of educational articles and a dedicated webpage on www.entnet.org as resources for members. In addition, we are working toward an ongoing initiative to develop new resources for members, which will be rolled out during the remainder of 2013 and the first half of 2014. A miniseminar will take place at the 2013 Annual Meeting & OTO EXPO℠ in Vancouver, Canada, which will include presentations by ICD-10 experts.

Currently available Academy ICD-10 resources include:

- **What's New**: http://www.entnet.org/Practice/International-Classification-of-Diseases-ICD.cfm
- **General Information**: http://www.entnet.org/Practice/International-Classification-of-Diseases-ICD.cfm
- **ICD-9 to ICD-10 Crosswalk for Top 200 ENT Codes**: http://www.entnet.org/Practice/loader.cfm?csModule=security/getfile&PageID=156407
- **ICD-9 Coding to the highest level of specificity**: http://www.entnet.org/practice/resources/upload/Coordinating%20ICD.pdf

Previous Academy *Bulletin* Articles include:

- **Conforming Your Otolaryngology Documentation to ICD-10**: http://aaobulletin-365.ascendeventmedia.com/highlight.aspx?id=2904&p=271
- **ICD-10**: What it Means for Your Practice: http://aaobulletin-365.ascendeventmedia.com/highlight.aspx?id=3516&p=310
- **Preparing for ICD-10**: http://aaobulletin-365.ascendeventmedia.com/highlight.aspx?id=3925&p=333

Other materials that may be useful to members seeking additional information include:

- **CMS PowerPoint on ICD 10 Transition**: http://www.cms.gov/Medicare/Coding/ICD10/Downloads/CMSICD-10Overview.pdf
- **CMS Implementation Guide**: http://www.cms.gov/Medicare/Coding/ICD10/downloads/ICD10SmallandMediumPractices508.pdf
- **CMS Proposed Timelines for Small, Medium, and Large Practices**: http://www.cms.gov/medicare/coding/ICD10/Downloads
- **AMA ICD Transition White Papers:** http://www.ama-assn.org/ama/no-index/about-ama/icd10-white-paper-confirmation.page
- **AAPC PowerPoint on Transition**: http://www.cms.gov/Medicare/Coding/ICD10/Downloads/AAPCICD-10WillChangeEverything.pdf
- **AAPC FAQ**: http://www.aapc.com/icd-10/faq.aspx#why
- **Understanding and Preparing for ICD-10: Making the Conversion from ICD-9 to ICD-10 Manageable**: http://www.mgma.com/workarea/downloadasset.aspx?id=1368339

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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

Congressional House Calls

Last year's AAO-HNS OTO Advocacy Summit was a great success, resulting in more than 100 pre-scheduled meetings on Capitol Hill with Members of Congress and their staffs. In these meetings, Academy members discussed issues affecting physicians across the nation, such as truth in advertising, scope-of-practice expansions, and the repeal of the antiquated Sustainable Growth Rate formula.

With 77 members already signed up for this year's Summit, it looks as if it will be another great year. However, if you are not able to attend the 2013 BOG Spring Meeting & OTO Advocacy Summit May 5-7, don't let that stop you from discussing important issues with your Members of Congress. You can still meet with your Congressional delegation close to home.

Stay Informed: Follow Government Affairs on Twitter

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

Reach Out

The first step is to contact the district office of your federal legislator and simply introduce yourself. Make sure you mention you are a physician and a constituent who would like to discuss some important issues affecting you and your patients. If you need some talking points about the Academy's legislative priorities, visit the Government Affairs webpage at www.entnet.org/Advocacy. In the event you do not feel comfortable reaching out to your Congressional offices, feel free to contact the Government Affairs team at govtaffairs@entnet.org, and they will contact the office on your behalf.

Preparation

Once a meeting is established, schedule a time to speak with a member of the AAO-HNS Government Affairs team to answer your questions or discuss your concerns. They can help familiarize you with issues that are currently under consideration in Congress and answer any questions you may have about etiquette during a legislative meeting. The team can also provide you with a customized form outlining the background and voting record of your Member of Congress. Finally, contact your local colleagues and invite them to join in this important conversation.

Follow-up

After the meeting with your legislator has concluded, reach out to the AAO-HNS Government Affairs team to debrief them. This will provide staff with important feedback on the legislator's policy positions and enable follow-up with the Congressional office to answer any questions you may not have been able to answer. Finally, it is important to send a thank you note to the office/legislator. In the note, outline the issues you discussed, offer to be a resource in the future, and thank the Member of Congress (or their staff) for his or her time.

ENT PAC

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

Things to Remember

- Physicians are considered important "local validators." Make sure you mention who you are and where you practice when contacting your Congressional offices. You are a constituent—aka, a potential vote.
- If you employ staff, advise your legislator you are also a businessperson in the community.
- You may speak/meet with staff instead of the Member of Congress. Don't underestimate the value of such encounters. Staff members are a fundamental part of the legislative process and often understand the many different nuances of an issue better than the elected official.
- Always be courteous, professional, and respectful—even if you "agree to disagree" on issues.
- The AAO-HNS Government Affairs team is available to assist in many ways. Simply email govtaffairs@entnet.org with any questions.

SGR Repeal Gains Momentum in U.S. House of Representatives

The Sustainable Growth Rate (SGR) formula, the flawed mechanism used to calculate payments to physicians within the Medicare program, has been the proverbial "thorn-in-the-foot" issue for the physician community for more than a decade. Created by the Balanced Budget Act of 1997, the SGR formula was intended to control growth in Medicare payments for physician services by basing payments on per capita growth in the gross domestic product (GDP). Under the SGR formula, physician payments are reduced when growth in Medicare patients' use of physician services exceeds the universal spending target set by the SGR formula. By faulty design, a weak economy could trigger a decrease in target spending even if use of physician services remained high. As a result, physicians have annually faced steep cuts to their payment rate, forcing Congress to take action almost every year to avert massive cuts in the Medicare system.

Since the trend toward negative annual payment updates began, the AAO-HNS and others in the physician community have continually urged Congress to repeal the flawed formula and replace it with a payment framework that would provide stability for physicians practicing within the Medicare program and ensure critical access to care for the nation's senior population. In this case, however, Congress' annual actions to avert the payment cuts have acted as a double-edged sword. The good? Steep payment cuts for physicians have been avoided. The bad? In most cases, Congress failed to identify appropriate "pay fors" to fund the elimination of each year's scheduled cuts. As a result, the Congressional Budget Office (CBO) estimated the cumulative debt associated with the SGR had grown to more than $300 billion by the end of 2012.

Despite wide conceptual support by both Democrats and Republicans for repealing the flawed SGR formula, the immense cost associated with such action has proved prohibitive. However, based on early Congressional attention and an updated cost analysis by CBO, it seems 2013 may be the year that the stars align and Congress finally takes action to fully repeal the SGR formula.

A Rare Opportunity

The first piece of good news for this year came in the form of a Congressional hearing. In February, the Health Subcommittee of the House Energy and Commerce Committee gathered to discuss and evaluate key components for developing a new Medicare physician payment model. While hearings on this topic are not particularly out of the ordinary, its scheduling so early in the 113th Congress signaled that SGR reform was a front-burner issue for many Members of Congress.

Soon thereafter, staff from the House Ways and Means Committee invited various physician specialty groups, including the AAO-HNS, to participate in a briefing session on the Committee's development of a proposal to repeal the SGR and put in place a framework for a Medicare physician payment system designed to incentivize the delivery of efficient, high-quality healthcare. During the meeting, Committee staff emphasized their need for input from the physician community and made a request for official written comments from all the groups in attendance.

Given the rare opportunity to take part in the infancy stages of developing a potential new payment model, the AAO-HNS Government Affairs and Health Policy teams, in conjunction with the Academy's Physician Payment Policy (3P) and Ad Hoc Payment Workgroup, began drafting comments specific to otolaryngology-head and neck surgery. In the past, most legislative proposals regarding the SGR have attempted to move the Medicare physician payment system to a one-size-fits-all approach. However, this year's initial proposal shows that Members of Congress have begun to understand that, given the dynamic nature of modern healthcare delivery, any payment model must also provide options to accommodate providers across the continuum of care.

The AAO-HNS has emphasized that in any sort of payment mechanism, each specialty must be afforded the opportunity to drive the metrics and/or standards by which they are measured. Given the complexity of developing a new payment system and the time required to adapt and test the functionality of new programs, the AAO-HNS also underscored the need for providing a stable payment period for all physicians within the Medicare program following the initial repeal of the SGR. The Academy's official comments, dated February 26, 2013, are available at www.entnet.org/advocacy.

While no one will argue about Washington's love of a wonky policy scheme, even the best intended proposal could become moot if costs remain prohibitive, right? Here lies the last bit of encouraging news regarding the possibility of SGR repeal in 2013. Also in February, the CBO announced a massive reduction (to $138 billion) in the estimated cost of repealing the SGR. Following the announcement, a seemingly dead-end issue has been revived in earnest and the chairs of the House Ways and Means and Energy and Commerce Committees have heralded SGR repeal as one of their top priorities.

Although no hard timeline had been established at the writing of this article, several Members of Congress are urging leaders to address the SGR issue prior to the August recess. However, it must also be said that despite all of this year's positive activity, ongoing negotiations to reach a compromise regarding an overall deficit reduction plan pose a serious risk of derailing efforts to address the SGR and many other legislative issues.

Nevertheless, the AAO-HNS remains hopeful that 2013 marks the year that the infamous SGR is finally laid to rest. And as many agree, repeal of the SGR is now on sale and Congress should act fast before the CBO changes its mind.

For more information about AAO-HNS legislative priorities in the 113th Congress, email legfederal@entnet.org.

Advocating for Truth in Advertising across the Nation

Because of the increasing ambiguity of healthcare provider terms used in advertisements and marketing, patients often lack information and are confused about the wide diversity of professionals who work in healthcare settings. Many patients mistakenly believe they are being treated by medical doctors (MDs or DOs) when they are actually seeing non-physician providers. Recent studies confirm America's patients prefer a physician-led approach to healthcare and need accurate information about the level of training and education of their healthcare providers—including physicians, technicians, nurses, physician assistants, and other allied providers.

To address this issue, the AAO-HNS and others in the healthcare community continue to advocate for effective state and federal legislation that would require all healthcare providers to fully disclose their credentials and/or level of training in all patient communications. The AAO-HNS, in collaboration with other specialty groups, has worked to perfect the language used in the American Medical Association's model bill concerning truth in advertising and the use of "board certification" by healthcare professionals.

Across the nation, there have been numerous state legislative proposals introduced in the past several years, with more states adopting and implementing transparency legislation each year. Prior to this year's state legislative sessions, truth-in-advertising legislation had been enacted in Arizona, California, Connecticut, Florida, Illinois, Oklahoma, Oregon, Pennsylvania, Tennessee, and Utah. In 2013, there have been truth-in-advertising bills—both good and bad—introduced in Arkansas, California, Florida, Idaho, Illinois, Maryland, Massachusetts, Nebraska, New Jersey, North Dakota, Vermont, Washington, and West Virginia. In addition, a bipartisan, truth-in-advertising bill (H.R. 1427) was introduced in the U.S. Congress recently.

> "Recent studies confirm America's patients prefer a physician-led approach to healthcare and need accurate information about the level of training and education of their healthcare providers"

To learn more about the Academy's advocacy efforts on truth in advertising, visit the AAO-HNS Legislative and Political Affairs webpage at www.entnet.org/advocacy or email the Government Affairs team at govtaffairs@entnet.org.

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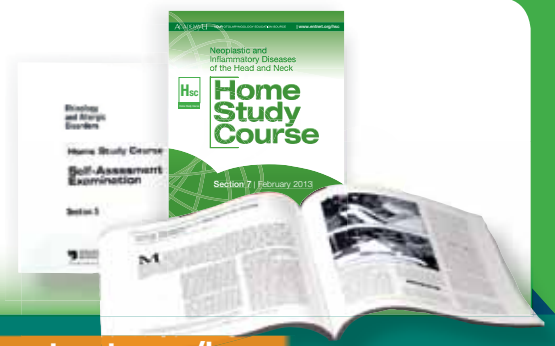

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AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY FOUNDATION

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❑ Resident in Otolaryngology–HNS

(Copies of your examination profiles will be sent to your program director)

Institution _____ Program Year _____ Program Director _____

❑ Practicing Otolaryngologist

❑ Other (specify) _____

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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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Subscription Products Offer In-Depth Study and Interactive Learning

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 contains elements that make up the breadth of the education opportunities available through the Academy. In this third article in the series we will explore the two subscription products published through AcademyU®: the Home Study Course (HSC) and Patient Management Perspectives in Otolaryngology (PMP).

The Home Study Course is the longest running education product produced by the Foundation, having first been published in 1940. It is also the second most popular education resource with more than 3,000 subscribers annually. More than 1,000 otolaryngology-head and neck surgery residents in more than 100 residency programs subscribe to it, as well as 2,000 practicing physicians.

In a two-year period, eight sections of HSC are published covering specific topics that reflect the breadth of the specialty. Two-year subscriptions are encouraged so subscribers will have access to all eight specialty areas. Registration for the 2013-2014 HSC year begins this month. Please see the registration form included in this *Bulletin* or visit www.entnet.org/HSC.

Each HSC "Red Book" provides a compendium of research articles pertaining to one of the eight subspecialties within otolaryngology-head and neck surgery. For example, the 2013-2014 course year offers articles on congenital and pediatric problems; clinical competency issues; trauma and critical care medicine; and plastic and reconstructive problems.

Each compendium is accompanied by an extensive bibliography and a self-assessment examination with a symposium discussion. Each section is designated for 40 *AMA PRA Category 1 credits*™. In addition to helping earn continuing education credit, HSC is a valuable resource for board exam preparation, certification and recertification, and CT Imaging accreditation.

Work groups within each of the eight education committees develop the courses. These hard-working volunteers serve for six years and produce three sections during that time.

Patient Management Perspectives in Otolaryngology PMP is an interactive electronic or print series that simulates real-life clinical decision-making. Each issue includes a clinical case study, visual materials, detailed patient management summary, references for further study, and a self-assessment post-test.

A PMP volume consists of eight issues published annually with topics covering the eight otolaryngology subspecialties. PMP is under the editorship of **Daniel J. Kirse, MD**, working with volunteer authors from the education committees.

Hsc
Home Study Course

Pmp
Patient Management Perspectives℠

Topics to be addressed in the 2013 volume include:

- Pharyngitis
- The Dizzy Patient
- Paragangliomas
- CSF Rhinorrhea
- Ear Deformity
- Child with Hoarseness
- Epiphora
- Interactions among Physicians and Physician Extenders.

PMP offers subscribers the opportunity to hone decision-making skills through full management of an individual patient from presentation to discharge and follow-up; an interactive question and answer format, with immediate feedback on each choice made; lab studies and imaging, surgery and possible complications, medical therapy, postoperative care and follow-up; opportunities to explore different options and pathways in patient management; visuals including x-rays, scans, surgical photographs, diagrams, and animated full-color graphics; and a thorough, fully referenced discussion of the patient case, presenting both the author's viewpoint and the broader background in the literature.

"In a two-year period, eight sections of HSC are published covering specific topics that reflect the breadth of the specialty. Two-year subscriptions are encouraged so subscribers will have access to all eight specialty areas. Registration for the 2013-2014 HSC year begins this month. Please see the registration form included in this Bulletin or visit www.entnet.org/HSC"

Subscribers can earn eight *AMA PRA Category 1 credits*™ with each issue of PMP for a total of 64 credits available in an entire volume.

"As the editor of PMP, I appreciate the hard work and dedication of the faculty who produce these highly interactive and practical learning resources," said Dr. Kirse. "I recommend physicians at all phases in their career subscribe to PMP. Not only can they earn up to 64 continuing education credits annually, but they will also gain new skills that can be immediately applied to their practice."

To subscribe to either of these valuable education resources, visit www.entnet.org/HSC or www.entnet.org/PMP. To view all of the Foundation's education and knowledge resources please visit www.entnet.org/academyu.

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VANCOUVER, BC, CANADA

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2. **Exceptional Educational Offerings**
   Attend instruction courses, miniseminars, and scientific oral presentations.
3. **Networking Opportunities**
   Reconnect and meet new colleagues from around the world in the OTO EXPO, evening events, and networking activities.
4. **The Latest Evidence-Based Information**
   Analyze evidence-based information and updates on practical applications affecting operative procedures, drugs, and medical devices.
5. **The Practice of Medicine Extends Beyond the Exam Room**
   At the OTO EXPO, review products and services from more than 300 companies that will help you provide the best patient care.

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Important Dates

- **May 6**
  Registration Open
- **July 12**
  Early Registration Rate Deadline
- **August 23**
  Advance Registration Rate Deadline
- **September 29-October 2**
  AAO-HNSF Annual Meeting & OTO EXPO℠

Welcome!

In its 117th year, the AAO-HNSF 2013 Annual Meeting & OTO EXPO℠ provides the opportunity for thousands of Academy members, non-member physicians, allied health professionals, administrators, and exhibiting companies to convene. It draws more than 5,500 medical experts and professionals from around the world and features instruction courses, miniseminars, scientific oral presentations, honorary guest lectures, and numerous scientific posters.

The 2013 annual meeting will take place in Vancouver, BC. Vancouver offers a winning combination of world-class hotels, meeting venues, and restaurants in a setting of spectacular beauty. Few convention cities offer such a wide range of cosmopolitan amenities in a downtown core that is safe, clean, pedestrian friendly, and stunning in its backdrop of mountains and ocean.

Whether you're an annual meeting veteran or a first-time attendee, attending one or more of the AAO-HNS/F activities will make the most of the meeting experience.

- **Maximize Your Membership—Get Involved with AAO-HNS/F**
  4:30–5:30 pm Saturday, September 28

This session will give you insights on how to maximize your membership in the AAO-HNS by taking advantage of all member benefits and opportunities to participate in AAO-HNS/F activities. These activities are designed to help you improve as a physician and a leader. Not an Academy member? Come to this session to learn about the value

Coming to Canada

Cell Phone Use in Canada

Attending the 2013 Annual Meeting & OTO EXPO℠ from the U.S. or internationally? Take note: Roaming charges and data plan fees for cell phones (especially smartphones such as the iPhone or Android) and tablets such as the iPad can be costly, with prices spiking as high as several dollars per minute.

Before catching your flight to Canada, contact your local cell phone carrier to get information about special pricing plans for calls, text messaging, and internet usage outside your home country. If you use a smartphone, ask your carrier about certain settings such as "airplane mode" that may help you save money on usage.

Credit Cards

Most major credit cards are accepted, but visitors are always advised to check with the vendor before a purchase is made. Cash machines with 24-hour access are available in many convenient locations throughout Greater Vancouver.

Weather

Warmed by Pacific Ocean currents and protected by a range of mountains, Vancouver enjoys mild temperatures year-round. September averages 65 degrees Fahrenheit (18 degrees Celsius).

Electricity

Outlets and voltage (110 volts) are the same as in the U.S. Small appliances such as hair dryers, irons, and razors, can be used in Canada. For those from other countries, adapters are required for electrical appliances. The frequency of electrical current in Canada is 60 Hz.

Language

Canada has two official languages: English and French. English is the predominant language in British Columbia. Vancouver is quite cosmopolitan and is a multicultural mix of many groups. Because of this, the city is considered multilingual on an unofficial level. Many banks, hotels, airline offices, service institutions, shops, and key tourist destinations have multilingual staff. After English and Chinese, the most common languages spoken are Punjabi, German, Italian, French, Tagalog (Filipino), and Spanish.

Time Zone

Most of British Columbia, including Vancouver, is in the Pacific Time Zone. During the annual meeting, Vancouver will be on Pacific Daylight Savings Time.

Cruise to the Meeting

A scenic Alaskan cruise is the perfect way to begin your visit to Vancouver for the 2013 Annual Meeting & OTO EXPO℠. You will discover a place where the mountains are taller, the rivers are mightier, and the wildlife is more plentiful than any place else.

Sailing dates: September 21–28

Cruise line: Holland America Line

Ship: ms *Zuiderdam* (1,916 passengers, 82,305 tons)

Itinerary: Seven-night Vancouver roundtrip (Inside Passage) Alaska cruise

Highlights: Cruising the Inside Passage, Tracy Arm, Juneau, Skagway, Ketchikan, and Glacier Bay National Park

Contact Jodi Pallan at 1-800-943-8687 or email jodi@alaskabysea.com for reservations.

of Academy membership, meet key leaders, and ask questions of knowledgeable staff members. To learn more, visit www.entnet.org/getinvolved.

- **First-Time Attendees Orientation**
  5:30–6:30 pm Saturday, September 28

  Learn what to expect and how to get the most out of your first AAO-HNSF Annual Meeting & OTO EXPO℠. This orientation is particularly important for all first-time attendees. However, even the most experienced AAO-HNSF meeting attendee can benefit. Learn how to maximize your annual meeting experience and how to organize your many ideas and activities so you can easily navigate your way around the meeting.

- **Career Fair-New this Year**
  6:00–8:00 pm Monday, September 30

  This year's most dynamic recruiting event, the AAO-HNSF Career Fair, is hosted by HEALTHeCAREERS Network. This evening event will take place on Monday at the Pan Pacific Hotel. The Healthcare Career Fair provides opportunities for candidates in all specialties and levels of training to speak face-to-face with hiring representatives onsite. Employers can leverage this opportunity to personally engage with numerous qualified job seekers at one time.

- **Instruction Course Tickets**

  The Instruction Course sessions are one- or two-hour sessions that address current diagnostic, therapeutic, and practice management topics, presented by both Academy members and non-members. Early registration for Instruction Courses increases the possibility of receiving your first-choice selections and saves money. Instruction Course fees are $50 per hour, and $70 per hour for hands-on courses, if you register in advance. Fees will increase to $70 per hour and to $90 per hour for the hands-on courses after the August 23 advance registration deadline. Register online at www.entnet.org/annual_meeting.

- **Interactive Itinerary Planner**

  Our itinerary planner grows more sophisticated each year, with new ways to design your schedule and customize your annual meeting experience. The education program will be available online. The revamped itinerary planner will allow you to search the education program by area of interest/track, date and time, and/or by program type. Networking opportunities such as alumni receptions will be searchable as well, along with the AAO-HNS/F committee meetings and other association events.

- **Session Recordings**

  Selected sessions will be available for download. Orders may be placed during the registration process, onsite, or online following the conference.

- **OTO EXPO℠**

  The practice of medicine extends beyond the exam room, and the OTO EXPO has nearly 300 companies that cater to every aspect of your practice—device manufacturers, pharmaceutical companies, collections, EMR systems, waiting room solutions, financial management firms, and more. Be sure to visit the OTO EXPO each day to see the best products and services our industry has to offer. Exhibits will be in Halls A-C of the Vancouver Convention Centre.

  The OTO EXPO will be open:

  - Sunday, September 29
    10:00 am–5:00 pm
  - Monday, September 30
    10:00 am–5:00 pm
  - Tuesday, October 1
    9:30 am–3:30 pm
  - Wednesday, October 2
    9:30 am–1:00 pm

  Children younger than 16 are not permitted in the Exhibit Hall.

- **ENT Careers Live!**

  Employers and job seekers will have an opportunity to participate in ENT Careers Live!, our employment event, during the Annual Meeting & OTO EXPO. It will be located on the show floor in Hall B, Booth 448. Don't miss this valuable networking opportunity. Visit ENT Careers, the trusted

Interested in holding a meeting or reception at the annual meeting?

Fill out a meeting space application today! Find it at www.entnet.org/annual_meeting.

Organizing an Alumni Reception? Email alsa@entnet.org soon to learn more about cost saving, food and beverage, and entertainment options.

Benefits of conducting a meeting through AAO-HNSF:

- Publicity. Meeting/event is published online and in the final program
- Convenience. Ease of being able to meet near the annual meeting
- Experience. Experienced staff working with you on your meetings/events

If you have any questions, please email alsa@entnet.org.

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1. **The World's Best Gathering of Otolaryngologists.** Join more than 5,500 medical experts from around the globe.
2. **Exceptional Education Offerings.** Earn up to 27.5 hours of continuing education credit by attending instruction courses, miniseminars, and scientific oral presentations.
3. **Networking Opportunities.** Reconnect and meet new colleagues from around the world in the OTO EXPO, evening events, and alumni receptions.
4. **The Latest Evidence-Based Information.** Analyze research and get updates on diagnosis, treatment, and operative procedures.
5. **The Practice of Medicine Extends Beyond the Exam Room.** At the OTO EXPO, review products and services from nearly 300 companies that will help you provide the best patient care.

otolaryngology employment source, at www.healthecareers.com/aaohns to learn more.

Networking Opportunities

- **Alumni Receptions**
  6:30–8:00 pm Tuesday, October 1
  Experience the revitalized Alumni Receptions. This year's alumni receptions have been enhanced to allow you to visit more easily with your friends and colleagues from other institutions, enjoy a lavish selection of regional Canadian morsels and treats, and be entertained by local talent. Visit www.entnet.org/annual_meeting frequently to see the latest list of Alumni Receptions.
- **International Reception (invitation only)**
  8:00–10:00 pm Tuesday, October 1
  All registered international attendees and their spouses are invited to this reception, where President **James L. Netterville, MD**, will honor the delegates from our guest countries—Canada, Kenya, Nigeria, and Thailand. We encourage international guests to wear national dress. Attendees enjoy a variety of desserts and DJ with dancing.
- **Poster Presentation Breakfast**
  7:00–8:00 am Tuesday, October 1
  This networking event will provide poster presenters an opportunity to interact and personally discuss their findings with annual meeting attendees.
- **President's Reception**
  6:00–7:30 pm Sunday, September 29
  The President's Reception is open to all Annual Meeting & OTO EXPO attendees, including registered guests and exhibitors. A well-attended event, it takes place on the first evening of the annual meeting in honor of the outgoing president. Badges are mandatory. If your guest has not registered, please do so before attending any annual meeting event.
- **Women in Otolaryngology Section Luncheon/General Assembly**
  12:00–2:00 pm Monday, September 30
  This year, the Women in Otolaryngology Section's keynote luncheon speaker features Christina M. Surawicz, MD, MACG, professor of medicine, division of gastroenterology, University of Washington, Seattle. Dr. Surawicz will address attendees on Women and Leadership. This will be followed by the Section's General Assembly meeting designed to facilitate the flow and exchange

Check out our Five Fall Flavors online at www.entnet.org/bulletin

of creative ideas and mentoring opportunities. Space is limited and tickets are required.

Education Program Overview

The 2013 Annual Meeting & OTO EXPO program, developed by the AAO-HNSF 2013 Program Advisory Committee and the Instruction Course Advisory Committee, is made up of the following sessions:

- **Scientific Program**

The Scientific Program of the Annual Meeting & OTO EXPO is composed of scientific oral presentations, miniseminars, and scientific poster presentations. The scientific posters will be on display throughout the conference during the hours of registration. The scientific oral presentations and miniseminars are included in the price of a full conference registration and begin at 10:30 am on Sunday and from 8:00 am to noon Monday through Wednesday.

- **Instruction Courses**

Instruction Courses are presented by experts in the field of otolaryngology and other healthcare professionals.

Education Offerings by Track

- Business of Medicine/Practice Management
- Facial Plastic and Reconstructive Surgery
- General Otolaryngology
- Head and Neck Surgery
- Laryngology/Broncho-Esophagology
- Otology/Neurotology
- Pediatric Otolaryngology
- Rhinology/Allergy
- Sleep Medicine

Registration Information

Register for the annual meeting and reserve your hotel room online at www.entnet.org/annual_meeting.

AAO-HNSF encourages all prospective attendees to register as soon as possible for the annual meeting to take advantage of reduced registration fees and to avoid waiting in lines onsite. Attendees can register online at www.entnet.org/annual_meeting until October 2, 2013.

Registration must be completed by midnight, Eastern Daylight Time on July 12, to obtain the lowest discounted rate. Fees increase at 12:01 am Eastern Daylight Time on July 13.

Your registration fee for the annual meeting includes the following:

- Access to all Scientific Sessions and Honorary Guest Lectures
- Entrance to the OTO EXPO
- The opportunity to review the latest scientific research in the poster area
- Access to complimentary shuttle service to and from most official AAO-HNSF hotels and the Vancouver Convention Centre
- Entrance to the Opening Ceremony and President's Reception.

Your registration fee for the annual meeting does not include the following ticketed events:

- Instruction Courses
- International Reception
- Ultrasound Workshop
- Otolaryngology Historical Society meeting

Travel Information

Every year, thousands of people visit Canada to attend conferences. We invite you to visit the Citizenship and Immigration Canada website at www.cic.gc.ca to obtain important information that will help you avoid problems that can affect your travel plans.

- Travel to Canada Checklist
  - **Make Sure you Have your Passport**. Be sure the expiration date is after October 2013. U.S. citizens renew or request a new passport from the State Department at www.travel.state.gov.
  - **Determine your Eligibility**. Find out if you qualify as a business visitor.
  - **Apply**. Before you plan your visit, you should find out if you need a visa to enter Canada. If you do not need a visa to enter Canada, you will still need to meet some specific requirements. If you do need a visa, find out how to apply.
  - **Check Processing Times**. Most applications for visitor visas (temporary resident visas) are processed within a few weeks or less. Processing times vary depending on the visa office.
  - **Prepare for Arrival**. Be prepared and know what to expect when you arrive in Canada.
  - **Extend your Visa**. To extend your stay in Canada, you should apply 30 days before your status expires.
  - **Bring a Guest to Canada**. You can avoid problems or delays when you bring your foreign business guests to Canada by planning in advance.
- **Airport**

Located nearly 20 minutes from downtown Vancouver, Vancouver International Airport (YVR) is ranked as one of the top airports in the world and is served by a wide variety of local, national, and international air carriers with direct routes to most major destinations.

Canada Border Services Agency (CBSA) is responsible for providing integrated border services and ensuring that all people entering Canada meet the requirements for entry. At YVR, CBSA officers are available around the clock, providing inspection services and promoting the free-flow of low-risk travelers, while enforcing laws and stopping potential threats.

Entry Requirements. Find out what documents and identification are required for Canadians and non-Canadians returning to or entering Canada at www.cbsa.gc.ca.

Currency Regulations. Carrying currency? Information for departing and arriving passengers about when and how to report currency to the CBSA can be found at www.cbsa-asfc.gc.ca.

CANPASS Air. Learn more about this expedited program for pre-approved travelers at www.yvr.ca.

- **Conference Airport Shuttle**

AAO-HNSF will provide direct-to-airport service available from the Vancouver Convention Center on Wednesday, October 2 from 11:45 am to 4:15 pm with continuous departures every half hour. The cost for this direct service is $20, which includes luggage handling. Due to limited seating, you are strongly encouraged to make your reservation well in advance once you arrive at the Convention Center. Keep in mind that the Vancouver International Airport is approximately nine miles from the convention center, so allow yourself ample time before your flight. All reservations must be paid in cash (CAD or USD) onsite in Vancouver at the AAO-HNSF Shuttle Information Center located outside on Waterfront Road, Exhibit level, prior to your departure.

Scientific Program Revamps Posters, Oral Presentations 2013

The Program Advisory Committee, led by **Eben L. Rosenthal, MD**, began preparing for the AAO-HNSF 2013 Annual Meeting & OTO EXPO℠ in September as it assessed the 2012 program, reviewed the attendee evaluation data, and refined the abstract/proposal criteria that would be vital in the selection process of this year's miniseminars and scientific presentations. The call for papers began in November for the miniseminar program and was reopened to scientific oral and poster abstracts from late January to mid-February. By late February, the committee had reviewed a few hundred miniseminar proposals and was then responsible for reviewing and evaluating more than 1,100 oral and poster abstracts. The 2013 Scientific Program was then created from this enormous pool of quality evidence-based research and case studies.

As is tradition, the 2013 Scientific Program will include five Honorary Guest Lectures whose esteemed lecturers were personally invited by AAO-HNS/F President **James L. Netterville, MD**. This year's guest lectures will cover topics from head and neck cancer to medical ethics. Be sure to review the enclosed Preliminary Program for the full list of lecturers and topics.

The Scientific Program comprises scientific oral presentations, miniseminars, and scientific poster presentations.

- Scientific Oral Presentations—Timely oral presentations that contain innovative information and present findings on scientific research, surgical procedures, practices, and approaches for practicing surgeons, residents, and medical students. During each session, the author will conduct a brief presentation and take questions from the audience.
- Miniseminars—Presentations, case studies, and/or interactive discussions that provide an in-depth, state-of-the-art look at a specific topic.
- Scientific Posters—The annual meeting features displayed posters that showcase the expansive range of studies in all areas of otolaryngology. More than 400 scientific posters contain innovative information and findings on original scientific research, case studies, surgical procedures, practices, and approaches for practicing surgeons, residents, and medical students. Scientific Posters will be located in Hall C of the Vancouver Convention Centre and can be viewed Sunday through Wednesday.

Poster Program Improved

Beyond the tried and true, this year's Scientific Program features some new and exciting additions to its core evidence-based education programming. Among them is the opportunity to view all 400-plus scientific posters from the convenience of your home/office computer or mobile device starting on Sunday, September 29. For additional convenience, each poster in the Poster Hall will have a corresponding QR code on its board. Scanning the barcode with a smartphone or camera-equipped tablet will allow you to access an electronic version of the poster. Computer kiosks will also be located in the Poster Hall for electronic poster viewing.

To further extend your interaction with the poster authors, the traditional poster reception has been converted to a Poster Presentation Breakfast. The breakfast will take place from 7:00-8:00 am Tuesday, October 1 in Hall C of the convention center.

This networking event will provide poster presenters an opportunity to present their data and respond to questions all, while enjoying a healthy breakfast before the start of that day's Scientific Program.

All New Oral Format

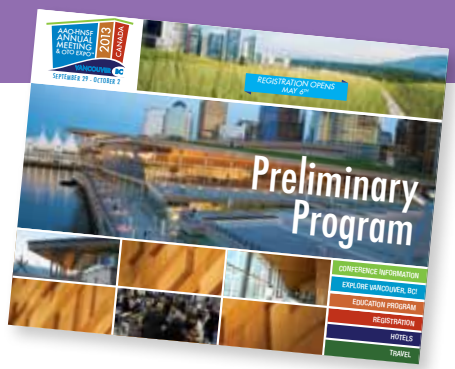
The oral presentations also will receive a facelift this year. In response to comments we received from oral presenters and previous years' attendees, some oral presentations will now be given in a quickshot talk format that consists of a three-minute oral presentation and two minutes of discussion. The new format will provide additional time for questions and answers after each oral presentation and allow us to expand the number of oral presentations that can be presented during the scientific program.

With three critical improvements to the Scientific Program and the beautiful backdrop of Vancouver, BC, Canada, this year's annual meeting is set to captivate and engage all participants. We look forward to your joining us and experiencing everything the annual meeting has to offer.

3P Miniseminar: Alternative Payment Models and Academy Advocacy

This miniseminar outlines the efforts the Physician Payment Policy Workgroup (3P) and the Ad Hoc Payment Workgroup have undertaken to prepare members for the implementation of Affordable Care Act (ACA) requirements by supplying the tools to participate in diverse payment systems and quality initiative programs. Topics include public and private payment models, including ACOs; bundling; and the importance of specialty-specific measures in quality and payment initiatives. Presenters will discuss strategies including how resources, such as the Clinical Indicators and Policy Statements, are used to advocate for appropriate policies by health insurance companies for coverage of services.

Bigger, Better Instruction Courses



Charged with organizing the instruction course program presented during the 2013 Annual Meeting & OTO EXPO℠, this past December the Instruction Course Advisory Committee, led by **Sukgi S. Choi, MD**, began the daunting task of reviewing and scoring the 512 instruction courses that were submitted for consideration for this year's program. The committee conducted a face-to-face meeting in February to discuss the merits of the submissions based on the committee member scores, previous attendance, and previous attendee evaluation scores for some of the most popular staple courses. After a rigorous discussion, the committee crafted a solid program that balances all fields of otolaryngology and targets the needs of our members.

This year's instruction courses program will be presented by the leading experts in the field of otolaryngology and other healthcare professionals. A majority of the program will be presented in a didactic setting, however it also includes courses presented for those who appreciate varying learning styles. The three subgroups outside the regular courses are:

- Hands-on—These courses allow each attendee to participate in the presentation and often involve simulation equipment or practical applications.
- Minicourse—Limited to 25 participants, minicourses promote informal discussion and the exchange of information.
- Interactive—Interactive courses will use an audience response system, allowing audience members to respond to the presenter via a polling mechanism during the course.

More Clinical Fundamental Courses

Capitalizing on the huge success of the two Clinical Fundamental instruction courses presented at the 2012 Annual Meeting & OTO EXPO℠ in Washington, DC, eight additional Clinical Fundamental instruction courses will be included on the 2013 program. These courses are designed to meet the American Board of Otolaryngology's Maintenance of Certification Part III requirements for Clinical Fundamentals and are eligible for *AMA PRA Category 1 Credit™*. Inquiries regarding MOC should be addressed to the ABOto at www.aboto.org. Dates and times will be announced later.

The Instruction Course sessions are one- or two-hour sessions that address current diagnostic, therapeutic, and practice management topics, presented by both Academy members and nonmembers. Early registration for Instruction Courses increases your possibility of receiving your first-choice selections and saves you money. Instruction Course fees are $50 per hour, and $70 per hour for hands-on courses, if you register in advance. Fees will increase to $70 per hour and to $90 per hour for the hands-on courses after the August 23 advance registration deadline. Register online at www.entnet.org/annual_meeting.

2013 Clinical Fundamental Courses

Business of Medicine/ Practice Management

- Clinical Outcome Measures/ Evidence-Based Medicine
  Michael G. Stewart, MD, MPH
- Management of the Addicted Surgeon
  Peter Sargent Roland, MD
- Universal Precautions for the Otolaryngologist
  Peggy E. Kelley, MD
- Ethics and Professionalism
  Roger D. Cole, MD
- HIPAA: Updates and What it Means for You
  Kathleen L. Yaremchuk, MD
- Integration of Quality and Safety into Otolaryngology
  Amy Clark Hessel, MD
- Pain Management in Head and Neck Surgery
  Christopher L. Oliver, MD

General Otolaryngology

- Anesthesia-related Topics for Otolaryngologists
  Murali Sivarajan, MD
- DVP: How, When, Why in Otolaryngology
  Amy Clark Hessel, MD

Rhinology/Allergy

- Treatment of Anaphylaxis
  John H. Krouse, MD, PhD

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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.

International Outreach Supports Academy's Core Mission

By M. Steele Brown

"Through collaboration with otolaryngologists around the world, the AAO-HNS reaches out to regions of every economic level," said **Gregory W. Randolph, MD**, AAO-HNSF Coordinator for International Affairs, "It's part of the Academy's core mission to further the specialty."

According to AAO-HNS/F past president **David W. Kennedy, MD**, the Academy works to empower its members by providing or supporting the highest possible level of professional and public education, research, and health policy advocacy.

But to sustain or improve its offerings, the Academy must remain healthy. The international arena, he noted, offers the most opportunity for growth. At present, the Academy has 1,205 international members (10 percent of the total membership), hailing from 88 countries on six continents.

J. Pablo Stolovitzky, MD, a past chair of the AAO-HNS Board of Governors, said the growing demand for knowledge that exists in many emerging countries—coupled with their often limited capacity to adequately fill that gap—offers the Academy an opportunity to do what it does best.

"The Academy is the world leader in otolaryngology and it has done that through education and through the AAO-HNSF Annual Meeting & OTO EXPO℠, which is the largest gathering of otolaryngologists in the world," he said.

"As a result, the meeting is the center of attention for the international otolaryngologic community due to the excellence of the activities—particularly educational and research—that it has presented over the last several decades."

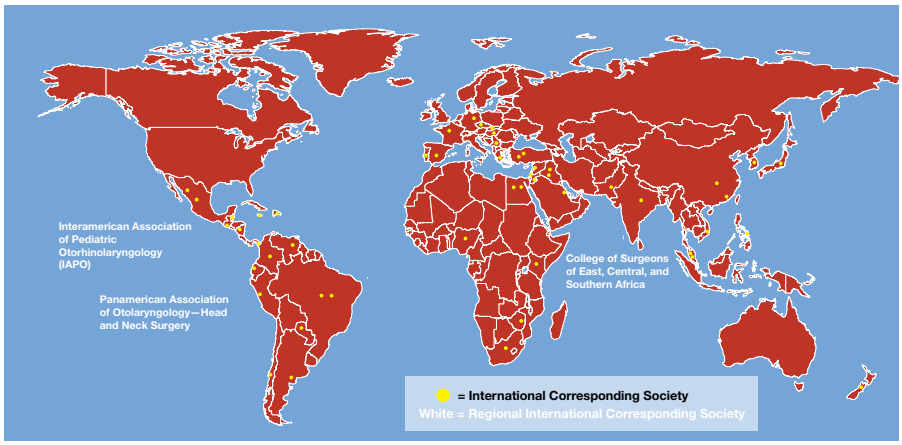
Dr. Stolovitzky affirmed that besides the tangible benefits generated through revenues from the Academy's growing international membership, there are other positives that are gleaned from international outreach.

"Revenues come in and allow the Academy to proceed with our national strategic planning activities, which definitely benefits both our U.S. and international members," he said.

"But the intangible benefit is the enrichment of the academic activity through collaboration with international members, which in turn develops research at the academic level in America by U.S. members."

"For example, research and education activities are enhanced by the participation of the international community through the Academy and that is done through the Annual Meeting & OTO EXPO℠, through publications submitted to our journal, and collaboration at the committee level," he added. "Numerous Academy committees have international members and/or participation."

Dr. Kennedy stressed, "I see our international efforts as particularly vital because the number of otolaryngologists in the U.S. is not likely to increase dramatically in the foreseeable future, while the potential for people to attend our Annual Meeting & OTO EXPO℠ from overseas and enroll as members is almost unlimited, So there exists a potential opportunity for both membership and revenue growth to help with our different missions."



Growing Our International Corresponding Societies Network

The Academy's growing network of 54-member International Corresponding Societies (ICS) is the mechanism through which the organization targets and reaches the otolaryngologists and their patients, Dr. Randolph said.

These national and, in some cases, regional societies affiliate with the Academy informally—there are no fiscal or legal ties—so leaders get to know one another to build trust and work together on issues of concern. Our International Steering Committee, with its 22 regional advisors and advisors-at-large, is the architecture that underpins that global effort, Dr. Randolph observed.

"We live in a big world, and because the American Academy of Otolaryngology—Head and Neck Surgery represents one of the foremost centers of otolaryngologic expertise on the planet, we have many global and international responsibilities," he said.

"Given the number and wide distribution of the ICS network, I crafted this system of Regional Advisors and appointed Academy leaders with deep experience in certain regions to mediate a particular area and keep up to date with the various International Corresponding Societies in their region. Because the advisors are familiar with all the leaders of these societies … it has been helpful to deepen our international relationships."

Catherine Lincoln, CAE, MA, the Academy's senior manager of international affairs, reported that joint meetings, generally occurring during the national

congress or annual meeting of an ICS, represent a significant opening for the Academy. She said the joint events might take the form of pre-congress workshops, miniseminar-style panels, or one- or two-day standalone courses.

"The host society selects the topics and ideally there will be equal numbers of American and host country speakers," she added. "Some otolaryngology societies like the Mexican, Turkish, and Venezuelan Societies hold a joint meeting every year."

Reaching Out to the Developing World

Besides the practical, self-sustaining benefits gained through international collaboration, AAO-HNS/F President **James L. Netterville, MD**, said the Academy focuses on humanitarian outreach.

Dr. Netterville, who serves as one of two regional advisors for Africa, revealed the AAO-HNS/F places a high value on developing outreach efforts in the areas of international medical missions, education and meeting support, as well as collaborative research and outcomes studies.

"It is not surprising that we gain as much from these interactions with our international colleagues as they do," he said. "Those of us in the Academy leadership actively look for ways to support our members in their efforts toward creative outreach activities."

G. Richard Holt, MD, D-BE, MSE, MPH, past Academy president and Regional Advisor for the Middle East, said it is critical to look at how American otolaryngology can boost or bolster research and clinical care in developing and emerging countries.

"We have—through our Academy and Foundation—probably the largest clinical and educational support group for otolaryngologists across the world, and that brings with it a responsibility to do everything we can to include our (international) colleagues in terms of making available what we have to offer," he said.

"We have a really strong obligation to give otolaryngologists in those countries the knowledge and tools to begin outcome studies and care for their patients at the highest level of care possible within the constraints of their country, and to show them that they are really not cut off. In countries like Iraq, where they have been both educationally and clinically isolated for some time, we have a real responsibility to help."

Exchanging Ideas through Research, Scholarships, and Journals

Dr. Stolovitzky, who serves as the Regional Advisor for Latin America, said he believes that because the Academy serves as a global forum, it has a duty to foster worldwide research communication.

"We are living in a global world and isolation does no good, particularly in science and more specifically in medicine," he said. "We need the collaboration and the participation to advance our knowledge base, and that is achieved if we have a world forum to do that."

Dr. Randolph said the Academy's International Visiting Scholarships (IVS) and International Travel Grants strengthen idea exchange.

"The IVS program funds individuals from abroad to help them attend the meeting and mediate an observership in the U.S., while travel grants enable foreign otolaryngologists to come to the meeting," he said.

"I think that the denominator for all of these programs is this: As we meet, so we become friends, and as we become friends, so we develop an ongoing relationship that aids in networking and building other relationships."

Dr. Holt, who formerly served as the editor-in-chief of *Otolaryngology—Head and Neck Surgery*, said the journal's strong international section now allows Academy members to share information online.

"It's even easier to share that information now, so somebody working in Germany knows what researchers in the U.S. are doing. If they have similar or complementary ideas, they can directly contact the U.S. researchers with the purpose of collaborating," he added.

"The same thing happens when you are at the AAO-HNSF Annual Meeting & OTO EXPO℠. So many ideas are exchanged, both clinical and research. You make contacts with people from other countries with the purpose of continuing to share ideas."

Dr. Kennedy, one of two Regional Advisors for Europe, said a good portion of the technology that U.S. otolaryngologists use frequently today came from overseas.

"Endoscopic sinus surgery was initially started in Europe, where I picked it up at a meeting," he recalled. "Since that time it has become one of the most frequently used procedures—and one of the major changes—within the specialty in the U.S. Within rhinology, the rigid optic telescope or rigid optic endoscope came from England."

Dr. Kennedy said in recent years, innovation has slowed in Europe, in part due to changes in the healthcare system and a growing emphasis on cost controls.

"Of course we are—to some extent—entering the same sort of period here in the U.S.," he said. "So I think it's critical that we keep this same kind of interchange going globally, because you never know where the next innovations will come from."

What Is Our Return on Investment?

According to Dr. Stolovitzky, it is not uncommon or unreasonable for U.S. Academy members to question the efficacy of investing in international outreach.

"We have limited resources, like any institution, and the pink elephant in the room is whether or not these international efforts are actually taking away from our own agenda here in the U.S.," he said.

"The expectation is for the Academy to concentrate on core activities like education and advocacy. Our U.S. members are definitely concerned about their medical practices and the socioeconomic and legislative issues affecting those practices."

"Members will ask themselves what the Academy can do to produce revenue through international outreach. We know for a fact that there has been a decline in corporate support for the specialty and our Academy needs to rely on additional sources of revenue to fund our core activities. Increased international membership and attendance to the Annual Meeting & OTO EXPO are critical to accomplishing this goal."

Otolaryngologists Needed in Rwanda

Representatives from the Rwanda Human Resources for Health (HRH) Program contacted the American Academy of Otolaryngology—Head and Neck Surgery about opportunities for otolaryngologists to work in teaching institutions in Rwanda, East Africa, starting August 2013.

The HRH Program seeks otolaryngologists to work for periods of three months to one year. Expected salaries are equivalent to about $140,000/year, in addition to a housing allowance, health insurance, and roundtrip travel costs.

Visiting otolaryngologists would work with both faculty and residents at teaching institutions in Kigali and Butare, Rwanda. The HRH program has requested these otolaryngology subspecialties in order of need:

1. Otology and neuro-otology
2. Rhinology and skull base
3. Pediatric ENT
4. General ENT

HRH also seeks laryngologists or reconstructive surgeons for focused three-month teaching positions. Ideal candidates are otolaryngologists with at least two years of experience beyond residency.

The AAO-HNSF International Steering and Humanitarian Efforts Committees urge otolaryngologists interested in positions within the HRH program to email Janet Hindsman at JLH8V@hscmail.mcc.virginia.edu.

For HRH FAQs on facilities, living conditions, housing, safety, schools, and visas for faculty and family members, visit http://hrhconsortium.moh.gov.rw/.

Dr. Dennis Snyder with young Rwandan patient.

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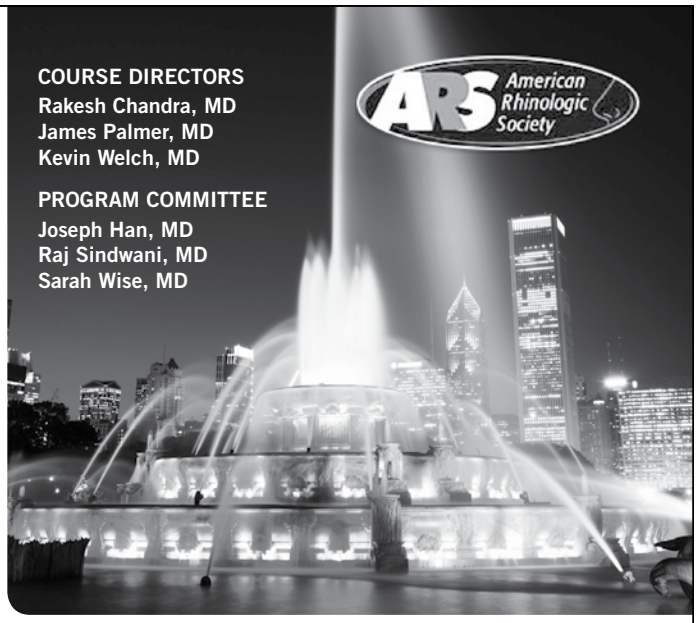

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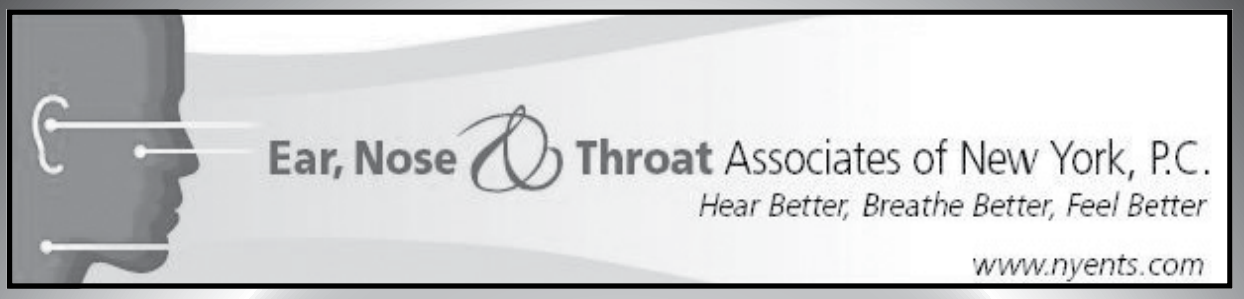

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The Department of Otolaryngology at West Virginia University is seeking a fellowship-trained head and neck surgeon to join a well established head and neck oncology service in the summer of 2013. Expertise with both ablative and reconstructive procedures 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.

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Laura Blake
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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
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Sewickley, PA 15143

MedStar Georgetown University Hospital

The Department of Otolaryngology-Head and Neck Surgery at Georgetown University Hospital is seeking a BC/BE physician with fellowship training in Otology/Neurotology to join our program. This position presents a unique opportunity for a full time academic surgeon to focus on the care of hearing and balance disorders as well as clinical/basic science research at two of the premier institutions in the metropolitan DC area: Georgetown University Hospital and Washington DC Veterans Affairs Medical Center. The candidate will be active in resident and medical student education and in clinical research.

Georgetown University Hospital is the largest academic medical center in the DC area and is part of the area's largest health care system, MedStar Health. The Washington DC Veterans Affairs Medical Center is a tertiary care teaching facility offering numerous opportunities for basic, translational and clinical research. For 30 years, the VAMC has been one of the major affiliated hospitals for the Georgetown Otolaryngology Residency Program.

Interested applicants should forward an updated CV to:
Bruce Davidson, M.D.
Professor and Chairman
Department of Otolaryngology-Head & Neck Surgery
Georgetown University Hospital
3800 Reservoir Road, NW
1st Floor Gorman Building
Washington, DC 20007
202-444-1351
Email: DAVIDSOB@gunet.georgetown.edu

AMERICAN HEARING RESEARCH FOUNDATION

Call For Research Proposals

The American Hearing Research Foundation is now accepting research proposals on hearing and balance disorders related to the inner ear for our 2014 funding cycle. Grants are $20,000 for one year of research. Only researchers in the United States holding PhD and/or MD degrees may apply. Priority is given to new investigators and researchers early in their careers.

Proposals are due by Thursday, August 1, 2013 at noon (CST) to Sharon Parmet as either a PDF or Word doc at sparmet@american-hearing.org. You may view the application guidelines at www.american-hearing.org. For further information contact: Sharon Parmet, Executive Director, at (312) 726-9670.

EMORY HEALTHCARE
THE EMORY CLINIC, INC.
OTOLARYNGOLOGY - HEAD AND NECK SURGERY

Emory University School of Medicine
Department of Otolaryngology – Head and Neck Surgery

The Division of Head and Neck Surgery in the Department of Otolaryngology – Head and Neck Surgery at Emory University in Atlanta, Georgia seeks to add a fellowship-trained Head and Neck/Microvascular surgeon, at the rank of Assistant Professor. The ideal candidate would also have experience with trans-oral robotic surgery (TORS). Duties will include resident and fellow level teaching and a clinical practice primarily involving mucosal tumors of the upper aerodigestive tract as well as a healthy free tissue reconstruction component. The position also includes a part-time VA component.

Our current practice features three full-time fellowship trained Head and Neck Surgeons and a new state-of-the-art head and neck clinic on the campus of Emory University Hospital Midtown. The practice also includes two full time nurse practitioners dedicated to the clinic. Multidisciplinary care is a priority with dedicated support in medical oncology and radiation oncology as well as the full complement of ancillary services.

Applicants must be Board Certified or Board Eligible.
Compensation will be commensurate with experience.

Interested applicants should forward letters of inquiry and curriculum vitae to:
Mark W. El-Deiry, MD, FACS
Assistant Professor and Chief of Head and Neck Surgery
Department of Otolaryngology – Head & Neck Surgery
550 Peachtree Street, Medical Office Tower, Suite 1135
Atlanta, Georgia 30308
or fax to (404) 778-2109
Email: meldeir@emory.edu
An Equal Opportunity / Affirmative Action Employer.
Qualified minority and female applicants are encouraged to apply.
EOP # 34944BR

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Improve your lifestyle.

Increase your surgical volume and income. Focus on your craft without the hassles and headaches of managing a practice. Work full or part time.

If you're a board-certified ENT/facial plastic or plastic surgeon and would like to learn more, **call 866.601.5438.**

Head and Neck Microvascular Surgeon

The University of Mississippi Medical Center

The Department of Otolaryngology, University of Mississippi Medical Center, seeks a head and neck microvascular surgeon. Responsibilities include teaching, research and patient care at our University Hospital and the adjacent Veterans Affairs Medical Center.

Requirements include M.D. or equivalent, completion of otolaryngology residency and fellowship in head and neck surgery. To apply, 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

Equal Opportunity Employer, M/F/D/V.

South Florida ENT 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

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 Division 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
Division Director; Ear, Nose, and Throat
rweatherly@cmh.edu
Phone: 866-CMH-IN-KC/866-264-4652
www.childrensmercy.org

UCLA

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

How would you like to become a part of a team providing compassionate and exceptional care to Veterans?

We are seeking a board certified or board eligible **Otolaryngologist and Section Chief** for the Jesse Brown VA Medical Center located in the Illinois Medical District in downtown Chicago. The position is accountable to the Chief, Surgical Service, for assuring the most effective delivery of care, while meeting and exceeding compliance standards.

The successful candidate will practice in collaboration with the oldest Otolaryngology department in the U.S. and will work closely with a talented group of residents in one of the world's greatest cities. As a VA professional, your opportunities are excellent. With many openings in the multiple functions of VA, you will have a wide range of opportunities at your fingertips.

VA professionals feel good about their careers and their ability to balance work and home life. VA offers generous paid time off and a variety of predictable and flexible scheduling opportunities.

Submit curriculum vitae by 6/1/13 to: J. Regan Thomas, MD, Mario D. Mansueto Professor and Head, UIC Department of Otolaryngology-Head and Neck Surgery (mc 648), 1855 W. Taylor, Chicago, IL 60612-7244 or via email to enthr@uic.edu

OTOLARYNGOLOGIST OPPORTUNITY

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

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

About the Position

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

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

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

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

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

Learn more at Join-Geisinger.org

GEISINGER HEALTH SYSTEM

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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

WestVirginiaUniversity.

The Department of Otolaryngology/Head & Neck Surgery at West Virginia University is seeking a general otolaryngologist to join a thriving academic practice in the summer of 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.

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

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

Laryngologist
Position Number M0204650
Join a busy voice and swallow team with a state-of-the-art laryngeal lab and experienced speech pathology support.

Head and Neck Surgeon
Position Number M0203642
Join a division of four head and neck surgeons. Fellowship in microvascular surgery, surgical oncology and an interest in oncologic research preferred.

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

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

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

KU UNIVERSITY of KANSAS
Department of
Otolaryngology
Head & Neck Surgery

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

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

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

WAYNE STATE UNIVERSITY
SCHOOL OF MEDICINE

Faculty Positions

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

ACADEMIC OTOLARYNGOLOGISTS

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

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

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

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OTOLARYNGOLOGY PRACTICE FOR SALE

Outstanding "turn key" otolaryngology private practice opportunity for sale. Solo M.D. retiring.

3000 sq. ft. condominium office fully equipped. Includes minor surgery suite, operating microscope Office endoscopy and audiology. Located in beautiful Port Orange,FL. (near Daytona Beach).

Five minute drive to beach and 5 minutes from nearest hospital. Terrific schools including public High School ranked in the top ten in the state. Opportunity to teach 3rd and 4th year FSU medical students and Halifax Hospital Family Practice and Gen. Surg. Residents. Call is 1:5. This is a fantastic opportunity for a new or established otolaryngologist!

Please contact H. Michael Seltzer, M.D. (386-788-4644) or E-mail at docseltzman@yahoo.com

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

Learn more at Join-Geisinger.org

GEISINGER
HEALTH SYSTEM
REDEFINING THE BOUNDARIES OF MEDICINE.

OFSC

Otolaryngology and Facial Surgery Centre

Join our team!

OFSC, a physician owned and operated general otolaryngology practice, is seeking a BC/BE full-time, otolaryngologist to join their five-physician team. We are the largest provider of comprehensive ENT services in the Northeast Arkansas area. OFSC has state-of-the-art equipment, complete audiology services, allergy clinic, in office lasers, and a fully integrated electronic medical records system (Greenway). We perform a wide array of ENT surgeries including pediatrics, endocrine, head and neck cancers, sinus procedures, and facial plastics with Moh's reconstruction.

Jonesboro, AR, situated one hour northwest of Memphis, TN, is home to Arkansas State University and offers numerous outdoor recreational activities.

Our opening for a General Otolaryngologist offers:

- **1:6 CALL**
- **Excellent Benefits, including 401k**
- **Relocation Package**
- **Primary Hospital: St. Bernard's Medical Center**
- **Outpatient Surgery Center (shareholder potential)**

Interested candidates should contact:
Shane R. Smith, M.D.
(870)761-9502
drsmith@jonesboroent.com

621 East Matthews // Jonesboro, AR 72401 // 870.932.6799

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

UTMSH is an equal opportunity employer.

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

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

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

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

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

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

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

University Hospitals

Head and Neck Surgery and Reconstruction Fellowship

The Department of Otolaryngology-Head and Neck Surgery in conjunction with University Hospitals Case Medical Center and the Seidman Cancer Center is proud to announce the establishment of a one-year Head & Neck Surgery and Reconstruction fellowship beginning **July 2014**. The head and neck surgical team includes **Drs. Pierre Lavertu**, **Rod Rezaee** and **Chad Zender**.

This one year fellowship offers advanced training in:

- Microvascular free tissue transfer
  - **Over 120 cases per year**
- Endoscopic and open skull base surgery
- Minimally invasive head and neck surgery
  - Transoral laser and transoral robotic surgery
- Sentinel node mapping for head and neck melanoma

Fellowship requirements and opportunities include:

- Clinical duties
- Teaching residents and medical students
- 1-11 call
- Clinical or basic science research
- Participation in our resident microvascular course and skull base workshop
- Travel and presentation at national meetings
- Productivity bonus in line with a competitive fellowship salary

Applicant requirements:

- Completion of an ACGME accredited Otolaryngology-Head and Neck surgery residency
- ABO board eligible or certified
- Ohio Medical license eligible

Please visit **http://uhhospitals.org/ENT** to view the position online and to submit CV for consideration.

For more information please contact:
Chad Zender, MD, FACS
Assistant Professor and Fellowship Director
University Hospital-Case Medical Center
Department of Otolaryngology-Head and Neck Surgery
Chad.Zender@UHhospitals.org
216-844-5307

Otolaryngologist Opportunity

Geisinger Health System (GHS) is seeking a BC/BE Otolaryngologist for Geisinger-Scenery Park, located in State College, Pa.

Bring your expertise to a growing practice with an established referral base. Enjoy a balanced schedule and the opportunity to participate in program development.

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.

The State College region offers an outstanding quality of life in a university town environment, including excellent restaurants and cultural activities, and some of the top nationally-ranked public and private schools. State College offers easy access to Interstate-80 and a local airport for weekend getaways to Philadelphia, Washington D.C. and New York City.

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

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