bulletin

American Academy of Otolaryngology—Head and Neck Surgery October 2013—Vol.32 No.10

DYMISTA™

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

First and Only

for rapid and more

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 Safety 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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complete *relief*

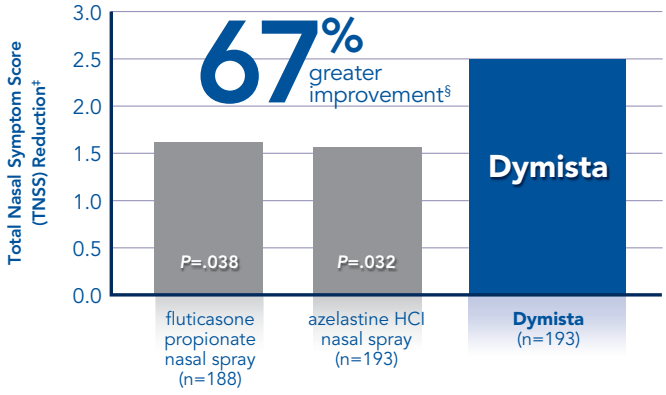
from seasonal allergy symptoms[1,2]

Rapid Symptom Relief vs Placebo

30 minute onset[*†]

Identified by patients as the most important attribute of SAR treatment[3]

Magnitude of Nasal Symptom Relief



Relative to fluticasone propionate and to azelastine HCl comparators[§1,2]

*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]

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

§Percent difference represents the improvement in TNSS with Dymista relative to fluticasone propionate or azelastine HCl comparator. The fluticasone propionate and azelastine HCl comparators used the same device and vehicle as Dymista and are not commercially marketed.[2]

References: 1. Dymista [package insert]. Somerset, NJ: Meda Pharmaceuticals Inc; 2012. **2.** Data on File. Meda Pharmaceuticals Inc. **3.** Marple BF, Fornadley JA, Patel AH, et al. Keys to successful management of patients with allergic rhinitis: focus on patient confidence, compliance, and satisfaction. *Otolaryngol Head Neck Surg.* 2007;136:S107-S124.

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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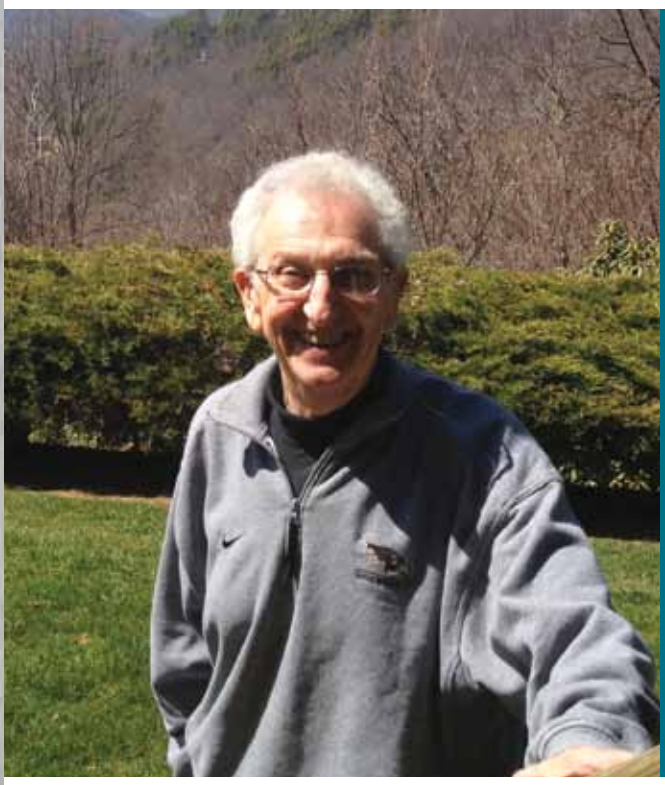

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This is the first in an occasional Bulletin series profiling otolaryngologists in later stage and/or no-longer-active practice. The series allows us to hear about and learn from the history, experience, and legacy of those otolaryngologists who have paved the way for others.

AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY

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October 2013 | Vol.32 No.10

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

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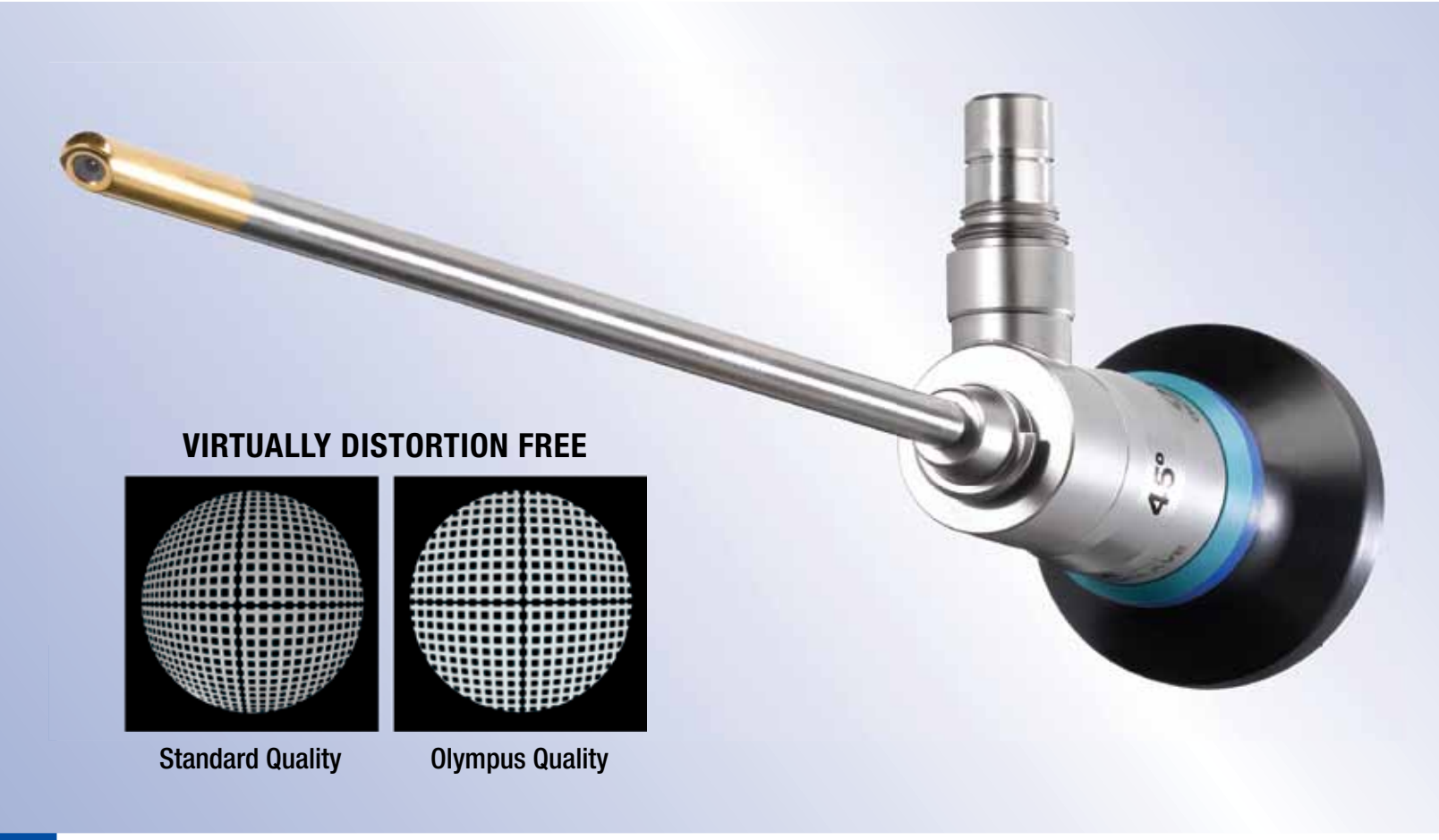

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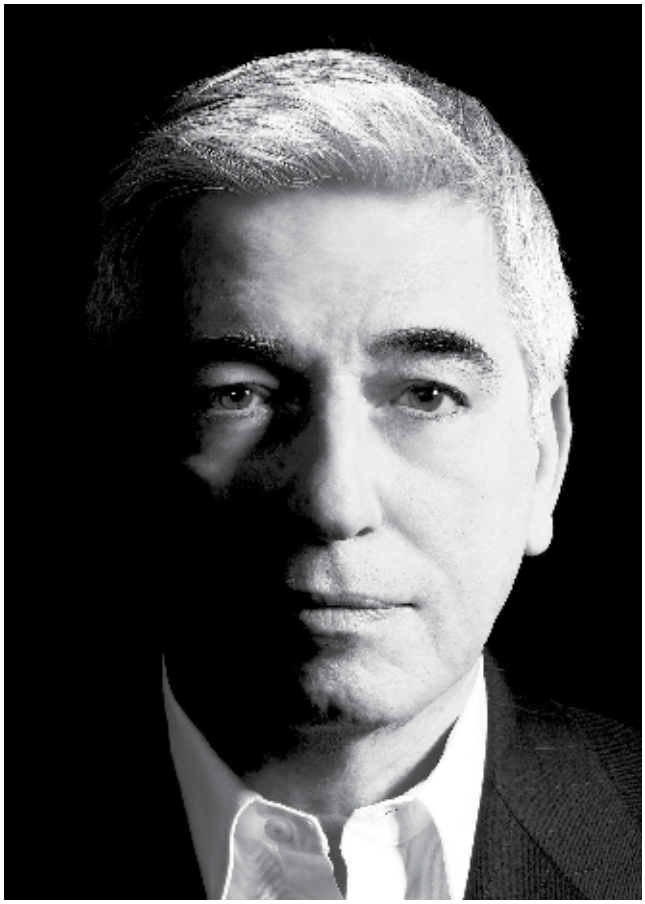

Donald J. Palmisano, MD, JD, FACS
Board of Governors, The Doctors Company
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A New Beginning in a Familiar Place

Richard W. Waguespack, MD
AAO-HNS/F President

This is a new beginning for me, but I am not a stranger here.

I received my medical degree from Louisiana State University School of Medicine in New Orleans and completed my residency at the University of Texas Medical Branch, Galveston, in 1980. After being a community-based practitioner for 33 years, I now have moved from that setting to become a clinical professor at the University of Alabama at Birmingham. I also serve as otolaryngology section chief at the Birmingham VA Medical Center.

Within our Academy, I have served in many different roles including board member, coordinator for socioeconomic affairs, and BOG chair. I am also a reviewer for *Otolaryngology-Head & Neck Surgery*. Throughout the years, I have chaired 3P (Physician Payment Policy Work Group) and our CPT/RVU Committee. On the education side, I have been a member of the Program Advisory Committee, the Instruction Course Advisory Committee, and, until recently, the Education Steering Committee, while chairing Core Otolaryngology Practice Management Education Committee. It is my honor now to serve you this next year as president of the Academy.

Within the specialty, I have been a senior examiner for the American Board of Otolaryngology (2008-2012) and on the Editorial Board of the *Laryngoscope*. I was honored to be named to the AMA CPT Editorial Panel (2004-2008), the body that creates and maintains CPT codes.

So, I come to this position with a variety of perspectives, especially in health policy and education, and am certain there are a number of opportunities for us to make a difference together.

In my June 2012 official statement as a candidate for AAO-HNS/F president-elect, I stated that our greatest strengths are our strategic planning process and the caliber of Academy leadership. Virtually every significant Academy activity is viewed from the perspective of adherence to this long-range planning that addresses the best interests of our members, and by extension, our patients. This strategic planning is as integral to our operations, as is the identification and mentoring of the next generation of leaders.

Our vulnerabilities include the risk of fragmentation, loss of specialty unity, and our relatively small size within the house of medicine. To thrive, we must engage the diversity within the specialty as we identify potential leaders and engage our subspecialty societies to further our advocacy, research and quality, and education activities. So this year I would like to help you, our members, continue to provide quality patient care both by leveraging our strengths and mitigating our weaknesses.

Education

Our tradition shows that we have been in the forefront of specialty education, but with your help we are adopting new methods of delivering relevant materials to members. For example, the award-winning Academy Q™ is helping many prepare for certification on their own schedule. Also note that AAO-HNSF collaboration with the American Board of Otolaryngology on the Fundamentals of Clinical Otolaryngology, (special educational offerings during this year's Annual Meeting) allowed participants to directly earn maintenance of certification credits. Coordinating education, advocacy, and research within the Academy and with our societies should help avoid duplication and boost productivity, while maintaining the highest standards.

We can work to strengthen these activities.

Policy and Research Combine for Quality Care

The relentless trend of decreased reimbursement coupled with increasing expense and administrative burden continues. Regardless of the fate of the Affordable Care Act, this squeeze is inexorable and will likely result in changes uncoupling reimbursement from the traditional fee-for-service model.

I am committed to advancing quality-driven patient care, and enhancing the specialty of otolaryngology-head and neck surgery. This requires evidence-based, health services research, which Academy leadership must help coordinate, foster, and disseminate.

Our cross specialty guideline development gives us visibility with primary care physicians, physician assistants, and nurse practitioners as well as consumer groups and ultimately the public. Working with primary care professionals allows us both to strengthen our working relationship and potentially open avenues for investigation for integrated services. The same is true of our RUC and CPT efforts. Through the Ad HOC Payment Model Work Group, we are actively participating and innovating within new models for payment delivery reform. These models are designed to meet the three aims of the National Quality Strategy in the delivery of healthcare services: better care, affordable care, and healthy people and communities. For more detail, visit http://www.entnet.org/practice/paymentreform.cfm.

My overarching goal this year is to provide members with as many tools as possible to deal with these challenges and, wherever possible, mitigate unreasonable burdens on our practices and patients.

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Committing to Self-government

David R. Nielsen MD

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

Each October signals the tenure of a new round of Academy leadership. Not only do we inaugurate and honor a new Academy president, but a significant number of board members of both the Academy and the Foundation, as well as committee members and chairs, turn over each year. As I reflect on the "changing of the guard," I experience two strong emotional responses. First, I am continually amazed and honored to be allowed to work so closely with such effective, selfless, and dedicated leadership. Working so closely with these remarkable men and women inspires me with confidence for the future. It is reassuring to know that we have an endless supply of talent and inspirational leadership.

> "The manner in which humans organize themselves to achieve things together that they could not achieve alone makes for interesting study."

Second, my gratitude for the voluntary service represented by these leaders (emblematic of the culture of service that pervades our entire membership) is hard to put into words. So it is with great thanks and some sadness that we say "thank you" to **James L. Netterville, MD,** for his very personable, gracious, and effective leadership during the last year, and welcome with enthusiasm and anticipation the energy and guidance of our new president, **Richard W. Waguespack, MD**. As you all know, for nearly two decades we have alternated the selection of many of our officers, board, and committees members between community-based and academic otolaryngologists. In that manner, directly elected board directors, Nominating Committee members, as well as the president always bring the perspective of our entire membership, not just a popular or more vocal segment, to the table.

This is a timely reminder, since this October issue of the *Bulletin* devotes focus to our membership and several committees. The structure of our Boards of Directors, the BOG, and our relationship with state, regional, or other specialty societies is designed to strike the optimal balance between the common ground that unites all of us as otolaryngologists and the desired autonomy of smaller societies who effectively provide community, subspecialty, or other interest or focus.

The manner in which humans organize themselves to achieve things together that they could not achieve alone makes for interesting study. Whether forming a new neighborhood tree house club or a new nation, humans have sought safety, camaraderie, solace, community, or collective action with likeminded people since before recorded history. While the consequences of the boundaries we formally place around our relationships, and the number of "groups" we feel a kinship with has a serious impact on many aspects of our lives, some of what we learn over time makes us ask, "What were they thinking?" (Or, perhaps more to the point, "What were we thinking?!") In his book, *How the States Got Their Shapes*, Mark Stein comments on the tremendous insight to be gained from researching this question. "Far more knowledge results from exploring why a set of conditions exists than from simply accepting those conditions and committing them to memory. Asking why a state has the borders it does unlocks a history of human struggles–far more history…" than the question implies. In studying why our geographic boundaries are the way they are, we learn about politics, war, grants, gifts, generosity, forgiveness, complaisance, incompetence, resignation, and regret. We discover the challenge of overcoming the inertia of culture, the bonds of familiarity, and the fear of the uncertain.

These ideas are affecting how we move forward as otolaryngologists in both our internal and external environments. Internally, we have for years benefited from addressing the challenge of asking why we are organized the way we are, why we do things the way we do, and are our traditions, assumptions, and expectations still valid and relevant. We are drafting an entirely new version of our Member Handbook, complete with standard operating procedures, documentation of processes, and accurate and updated application of bylaws, policies, and positions that benefit our members, and by extension, our patients. Externally, we are being forced by economics, politics, and our professional desire to be the best to challenge foundational assumptions of how we organize healthcare, delivery and payment models, and methods for ensuring the highest quality of care can be delivered with the most effective utilization of resources.

As we return to our practices after another successful Annual Meeting & OTO EXPO℠, let us meet the challenge to bring out the best in each other, professionally, personally, and organizationally. Let us use our leadership to focus on what unites us. Let's be sure that when it comes to the American Academy of Otolaryngology–Head and Neck Surgery that the whole is much greater than the sum of its parts.

Board of Governors Update

Peter J. Abramson, MD
Chair, Board of Governors

Regionalization of the Board of Governors

This is the start of another exciting year in the Board of Governors (BOG). This year implementation and activation of the Regional Plan will be high on the priority list. This plan divides the country into 10 regions following roughly the same lines of division as the Department of Health and Human Services (DHHS). There will be a regional representative from each of the regions charged with keeping the BOG up to date on socioeconomic and grassroots issues affecting each area of the country. The plan is that this will be done primarily through regional reports at the fall and spring BOG meetings, Academy staff coordinated conference calls, and direct communication with the BOG Executive Committee.

This plan puts a point of communication closer to the area of action. This is a two-way street. Our goal is not only to receive important updates from the regions but also to use this as an effective tool to stream critical information from the BOG to member societies and practicing physicians. Thus far we have had regional reporting at the last two annual fall meetings. As valuable information is shared, trends emerge and action plans are developed and communicated back to those groups and individuals in the regions that can help us achieve our goals on your behalf. The idea of regionalization of the BOG has been at least two years in development and has come a long way. This large task cannot be accomplished effectively without the direct help of every member society and otolaryngologist in these regions. The regional reps will be reaching out to you within the next several months. Please help us get closer to the concerns that affect you on the ground level.

Polls

As we implement the regional plan, the BOG from time to time will be polling the membership on topics of importance. Our first go at this was a poll on the member opinion on subcertification in advanced pediatric otolaryngology. More than 30 member societies responded, a 42 percent response rate. More than 1,000 individuals responded representing almost 4,500 members. The BOG received exceedingly positive feedback for engaging the membership in this fashion. We found an impassioned voice from our responders and time and time again commentary indicated an appreciation for asking their opinion. We will continue this method of feedback and will rely on the member societies to help us implement this powerful technique of information gathering. In the coming year we will be helping the societies to discover the most effective method of implementation for maximal input.

Your participation is a necessity and empowers the membership. Your thoughts and concerns do matter and they guide and empower the BOG to develop thoughtful, effective, timely, and prescient action plans that benefit our entire community.

Residents, Fellows, and Young Practicing Physicians

Young physician, resident, and fellow involvement has been and will remain a priority for the BOG. The BOG Executive Committee and Academy staff have made it a priority to harness the energy of our youngest otolaryngologists and those in training.

We had more than 30 residents and fellows at the BOG Spring Meeting, many of whom were recipients of generous member, member society, and academy grants for participation. Also, the residency program directors and chairs were gracious in allowing the residents the time and support they needed to participate. We had quite a few young physicians join us as well. This group is one of the most active and passionate that we have. They want to be involved and have a positive influence in the future of our specialty. It is our responsibility to help them make sure this happens.

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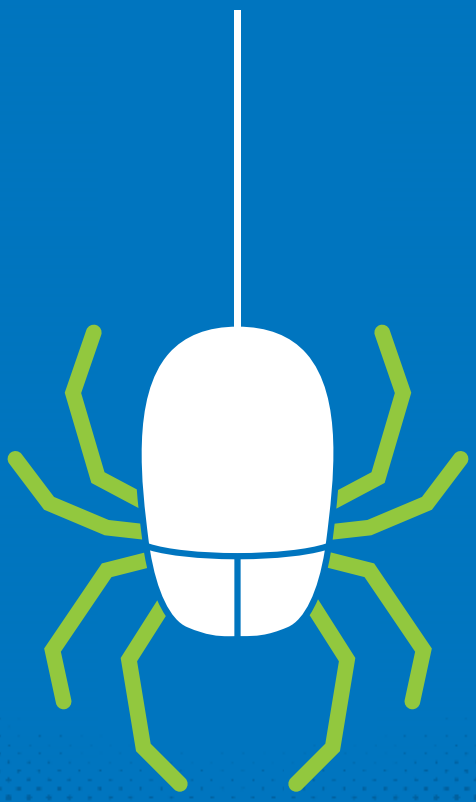

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From the OHS: History of Pediatric Airway Reconstruction

Ron B. Mitchell, MD
Chief of Pediatric Otolaryngology
University of Texas Southwestern and Children's Medical Center, Dallas for the Otolaryngology Historical Society

Laryngotracheal stenosis has plagued its victims and frustrated otolaryngologists for more than a century.[1] Before 1935, laryngeal infections, including diphtheria and syphilis, were the main causes of laryngotracheal stenosis. Between 1935 and 1970, trauma (mostly by motor vehicle accidents) became the leading cause of laryngotracheal stenosis. Post-1970, prolonged endotracheal intubation in neonates became and remains the primary cause of laryngotracheal stenosis in children.

Chevalier Jackson, MD,[2] considered by many as the father of bronchoesophagology, performed laryngoscopy in the pre-1935 era. This was an open procedure performed under local anesthesia with a solution of cocaine, salt, and carbolic acid. He referred to these patients as *canulard*, a French word meaning "a patient who cannot abandon his cannula."

Dr. Jackson reported successful decannulation in more than 80 percent of patients, all of whom were adults. The procedure was time-consuming and tedious, but considered a worthwhile alternative to a permanent tracheotomy.

In 1938, Edward A. Looper, MD,[3] reported the use of the hyoid bone as a graft for correction of laryngotracheal stenosis. In the 1950s, Aurel Rethi, MD,[4] began dividing both the anterior and posterior lamina of the cricoid cartilage to enable expansion of the subglottic lumen.

> Advancements using tissue grafts and techniques to expand the subglottic space foretold their widespread use in future laryngotracheal surgery in children.

Advancements using tissue grafts and techniques to expand the subglottic space foretold their widespread use in future laryngotracheal surgery in children. However, these procedures involved a long postoperative course and high recurrence rates.

> In 1993, Philippe Monnier, MD,[6] introduced the use of cricotracheal resection (CTR) for severe laryngotracheal stenosis in children and reported decannulation in the vast majority of these patients. These advances have resulted in decreased morbidity, tolerability, shorter recovery time, and fewer stages of reconstruction, as well as a success rate that surpasses 99 percent.

Around the 1960s, tracheotomy was increasingly performed in neonates for laryngotracheal stenosis caused by prolonged intubation. Mortality rates as high as 24 percent were reported. This set the stage for pioneering work directed at avoiding this unacceptable mortality rate in children.

Blair W. Fearon, MD, and Robin T. Cotton, MD,[5] started working on methods of enlarging the cricoid lumen using laryngotracheal reconstruction with costal cartilage. **John N.G. Evans, MD, FRCS**, reported success with a laryngotracheoplasty involving division of the thyroid and cricoid cartilages followed by castellation of the proximal trachea. Drs. Cotton and Evans, in a collaborative manuscript in 1981, reported a 90 percent decannulation rate and concluded that the procedures were largely interchangeable.

In 1993, Philippe Monnier, MD,[6] introduced the use of cricotracheal resection (CTR) for severe laryngotracheal stenosis in children and reported decannulation in the vast majority of these patients. These advances have resulted in decreased morbidity, tolerability, shorter recovery time, and fewer stages of reconstruction, as well as a success rate that surpasses 99 percent. With the addition of transplantation, there may be a time in the near future when children with laryngotracheal stenosis will live a life independent of a tracheotomy tube.

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From the OHS: Avicenna's Treatise on Otology in Ancient Persia

Hossein Mahboubi, MD, Yaser Ghavami, MD, and Hamid R. Djalilian, MD, for the Otolargyngology Historical Society

Avicenna (AD 980-1037), born in ancient Persia, is one of the best-known physicians of all time whose legacy has lasted for centuries.

As the king's physician and governor of two major states, who had access to the Samanid royal library, Avicenna wrote 450 books and added many original contributions to the diagnosis and treatment of diseases in addition to what was known in Persian and Greek medicine.

He is best recognized for his book, *The Canon of Medicine*, which was one of the primary medical textbooks throughout Europe and the Persian Empire for more than five centuries. *The Canon of Medicine*, described as the medical bible by Sir William Osler, consists of five volumes discussing general principles of physiology and hygiene, simple drugs and their effects, diseases, and medication recipes.

Otologic diseases have a dedicated chapter in the *Canon* consisting of separate treatises for ear anatomy, earache, tinnitus, ear purulence and ulcers, ear obstruction, water in the ear, bleeding from the ear, insects in the ear, and trauma. Despite restricting Islamic rules on autopsy, Avicenna's description of the ear anatomy resembles the modern classifications.

His theories on hearing damage and types of hearing loss were quite fascinating for his time. He classified hearing loss into three types and distinguished between conductive and sensorineural hearing loss. He described earaches that were caused by inflammation, foreign objects, ear trauma, and cold and warm temperatures.

Although he thought of tinnitus as a ringing sound generated by the movement of air inside the ears of patients with powerful or weak senses, his recognition of trauma, inflammation, and drugs as causes of tinnitus was remarkable. He described a variety of topical therapies for tinnitus.

Avicenna's theories on abscess formation were based on humors similar to his predecessors. He treated abscesses by drainage using a knife. To alleviate abscess-associated pain, his prescription consisted of salt, chamomile, or poppy ointment.

In his second book, where he described the ear diseases, he usually recommended topical medications as treatment. Avicenna's review on otology provided new information and greater insight into the anatomy and physiology of the ear. His in-depth descriptions of the pathology, signs, and symptoms of various ear diseases and how to effectively treat them illuminated the path to modern otology.

Avicenna's *Canon* was translated into Hebrew in the 1200s and Latin in the 1400s, and remained the main textbook of medicine in Persia and Europe until the 17th century.

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Next Month in the Bulletin:

Every month the Bulletin delivers news relevant to your membership and the specialty.

November will feature:

- **Bell's Palsy Clinical Guideline Executive Summary**
- **The New Committee Rosters**
- **And editorials by Richard W. Waguespack, MD; David R. Nielsen, MD, and Joseph E. Hart, MD**

On the go, access the Bulletin at www.entnet.org/bulletin to read each issue online.

From the Diversity Committee: LGBTIQ (Lesbian, Gay, Bisexual, Transgender, Intersex, Questioning) HEALTH EQUITY

Phyllis B. Bouvier, MD

Editor's Note: *Dr. Bouvier has just received the Arnold P. Gold Foundation Award for Humanism in Medicine during our annual meeting. She is also a committee member of both our Diversity Committee and that of the National Medical Assocication. She is also Co-Director of Diversity for Kaiser Permanente, CO, and author of Kaiser Permanente's, "Handbook on Culturally Competent Care.*

Our increasingly diverse healthcare consumer market is demanding concrete evidence of our ability to provide high quality, cost-effective care. This can only be possible by delivering culturally competent care, care that depends on our ability to acknowledge and understand cultural diversity in the clinical setting, demonstrate respect of the patient's health beliefs and practices, and which values cross-cultural communication and collaboration. Health equity is the attainment of the highest level of health for all people, and when inequities exist, they result in health disparities for individuals, communities, and global societies.

> "We must strive to make healthcare an inclusive and safe environment for all."

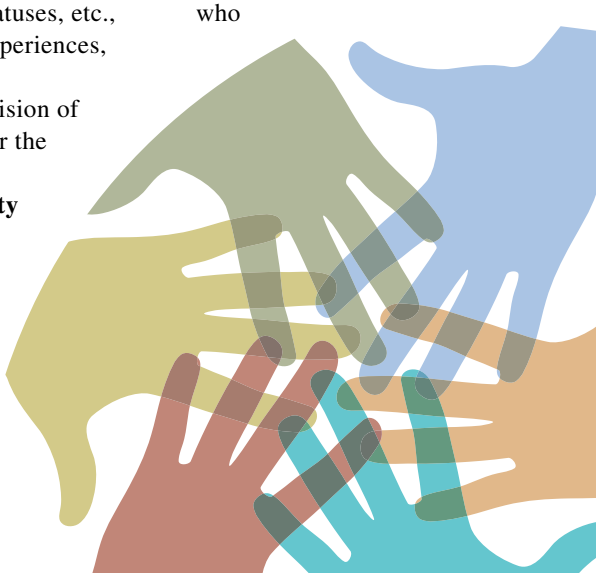
In the U.S., about 9 million people (3.5 percent) identify as "lesbian, gay, or bisexual" (LGB), but about 19 million in the U.S. (8.2 percent) have acknowledged engaging in same-sex sexual behavior. About .3 percent identify as "transgender," that is, a person whose gender identity (the sense of whether you are male or female) may not be the same as one's physical birth sex. "Transsexual" is a subset of transgendered. This population has so much gender dysphoria that hormone therapy or surgery is used to make the body genitally congruent with the gender identity. "Intersex" describes the condition in which one is born with external genitalia and/or internal reproductive or sexual anatomy that may not fit the typical definitions of male or female. The number of intersex individuals is estimated to be one in 2,000 newborns each year in the U.S. "Q" refers to someone who is questioning what his or her sexual orientation or gender identity is. The term "queer" may be used by many LGBT youth in the U.S. as a prideful and empowering term, but may have negative connotations depending on the social environment. Sexual behavior may be fluid throughout life, and self-identity may be as well.

Sexual orientation (our emotional and physical attraction to others of a particular sex) is only a part of someone's identity. The LGBTI population is made up of individual heterogeneous groups that include all races, ethnicities, age, socioeconomic status, education, disability or veteran statuses, etc., with distinct health risks, experiences, and care needs.

Major barriers to the provision of culturally competent care for the LGBTI patient are:

1. **A patient's sexual identity may be invisible to the physician.** Patients are often unwilling to self-identify because of fear of discrimination through historically negative interactions with healthcare institutions and providers. Until recently in parts of the U.S., certain aspects of an individual's sexuality were illegal. Before 1973 homosexuality was listed as an illness or pathological condition by the American Psychiatric Association.
2. **There is often a delay in seeking healthcare.** Issues of confidentiality are especially important in the healthcare setting since unintentional "outing" can have significant consequences on social and work status. An additional dilemma for providers involves patients who

Phyllis Bouvier, MD



are minors, since parents would ordinarily be able to review the medical record.

3. **A physician's biases, either implicit (unconscious) or explicit (conscious), may affect the quality of the interaction.** This includes: homophobia (fear of same-gender sexuality); transphobia (fear/hatred of transgendered individuals); and heterosexism (the belief that heterosexuality is the only form of sexuality). Both heterosexual and the homosexual communities often shun bisexuals. Bisexuality is frequently seen as a nonentity—a transitional phase from heterosexuality to homosexuality or vice-versa and/or as denial that one is actually homosexual. Social stigmatization is still prevalent. In the clinical setting, avoid the use of the term "straight" to identify heterosexuals, as it may imply to the LGBTI patient that anything other than straight is "twisted."
   - **There is limited epidemiological research and lack of provider knowledge of specific LGBTI healthcare issues.** Invisibility makes it difficult to accrue demographic data that can help identify needs and expectations of this population. What little is known indicates severe disparities for this population. Alcoholism/binge drinking is prevalent and persists with age. Added stresses of being without full legal protection and lack of societal supports for relationships often leads to increased depression and suicide risk. Lesbians have predicted increased risks of breast and ovarian cancer. Transgendered patients may be at increased risk for HIV/AIDS, but remember that sexual behavior and not sexual orientation causes the disease.
4. **Transexuals in transition may be more complicated to provide care for with the onset of the Electronic Medical Record.** Some transgendered may be living as the opposite sex for one year before surgery has been completed, and they will still require the preventive care of their birth sex.

For example, a female transitioning to a male (FTM) still requires a pap test; a MTF will still need a prostate exam. Not surprisingly, the lab thinks there is an error with the test ordered.

5. **Intimate partner violence exists.** Batterers can be misidentified as victims and treated as such by police and healthcare providers.

We must strive to make healthcare an inclusive and safe environment for all.

2014 Committee Applications Opens November 1

Want to get more involved with your Academy?

Apply to become a committee member! The 2014 applications will open November 1. You can join an education committee to become more involved in the Academy's education activities, a BOG committee to become more involved in the grassroots arm of the Academy, or one of the Academy or Foundation committees that fits your area of expertise.

Learn more at www.entnet.org/community/committees.cfm.

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A Proactive Treatment Plan Addressing ICD-10-CM "Code Z56.5"*

According to the most recent ICD-10-CM/PCS implementation timeline released by the Centers for Medicare & Medicaid Services (CMS), small, medium, and large practices should already have conducted high-level training on ICD-10-CM for clinicians and coders. To stay on track with the timeline, those practices should currently be testing clinical documentation, coding practices, software, and billing, with October 2013 as the time for practices to begin testing claim transactions with business partners. January 1–April 1, 2014, is the designated time to review coder and clinician preparation with detailed ICD-10-CM coding training. There will be no further delays, and the implementation date is firmly October 1, 2014, for all healthcare providers.

For the otolaryngologist, this new generation of coding will facilitate the capture of much greater specificity and clinical information, resulting in increased sensitivity when refining diagnosis grouping and establishing reimbursement methodologies. Plus, better coded data improves clinical decision making and outcomes measurement.

While the challenges of coding with ICD-10-CM for otolaryngology are perhaps less significant than for other specialties, they still exist. So what are the steps you can take now to avoid the condition described by ICD-10-CM code Z56.5?*

Step 1:

Relax, most of the significant changes: code expansion, coding guidance, coding instruction, and classification axes have, for the most part, left the most commonly assigned codes in otolaryngology unscathed. That's not to imply that solid coding training and preparation can be ignored. Coding training and documentation improvements are necessary to achieve coding compliance. What is important is that this advantage of fewer changes provides a head start in several ways. First, the historical ICD-9-CM coded data will be more easily mapped to ICD-10-CM and will continue to provide valuable data. Second, documentation improvement necessary for coding will not be a giant leap. Third, coding training can be focused, and risks associated with delayed claim submission and denials can be avoided.

Step 2:

Initiate the action plan for real-time coding training.

- Appoint an ICD-10-CM coding trainer to take the lead in this action plan.
- Identify a critical subset of ICD-9-CM codes based on utilization/reimbursement assessment.
- Code the subset of diagnoses using ICD-10-CM. Mapping can assist in this task as long as it is used in combination with code set knowledge, anatomy and physiology fundamentals, and proper coding practices.
- Identify any differences in clinical concepts, classification axes, coding practices, and terminology for the specific subset of codes.
- Assess and implement documentation improvement and coding practices concerning the identified coding differences required for accurate code assignment.
- Focus ICD-10-CM training based on the code utilization subset including the clinical concepts, classification axes, coding practices, and terminology challenges for the subset of codes.
- Assess skill levels after training and institute periodic refresher training and coding issue discussions.

Step 3:

Address these coding/documentation issues challenges.

- Aftercare versus subsequent encounter:
  - Aftercare visit codes cover situations when the initial treatment of a disease has been performed and the patient requires continued care during the healing or recovery phase or for the long-term consequences of the disease.
  - Subsequent encounter codes cover encounters after the patient has received active treatment for the injury and is receiving routine care for that injury.
- Laterality: right, left, and bilateral options
- Asthma: mild intermittent, mild persistent, moderate persistent, and severe persistent classification
- Recurrent versus nonrecurrent episodes of infections

Step 4:

Create a work environment that embraces a positive attitude toward change, and thus avoid unnecessary stressors associated with a change as fundamental as a new coding classification system. Taking the steps outlined above will provide a solid foundation for transitioning to ICD-10-CM and avoid the condition described by Z56.5.

***Z56.5 Uncongenial work environment (Difficult conditions at work)**

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Member Profile: Learning and Listening with Earl Singleton, MD

This is the first in an occasional *Bulletin* series profiling otolaryngologists in later stage and/or no-longer-active practice. The series allows us to hear about and learn from the history, experience, and legacy of those otolaryngologists who have paved the way for others. Dr. Singleton perfectly models an ideal of the "quiet giant" that was coupled with an amazing zest for learning and resulted in influence beyond his small community. His story came to the *Bulletin* as a result of the readership survey (to be fully reported in our December issue). Member **Jeevan Ramakrishnan, MD**, wrote, "My father-in-law recently retired after practicing otolaryngology for 50 years. He spent most of his career in private practice in a small town in north Texas. His story is fascinating." Dr. Ramakrishnan concluded, "I think it [this and other such stories] might create ... the opportunity to get to know one another a little better."

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

By all accounts, **Earl F. Singleton, MD**, was one heck of a country doc, but he would've been outstanding regardless of locale.

A recently retired otolaryngologist-head and neck surgeon and Academy Life-Fellow who spent 39 years in a single specialty private practice in the North Texas border town of Wichita Falls, Dr. Singleton said he never planned to return to practice medicine in his hometown.

"I came home to visit my mother and my sister—my dad had died when I was seven—and a doctor who had just opened his ENT practice after getting out of the [U.S.] Air Force at Sheppard Air Force Base there in town, asked me to join him," Dr. Singleton said. "So he guaranteed me a salary for the first year and we opted to go to work together—thinking that if it worked out that's great, and if it didn't, it wouldn't be a big deal because no anti-compete clauses were in effect. We ended up working together for nearly four decades, so I guess it worked out all right."

Family Ties

Regardless of where he ended up, Dr. Singleton may have been genetically predisposed to practice medicine.

"Both my dad and his younger brother, my uncle, were physicians," Dr. Singleton said. "To get through school, they would take turns working and going to school—one would teach while the other one went to (medical) school and they would switch back-and-forth. My dad, who finished first, went into general practice, while my uncle eventually did his residency in ENT in Philadelphia."

"On top of that, my older brother, George Singleton, MD, started the ENT program at the University of Florida (Gainesville) in 1961," he said. "So while the history only goes back one generation, you get four doctors out of that."

After finishing his undergraduate degree at Rice Institute (now Rice University), Dr. Singleton went to medical school and surgical internship

Dr. Singleton in his backyard in Waynesville, NC.

at the University of Texas Medical Branch in Galveston.

"I went to medical school in Galveston because it was the only one that would have me, what with my graduating 'laude-how-come' from college," he joked. "I absolutely loved medical school. My wife was pregnant and delivered our first child 36 hours after graduation. So, we decided to stay in Galveston and do a straight surgical internship."

From there, Dr. Singleton completed his year of general surgery at the University of Florida in Gainesville before moving to Boston to do his otolaryngology-head and neck surgery residency at Harvard University Medical School. He said that in medical school he waffled between plastic surgery and otolaryngology-head and neck surgery for a time, but eventually gravitated to otolaryngology because he loved the intricacy of the anatomy of the head and neck.

"I thought that a lot of plastic surgery was burn surgery from my medical school exposure and I didn't want to do that, but I eventually figured out that I could find everything I loved about plastic surgery in ENT," Dr. Singleton said. "We went to the University of Florida (my wife is from Gainesville) for the year of general surgery and then finished my training in 1969 at the Massachusetts Eye and Ear Infirmary.

> "For one thing, I could usually learn how I could do something better or different—be it fixing something at home or fixing somebody in the operating room—by listening to my patients."

Harvard was a wonderful training experience for him, with surgical giants such as Harold F. Schuknecht, MD; William Montgomery, MD; Richard Gacek, MD; and Charles Gross, MD, helping him to hone his craft. "He got a wide variety of experience," according to **Jeevan Ramakrishnan, MD**, Singleton's son-in-law and an otolaryngologist-head and neck surgeon in Raleigh, NC. "Harold F. Schuknecht personally taught him how to do stapes surgery."

Top Shelf Country Medicine

After completing his residency, Dr. Singleton was in the USAF at Andrews AFB for two years and then was on staff at the University of Michigan for two years, under then-department chief Walter Work, MD, and alongside Roger Boles, MD, former chair of Otolaryngology—Head and Neck Surgery at the University of California, San Francisco, as well as Frank Ritter, MD. As a young attending surgeon at Michigan, he also had the privilege of teaching a veritable Who's Who group of residents including **Michael Johns, MD**, the eventual chancellor of Emory University; Dale Rice, MD, University

Southern California department chair and former Drexel University chair of Otolaryngology-Head and Neck Surgery, **Robert Sataloff, MD**, among others.

Then he decided to give up his promising career in academic medicine and open up shop back home in Texas. When they started the practice, Dr. Singleton and his partner were the only two "modern trained" ENTs in Wichita Falls. In a few years they added another associate and the three of them worked together for more than 30 years.

"They were go-getters in terms of work and intellectually, so it was really fun," Singleton said. "We focused mainly on the broad field of general ENT and added facial plastic surgery in there as time went by. We had some training in that field because of our work with the nose, but we also became active in terms of skin cancers, because in our area, there was nobody else doing plastic surgery of that type.

Dr. Singleton, Beverly Singleton (wife), Suzanne Ramakrishnan (daughter), Jeevan Ramakrishnan (son-in-law), Kaia Ramakrishnan (granddaughter), and Montana Ramakrishnan (grandson)

"The general surgeons couldn't do it as well as we did," he said. "So we ended up working closely with the dermatologists in an office-surgical setting that saved everybody time, money and effort and probably risk, as we were able to do things in the office with minimal sedation. It just ended up being a really neat way to practice country medicine."

Ramakrishnan said that, considering his father-in-law's expertise, it was more than that.

"He didn't just stick with what he was taught in medical school and residency, he continued to improve and learn," Ramakrishnan said. "His patients just didn't know how good a doctor he was and how lucky they were to have this top-notch doctor taking care of them."

Dr. Singleton, who retired to live in the mountains near Waynesville, NC, near his children and grandchildren, said that, as a "country doc," the physician-patient relationship was an important part of practicing medicine.

"That may be family heritage, you know, coming from a family of general practitioners, but I also think that I came through medical school at an extremely practical time, which was ideal for me," Singleton said. "I always liked to know what people did [for a living]. For one thing, I could usually learn how I could do something better or different—be it fixing something at home or fixing somebody in the operating room—by listening to my patients."

"It helped that I could always extrapolate and figure it out as I went without necessarily having to be taught to do something," he said. "I might have picked up a trick from a plumber or other field, on how to do something different and often better."

Dr. Singleton said that listening also helped him decide when not to do some things as well.

"Those conversations usually gave me an insight as to what might be playing a role in what was going on, even if we are just talking about what they do for a living," he said. "I think as a part of that, I got to know my patients and their family dynamics.

"And I'm not trying to be a psychiatrist, but I think that there are psychological aspects to so many ailments, even including the common cold at times, and I think some of those issues have always played a role in how I treated patients and lent me a degree of understanding that formed how I practiced. I found that many times, just telling somebody that their response was normal was very helpful."

Dr. Singleton said the isolated location of Wichita Falls—roughly 150 miles south of Oklahoma City, Okla. and 130 miles west of Dallas—and some really good timing contributed to his amazing experience. "There were no plastic surgeons, neurologists, pulmonologists, gastroenterologists, oncologists or other specialties that overlapped with general ENT," he said. "We did everything we were trained to do and then some. You had to learn how to problem-solve and make it happen; and it was amazing if you went a day without learning something."

Dr. Singleton and Suzanne Ramakrishnan (daughter).

"There was one neurosurgeon in town when I got there who I was able to work with very closely, and I started doing pituitaries with him," he said. "To bring that kind of thing in to a town of 100,000 people part way between Dallas and Amarillo was pretty extraordinary. Looking back, I feel like we had as many resources as anybody around [in the field] and more opportunity than a lot, I'd like to think.

"One has to remember that this story began in the day when we used head mirrors for exams, tomography was the new thing and CT's, MRI's, flexible scopes and many of lab tests, antibiotics etc. were not around yet. It was truly a fun and great time to have practiced medicine when we pretty well kept up with all the changes and expertise."

They had a group that expanded to five ENT doctors that continues to serve that community and otolaryngology-head and neck surgery well.

Dr. Singleton feels one of the important things is that we flourish when we are happy. For us to be happy, we must create and seek well as much as we can—this includes family, office and hospital staff, and patients as well as in our other associates and acquaintances. As we often ask our patients "How are you doing?" It's important to also ask that of our families, staff, and associates. It certainly lets them know that we care, which adds to their happiness and it is often returned several fold to you, the physician.

Recent AMA Policy Changes Affecting Our Specialty

Liana Puscas, MD
Chair, AAO-HNS Delegation to the AMA House of Delegates

In June, the American Medical Association (AMA) conducted its annual House of Delegates meeting in Chicago. Below are some issues judged to be of increased interest to members of our Academy.

- *Use of Patient Satisfaction Surveys in Determining Physician Payment*. Patient satisfaction surveys are increasingly used for both marketing and regulatory purposes. However, spuriously negative surveys can be unfairly detrimental to a physician's practice. The House of Delegates adopted policy that the AMA work with Centers for Medicare & Medicaid Services (CMS) and non-government payers to ensure that physician payment, when incorporating quality parameters, only consider measures that are under the direct control of the physician. Also, this new policy calls for such surveys to be used only as an adjunctive and not a determinative measure of physician quality for the purpose of physician payment.
- *Scheduling of Hydrocodone.* In response to indications from the FDA that it was considering rescheduling hydrocodone from schedule III to schedule II, the AMA adopted policy specifically asking the FDA to keep it as a medication on schedule III of the Controlled Substances Act. There was significant concern that reclassification would restrict access to this common pain medication since schedule II drugs require triplicates and refills are not allowed.
- *Compatibility of EHR systems.* The House of Delegates also voted that the AMA will seek legislation or regulation to require all electronic health record (EHR) vendors to utilize interoperable software technology to enable use of EHRs across healthcare delivery systems and community-based settings of care. This policy will result in improved patient care while making it the responsibility of the vendors to ensure interoperability rather than physicians.
- *ICD-10.* ICD-10 is scheduled for mandatory implementation by CMS on October 1, 2014. The Cutting Costly Codes Act of 2013 (H.R. 1701) has been introduced in Congress to repeal implementation of ICD-10. The AMA already has policy advocating for delay and repeal of ICD-10. However, should ICD-10 be implemented (or ICD-11 in its stead), the House of Delegates passed another resolution asking insurers for a two-year period in which physician payment would not be denied based on lack of specificity in ICD-10/11 coding.

At the meeting, the AAO-HNS delegation consisted of **Liana Puscas, MD**, chair of the delegation, **Michael S. Goldrich, MD**, **Robert Puchalski, MD, Shannon Pryor, MD**, and **David R. Nielsen, MD** (Academy EVP/CEO and Alternate Delegate). Joy Trimmer, JD, senior director of Government Affairs, Jenna Kappel, director of Health Policy, and Joe Cody, Health Policy analyst, provided staff support.

Also of note from this meeting, Dr. Puscas was elected to the AMA's Council on Medical Education and Dr. Pryor was elected chair of the newly created Women Physicians Section. Prior to the meeting, Dr. Puchalski was elected secretary of AMPAC, the AMA's political action committee.

The next meeting of the AMA House of Delegates will take place November 16-19 in Fort Washington, MD.

On the Frontlines: State Legislative Tracking

AAO-HNS members are a key resource for tracking state legislation and helping to communicate to policymakers its influence on the specialty and patients. Join the growing team of AAO-HNS state trackers by signing up at govtaffairs@entnet.org to receive daily or weekly legislative tracking updates. *If you identify legislation needing Academy action (e.g., letter, action alert, testimony), simply fill out the new online State Action Form at www.entnet.org/Advocacy.*

Follow Government Affairs on Twitter

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

ENT PAC

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

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Application to be submitted electronically by **January 15, 2014 midnight ET**

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AAO-HNSF Resident Research Grant sponsored by The Alcon Foundation $10,000, non-renewable, one year to complete project. One available annually.

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AAO-HNSF Maureen Hannley Research Grant $50,000, renewable, one to two years to complete project. One available annually.

AAO-HNSF Percy Memorial Research Award $25,000, non-renewable, one year to complete project. One available annually.

AAO-HNSF Health Services Research Grant $10,000, non-renewable, one year to complete project. One available annually.

AAO-HNSF Rande H. Lazar Health Services Research Grant $10,000, non-renewable, one year to complete project. One available in 2014.

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AHNS/AAO-HNSF Young Investigator Combined Award $40,000 ($20,000 per year), non-renewable, two years to complete project. One available annually.

AHNS/AAO-HNSF Translational Innovator Combined Award $80,000 ($40,000 per year), non-renewable, two years to complete project. One available annually.

AMERICAN HEARING RESEARCH FOUNDATION (AHRF) AHRF Wiley H. Harrison, MD Memorial Grant $25,000, non-renewable, one year to complete project. One available annually.

AMERICAN LARYNGOLOGICAL ASSOCIATION (ALA) ALA-ALVRE Research Grant, $10,000, non-renewable, one year to complete project. One available annually.

ALA-Seymour R. Cohen, MD Research Grant, $15,000, non-renewable, one year to complete project. One available annually.

THE AMERICAN LARYNGOLOGICAL, RHINOLOGICAL AND OTOLOGICAL SOCIETY, INC., AKA THE TRIOLOGICAL SOCIETY

The Triological Career Development Award $40,000, non-renewable, one to two years to complete project. Five awarded annually.

AMERICAN NEUROTOLOGY SOCIETY (ANS) ANS/AAO-HNSF Herbert Silverstein Otology and Neurotology Research Award, $25,000, non-renewable, one to two years to complete project. One available in 2014.

AMERICAN RHINOLOGIC SOCIETY (ARS) ARS New Investigator Award $25,000 ($12,500 per year), non-renewable, two years to complete project. One available annually.

ARS Resident Research Grant $8,000, non-renewable, one year to complete project. Two available annually.

ARS/AAOA Joint Clinical Research Award $40,000/year renewable for up to a total of three years if milestones are met. One available in 2014.

AMERICAN SOCIETY OF PEDIATRIC OTOLARYNGOLOGY (ASPO)

ASPO Dustin Micah Harper Recurrent Respiratory Papillomatosis Research Grant $10,000, non-renewable, one year to complete project. One available annually.

ASPO Research Career Development Award $40,000, non-renewable, one to two years to complete project. One available annually.

ASPO Research Grant $20,000, non-renewable, one year to complete project. Two available annually.

COOK MEDICAL

AAO-HSNF Resident Research Grant sponsored by Cook Medical $10,000, non-renewable, one year to complete project. One available annually.

THE DOCTORS COMPANY FOUNDATION

AAO-HNSF Resident Research Grant sponsored by The Doctors Company Foundation $10,000, non-renewable, one year to complete project. One available annually.

THE EDUCATIONAL AND RESEARCH FOUNDATION FOR THE AMERICAN ACADEMY OF FACIAL PLASTIC AND RECONSTRUCTIVE SURGERY (AAFPRS)

AAFPRS Leslie Bernstein Grant $25,000, non-renewable, up to three years in which to complete project. One available annually.

AAFPRS Leslie Bernstein Resident Research Grant $5,000, non-renewable, up to two years to complete project. Two available annually.

AAFPRS Leslie Bernstein Investigator Development Grant $15,000, non-renewable, up to three years to complete project. One available annually.

AAFPRS Research Scholar Award $30,000, renewable, may receive grant in second and third year, up to three years to complete project. One available annually.

KNOWLES HEARING CENTER AT NORTHWESTERN UNIVERSITY

Knowles Hearing Center Collaborative Grant $30,000, non-renewable, one year to complete project. One available annually.

THE OTICON FOUNDATION

AAO-HNSF Resident Research Grant sponsored by the Oticon Foundation $10,000, non-renewable, one year to complete project. One available annually.

For more information about these grants and the application process visit: www.entnet.org/CORE. Questions? Contact Stephanie L. Jones sljones@entnet.org or Sarah O'Connor soconnor@entnet.org

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2014 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems Proposed Rule

On July 8, the Centers for Medicare & Medicaid Services (CMS) released its 2014 proposed rule for the hospital outpatient prospective payment (OPPS) and ambulatory surgical center (ASC) payment systems. Below are a few important changes relevant to otolaryngology for CY 2014. A complete summary of the proposed rule can be found at http://www.entnet.org/Practice/CMS-News.cfm.

Hospital Outpatient Prospective Payment System (OPPS)

As members know, OPPS payments cover facility resources including equipment, supplies, and hospital staff, but do not pay for the services of physicians and non-physician practitioners who are paid separately under the Medicare Physician Fee Schedule (MPFS). All services under the OPPS are technical and are classified into groups called Ambulatory Payment Classifications (APCs). Services in each APC are grouped by clinically similar services that require the use of similar resources. A payment rate is established for each APC using two-year-old hospital claims data adjusted by individual hospitals cost-to-charge ratios. The APC national payment rates are adjusted for geographic cost differences, and payment rates and policies are updated annually through rulemaking.

OPPS 2014 Proposed Payment Rates

For CY 2014, CMS proposes a hospital outpatient department conversion factor rate increase of 1.8 percent. CMS has also proposed to continue the statutory -2 percent reduction in payments for hospitals that fail to meet the hospital outpatient quality reporting (OQR) requirements. See the summary link from paragraph one to access changes in reimbursement under the proposed rule for CY 2014 for the 100 most frequently billed ENT services in the OPPS setting.

Updates Affecting OPPS Payments

In CY 2014, CMS has proposed to continue the changes made in 2013 to base the relative weights on geometric mean costs rather than previously utilized median costs. It will continue to use these weights to set a cost-to-charge ratio within an APC to determine payment for services within an APC. In CY 2014, CMS proposes several significant changes to their methodology to calculate APC payments, including:

- Establishing comprehensive APCs for 38 device-dependent services and applying a single payment for the comprehensive service based on all OPPS payable charges on the claim
- Expanding the types of services that are packaged and not paid separately
- Replacing the current five levels of visit codes for the clinic with three new Level II HCPCS codes, which represent a single level of payment for each of the three visit types

Changes to otolaryngology related to many of these policies are outlined below, however, members seeking additional information can access our full summary via the link above, which includes a complete list of APCs and changes to their payment rates.

New Comprehensive APCs

In an effort to improve accuracy and transparency of certain device-dependent procedures, CMS proposes 29 new comprehensive APCs to prospectively pay for the most costly device-dependent services.

These APCs will replace 29 of the most costly device-dependent APCs. **A comprehensive APC would be defined to include the provision of a primary service and all adjunctive services provided to support the delivery of the primary service. Under the proposal, the entire claim, including the primary service, would be associated with a single comprehensive service and all costs reported on the claim would be assigned to that service.**

The comprehensive APC would treat all individually reported codes as representing components of the comprehensive service

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and would make a single payment based on the cost of all individually reported codes, representing provision of the primary service, and all adjunctive services provided to support delivery of the primary service. CMS believes this will increase the accuracy of the payment for the comprehensive service and also increase the stability of the payment from year to year.

CMS proposes to include packaged services and supplies; adjunctive services; devices, durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS); OPD services reported by therapy codes that are provided within the perioperative period of the primary service; hospital room and board revue centers; and hospital-administered drugs as part of these new comprehensive APCs. Payment for comprehensive APCs would be made for the largest comprehensive payment associated with the claim based on the listed CPT codes, however, all costs on the claim will be considered in rateseting for the comprehensive APC. **Of note, APC 0259, which includes CPT 69930 Implant Cochlear Device will be included as a comprehensive APC for CY 2014.**

Proposed New Packaging Policies for CY 2014

For CY 2014, CMS proposes to add the following five items and services to those that will be packaged under the OPPS.

1. Drugs, biologicals, and radiopharmaceuticals that function as supplies when used in a diagnostic test or procedure
2. Drugs and biologicals that function as supplies or devices when used in a surgical procedure
3. Clinical diagnostic laboratory tests
4. Procedures described by add-on codes
5. Ancillary services (status indicator "X")

The packaging policies that influence otolaryngology are discussed in greater detail in our full summary; however, we note that **items 2-5 on the list above capture at least one ENT service. Affected services include laryngology procedures, head and neck imaging services, audiology, and SLP services.** Access the online summary for a full list of affected CPT codes and APCs by policy proposal.

CMS also indicates it is considering a proposal for 2015 that would conditionally package all imaging services with any associated surgical procedures. Imaging services not provided with a surgical procedure would continue to either be separately paid according to a standard clinical APC or a composite APC.

Visit Type	CY 2013		Proposed CY 2014	
	HCPCS	APC	NEW HCPCS	NEW APC
Clinic Visit	99201	0604	GXXC	0634
	99202	0605		
	99203	0606		
	99204	0607		
	99205	0608		
	99211	0604		
	99212	0605		
	99213	0605		
	99214	0606		
	99215	0607		
Type A ED Visit	99281	0609	GXXA	0635
	99282	0613		
	99283	0614		
	99384	0615		
	99285	0616		
Type B ED Visit	G0380	0626	GXXB	0636
	G0381	0627		
	G0382	0628		
	G0833	0629		
	G0834	0630		

OPPS Payment for Hospital Outpatient Visits

For CY 2014, CMS is proposing to replace the current five levels of visit codes describing clinic visits, Type A and Type B emergency department visits, and critical care services with three alphanumeric Level II HCPCS codes representing a single level of payment for three types of visits. CMS believes a policy that recognizes a single visit level for clinic visits, Type A ED visits, and Type B ED visits for payment under the OPPS is appropriate for several reasons, including:

- To incentivize hospitals to maximize efficiency
- Remove incentives of providing unnecessary services or expending unnecessary resources
- Reduce administrative burden
- Eliminate the need to distinguish between new and established patients
- Eliminate incentives to "upcode" patients whose visits don't fall into a clear category

Under this proposal, beginning in 2014, physicians and hospitals would begin using the coding structure displayed in the chart to report their visits in the OPPS setting.

Supervision of Outpatient Therapeutic Services in CAHs and Small Rural Hospitals

CMS proposed to end its non-enforcement policy requiring direct supervision of outpatient therapeutic services in CAHs and small rural hospitals. Thus, for years beginning with 2014, CAHs and small rural hospitals would have to comply with the CMS supervision policy, which requires direct supervision of therapeutic services except for those that CMS identifies as appropriate for general supervision, based on input from the Advisory Panel on Hospital Outpatient Payment (Advisory Panel). **CMS believes it is appropriate to let this grace period expire to ensure the quality and safety of hospital and CAH outpatient therapeutic services provided by Medicare.**

Supervision for Observation Services

CMS also clarified that for observation services, if the supervising physician or appropriate non-physician practitioner determines and documents in the medical record that the beneficiary is stable and may be transitioned to general supervision, general supervision may be furnished for the duration of the service. Medicare will not require an additional initiation period(s) of direct supervision during the service. **CMS believes this clarification will assist hospitals in furnishing the required supervision of observation services without undue burden on their staff.**

Hospital Outpatient Quality Reporting (OQR) Program

As established in previous rules, **hospitals will continue to face a -2 percent reduction to their OPD fee schedule payments for failure to report on quality measures in the OQR Program in CY 2014.** Program measures and details on timing and reporting periods can be accessed on the CMS Quality Net website at https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1191255879384.

For 2014 reporting, CMS proposes five new quality measures and removes two measures from the OQR program for CY 2016 payment. None of the five new measures are applicable to our specialty; however, one of the two measures proposed for deletion (Transition Record with Specified Elements Received by Discharged Patients) may have been reportable by ENTs.

Surgical Specialty Group	Estimated 2013 ACS Payments (in Millions)	Estimated 2014 Percent Change
Total	$3,625	1%
Eye and ocular adnexa	$1,496	-3%
Digestive system	$743	8%
Nervous system	$540	0%
Musculoskeletal system	$441	-1%
Genitourinary system	$159	5%
Integumentary system	$130	8%
Respiratory system	$46	7%
Cardiovascular system	$32	-3%
Ancillary items and services	$20	-12%
Auditory system	$12	4%
Hematologic and lymphatic systems	$5	17%

Additional Resources
To access the full OPPS/ASC proposed rule for CY 2014 visit http://www.gpo.gov/fdsys/pkg/FR-2013-07-19/pdf/2013-16555.pdf.

Ambulatory Surgical Centers

CMS performs an annual review of the legislative history and regulatory policies regarding changes to the lists of codes and payment rates for covered surgical procedures and covered ancillary services in an Ambulatory Surgical Center (ASC) setting. Covered surgical procedures in the ASC setting are defined as procedures that would not be expected to pose a significant risk to the beneficiary's safety when performed in an ASC and that would not be expected to require active medical monitoring and care at midnight following the procedure.

ASC 2014 Proposed Payment Rates

For CY 2014, CMS proposes a .9 percent increase to the ASC conversion factor. The table above reflects the major categories of procedures in the ASC setting, the amount paid to each of those settings in 2013, and the estimated percentage change in payments to those categories for 2014. **Of note, otolaryngology procedures fall within several of the key categories, including Eye, Integumentary, Auditory, Lymphatic, etc.**

Ambulatory Surgical Center Quality Reporting Program (ASCQR)

In 2012, CMS finalized the implementation of an ASC quality reporting program (ASCQR), which will begin with 2014 payment determination. Quality measures have been adopted for the calendar years 2014-2016. The measures can be found on the CMS Quality Net website previously referenced.

CMS continues their proposal to apply a **-2 percent payment reduction for ASCs that fail to properly report their quality data in CY 2014.** Penalties will be applied in CY 2016 payments based on 2014 reporting.

Payer Appeals Process Assists Members with Claim Denials

The Academy receives daily member inquiries and notifications regarding claim denials and payment policy issues that arise when seeking reimbursement for otolaryngology procedures from private insurers and Medicare. In response, the Academy has a wealth of resources available to members, including: CPT for ENT articles, appeal template letters, clinical indicators, and position statements to help members obtain appropriate reimbursement for various otolaryngology procedures. These resources are available on the Academy's "Coding Corner," which is available at http://www.entnet.org/practice/codingResources.cfm.

Due to a large volume of national policy issues submitted to the Health Policy Unit, the Academy works to prioritize and respond to payer coverage issues according to the number of members or geographic regions affected by each policy. Based on time and resources available, the Health Policy department and the Physician Payment Policy (3P) Workgroup may offer assistance for issues affecting many members at the state or national level in cases where the appeals process has been exhausted and resulted in an unsuccessful outcome.

Upon receipt of inquiries regarding private payer denials we work to determine whether the issue is a local or state based, or if it is a national issue that the Academy 3P workgroup should

be involved in. **Outlined below are the recommended steps for members who encounter difficulty obtaining reimbursement for their services.**

1. Ensure that the service was billed appropriately (e.g., appropriate modifiers used with appropriate CPT codes).
2. Consult the Academy website for various resources to assist with an appeal for a specific service. Some helpful resources include:
   - CPT for ENT coding guidance articles: http://bit.ly/CPT4ENT
   - Code changes for CY 2013: http://bit.ly/2013codes
   - Information on NCCI /MUE Edits: http://bit.ly/ENTcoding
   - Audiology FAQs: http://bit.ly/audiologyFAQs
   - E/M Documentation guidelines: http://bit.ly/EMguide
   - Template payer appeal letters for services commonly denied: http://bit.ly/entappeals
3. Do you have the local payer policy for the procedure? Access the carrier's website, logging in as a provider, and search for the policy relevant to your geographic jurisdiction.
4. The Academy cannot represent physician members individually on each issue with payers, but health policy staff does track the issues and monitors whether a local or state issue becomes a national issue that 3P should address on behalf of all members.
5. Talk to the medical director to get more information on the rationale used for the denial. We have found that many times there is a better outcome when the local AAO-HNS physician members who work directly with the payer's medical director on issue resolution address a local issue.
6. If 3P determines that the issue is a regional or national issue that could affect many otolaryngologists, information on the payer policy and the rationale used by the payer's medical director is helpful for Health Policy staff to determine if this is a local issue. If that information is available to forward, that is helpful for 3P to know as well. All of this information helps us as we determine the best course of action for your request, and track members in certain states who are having difficulty with specific payers.

To find out how widespread an issue is, we strongly recommend you work with your state society of otolaryngology-head and neck surgery, Board of Governors representatives, and state medical society to report the issue so they may attempt to assist you. They may also be able to provide a better idea of how widespread an issue is among providers in the area. You can access contact information for several state otolaryngology societies on our website at http://www.entnet.org/Community/BOGSocieties.cfm?View=State (Login required).

We strongly recommend that you also contact others in your community to determine if they are having the same issues. The Academy coordinates with the Association of Otolaryngology Administrators (AOA) Advocacy and recommends that you reach out to the AOA [www.oto-online.org] to determine if other practices are having similar issues. Since state issues are usually best resolved with leaders at the state level, we recommend administrators and their physicians contact the AOA to receive resources that others may have used in other states to resolve the issue. The Academy offers the AOA the resources that we have available, such as a comment letter, if 3P determines it could affect many members and would help with advocacy efforts.

For Medicare payment issues, we often recommend you contact the Medicare Administrative Contractor (MAC) medical director directly, and contact your regional MAC's Carrier Advisory Committee (CAC) representative. Currently, there is an ENT CAC representative designated to each state within a MAC jurisdiction (15 geographic regions nationwide). Each representative acts as a liaison between Medicare Contractors and state specialty societies. For more information on the CAC representative nomination process, or for local CAC representative contact information, email Health Policy at healthpolicy@entnet.org.

The Academy encourages members to take full advantage of available appeals processes when encountering denied claims. Even in cases where you may feel no progress is made, it is important to exhaust your right to appeal in order to gather all the pertinent information necessary for the Academy to assist you with your issue. Once the recommended efforts have been exhausted, if you still believe a service is being inappropriately denied, the Health Policy team will request a copy of the Explanation of Benefits (EOB) form (with patient HIPAA information redacted) and a copy of the applicable payer policy (this includes denial letters, national or local coverage policies, or any other documentation the payer has provided you during your appeals process), so staff and 3P can determine the root cause of the payer's denial. 3P will then determine how widespread your specific issue is and whether additional advocacy efforts are required.

If you believe services are being inappropriately denied by a third party payer, or your MAC and have exhausted all appeal options to rectify payment, please contact the health policy team at healthpolicy@entnet.org.

Resources: A NY State Example

A current example of how your state society can assist you comes from the **New York State Society of Otolaryngology (NYSSO),** which provides assistance to otolaryngologists at the state society level, as part of their member benefits package, and allows NYSSO members in good standing to take advantage of free, unlimited consultation for health insurance coding and billing issues. This service is provided by the Society's Third Party Consultant, James McNally, who assists otolaryngologists with questions about policy interpretation, use of modifiers, supported diagnosis codes, and non-payment/underpayment of claims for both public and private carriers. In most cases, physicians receive a response within 24 hours.

New York members can contact the NYSSO office at 1-518-439-2020 or meetings@nyssohns.org.

Triological Society Research Grants

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

Triological Society Research Career Development Awards

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

Letters of intent are due December 16, 2013 (midnight ET) and applications are due January 15, 2014 (midnight ET) through the CORE grant program.

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

Triological Society/American College of Surgeons Clinical Scientist Development Award

This award provides supplemental funding to otolaryngologists-head and neck surgeons who receive a new NIH Mentored Clinical Scientist Development Award (K08/K23) in 2012/2013 or have an existing award with a minimum of 3 years remaining in the funding period as of June 1, 2014. This award is being offered as a means to facilitate the research career development of otolaryngologists-head and neck surgeons, with the expectation that the awardee will have sufficient pilot data to submit a competitive R01 proposal prior to the conclusion of the K award. This award will provide financial support in the amount of $80,000 per year for up to five years, or for the remainder of the term of existing grants, to supplement the K08/K23 award. Funding is dependent upon receipt of meritorious applications.

The application deadline is May 10, 2014.

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

Call for Proposals

How to Obtain a CPT Code? The Revised New Technology Pathway Application

As members may be aware, the Academy released the New Technology Pathway Application and guidance document in 2010 to provide clarity for members, committees, and industry partners requesting Academy support for revisions to, or the creation of, new Category I and Category III CPT codes. The application can be found at www.entnet.org/Practice/Valuing-CPT-Codes.cfm by clicking on "New or Revised CPT Code Application." An overview of the process for reviewing these materials is outlined in the figure.

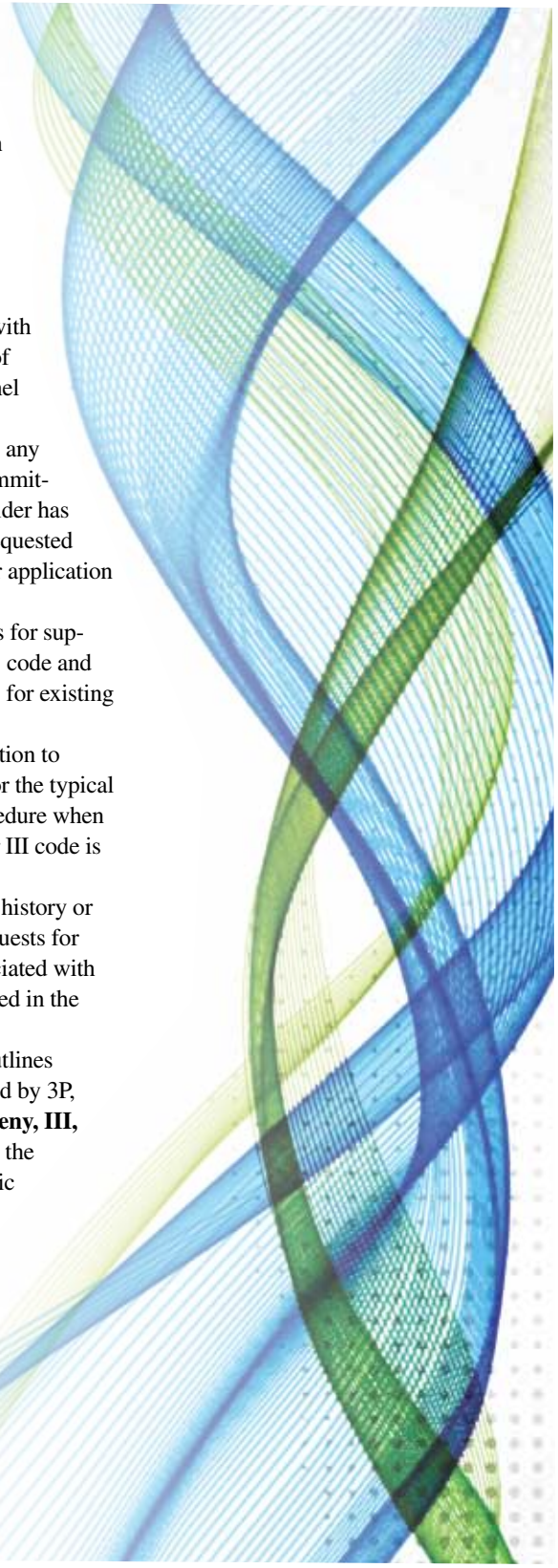
> 3P evaluates inquiries for new technology coding and requests for new Current Procedural Terminology (CPT) codes, revisions to existing CPT codes, and requests for support of new HCPCS codes.

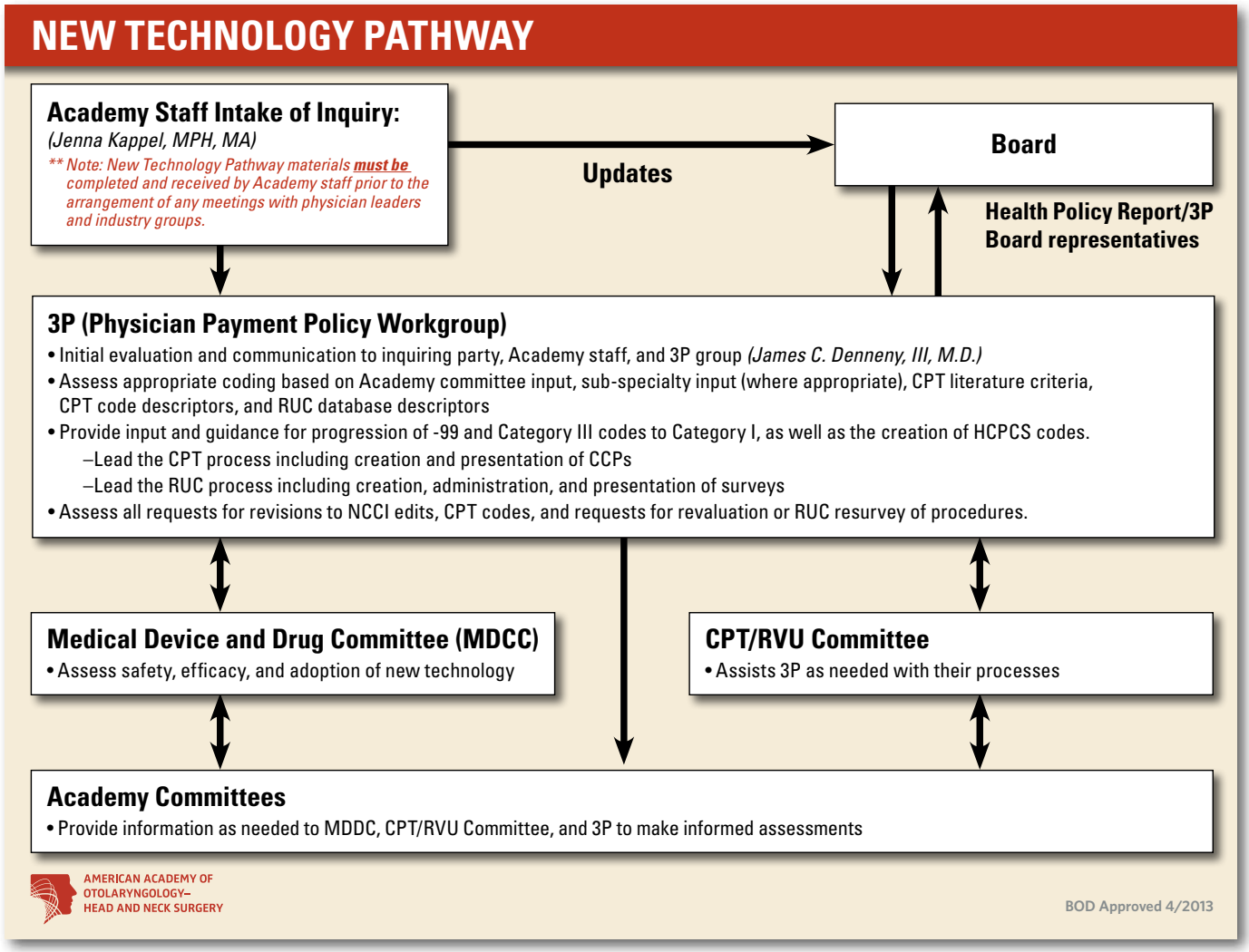
The New Technology Pathway Process was initially developed to provide a more streamlined process, consistent with approaches adopted by other specialty societies. The process requires that the New Technology Pathway Application be completed and submitted to Academy Health Policy staff for any requests for guidance on how to code for a new technology, the development of new CPT codes for services or procedures, or revisions or revaluations of existing codes. The process includes coordination between the Physician Payment Policy Workgroup (3P) and experts from other applicable AAO-HNS committees (e.g., Medical Device and Drug Committee, CPT/RVU Committee, etc.) as a way to incorporate all of the resources and clinical expertise of the Academy in the interest of the members.

Changes to the process were made this year in response to input from submitting stakeholders and were based on experience with the applications received since the inception of the process in 2010. Key changes made this year include:

- Implementation of an anti-lobbying policy consistent with the rules and requirements of the AMA CPT Editorial Panel and the AMA RUC.
- Requests for information on any AAO-HNS subspecialty committees with which the stakeholder has shared information or has requested support from regarding their application request.
- Modified to include requests for support to create a new HCPCS code and modifications to NCCI edits for existing CPT codes.
- Modifications to the application to request a clinical vignette for the typical patient undergoing the procedure when a request for a Category I or III code is made.
- Requests for any applicable history or background on previous requests for HCPCS or CPT codes associated with the procedure/service outlined in the application.

As the guidance pathway outlines above, all requests are reviewed by 3P, co-chaired by **James C. Denneny, III, MD**, and **Jane T. Dillon, MD,** the coordinators for Socioeconomic and Practice Affairs, which is the senior advisory body to Academy leadership and staff on issues related to socioeconomic advocacy, regulatory





activity, coding/reimbursement, and practice services/management. 3P evaluates inquiries for new technology coding and requests for new Current Procedural Terminology (CPT) codes, revisions to existing CPT codes, and requests for support of new HCPCS codes. Members of 3P, including **Richard W. Waguespack, MD**, **Bradley F. Marple, MD**, and **Lawrence M. Simon, MD**, represent the Academy on the AMA CPT Editorial Panel's Advisory Committee. Our CPT representatives advocate for otolaryngology by presenting new and revised CPT codes to the CPT Editorial Panel for inclusion in the CPT code set used for physician billing.

When it comes to valuing CPT codes, 3P serves as the expert consensus panel to analyze surveys completed by Academy members and make recommendations for appropriate physician work and practice expense Relative Value Units (RVUs) to the AMA/Specialty Society Relative Value Update Committee (RUC) for otolaryngology-related codes. The Academy is represented at the RUC by **Wayne M. Koch, MD, John T. Lanza, MD, Peter Manes, MD**, and **Pete Batra, MD. Charles F. Koopmann, MD, MHSA**, and **Jane T. Dillon, MD**, serve as RUC panel members. The RUC makes recommendations on the Relative Value Units (RVUs) of new and revised physician services to the Centers for Medicare & Medicaid Services (CMS). The RUC also performs broad reviews of the Resource Based Relative Value System every five years and rolling reviews of many codes based on screens such as high utilization, frequency of codes used together, and codes not surveyed since the beginning of the RUC process, more than 20 years ago.

We are confident the New Technology Pathway addresses such requests in a manner that is clearly defined, consistent with AMA CPT and RUC guidelines, accounts for the interests and perspectives of all stakeholders, while protecting against undue influence of any group or individual, encourages the collection of reliable data, and promotes efficient, fair reimbursement for our members and appropriate access to new procedures and services for patients. Inquiring parties, including physicians and industry representatives, should send the completed application to Jenna Kappel, the Academy's director of health policy, at JKappel@entnet.org.

Big Brother Is Watching

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

I have often chatted with fellow physicians and Academy members about the massive amount of data that is being accumulated on our practice patterns from not only our own hospitals and payers (private and the government), but from sources such as electronic medical records and even companies that track patient satisfaction scores. As big data becomes more manageable in the digital revolution, the ability to synthesize through hundreds of thousands of records becomes expected and the norm, rather than an anomaly. The major concern is then, what comes of this big data and how is it synthesized and analyzed before it is presented?

A major player in the electronic medical records industry, Practice Fusion®, recently came under fire from practices that used their free platform as there were concerns about the company's intent to aggregate big data, parcel the data, and sell it for analysis (for example, macro level data on thousands of patients with diabetes could be invaluable for a pharmaceutical company).

> "As big data becomes more manageable in the digital revolution, the ability to synthesize through hundreds of thousands of records becomes expected and the norm, rather than an anomaly."

There must be similar concern about what is going to happen to the practice of medicine under the extreme scrutiny of the untrained, emotional eye of the observer. For example, what if the big data demonstrates that in my practice region of the greater Washington, DC, area I am an outlier (this is hypothetical of course) for complications? What if the data demonstrated that I had a higher-than-average right-sided post-tonsil bleed rate? Remember, with big data the data can be analyzed and twisted and turned in myriad fashions. So, let us play out the scenario above. What are my patients going to do when they find out that my right-sided post-tonsillectomy bleed rate is higher than my peers in our practice region? Furthermore, what is the hospital going to do about credentialing my focused practice-performance evaluations and my privileges? Will my right-tonsillectomy privileges be rescinded? What if all of my patients who bled in the preceding time period had bleeding diatheses that were neither captured nor reported by those that aggregate our patient data (i.e., lack of risk adjustment)?

This issue is in distinction to doctor's review sites that are public sites where people blog about their physicians and can give them rankings, such as ZocDoc.com. These sites provide more granular level data that one can argue is actionable. However, the big data being collected about our practice patterns and outcomes is different because it is provided to agencies from hospital administrative staff, and often lacks actionable data or granularity. There can be issues with attribution and coding of cases, which can affect the macro level trend data.

So What Are We To Do?

There are many options, but the two that resonate the most with me is to first, understand the major data reporting repositories so you understand their methodology and how they report out data. Understanding how the data is collected and what it means can help you explain to your patients why the hospital you operate at is below the national benchmarks for specific case types and various other indicators (hospitalcompare.hhs.gov). Once you know where your data and

your hospital's data are being reported, you can speak with the administrative individual at your local hospital that is providing the data to ensure proper and complete case capture.

Finally, we must own our patient's outcomes and data. There are now data registries where one can sign up through national organizations, such as the American College of Surgeons. If we can be stewards of our own data, then we can ensure that it is risk-adjusted, accurate, and reflects our true practice patterns.

On a personal level, this article is even more pertinent, because my real "big brother" is also a pediatric otolaryngologist at Nemours in Wilmington, DE. He can watch his younger brother anytime and pretty soon—with the way that data transparency is coming along, he will not even have to watch me—he can go to the Internet and check my metrics to ensure that I am causing no harm!

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

AAO-HNS
irt industry round table

Special Thanks to Our IRT PARTNERS

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

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For more information on **support opportunities,** please contact:

David Buckner
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As of August 2013

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Education Committees Productive at 2013 Annual Meeting

Each year at the Annual Meeting & OTO EXPO℠ the eight Foundation Education Committees meet to develop their new work plans. These committees, organized around the otolaryngology specialty areas, take the lead in developing the education activities and knowledge resources produced by the Foundation. In Vancouver, the planning process was organized a little differently than in the past, but equally productive.

As has been discussed earlier, an Education Needs Assessment Initiative was implemented this year. Its purpose is to determine how to best meet the education needs of the Foundation's members and other constituents. The Initiative began with an Education Committee Survey and SWOT Analysis and also included a review of past education activity participant evaluation data, a business model analysis of all current education activities and knowledge resources, and most importantly, a membership-wide education needs assessment survey, which was conducted in August. Results were summarized and shared with the Education Committees in September.

> "The data will help determine not only priority course topics, but the most effective education design and format including the media best used to educate and inform the members."

In order to most efficiently present this important information, a Joint Education Committee Meeting took place on the Saturday before the Annual Meeting. More than 200 committee members met to hear the Education Needs Assessment Summary Report. A joint presentation was given by Education leadership and staff as well as with representatives from Loyalty Research Center, who conducted the membership needs survey for the Foundation.

This joint meeting was a great way to present the information to everyone at the same time and to provide an opportunity for the committees to ask questions. More importantly, it offered everyone the chance to discuss the findings with each other and what the implications are for the future of professional education at the Foundation.

The committees were presented with four outcome objectives from this needs assessment initiative. They were to develop an action plan to improve the member education experience; design education activities that meet the clinical needs of our members; increase member involvement in and satisfaction with education offerings; and enhance member knowledge, competence, and skill in their practice of otolaryngology-head and neck surgery.

Immediately following the joint meeting the individual education committees divided up and met for their traditional annual committee meeting. It was during these individual meetings that the committees discussed how best they could meet these four objectives based on the evaluation and survey data they had just received. This discussion will inform the committees' 2013-14 work plan.

The results of the year-long analysis will provide useful information to the committees as they plan more focused education activities. The data will help determine not only priority course topics, but the most effective education design and format including the media best used to educate and inform the members. The Education Committees are now tasked with ascertaining how the members need and want to engage in lifelong learning and developing an education and knowledge platform to meet those needs.

ACADEMYU®
YOUR OTOLARYNGOLOGY EDUCATION SOURCE

The outcome objectives from the year-long needs assessment initiative are:

- Develop an action plan to improve the member education experience
- Design education activities that meet the clinical needs of our members
- Increase member involvement in and satisfaction with education offerings
- Enhance member knowledge, competence, and skill in their practice

Look for the complete Education Needs Assessment Initiative Summary in future issues of the *Bulletin* and other AAO-HNSF communications. The January *Bulletin* will be dedicated to the education and knowledge efforts of the Foundation and especially the hard work of the eight Education Committees. Many exciting changes may be underway as we shift our education efforts to best meet the needs of our members.

If you have any suggestions about Professional Education at the Foundation, please email us with your feedback at education@entnet.org.

Coalition for Global Hearing Health: 4th Conference an International Success

With a record number of firsts, the 4th Conference of the Coalition for Global Hearing Health (CGHH) at Vanderbilt University's Bill Wilkerson Center, Nashville, TN, May 3-4, was rated a resounding international success by attendees from 15 countries.

As in past conferences, multiple disciplines around the globe conferred for two days on global hearing healthcare provided in lower-resourced regions.

This year's "firsts" included:

- Offering individual and organizational CGHH membership. Annual individual membership is $25, and organizational memberships are $100 for organizations with offices in HINARI (Health InterNetwork Access to Research Initiative) A and B Category countries, and $250 for organizations in other countries.
- Awarding the first travel scholarship to Ned Carter of All Ears Cambodia, who said, "I couldn't have attended the conference, if it weren't for this scholarship offered by Bob and Jean Johnson. I am most grateful."
- Awarding 12 portable battery-powered audiometers to humanitarian projects globally, donated by Purdue Pharmaceuticals.
- Introduction of a poster session/reception due to an abundance of high quality submissions.

Among many highlights this year, Lady Jean Wilson, OBE, FRCOphth (Hon), gave the conference keynote speech at the historic Travellers Rest Plantation. She founded the Royal Commonwealth Society for the Blind with her husband, Sir John Wilson, and is currently chair of the Hearing Conservation Council; president of the UK Impact Foundation, and vice president of Sightsavers International.

Conference co-organizers, **James E. Saunders, MD**, Dartmouth Hitchcock Medical, and Jackie L. Clark, PhD, University of Texas at Dallas, have long-established roots in international arenas as humanitarian committee chairs of their professional organizations—the American Academy of Otolaryngology—Head Neck Surgery Foundation and International Society of Audiology, respectively.

CGHH International attendees at the historic Travellers Rest Plantation.

Next year's conference will take place at St. Catherine's College, Oxford, UK, July 25–26, 2014. To learn more on upcoming or past conferences, visit the CGHH website: http://coalitionforglobalhearinghealth.org/ or email James.E.Saunders@Hitchcock.org, jclark@utdallas.edu or Conference@CoalitionForGlobalHearingHealth.org.

Poster presentation session

ABFPRS Certifies 33 Surgeons

At its June 22 meeting, the American Board of Facial Plastic and Reconstructive Surgery (ABFPRS) board of directors determined that the following 33 surgeons had met all of the requirements to become ABFPRS diplomates. The action brings the total number of active diplomates to 1,050.

Shervin Aminpour, MD

Dominic M. Castellano, MD

Jen Y. Chow, MD

Kristin K. Egan, MD

Waleed H. Ezzat, MD

Rebecca E. Fraioli, MD

Alexis Furze, MD

Jason M. Guillot, MD

Douglas K. Henstrom, MD

Laura E. Hetzler, MD

Tang Ho, MD

Jared C. Inman, MD

Keith Michael Ladner, MD

Patrick Chase Lay, MD

Jacque Perrin LeBeau, MD

William D. Losquadro, MD

Umang Mehta, MD

Timothy Minton, MD

Jason Moche, MD

Sachin S. Parikh, MD

Shari Reitzen-Bastidas, MD

James M. Ridgway, MD

Alicia R. Sanderson, MD

Maya G. Sardesai, MD

Christopher R. Savage, MD

Ali Sepehr, MD

Anita Sethna, MD

Taha Z. Shipchandler, MD

Christian L. Stallworth, MD

Scott J. Stephan, MD

Samir Undavia, MD

Preston Daniel Ward, MD

Cory Chi-Hong Yeh, MD

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Temporal Bone & Cranial Base Microdissection Course

Please join us for an intensive two day course emphasizing temporal bone microdissection with didactic lectures covering the breadth of otologic surgery. All dissection equipment will be provided along with whole head specimens.

Course Directors:
Moises A. Arriaga, MD
Anita S. Jeyakumar, MD
Yu-Lan M. Ying, MD
Robert G. Peden, MD

Course Dates:
December 13-14, 2013
January 17 – 18, 2014
April 11 – 12, 2014

Guest Faculty:
Peter S. Roland, MD
Craig A. Buchman, MD
Nikolas H. Blevins, MD

Tuition: $450 Physicians in Practice
$250 Residents (with letter from Chairman)

CME: 14 Category 1 Credits
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For more information, contact
Department of Otolaryngology – Head and Neck Surgery
Deanna Loerwald
dstrah@lsuhsc.edu
Tel: 504-568-4785 Fax: 504-568-2198

MD/DO ENT, BE/BC
Central Oregon ENT

Bend, OR sits on the eastern slopes of the Cascade Mountains in Central Oregon's high mountain desert and enjoys 300 days of sunshine. We are surrounded by year round outdoor activities including world class skiing, fishing, water sports, golf and rock climbing. Bend's small town family atmosphere is home to rich cultural, excellent educational and exciting entrepreneurial opportunities. Escape to the "big city" of Portland a few hours away.

Central Oregon ENT, since 1964, is a full service clinic with six physicians and two audiologists plus a full range of support services and experienced staff. Our focus includes general ENT, Sinus and Skull-based surgery, Head & Neck, Voice & Swallowing, Allergy, Audiology and Hearing Aids. We have a large existing patient population and strong referral base with two offices plus satellite offices, we serve all of Central and Eastern Oregon; our greater area has a population of over 200,000. Our practice emphasizes community based otolaryngology care and practices excellent, compassionate clinical care.

We are recruiting a BE/BC MD/DO ENT to become part of our practice. Candidate will have strong interest/focus or be fellowship trained in Head/Neck disease and surgery. We offer a full benefit package and generous salary structure. We are financially stable and have proven and successful track to full partnership.

CONTACT:
Lorin Easly
Central Oregon ENT, LLC
2450 NE Mary Rose Place, Ste 120
Bend, Oregon 97701
leasly@coent.com

UNIVERSITY of VIRGINIA HEALTH SYSTEM

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

RHINOLOGY - TENURED OR TENURE-ELIGIBLE

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

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

LARYNGOLOGY - TENURE-ELIGIBLE

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

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

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

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

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

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
- Teach residents
- Pursue research in your area of interest

Medical school loan repayment and residency and fellowship stipends are available.

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. GWV is affiliated with an accredited Otolaryngology residency program.

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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GEISINGER HEALTH SYSTEM

Six-physician single specialty group seeking a partner with BC/BE physician interested in general ENT with Laryngology emphasis. Fellowship training preferred but not required. Successful practice provides broad spectrum of ENT care with subspecialties in rhinology, head and neck surgery, facial plastic and reconstructive surgery. Our 16,000 square foot facility includes an AAAHC approved Surgery Center, an in-house CT scanner, full service Audiology and Allergy departments. Office is adjacent to a regional medical center.

Compensation package includes a first year salary with productivity incentives and the opportunity for partnership after the 1st year.

Boise is often cited as one of the top 10 best cities in which to live. It is a safe, family-oriented community with an excellent education system and a wonderful climate. Boise's Rocky Mountain location offers plenty of recreational activities including skiing, white water rafting, mountain biking, fishing, hunting, etc.

Full Time Faculty Opportunities
University of Rochester Medical Center

Clinician-Scientist / Neurotologist
BC/BE, fellowship trained boarded neurotologist with appropriate research training at any rank is sought to develop an outstanding clinical practice and externally funded research program and join three other practicing neurotologists. Applicants must also contribute to resident and medical student education. Basic, translational, or patient-oriented research programs are desired. Protected research time and resources are available.

Pediatric Otolaryngologist
BC/BE, fellowship trained pediatric otolaryngologist at any rank is sought to practice at the brand new Golisano Children's Hospital, opening in 2015. This position offers excellent opportunities to practice the full range of the specialty in state of the art facilities. Resident teaching is expected and scholarly activities strongly encouraged. Protected research time and resources are available for candidates seeking a career as a clinician-scientist.

General Otolaryngology
BC/BE otolaryngologists with broad clinical interests are sought to develop a general otolaryngology practice in a community setting with full academic support.

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

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

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

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

HEAD AND NECK ENDOCRINE SURGEON
DEPARTMENT OF OTOLARYNGOLOGY -
HEAD & NECK SURGERY
UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

Because of the demonstrated success and growth of the oncologic head and neck surgery program at the University of California, San Francisco (UCSF) Medical Center, the Department of Otolaryngology-Head and Neck Surgery is seeking a Fellowship-trained head and neck oncologic surgeon to join the practice and department. The practice is part of the NCI-designated Helen Diller Family Comprehensive Cancer Center and is one of the nation's premier centers. In 2015 UCSF will add a dedicated 70-bed cancer hospital to its existing patient facilities. The Head and Neck Surgery faculty has an opportunity to further develop the practice as part of UCSF's ongoing market development. The candidate for the position should have a strong background in endocrine surgery, experience with ultrasonography, and an interest in practice development and outreach. The candidate will be responsible for providing excellent clinical care, for teaching all levels of trainees, and for contributing to a research program. This position is full-time and requires a strong commitment to partnership with an outstanding team of academic faculty. It requires the ability to collaborate in a multi-disciplinary surgical environment, leadership skills, teaching proficiency, clinical expertise and a strong interest in building a productive academic career. MD or MD/PhD and completion of an accredited residency in Otolaryngology and fellowship in Head & Neck Surgery required. Must be BE/BC.

Please forward a letter of inquiry and C.V. to:
Lisa Orloff, MD, FACS
Chair, UCSF Search Committee
Department of Otolaryngology-Head and Neck Surgery
University of California, San Francisco
2233 Post Street, 3rd Floor, Box 1225
San Francisco, CA 94115
Telephone (415) 353-2870
Fax (415) 885-7546
lorloff@ohns.ucsf.edu

UCSF seeks candidates whose experience, teaching, research, or community service has prepared them to contribute to our commitment to diversity and excellence. UCSF is an Equal Opportunity/Affirmative Action Employer. The University undertakes affirmative action to assure equal employment opportunity for under utilized minorities and women, for persons with disabilities, and for covered veterans. All qualified applicants are encouraged to apply, including minorities and women.

Search number # M-3329

MAYO CLINIC

Pulmonary/Critical Care/Sleep Physician

Heal the sick, advance the science, share the knowledge.

The Department of Otorhinolaryngology, Division of Rhinology at Mayo Clinic in Rochester, MN is seeking a board-certified or board-eligible Rhinologist to join a busy tertiary care practice.

The division is seeking a quality individual with demonstrated expertise and primary interest in Rhinology and skull base surgery to complement the practice. A strong collaborative interest in multidisciplinary clinical research and teaching will be expected as well.

Candidates must be board-certified or board-eligible in Otorhinolaryngology. Fellowship training (or equivalent experience) is preferred. The candidate should be capable of managing the full gamut of clinical and surgical rhinologic disorders.

Mayo Clinic is an excellent choice for the candidate who is seeking a career in a world-class academic medical center that is consistently recognized by *U.S. News & World Report* as one of America's "Best Hospitals." Mayo Clinic's multi-disciplinary group practice focuses on providing high-quality, compassionate medical care with a primary value that "the needs of the patient come first." Mayo Clinic is a nonprofit organization with approximately 3,800 physicians and scientists across all locations working in a unique environment that brings together the best in patient care, groundbreaking research and innovative medical education.

Mayo Clinic in Rochester combines the comfort of small city living with easy access to rich cultural and entertainment opportunities in nearby Minneapolis/St. Paul. Mayo Clinic has been recognized by *Fortune* magazine as one of the "100 Best Companies to Work For."

To apply and learn more, please visit **www.mayoclinic.org/physician-jobs** and reference job posting **21297BR**. Letters of interest should be directed to:

Colin L.W. Driscoll, M.D.
Chair, Department of Otorhinolaryngology
c/o Andy Seidl, Human Resources

Mayo Clinic
200 First Street S.W.
Rochester, MN 55905

Email: Seidl.Andrew@mayo.edu

Mayo Clinic is an affirmative action and equal opportunity educator and employer. Post offer/pre-employment drug screening is required.

JOIN SANFORD EAR, NOSE & THROAT CLINIC

SANFORD HEALTH

Sanford Health is seeking BC/BE Ear, Nose and Throat specialists to join a fast-paced, physician-led practice in the upper Midwest where there is opportunity to grow your patient base rapidly. Locations include Minnesota, North Dakota and South Dakota.

General – Bemidji, MN; Bismarck, ND; Fargo, ND; Aberdeen, SD; Sioux Falls, SD
Pediatric – Fargo, ND

We offer a competitive salary and comprehensive benefits package, paid malpractice and relocation assistance. Communities offer high quality of life, affordable living, culture and education.

At Sanford Clinic, our talented and diverse team of dedicated physicians creates a strong foundation of excellence. With more than 1,400 primary and specialty care physicians, 140 locations, and 80 specialties, Sanford Health is the largest not-for-profit rural health care system in the nation.

500-51030-0114 Rev. 9/13

Connie Long
Bismark
(701) 323-5417
connie.long@sanfordhealth.org

Celia Beck
Bemidji
(218) 333-5056
celia.beck@sanfordhealth.org

Kathryn Norby
Fargo
(701) 417-4851
kathryn.norby@sanfordhealth.org

Jessilyn Healy
Sioux Falls/Aberdeen
(605) 328-6986
jessilyn.healy@sanfordhealth.org

Go to: practice.sanfordhealth.org for a listing of all of our opportunities.

THE UNIVERSITY OF UTAH

Facial Plastic and Reconstructive Surgeon

University of Utah Otolaryngology-Head and Neck Surgery seeks BC/BE Assistant/Associate Professor faculty with fellowship training in facial plastic and reconstructive surgery. This is a full-time tenure track position. Responsibilities will include teaching, research and clinical care in our community clinics. Research opportunities are plentiful with intramural funding available. Candidates should be prepared to build a practice strong in both reconstructive and aesthetic surgery. Candidates with skills that augment our Facial Plastic surgery section will receive the highest priority. Position available immediately.

The University of Utah is an Equal Opportunity/ Affirmative Action employer and educator. Minorities, women, and persons with disabilities are strongly encouraged to apply. Veterans preference. Reasonable accommodations provided.

Applicants must apply at:
http://utah.peopleadmin.com/postings/25667
For additional information, contact:
Clough Shelton, MD, FACS, Professor and Chief
University of Utah School of Medicine
50 North Medical Drive 3C120
Salt Lake City, Utah 84132
Phone: (801) 585-1626
Fax: (801) 585-5744
E-mail: inga.journey@hsc.utah.edu

Southern New England
Connecticut

Otolaryngologist/Subspecialty Interests Welcome

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

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

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

ProHealth PHYSICIANS

"Love life. Step into financial success and clinical satisfaction while surrounding yourself with all the beauty and activities the Jersey Shore has to offer."

Fellowship trained Neurotologist, Head and Neck Surgeon and Rhinologist

Coastal Ear, Nose and Throat (Coastal) is an extremely successful three physician private practice located along the shore in Central New Jersey. Coastal's award winning team consists of a two General Otolaryngologists and a fellowship- trained Pediatric Otolaryngologist. We are currently searching for a fellowship trained Neurotologist, Head and Neck Surgeon and Rhinologist to assist in meeting the patient demand for our established, growing practice.

Coastal is associated with the 610-bed Jersey Shore University Medical Center (JSUMC). JSUMC is the academic center of Meridian Health and is the university affiliate of UMDNJ Robert Wood Johnson School of Medicine. Coastal ENT's 11,000 sq ft office and ambulatory surgery center offer state –of- the- art facilities close to the medical center. Ancillary services include: Allergy and Research, full time Clinical Research Coordinator on staff, Vestibular Physical Therapist on site and fully Integrated EMR. Compensation and benefits are highly competitive. Financials are transparent from recruitment to partnership.

Monmouth and Ocean Counties are desirable New Jersey shore communities in close proximity to New York City and Philadelphia. Please feel free to visit our website at www.coastalearnoseandthroat.com.

Coastal
Ear, Nose & Throat

For immediate consideration, please submit your CV to:
Carol A. Petite
In House Physician Recruiter
Meridian Health
cpetite@meridianhealth.com
732-673-5000

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

Head and Neck Fellowship

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

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

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

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

Pediatric Otolaryngologist Faculty Advertisement

The Department of Otolaryngology - Head and Neck Surgery at Saint Louis University, a Catholic, Jesuit institution dedicated to student learning, research, health care and service is currently seeking applications for a Fellowship Trained Pediatric Otolaryngologist. The position is based at the Sisters of St. Mary Cardinal Glennon Children's Medical Center. Appointment in Pediatric Otolaryngology is available at the level of Assistant/Associate Professor. Candidates must be Board Certified in Otolaryngology - Head and Neck Surgery.

SSM Cardinal Glennon Children's Medical Center is a 160-bed free-standing hospital located in midtown Saint Louis, adjacent to Saint Louis University and Saint Louis University Hospital. The Hospital serves a diverse population from the inner city, the metropolitan area and a 200-mile referral radius. St. Louis is an urban center with a population of 2½ million and ample cultural, sports and entertainment opportunities.

Interested candidates must submit a cover letter, application and current curriculum vitae to: https://jobs.slu.edu. Review of applications begins immediately and continues until the position is filled. For further information contact:

Mark A Varvares, M.D., Chairman
Department of Otolaryngology – Head and Neck Surgery
Saint Louis University School of Medicine
3635 Vista at Grand Boulevard
6th fl, FDT
St. Louis, MO 63110-0360
varvares@slu.edu

Saint Louis University is an affirmative action, equal opportunity employer and encourages nominations and applications of women and minorities.

Two General Otolaryngologists Needed in Charlotte NC

Charlotte Eye Ear Nose and Throat Associates, PA (CEENTA) is a multi-specialty practice of Ophthalmology and Otolaryngology. Our 90 year old practice has 78 providers and 14 offices spread over a geographic area with a radius of approximately 50 miles centered on Charlotte NC.

Due to continued expansion, CEENTA has openings for 2 General Otolaryngologists in the greater Charlotte metro region.

The group has all subspecialties represented, an established referral base, and an in-house contract research organization.

Charlotte is two hours east of the Appalachian Mountains and 3 1/2 hours west of the Atlantic Ocean. It is home to the University of North Carolina, Charlotte, the NFL Panthers, the NBA Bobcats and a variety of cultural venues. Charlotte and its metropolitan area, have one of the fastest growing populations of mid-sized metropolitan areas in the United States.

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

For immediate consideration, please send CV to:

anash@ceenta.com
or
Director-Human Resources
Charlotte Eye Ear Nose and Throat Associates, PA.
6035 Fairview Road
Charlotte, NC 28210

Fax: (704)295-3415

EOE

CHARLOTTE EYE EAR NOSE & THROAT ASSOCIATES, P.A.

GENERAL OTOLARYNGOLOGY

The Department of Otolaryngology at the Massachusetts Eye and Ear Infirmary seeks a qualified candidate for a full-time position with principal location at its Concord Center for Otolaryngology-Head and Neck Surgery. The successful candidate would have the opportunity for a broad clinical practice in General Otolaryngology. In addition, there are opportunities to participate in basic and clinical research and/or teaching within the Infirmary and the Department of Otology and Laryngology at Harvard Medical School. The successful candidate must be board-certified or board-eligible in Otolaryngology.

Qualified female and minority applicants are encouraged to apply.

Please send a letter of interest and curriculum vitae to:

Stephen Smith, M.D.
Massachusetts Eye and Ear Associates
290 Baker Avenue
Concord, Massachusetts 01742
(978) 369-8780
stephen_smith@meei.harvard.edu

utmb Health

Otolaryngologic Allergist
FULL-TIME BC/BE FACULTY

The Department of Otolaryngology at UTMB Health in Galveston, Texas is actively recruiting qualified candidates for a full-time academic position, which carries opportunities to participate in all aspects of clinical practice, teaching, and research. Excellent research resources are available. The position is suitable for full-time clinician-educators or clinician-scientists. We offer competitive salary, incentive, and generous benefits packages.

Please direct your Letter of Interest and CV to:
Vicente Resto, MD, PhD, FACS
Chair, Department of Otolaryngology
The University of Texas Medical Branch,
301 University Boulevard, Galveston, TX 77555-0521
Email: varesto@utmb.edu
Phone: 409-772-2701 Fax: 409-772-1715

UTMB is an equal opportunity, affirmative action institution which proudly values diversity. Candidates of all backgrounds are encouraged to apply.

Coastal
Ear, Nose & Throat

"Love life. Step into financial success and clinical satisfaction while surrounding yourself with all the beauty and activities the Jersey Shore has to offer."

GENERAL OTOLARYNGOLOGIST
Location: Monmouth County, NJ

Coastal Ear, Nose and Throat (Coastal) is an extremely successful three physician private practice located along the shore in Central New Jersey. Coastal's award winning team consists of a two General Otolaryngologists and a fellowship- trained Pediatric Otolaryngologist. We are currently searching for an additional highly skilled General Otolaryngologist to assist in meeting the patient demand for our practice.

Coastal is associated with the 610-bed Jersey Shore University Medical Center (JSUMC). JSUMC is the academic center of Meridian Health and is the university affiliate of UMDNJ Robert Wood Johnson School of Medicine. Coastal ENT's 11,000 sq ft office and ambulatory surgery center offer state –of- the- art facilities close to the medical center. Ancillary services include Allergy and Research. Full time Clinical Research Coordinator on staff. Vestibular Physical Therapist on site. Fully integrated EMR. Compensation and benefits are highly competitive. Financials are transparent from recruitment to partnership.

Monmouth and Ocean Counties are desirable New Jersey shore communities in close proximity to New York City and Philadelphia. Please feel free to visit our website at www.coastalearnoseandthroat.com. All interested candidates please email bmlauer@coastalhearing.com.

GENERAL OTOLARYNGOLOGY

The Department of Otolaryngology at the Massachusetts Eye and Ear Infirmary seeks a qualified candidate for a full time position with principal location at its Stoneham Center for Otolaryngology-Head and Neck Surgery. The successful candidate would have the opportunity for a broad clinical practice in General Otolaryngology. In addition, there are opportunities to participate in basic and clinical research and/or teaching within the Infirmary and the Department of Otology and Laryngology at Harvard Medical School. The successful candidate must be board-certified or board-eligible in Otolaryngology.

Qualified female and minority applicants are encouraged to apply.

Please send a letter of interest and curriculum vitae to:

David M. Bowling, M.D.
Massachusetts Eye and Ear Associates
One Montvale Avenue
Stoneham, Massachusetts 02180
(781) 279-2788
david_bowling@meei.harvard.edu

THE UNIVERSITY OF UTAH

Head and Neck Oncology Surgeon/Scientist

University of Utah Otolaryngology—Head & Neck Surgery seeks BC/BE faculty with fellowship training in head and neck oncology. This is a full-time tenure track position at the Assistant or Associate Professor level. Must have MD PhD, additional research training (T-32) or competitive, extramural funding. The successful candidate should be able to lead an extramurally-funded research effort and also participate in clinical care and resident education. Position available immediately.

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

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

Seeking Full Time BC/BE ENT

CEDARS-SINAI

Cedars-Sinai Medical Group is a premier multi-specialty medical group located in Beverly Hills, CA. We are physician directed and committed to providing personalized, comprehensive healthcare with an emphasis on quality.

We are seeking a full-time BC/BE Otolaryngologist to join our busy three Physician and two Physician Assistant ENT practice. The candidate should have an interest in General and Pediatric Otolaryngology but clinical interest in Otology/Neuro-otology, Head and Neck Surgery, or Laryngology a bonus. Those interested in Facial Plastics need not apply. Excellent interpersonal skills and the motivation to build and maintain a busy practice are essential.

We offer a competitive salary and benefits package.

Please submit CV to: **Gene.Liu@cshs.org**

There will be opportunities to interview at the AAO in Vancouver.

Cedars-Sinai Medical Center welcomes and encourages diversity and is committed to maintaining a drug- and alcohol-free workplace. AA/EOE.

Children's Mercy HOSPITALS & CLINICS | Kansas City

Kansas City's Children's Mercy Hospital and Clinics, in affiliation with the University of Missouri-Kansas City, is seeking fellowship trained Pediatric Otolaryngologists. Our current faculty includes 7 Pediatric Otolaryngologists and 3 Neurotologists. Our robust Division is dedicated to providing comprehensive treatment to patients in a family centered care environment. With the completion of the new patient tower at our Missouri based hospital, we have expanded to 400 beds increasing the PICU capacity to 41 beds and the NICU to 80 beds.

The responsibilities of this position include clinical care, research, and teaching medical students and the residents in our Pediatric and Otolaryngology programs. Salary and academic range are commensurate with experience. EOE/AAP

Kansas City is a metropolitan area of more than two million people spanning the Missouri–Kansas border. It has an extensive offering of arts, entertainment, and sports with a number of new venues having just opened within the past few years. K C is home to several major colleges and universities. Our metropolis contains a wide selection of highly rated public and private schools.

For more information check us out at www.childrensmercy.org or contact:

Robert A. Weatherly, MD; Division Director; Ear, Nose, and Throat
rweatherly@cmh.edu
Phone: 866-CMH-IN-KC/866-264-4652

KANSAS CITY, a GREAT place to Live and Work!!
http://www.thinkkc.com/livingworking/livingworking.php

MedStar Washington Hospital Center

The Department of Otolaryngology-Head and Neck surgery at MedStar Washington Hospital Center presents a full time position to a BC/BE physician. The candidate should have an interest in practicing general otolaryngology. The candidate will be active in resident and medical student education and in clinical research as part of the Georgetown University residency program.

The practice opportunity will be located at the MedStar Washington Hospital Center and a satellite office in Waldorf, MD. Waldorf is located within easy commuting distance of Washington, DC.

MedStar Washington Hospital Center is the largest not-for-profit teaching hospital in metropolitan Washington, DC. The Hospital is part of MedStar Health, a $2.7 billion not-for-profit healthcare organization and a community-based network of nine hospitals and other healthcare services in the Baltimore-Washington region. This network is the largest health system and one of the largest employers in the Baltimore/Washington area.

Interested applicants should forward an updated CV to:
Stanley Chia, M.D., F.A.C.S.
Associate Chairman
Department of Otolaryngology-Head and Neck Surgery
Washington Hospital Center
110 Irving Street NW, GA-4
Washington, DC 20010
202-877-6219
email: stanley.h.chia@medstar.net

CHOP® Penn Medicine

Assistant or Associate Professor, ORL-HNS
Otorhinolaryngology: Head and Neck Surgery

The Children's Hospital of Philadelphia and the Department of Otorhinolaryngology: Head and Neck Surgery at the Perelman School of Medicine at the University of Pennsylvania seek candidates for several Assistant or Associate Professor positions in either the non-tenure clinician-educator track or the non-tenure academic-clinician track. Track and rank will be commensurate with experience. The successful applicant will have experience in the field of Otolaryngology with a focus on Pediatric Otolaryngology. Responsibilities include patient/clinical care, research, and participation in medical student, resident, and fellow education. Applicants must have an M.D. or M.D./Ph.D. degree and have demonstrated excellent qualifications in education, research, and clinical care. While evidence of scholarship is required in the clinician-educator track, research is not required in the academic clinician track. Applicants must be certified by the American Board of Otolaryngology.

Candidates must have completed a fellowship in Pediatric Otolaryngology. The primary location of this position will be at The Children's Hospital of Philadelphia.

We seek candidates who embrace and reflect diversity in the broadest sense. The University of Pennsylvania and The Children's Hospital of Philadelphia are equal opportunity, affirmative action employers.

Apply for this position online at: http://www.med.upenn.edu/apps/faculty_ad/index.php/g329/d3318

Assistant, Associate or Full Professor of Pediatric Otolaryngology
Stanford University School of Medicine Department of Otolaryngology/ Head and Neck Surgery

The **Division of Pediatric Otolaryngology** in the Department of Otolaryngology/ Head and Neck Surgery at **Stanford University School of Medicine** seeks a Pediatric Otolaryngology Fellowship-trained Otolaryngologist to join the department in the University Tenure Line or the Medical Center Line, depending on qualifications. Faculty rank will be professor, associate professor or assistant professor, determined by the qualifications and experience of the successful candidate.

The predominant criterion for appointment in the University Tenure Line is a major commitment to research and teaching. The major criteria for appointment for faculty in the Medical Center Line shall be excellence in the overall mix of clinical care, clinical teaching, scholarly activity that advances clinical medicine and institutional service appropriate to the programmatic need the individual is expected to fulfill.

The successful applicant should be board eligible or board certified in Otolaryngology/Head & Neck Surgery and be enrolled in or have completed a fellowship in pediatric otolaryngology. We expect the successful candidate to develop an active clinical practice in the field of pediatric otolaryngology, be an active teacher of medical students and residents and develop a robust scholarly/research program

Applications will be reviewed beginning September 1, 2013 and accepted until position is filled.

Stanford University is an equal opportunity employer and is committed to increasing the diversity of its faculty. It welcomes nominations of and applications from women and members of minority groups, as well as others who would bring additional dimensions to the university's research, teaching and clinical missions.

Applicants must submit a curriculum vitae, a brief letter and the names of three references to:

Anna H. Messner, MD
Professor and Vice-Chair
Department of Otolaryngology/Head and Neck Surgery
801 Welch Road
Stanford, CA 94305
amessner@ohns.stanford.edu
650-725-6500 (phone) 650-725-8502 (fax)

HEAD*AND* NECK* SURGERY
STANFORD* OTOLARYNGOLOGY*

THE UNIVERSITY OF UTAH

Pediatric Otolaryngology
Surgeon/Scientist

University of Utah Otolaryngology–Head & Neck Surgery seeks BC/BE faculty with fellowship training in Pediatric Otolaryngology. This is a full-time tenure track position at the Assistant or Associate Professor level. Must have MD PhD, additional research training (T-32) or competitive, extramural funding. The successful candidate should be able to lead an extramurally-funded research effort and also participate in clinical care and resident education. Position available July 2014.

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

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

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

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

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

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

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

WestVirginiaUniversity.

The Department of Otolaryngology 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 2014 or sooner. Expertise with both ablative and reconstructive procedures is desired. Responsibilities include education of residents and medical students and patient care. Opportunities are available for those interested in clinical/basic research.

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

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

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

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

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

Children's Hospital LOS ANGELES

DIVISION OF OTOLARYNGOLOGY HEAD AND NECK SURGERY

Division of Otolaryngology-Head and Neck Surgery
Children's Hospital Los Angeles

Department of Otolaryngology
Keck School of Medicine
University of Southern California

Full-Time Pediatric Otolaryngologist at the Assistant/Associate Professor level with the University of Southern California at Children's Hospital Los Angeles.

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

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

Excellent benefits available through USC
USC and CHLA are equal opportunity and affirmative action employers.
Woman and men, and members of all racial and ethnic groups are encouraged to apply.
Academic appointment through USC Keck School of Medicine is available at a level appropriate to training and experience.

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

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

COASTAL CAROLINA OTOLARYNGOLOGY ASSOCIATES, P.A.

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

- Located in Myrtle Beach, South Carolina
- Associated but independent from Grand Strand Regional Medical Center
- In-Office CT scanner
- Full audiology department
- Competitive Salary Base plus percentage
- Main office located above a multi specialty ambulatory surgery center

Must be BC/BE

Please Contact:
Debrah Ripple
1021 Cipriana Drive, Suite 220
Myrtle Beach, SC 29572
debbieripple@aol.com
or Fax CV to 843-449-1069

WestVirginiaUniversity.

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

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

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

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

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

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

EAR, NOSE & THROAT CONSULTANTS
Quality Hearing Aid Center

SEEKING OTOLARYNGOLOGY – HEAD AND NECK SURGEON IN SOUTHEAST MICHIGAN

Ear, Nose & Throat Consultants, P.C. is a full service, private practice with 4 well located offices in affluent suburbs in Southeast Michigan. This lucrative, very busy practice is currently staffed with 3 Otolaryngologists and there is an opening for a 4th due to a recent retirement. The practice has 1250 square miles of referral area. Physicians have credentials at 4 major hospital networks and a physician owned ASC. Physicians hold medical school Assistant Professor-Clinical appointments.

Comprehensive audiology services are provided by 5 audiologists and include audiometry, full electrophysiology, and progressive hearing aid sales. We have on site Videostroboscopy and Speech Therapy.

The candidate must be board certified/eligible by the American Board of Otolaryngology.

Senior residents and established physicians may apply. Clinical excellence is a requirement.

This position will remain open until filled.

Excellent compensation options and negotiable benefits.

Contact: Jeffrey S. Weingarten, M.D.
entconsul@yahoo.com
248-569-5985
ENTforYOU.com

Cooper Medical School of Rowan University
Cooper University Health Care

OTOLOGIST/NEUROTOLOGIST

The Division of Otolaryngology-Head & Neck Surgery in the Department of Surgery is seeking a fellowship-trained Otologist/Neurotologist to join our dynamic academic practice at a time of unprecedented growth and development within the division. The candidate will be able to qualify for faculty appointment at the Assistant Professor or Associate Professor level, commensurate with his/her level of experience.

The successful candidate must be a highly motivated individual with interests and capability in all aspects of medical and surgical otology and neurotology. Responsibilities include serving as Director of Otology/Neurotology, and leading a group of 3 doctorate-level Audiologists with high-level training in hearing and balance disorders, as well as cochlear implantation. The candidate will work closely and collaborate with the Department of Neurosurgery and be an integral part of the skull base surgery team. The candidate will also serve as Medical Director of Audiology Services in the health system.

Our division currently has 7 otolaryngologists, 3 Nurse Practitioners and 3 Audiologists and is expanding. We are actively engaged in medical student teaching and training residents within the hospital. Our plan is to obtain a residency program in the near future. Opportunities are available for those interested in clinical/basic science research, especially in regenerative medicine, which is the focus of the laboratory.

Cooper University Hospital, the clinical campus of Cooper University of Rowan University, is the leading provider of health services to Southern New Jersey. Cooper's main hospital is located in Camden, NJ, right across the river from Philadelphia. Cooper also has satellite offices in the surrounding suburbs, including Cherry Hill, Moorestown, Voorhees and Washington Township with a surgery center based in Voorhees.

The location is ideal and in close proximity to Philadelphia, New York City, the Jersey shore and its beaches, Baltimore, and Washington DC

This is an outstanding and unique opportunity for a Otologist/Neurotologist to establish, lead and grow an academic practice in Otology/Neurotology and be part of the development of a residency program.

Academic appointment and compensation is commensurate with training and experience.

Interested applicants should contact:

Nadir Ahmad, MD, FACS
Division Head, Otolaryngology-Head & Neck Surgery
Three Cooper Plaza, Suite 404
Camden, NJ 08103
Email: ahmad-nadir@cooperhealth.edu

PEDIATRIC OTOLARYNGOLOGIST

The Division of Otolaryngology-Head & Neck Surgery in the Department of Surgery is seeking a fellowship-trained **Pediatric Otolaryngologist** to join our dynamic academic practice at a time of unprecedented growth and development within the division. The candidate will be able to qualify for faculty appointment at the Assistant Professor or Associate Professor level, commensurate with his/her level of experience.

The successful candidate must be a highly motivated individual with interests and capability in all aspects of medical and surgical pediatric otolaryngology. Responsibilities include serving as Director of Pediatric Otolaryngology, and leading the focus of all aspects of pediatric otolaryngology within Cooper University Hospital. Candidates have no restrictions and are free to practice any aspect of pediatric otolaryngology including: cochlear implantation, airway reconstruction, and craniofacial surgery. The otolaryngologists truly welcome all advanced skill sets and will work as a group to facilitate the clinical and academic growth of the candidate.

Our division currently has 7 otolaryngologists, 3 Nurse Practitioners and 3 Audiologists and is expanding. We are actively engaged in medical student teaching and training residents within the hospital. Our plan is to obtain a residency program in the near future. Opportunities are available for those interested in clinical/basic science research, especially in regenerative medicine and stem cell research, which is the focus of the laboratory.

Cooper University Hospital, the clinical campus of Cooper University of Rowan University, is the leading provider of health services to Southern New Jersey. Cooper's main hospital is located in Camden, NJ, right across the river from Philadelphia. Cooper also has satellite offices in the surrounding suburbs, including Cherry Hill, Moorestown, Voorhees and Washington Township with a surgery center based in Voorhees.

The location is ideal and in close proximity to Philadelphia, New York City, the Jersey shore and its beaches, Baltimore, and Washington DC

This is an outstanding and unique opportunity for a Pediatric Otolaryngologist to establish, lead and grow an academic practice and to be part of the development of a residency program.

Academic appointment and compensation is commensurate with training and experience.

Interested applicants should contact:

Nadir Ahmad, MD, FACS
Division Head, Otolaryngology-Head & Neck Surgery
Three Cooper Plaza, Suite 404
Camden, NJ 08103
Email: ahmad-nadir@cooperhealth.edu

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New England

Established group seeks 3rd otolaryngologist for a general ENT practice. You will be busy from day one and have the ability to develop most subspecialties of interest. Enjoy strong support from a 24/7 hospitalist team, a superb head and neck reconstructive team and the department of plastic surgery as well as outstanding staff that includes a nurse practitioner and 3 audiologists. Our state-of-the-art facilities include HD endoscopic equipment and 3D Stealth navigational system, and our office has balloon sinusplasty capabilities. Candidates trained in BAHA attractive.

We are just 2.5 hours from Boston, 40 minutes to the coast, 5 minutes to the lake with skiing in our own backyard.

For more information please contact:

Kim DeBlasi
800-678-7858 x64558
kdeblasi@cejkasearch.com

ID# 146125AD cejkasearch.com

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THE UNIVERSITY OF ARIZONA | COLLEGE OF MEDICINE

Rhinologist/Endoscopic Skull Base Surgeon

The Division of Otolaryngology at the University of Arizona in Tucson, AZ is seeking a fellowship trained rhinologist/skull base surgeon at the assistant or associate professor level. With a current faculty of 7 full-time and 2 part-time physicians and a recently begun ACGME residency in Otolaryngology, the otolaryngology program has made rapid strides toward becoming a leader in academic otolaryngology in the Southwest.

The applicant will be expected to partner with the existing rhinology and skull base program to further develop its clinical and academic enterprise. Minimum qualifications include an MD (or equivalent), Arizona Medical license (or ability to obtain), Board eligibility or Board Certification in Otolaryngology. Preference will be given to candidates with evidence of scholarly activity. Tenure eligibility and salary determined by experience; excellent UA and practice plan benefits.

Please send a CV, a cover letter and the names and contact information of two references to:

Alexander Chiu, MD
Professor and Chief
Division of Otolaryngology, Department of Surgery
1501 North Campbell Avenue, Rm 4402
Tucson, AZ 85724
520-626-6673
achiu@surgery.arizona.edu

Join A Well Established Practice In **North Carolina**

Our ENT practice is seeking a BC/BE Otolaryngologist to join our current five-physician practice. This practice enjoys a full spectrum of ENT services including head and neck surgery, otology, allergy testing and treatment, CT scanner on site, EHR (Electronic Health Records), audiology and hearing aid dispensing.

Our benefit package includes excellent starting salary with partnership anticipated after two years, 401(k), professional liability insurance, and health insurance.

Interested individuals should send Curriculum Vitae to:
Fayetteville Otolaryngology
Head & Neck Surgery, P.A.
1839 Quiet Cove
Fayetteville, N.C. 28304

Phone (910) 323-1463 Fax (910) 222-6551
Website: fayent.com
Email: gparksfayent@nc.rr.com

Contact: Elizabeth Hueman, M.D. or Gwendolyn Parks, Practice Administrator.

THE UNIVERSITY OF UTAH

General Otolaryngologist

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

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

Applicants must apply at:
http://utah.peopleadmin.com/postings/18379

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

MICHIGAN

Located in the upscale community of Farmington Hills this 5 physician SSG is looking to enhance the practice with the addition of 3 new associates. An ENT Allergist, a Head & Neck Surgeon and Laryngologist, all with fellowship training. The practice was founded 75 years ago and in addition to the main clinic they have two suburban offices. Close to hospitals and surgery centers the offices all offer modern and up to date equipment and a well trained staff well managed practice with below average overhead and expenses. The practice will offer a Partnership track opportunity, competitive salary with health care benefits, life insurance, and IRA.

Send CV to Carl Sivia at carlsivia@gmail.com or fax to 636-272-1718

South Florida ENT Associates, P.A.

South Florida ENT Associates, a forty five physician group practice in Miami-Dade, Broward and Palm Beach has immediate openings for full- time ENT Physician's. South Florida ENT provides full service ENT practices with audiology, hearing aid sales, allergy, and facial plastics.

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:
Board Certified or Board Eligible
MD/DO from approved medical/osteopathy school and graduation from accredited residency program in ENT
Bilingual (English/Spanish) preferred
Excellent communication and interpersonal skills.
ENT Experience a must

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

Assistant, Associate or Full Professor in Otology/Neurotology Division
Stanford University School of Medicine Department of Otolaryngology/Head and Neck Surgery

The Division of Otology/Neurotology in the Department of Otolaryngology / Head and Neck Surgery at Stanford University seeks a board certified, or board eligible, otolaryngologist with an interest in vestibular disorders to join the division as **Assistant Professor, Associate Professor or Full Professor in either the Medical Center Line or the University Tenure Line**. Faculty rank and line will be determined by the qualifications and experience of the successful candidate.

- The predominant criterion for appointment in the University Tenure Line is a major commitment to research and teaching.
- The major criteria for appointment for faculty in the Medical Center Line shall be excellence in the overall mix of clinical care, clinical teaching, scholarly activity that advances clinical medicine, and institutional service appropriate to the programmatic need the individual is expected to fulfill.

The successful applicant should be eligible for and maintain a medical license in California, and be eligible for and maintain certification from the American Board of Otolaryngology. We expect the successful candidate to oversee the Vestibular Disorders Clinic within the Stanford Ear Institute, a state-of the art facility opening in 2014 with comprehensive diagnostic testing, hearing devices, cochlear implantation and a multidisciplinary balance center. In conjunction with seven faculty otologists and a community of over seventy hearing scientists, the position offers extensive research opportunities in clinical and basic science as well as in device-oriented technology. Clinical and/ or basic science research interests focused on vestibular disorders is preferred.

Applications will be reviewed beginning September 30, 2013 and accepted until position is filled.

Stanford University is an equal opportunity employer and is committed to increasing the diversity of its faculty. It welcomes nominations of and applications from women and members of minority groups, as well as others who would bring additional dimensions to the university's research, teaching and clinical missions.

Submit CV, a brief letter and the names of three references to:
Nikolas H. Blevins, MD
Larry and Sharon Malcolmson Professor
Chief, Division of Otology/Neurotology
Department of Otolaryngology/Head and Neck Surgery
801 Welch Rd, 2nd Floor, Stanford, CA 94305-5739
650-725-6500 (phone) 650-725-8502 (fax)
nblevins@stanford.edu

HEAD*AND*NECK*SURGERY
STANFORD*OTOLARYNGOLOGY*

Weill Cornell Medical College

NewYork-Presbyterian Hospital
Weill Cornell Medical Center

PARKER INSTITUTE FOR VOICE DISORDERS

ACADEMIC LARYNGOLOGY IN NEW YORK CITY

Join the newly-established Sean Parker Institute for Voice Disorders in the Department of Otolaryngology-Head and Neck Surgery at Weill Cornell Medical College. Applicants should be fellowship trained in laryngology and have a strong interest in clinical and translational research.

Opportunities include:

- Help build a first-class clinical and research laryngology program in the performing arts, media and business hub of the nation.
- State-of-the-art ambulatory care facitilies
- Ivy League medical school
- Top 10 rated academic hospital
- Faculty housing available

If interested, please contact Lucy Georgeou at lbg2002@med.cornell.edu

EOE M/F/D/V

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 # 0819537. 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 October 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

Sleep Surgeon
Stanford University School of Medicine
Department of Otolaryngology & Head and Neck Surgery

The **Department of Otolaryngology/Head and Neck Surgery** and the Stanford Sleep Center at **Stanford University School of Medicine** seeks a board certified otolaryngologist to join the department in the Medical Center Line. Faculty rank will be at the level of professor, associate professor, or assistant professor, determined by the qualifications and experience of the successful candidate.

The major criteria for appointment for faculty in the Medical Center Line shall be excellence in the overall mix of clinical care, clinical teaching, scholarly activity that advances clinical medicine, and institutional service appropriate to the programmatic need the individual is expected to fulfill.

The successful applicant should be board eligible or board certified in Otolaryngology/Head and Neck Surgery and be enrolled in or have completed a fellowship in sleep surgery or its equivalent. We expect the successful candidate to develop an active clinical practice in the field of sleep surgery, be an active teacher of medical students and residents, and develop a robust scholarly/research program.

Applications will be reviewed beginning September 15, 2013 and accepted until the position is filled.

Stanford University is an equal opportunity employer and is committed to increasing the diversity of its faculty. It welcomes nominations of and applications from women and members of minority groups, as well as others who would bring additional dimensions to the university's research, teaching and clinical missions.

Submit CV, cover letter and the names of three references to:

Edward J. Damrose, MD, FACS
Chair, Sleep Surgery Search Committee
Department of Otolaryngology/Head and Neck Surgery
801 Welch Road, 2nd Floor
Stanford, CA 94305
edamrose@ohns.stanford.edu

HEAD*AND*NECK*SURGERY
STANFORD*OTOLARYNGOLOGY*

ALBANY ENT & Allergy Services, PC

Gavin Setzen MD
Lawrence S. Kaufman MD
Siobhan Kuhar MD
Nora Perkins MD
John Gavin MD
Robert T. Adelson MD
Michael Dailey MD

Fellowship Trained BC/BE Neuro-Otologist

Albany ENT & Allergy Services is a well-established Otolaryngology-HNS-Allergy practice in upstate New York's Capital Region with diverse ancillary services including audiology, allergy testing and immunotherapy, speech and swallowing therapy, CT imaging and sleep laboratory with convenient access to ambulatory and hospital based surgery centers. As the largest ENT practice in the region, our physicians address the full spectrum of Otolaryngology; however, this region is underserved in Neuro-Otology, and our large catchment area presents a wide range of Neuro-Otologic conditions that would benefit from fellowship level care.

Located in a newly constructed medical park, AENT is an innovative and progressively managed practice (~30,000 sq. feet) utilizing electronic health records, digitized file storage & PACS.

AENT is a member of the CHEER network and is actively involved in multiple clinical trials facilitated by our research nurse coordinator, offering many opportunities for both research and academic involvement.

The practice's audiology services include 4 clinical audiologists (AuD) and state-of-the-art audio-vestibular testing with room for expansion to include a cochlear implant program or other Neuro-Otology services.

A supportive clinical staff includes seven physicians, four physician assistants, four audiologists (AuD), speech pathologist, radiology technician, clinical research coordinator as well as a large allergy staff.

A full patient schedule, call 1:8, generous compensation and benefits including 401k and profit sharing plan, as well as partnership potential await qualified candidates.

Please send confidential inquiries to:
Deborah Elia
Practice Manager
518.701.2070
delia@albanyentandallergy.com

Visit us on the web at www.albanyentandallergy.com to learn more about our practice!

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*Independent research completed 11/08 by Kelton Research