bulletin

American Academy of Otolaryngology—Head and Neck Surgery September 2013—Vol.32 No.09

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*

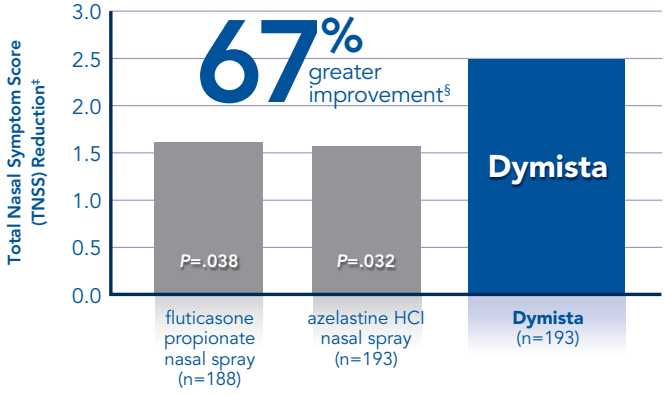
from seasonal allergy symptoms[1,2]

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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American Academy of Otolaryngology—Head and Neck Surgery September 2013—Vol.32 No.09

Guest Lecturers Carry on Tradition of Excellence

The leaders in medical science of the past built a platform for the leaders of today. And those leaders are now building a platform for the leaders to come. Sometimes their paths have crossed generations, sometimes not.

AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY

David R. Nielsen, MD
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September 2013 | Vol.32 No.09

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.

Periodical postage paid at Alexandria, VA, and additional mailing offices. Yearly subscription included in dues of Academy Members: $27 U.S., and $52 International. Nonmembers: U.S. $55 per year; International $65 per year. Allied Health Personnel: $25 per year. Copy deadline: first of preceding month.

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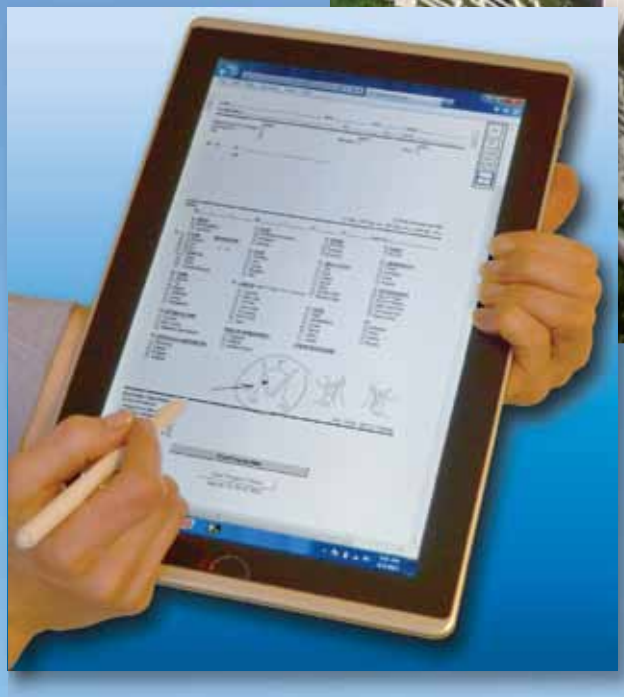

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The Community of, and for, Otolaryngology

So I came in a believer, and I go out a believer—I believe in our "Community of Otolaryngology."

I think this is a wonderful outcome for my presidential year at the AAO-HNS/F.

I have become more aware during this past year of the threats and distractions that are a constant for those who take on the job of keeping our community together. As I was thinking about this, my last column, the U.S. Senate has just barely avoided use of the nuclear option over presidential executive branch approvals. While I am relieved by this news, I am not untouched by the drama. I can see more clearly than ever that for a community to be sustained, its members must put the health of the community before the concerns of its components. I am convinced we must persist in our scientific and humanistic engagement.

What Defines Our Community?

I have tried to put my arms around our own community to isolate the basis of its power. Our community experiences all the challenges of similar groups: It struggles with diversity, growth cycles, challenges to its purpose, claims for its attention, changing demographics, and technology to name a few. It has many aspects of a scholarly community. It regularly collaborates toward continued improvement in outcomes and learning through supportive leadership and structural conditions. It collectively challenges, reflects, and advances understanding; it acts with consensus on essential activities.

It has similar challenges to that of a business community—it is not a static entity. It has cycles that are specific to its groups and its governance. It needs to respond to its members' needs, innovate, sustain, grow, and maintain a mutually trusting relationship that is both personal and professional. It needs economy of scale, and it is challenged to be more personal and available.

Late last decade, we recognized the emergence of Communities of Practice. These were defined as groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly. They enable practitioners to take collective responsibility for managing the knowledge they need, recognizing that given the proper structure they are in the best position to do this. There is no doubt that the broader otolaryngology community functions in the same way.

What Do We Have in Common?

Well, I think we are all of these types of community and more. Aside from our particular expertise and unique medical skills, we share a vision and a mission for this community. We consistently demonstrate commitment to patient care, improving world health, and supporting the whole medical community. We challenge each other to be our best, to move forward, to improve and grow as a group, and as individuals. While community identity is hard to pin down, there is a sense that a desire to be part of a community is strengthening.

I have seen evidence of our commitment and passion with every issue of the *Bulletin* published during my presidential year. I invite you to review the reading list below from this year's *Bulletin*. Taken together, these articles articulate a community that is vital, challenging, questioning, and committed to our future.

2012
October page 20—Academy and Foundation Cluster and Committee Rosters
October page 41—Summary: Proposed CY 2013 Medicare Physician Fee Schedule
November Center insert—2012 Annual Report
November page 20—The Hal Foster, MD Endowment—From Dream to Reality
December page 20—Education: Meeting the Needs of All Our Learners
December page 25—You Asked and The Academy Answered: Introducing AcademyQ
January pages 34 & 35 Academy Highlights Success: Changes in 2013 Coding and Reimbursement for ENT Services in 2013

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

2013
January page 37—Clinical Consensus Statement: Tracheostomy Care
February page 30—Position Statement Updates (A second round will be completed this month).
February page 41—Communication Is Key (Continuing series on Patient Safety by Rahul K. Shah, MD)
March page 14—Choosing Wisely: Our List of Five Things Physicians and Patients Should Question
March page 20 and insert—World Voice Day 2013: Connect with Your Voice (included poster)
April pages 26 & 27—Overviews of 2013 Federal Legislative Priorities and State Legislative Priorities
April page 22—The BOG Spring Meeting & OTO Advocacy Summit
May page 36—You're Invited: 2013 Annual Meeting & OTO EXPO℠
May page 18—Ad Hoc Payment Workgroup Evaluates Payment Models
June page 14—Clinical Practice Guideline Summary: Improving Voice Outcome after Thyroid Surgery
June page 46—Face the Future Humanitarian Mission to Rwanda (supported by grants from the AAO-HNSF Humanitarian Efforts Committee and the Alcon Foundation)
July page 11—Clinical Practice Guideline: Tympanostomy Tubes in Children (with clinical and patient informational posters inside this issue.)
July page 24—CORE Grant Program Breaks Record
August page 13—Board of Governors Candidates for Office

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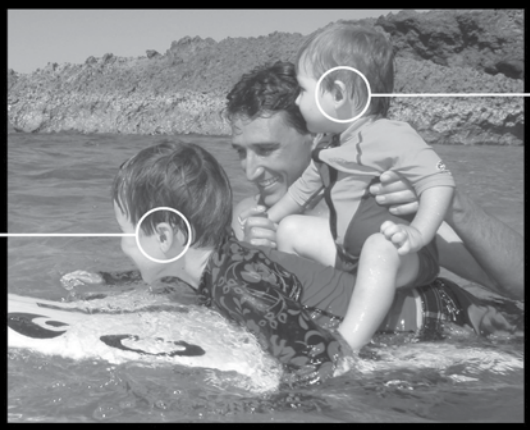

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A Preparation Medley

David R. Nielsen MD

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

This is the month of our Annual Meeting & OTO EXPO℠. By now, most of you have made preparations to attend. The excitement this year is extremely high as once again (for only the second time in Academy history) we cross our northern border and join our colleagues in Canada to conduct our Annual Meeting in Vancouver. Our previous foray into Canada was to Toronto in 2006. If there are any of you who have not yet completed your plans, we hope you will take the time to join us for this outstanding gathering of the world's most collegial doctors, the best exhibit hall in the specialty, the expansive educational offerings, and the community and connection that many of us find to be the best reason to attend.

While the meeting educational content and programming is superb, what is unique about our Annual Meeting & OTO EXPO is the unparalleled opportunity for combining great programming with discussions, interaction, committee work, social renewal, coordinating specialty society action, and invigorating our practices. Since a large number of our members practice in settings of five or fewer otolaryngologists, the social interactions and the clinical discussions and sharing are a great relief. Having spent 13 years as a solo practitioner, I remember with fondness the satisfaction of having my friends and colleagues at my elbow for the week of the Annual Meeting.

Upholding Our Public Image

Public perception of the medical profession remains a challenge. Several times during the last year, articles have appeared in major newspapers with an exposé or "investigative reporting" tone, casting a negative light on the AMA Relative Value Update Committee (RUC) that advises CMS on setting appropriate relative value units (RVU's) for medical services. The RUC does not set physician prices, but only addresses relative values of services across the Medicare Physician Fee Schedule (MPFS). It is not a "secret committee" as reported, but invites all relevant stakeholders, including Centers for Medicare & Medicaid Services (CMS) representatives and members of the Medicare Payment Advisory Commission (MedPAC), to attend and only embargoes its work to prevent exploitation prior to publication of final MPFS each fall. The Academy has been involved in the RUC process since its inception more than 20 years ago, and we support continued use of the AMA RUC as the primary method for validating physician work RVUs. We believe physician input allowed by the RUC valuation process serves as an essential piece of evaluation for the work and intensity of physician services.

The continued and almost willful misinformation that is generated paints physicians as self-serving and incorrectly tarnishes those who contribute many hours of service to help navigate the morass of codes and descriptors we must use to report our work. One of the most recent examples in *The Washington Post* on July 21 took particular issue with what it presented as physicians padding the time it takes to perform a procedure. While the article focused on gastroenterology, orthopedics, hand surgery, and ophthalmology, the implication is that the practice of reporting more time than actually needed for a procedure is widespread and intentionally done to increase reimbursement.

The AMA staff and RUC leadership have responded with appropriate corrections to the misinformation and made these available. We should familiarize ourselves with the correct information and at least have a minimal understanding of how we participate to fairly represent the relative value of our work. See www.bit.ly/RUCprocess.

Spearheading Our Leadership Selection

By the time you read this, those elected to Academy office this summer will already have been announced and will be assuming their roles very shortly. Periodically, I try to remind each of us of the great depth of effective leadership, mentors, and role models within our membership. We have a Nominating Committee, which takes seriously its charge to put forward names of highly motivated and devoted individuals who will serve the Academy and Foundation well. Most of our Nominating Committee members do their work quietly and without much notice from the majority of the Academy members. But their task is arguably one of the most *important* of all our elected officials, as they are primarily responsible for the quality of the next generation of board members and officers. I take this opportunity to thank them for their work on behalf of the entire membership and personally as well.

The process by which they consider and choose candidates has improved each year. More preparation goes into studying what is needed for each position. More familiarizing takes place on the strategic plan and direction of the Academy and Foundation. Knowing that every name they consider is a leader and an exceptional physician, they keep their discussions confidential and discreet, and ensure the names of all being considered are given the respect and honor they deserve.

Next month we will begin a new leadership year. Please join us in Vancouver as we celebrate an exceptional year of accomplishment and kick off a new year of continued growth and improved service to all otolaryngologists.

The BOG Is Ready to Help You Navigate the Waters of Healthcare Reform

The AAO-HNSF 2013 Annual Meeting & OTO EXPO℠ will convene at the end of this month in the beautiful city of Vancouver, BC, Canada. The setting, off the gorgeous Strait of Georgia and Vancouver Bay, will be truly inspiring. The trip to one of our northern neighbors' most impressive cities will no doubt enlighten the international audience of otolaryngologists, residents, scientists, and administrators. We encourage all AAO-HNS members to register and take full advantage of the research presentations, miniseminars, clinical courses, and the always-informative OTO EXPO while in Vancouver.

The international flavor of this year's meeting gives us the opportunity to look at our healthcare delivery system from a global perspective as we work to fully understand, and to mold, the details of healthcare reform. The changes currently underway ensure our healthcare system will demand that we adapt appropriately to these changes, and work to ensure our ability to provide the best care possible to our patients and their families.

Your BOG and the AAO-HNS are poised to help guide you through the myriad changes that have already occurred as a result of the Affordable Care Act (ACA) and will work to inform you of the further changes that await us in the coming years. The BOG meetings, in conjunction with related miniseminars being held during the Annual Meeting, will give members multiple opportunities to be informed about our changing healthcare system and to evaluate the impact of these changes on providers' practices.

The BOG kicks off its events beginning on Saturday morning, September 28, with its Rules and Regulations Committee, Legislative Representatives Committee, and Socioeconomic and Grassroots Committee meeting sessions. These committees will discuss topics including pay-for-call, maintenance of hospital privileges, and acquisition of practices by hospital systems, as well as current legislative issues. We will have reports from the regional BOG representatives giving us an update of the current issues affecting their component local societies.

The regionalization of the BOG state and local societies is a modification of the BOG structure that was initiated more than a year ago. The BOG regions match the HHS regions that we are all familiar with. This regionalization will help solidify the conduit for the free flow of information from the local societies to the Academy and back. This regional approach will be vital as local issues related to healthcare reform, and/or local state legislative challenges occur. Changes are occurring swiftly and our ability to gather information and respond will be vital as we work to properly influence these changes.

Also on Saturday, there will be a BOG luncheon seminar where C. Brett Johnson, MD, the associate director of the Center for Medical and Regulatory Policy for the California Medical Association, will talk to us about Health Exchanges and the implications for our practices.

The Physician Payment Policy (3P) workgroup, in conjunction with the BOG, will present a miniseminar at 10:30 am on Sunday, September 29, called "Alternative Payment Models and Academy Advocacy for Physician Payment: What You Should Know." **Michael Setzen, MD**, will moderate this discussion, which should be timely and relevant. There will be an additional miniseminar at 8:00 am on Monday, September 30, to prepare members for the transition to ICD-10 in 2014.

The BOG Executive Committee-sponsored miniseminar will take place at 8:00 am on Tuesday, October 1. This year's seminar will address the impact of Accountable Care Organizations (ACO)s for the otolaryngologist practice. BOG Secretary **Wendy B. Stern, MD**, will moderate the seminar and our guest speakers will include Raymund King, MD, JD, who will talk to us on the legal implications of an ACO, and **C. Brett Johnson, MD**, who will be addressing physician concerns when considering joining an ACO. We hope to see many of you there and the panel will be ready to take your questions.

Denis C. Lafreniere, MD
Chair, BOG

The obstacles we face every day in both the academic and private practice setting can be daunting as costs rise and reimbursement drops, making our goal of excellent patient care, delivered in an efficient manner, a challenge. Informing our members and responding to their needs is why the BOG exists. Our plan is to consistently provide our members with the most current information regarding the ever-changing healthcare landscape. We encourage all of you to make the trip north and enjoy the hospitality of our Canadian neighbors. Your BOG will help to provide you with the tools you need to navigate the healthcare rapids that may lie ahead in our home waters. See you soon in Vancouver!

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John Joseph Conley, MD: Innovator in Head and Neck Reconstructive Surgery

Masoud Saman, MD, with Claude Douge, MD

Having completed my surgical internship at Saint Vincent's Hospital (affectionately known as "Vinny's") Manhattan, NY, the year its doors were permanently shut, I feel compelled to ponder the life of a man whose portrait hung by the elevators and whose anecdotes I heard each time my attendings remembered that I was an OTO-HNS resident. The portrait's subject was the prominent surgeon, musician, and gentleman from Pennsylvania, who spoke with a noble accent and whose charisma enlightened any room: **John Joseph Conley, MD.**

After receiving his medical degree in 1937, Dr. Conley started residency at Kings County Hospital in cardiology. Soon after, he was diagnosed with paroxysmal atrial tachycardia and was advised to switch to a less demanding specialty: otolaryngology.

His years during World War II in the U.S. Army Medical Corps in the South Pacific, working alongside plastic and maxillofacial surgery colleagues on reconstructing traumatic head and neck defects, gave him the experience that proved to be instrumental in his rise as a leader and innovator in head and neck and facial surgery upon his return to New York.

Dr. Conley was known to be eloquent and captivating. Once as the defendant in a case, he told the court that he would summon himself to the stand as the expert witness. He dressed handsomely and walked with authority. At Vinny's, he worked with Ricardo Bizi, MD, the son of an Argentine otolaryngologist, and Robert C. Eberle, MD, of Geneva. Among his many unsalaried fellows were Peter Cinelli, MD, and **Stanley M. Blaugrund, MD**, with whom Dr. Conley chose to have surgery himself.

Dr. Conley's contributions to head and neck surgery and facial plastic surgery ranged from novel techniques and approaches in cancer extirpation, to various flaps in facial reconstruction, and more. He paved the way for the new generation of otolaryngologists interested in these subspecialties. It is upon the shoulders of giants like Dr. Conley that we stand and proudly represent our field.

The John Conley, MD Lecture on Medical Ethics was founded in his name, and is delivered during the Opening Ceremony at every AAO-HNSF Annual Meeting & OTO EXPO℠.

Celebrate the Specialty's History with Us

Marc D. Eisen, MD, PhD, cordially invites Academy members and their guests to the next meeting and reception of the Otolaryngology Historical Society (OHS), in Vancouver's historic and elegant Vancouver Club, taking place in conjunction with the 2013 Annual Meeting & OTO EXPO℠.

Date: Monday, September 30, 2013
Time: 6:30 pm–8:30 pm
Place: Vancouver Club
Room: Bar Room III

An informal reception will follow a short program of presented papers on a variety of historical topics about the specialty.

Program

- Marc D. Eisen, MD, PhD, president, Otolaryngology Historical Society
  Welcome and Introductions
- P. Ryan Camilon, BA, University of South Carolina Medical School
  "Vestibular Experiments Conducted in Space"
- Amit A. Patel, MD, University Medicine and Dentistry of New Jersey
  "Thyroglossal Duct Cysts, Elephantitis, and More: the Different Sides of William E. Sistrunk"
- **C. Eduardo Corrales, MD**, Stanford University "Otologic Anatomical Advancements in 18th Century England—or Lack of: the Case of William Cheselden"
- **Lanny G. Close, MD**, Columbia University "Medical Education in America: the Impact of the Flexner Report over the Past 100 Years"

OHS members receive advance notice and a complimentary ticket for the evening reception. To renew your OHS membership dues of $50, please email memberservices@entnet.org.

For OHS members who wish to bring a guest, there is a fee of $85 per guest ticket. If you are not an OHS member, but wish to attend this event, there is an $85 fee. Please email ohs@entnet.org for RSVP information.

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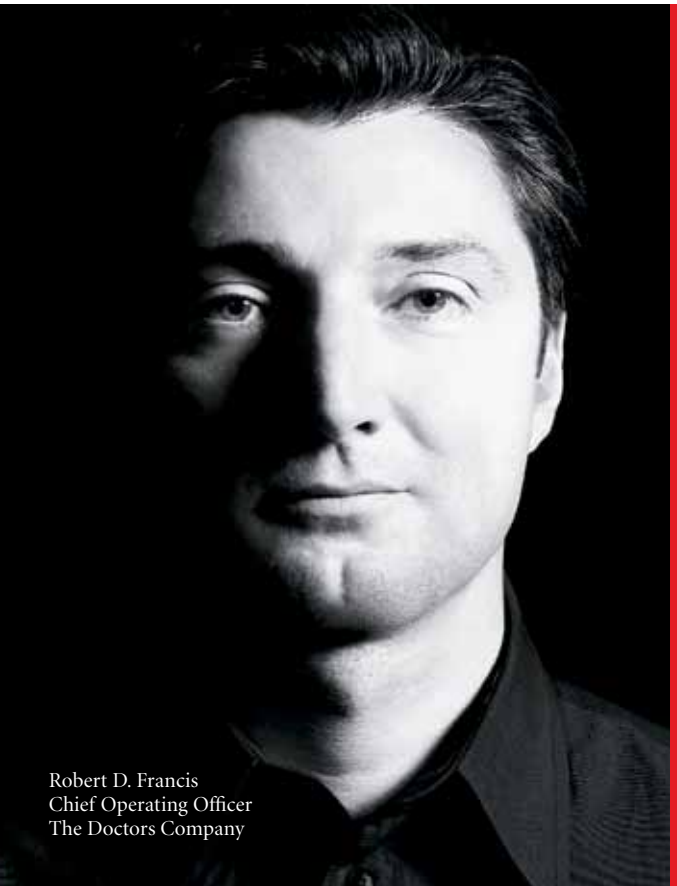

Robert D. Francis
Chief Operating Officer
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Time to Retool the Mommy Track from the WIO Section

Cristina Cabrera-Muffly, MD
Assistant Professor, University of Colorado Aurora, CO for Women in Otolaryngology (WIO) Section

Last month, while driving my 3-year-old to daycare, he emphatically stated, "Mommy, you can't be a doctor and a mommy." This was a complete *non sequitur* to the prior discussion of trucks on the highway that morning.

Completely taken aback, it took all my willpower not to pull over and address his comment. Instead, I calmly stated that I was both a mommy and a doctor and vowed to repeat this message multiple times in the coming weeks. His statement did get me thinking, however. Is this just "kids say the darndest things," or does he have a point? As an academic otolaryngologist, can I be as successful and advance in my career as quickly and as effectively as my male colleagues, or does motherhood put me on the dreaded "mommy track" to nowhere?

There has been a lot of discussion about motherhood and career advancement recently. The two loudest voices in popular culture are Facebook COO Sheryl Sandberg through her book *Lean In: Women, Work, and the Will to Lead* (which reached No. 1 on *The New York Times* bestseller list) and Anne-Marie Slaughter, whose article in *The Atlantic*, "Why Women Still Can't Have It All," was the most read story on *The Atlantic's* website ever. While both argue that societal constructs such as lack of female role models to sponsor changes, the stigma of maternity leave, and impractical school schedules keep women from advancing in their fields, they differ in their opinions about how to solve the problem. Sandberg puts the onus on women themselves, advising them to be more ambitious and aggressive. Slaughter opines that ambition is not enough, and real progress will not occur until the subtle (and sometimes not-so-subtle) stereotypes about working mothers begin to change.

In light of this debate, I turned to other female academic otolaryngologists for their opinions. One woman stated, "There is no such thing as 'mommy track,' and I think we have to be careful what women in otolaryngology or any field use as a term to describe what we want." Another recommended renaming the mommy track to the "integrated career and family track." No one liked the term "mommy track" and I wholeheartedly agree. If we are to propagate the species, pregnancy and childbirth are a biologic fact for women, not a "track" to be chosen in lieu of a career. By labeling working mothers in this way, we become an easy target for our colleagues to diminish our contributions. After all, women do not leave medicine only for motherhood. No one would think to label an "illness or disability track."

How do we become both the types of doctors and mothers we want to be? The greatest frustration voiced by many women was the lack of work schedule flexibility. While in medicine we cannot work from home, adjustments in school schedules and operating room schedules would make it significantly easier to care for both our patients and our children. Summer vacations and late school start times are difficult for any working parent, not just female physicians. The ability to be flexible also depends on the home support system. Most women I spoke with who had partners at home attributed much of their success to such assistance.

Another theme was that opinions about female career advancement seem to be a "generational difference, not a gender difference." One woman stated that both she and her male colleague have young children, and they both work hard during the week but do not volunteer for "extras" such as having dinner with a new faculty candidate or spending Saturday at a low-yield meeting. Most women felt that faculty members early in their careers, whether male or female, prioritize family life more than a generation ago. Another woman commented, "The old guard that worked and neglected their families might not only have it wrong, but their disconnect from society might keep them from being as good a doctor as one with a balanced life. There is value in life outside of medicine, and we are richer for it."

"Solutions for systems and institutions must meet and improve lives for all, not just one group, and not just for women" stated one. I could not have put it better myself. It is critical to have a supportive chair and mentor who can facilitate these solutions. Subtle departmental cues, like believing that it is okay to

"How do we become both the types of doctors and mothers we want to be? The greatest frustration voiced by many women was the lack of work schedule flexibility. While in medicine we cannot work from home, adjustments in school schedules and operating room schedules would make it significantly easier to care for both our patients and our children."

go home early to play a round of golf but not to take your child to the doctor, negatively impact every member of the department. Why should chairs and mentors strive to help women find solutions for balancing work and home? The answer is to improve both immediate and future productivity. Women who feel supported will work harder and be more committed to their careers and their departments.

In "Gender disparities in scholarly productivity within academic otolaryngology departments" Eloy, et al.[1] show that women produce less research output early in their careers, but meet or exceed this output later in their careers. If women leave before they become a professor, they will never achieve that later career contribution. Secondly, there is a significant potential impact of having a female mentor available to you as a female resident or medical student.

The only way to increase the number of female professors and chairs is to encourage them to step into the pipeline when they are residents. Is it any surprise that in my role as associate program director to a male program director, female residents turned to me first when divulging they were pregnant? In my case, the male program director was just as supportive as I was, but as a woman who had just had a child, they felt more comfortable approaching me about how to announce their pregnancy to the department. When they confided in me, I always told them the road would be difficult, but it was still possible to achieve their goals in their career. The keys are to work as hard as possible, find good help at home, and don't let anyone have low expectations of you. In short, they, too, can be both a doctor and a mommy. Hopefully, some day, my son will understand this, too.

Reference

1. Eloy JA, et al. Gender disparities in scholarly productivity within academic otolaryngology departments. *Otolaryngol Head Neck Surg*. 2013 Feb;148(2):215-222.

Dates to Remember

Go to http://www.entnet.org/conferencesandevents to see a full listing; to list events, email memberservices@entnet.org

September 29-October 2
AAO-HNSF 2013 Annual Meeting & OTO EXPO℠

Coding and Reimbursement Workshops

- **September 13-14**
  Minneapolis, MN
- **October 25-26**
  Las Vegas, NV
- **November 8-9**
  Chicago, IL

November 4
Instruction Course and Miniseminar
Call for Papers is open.

Guest Lecturers at the Annual Meeting

Guest Lecturers Carry on Tradition of Excellence

The leaders in medical science of the past built a platform for the leaders of today. And those leaders are now building a platform for the leaders to come. Sometimes their paths have crossed generations, sometimes not. One such leader, Nancy L. Snyderman, MD, a TV medical news star and a head and neck surgeon, will present the John Conley, MD Lecture. Dr. Conley was famous as one of the most innovative and successful of otolaryngological surgeons. **Derald E. Brackmann, MD**, another of the special speakers at the AAO-HNSF 2013 Annual Meeting & OTO EXPO℠, will present a lecture in the name of his own mentor, who taught him, "Always adapt to changes as they develop."

Change in all medical particulars is the norm now, from economics to reporting systems to the practice of medicine. Some of the leading otolaryngology-head and neck surgery experts will speak before the attendees at this year's meeting. They will provide the platform to educate their peers and the young physicians who will follow.

John Conley, MD Lecture on Medical Ethics
9:10 am-9:30 am
Sunday, September 29
"Conversations with Yourself: The Natural Metamorphosis of a Surgeon"

Nancy L. Snyderman, MD, has won research grants and journalism awards, a rare combination in either medicine or journalism, and a tribute to her drive and the conquering of fear, which she says keeps many people from achieving everything they want. She told a biographer: "When I'm sitting at a patient's bedside explaining surgery, my challenge is still to take very complicated stuff, and in a non-condescending manner, talk to a patient. Well, on television it's the same thing. I have to take complicated stuff and explain to 10 or 12 million people. The skill set is exactly the same."

A third-generation physician, she says her three mentors were her parents and her chief of surgery during her residency at the University of Pittsburgh, **Eugene N. Myers, MD, FRCS Edin. (Hon)**. "He taught me how to be a really good surgeon. … and it's a lot for him that I vowed that no matter what my other careers were, I would never give up medicine." And she hasn't; she is still a practicing head and neck cancer surgeon. She is also Chief Medical Editor for NBC News and *AARP The Magazine's* newest columnist.

Eugene N. Myers, MD International Lecture on Head and Neck Cancer
9:30 am-10:20 am
Monday, September 30

Piero Nicolai, MD, will deliver the Myers lecture, contributing his extensive experience on the subject of when, what kind of surgery, what is new, and more. Nicolai is professor and chairman of the department of otorhinolaryngology at the University of Brescia, in northern Italy. He completed his residency in otolaryngology and subsequently in medical oncology. His clinical and research activities are focused on head and neck oncology and endoscopic sinus and skull base surgery. He has traveled extensively to advance the knowledge of his specialty.

In April, he participated in an endoscopic sinus and skull base surgery program presented in Phoenix as a Mayo Clinic Continuous Professional Development program, and he has been awarded the American Academy of Otolaryngology—Head and Neck Surgery Honor Award in recognition of his volunteer contributions to the Academy and its Foundation.

Eugene N. Myers, MD, FRCS Edin (Hon), is Distinguished Professor and Emeritus chair, department of otolaryngology of the University of Pittsburgh Medical College. A man active in the practice and the science of medicine, he is a celebrated author of many books in the field. His own research specialty is head and neck oncologic surgery.

Neel Distinguished Research Lecture
9:30 am-10:20 am
Tuesday, October 1

Martin A. Birchall, MD, FRCS, and Professor of Laryngology at the University College of London Ear Institute, Royal National Throat, Nose, and Ear Hospital, will present the Neel lecture. The Neel family and friends established the award in 1993 to disseminate information on new developments in biomedical science. Dr. Birchall will bring his expertise to bear on a subject guaranteed to spur discussion and draw listeners: the exciting prospects and problems with stem cells and airway transplantation. His view: "The drive to regenerate man, or indeed create new human life in whole or in part, is as old as history itself. The legend of Prometheus has been recapitulated throughout the centuries, including by Mary Shelley and Asimov. The contemporary surgeon can take parts from dead human donors and bring them 'back to life' in transplantation.

"Early first-in-man successes with stem-cell based tracheal replacements in adults and children suggest great promise for such technology… [but] before the Promethean dream can be realized, if indeed it is, many hurdles, scientific, practical, financial and ethical, have to be negotiated. A potential route to clinic will be presented for these exciting new therapies."

Howard P. House, MD Memorial Lecture for Advances in Otology
8:00 am-9:20 am
Tuesday, October 1

Derald E. Brackmann, MD, of the House Clinic, trained with the medical genius who was **Howard P. House, MD**. Dr. House, who died at age 95 in 2003, is a legend in the hearing impairment world, having developed groundbreaking surgeries to restore hearing. His one-man laboratory in Los Angeles eventually became the clinic that draws otolaryngologists from around the world to advance treatments for hearing problems.

Dr. Brackmann joined the House Institute in the early 1970s. He is now a foremost neurotologist, and will speak on skull base tumors. Dr. Brackmann has helped develop the auditory brainstem implant and is a leader in removal of acoustic neuromas. "Many changes have occurred in the management of skull base tumors during my career," Dr. Brackmann said, and his work with Dr. House trained him to be prepared for changes. Author of four textbooks and co-editor of an annual series on advances in otolaryngology and head and neck surgery, Dr. Brackmann is clinical professor of otolaryngology and head and neck surgery and neurosurgery at Los Angeles County USC Medical Center.

Cotton-Fitton Endowed Lecture In Pediatric Otolaryngology
9:30 am-10:20 am
Wednesday, October 2

A lecture established to educate otolaryngologists in the care of children will have acclaimed physician **Joseph E. Kerschner, MD**, as its speaker. Dr. Kerschner is dean of the medical school and executive vice-president of the Medical College of Wisconsin. His subject will be otitis media (OM). He explained, "As we have entered the age of molecular and personalized medicine, our relatively basic understanding of mechanisms of pathophysiology has made quantum leaps with the promise for innovative and novel solutions for OM in the near future."

Dr. Kerschner has a long history of work in pediatric medicine, including as president-elect of the American Society of Pediatric Otolaryngology. He has written 17 books, is a mentor to students, residents, and junior faculty, and maintains an active clinical practice. He also represents his fellow physicians, for example, as a co-writer of a white paper published in the *Milwaukee Journal-Sentinel* on the dangers of sequestration to Wisconsin's medical services.

2013 Presidential Citation Recipients

Each year at our Annual Meeting, AAO-HNS/F presidents honor those who have made significant contributions to otolaryngology and have been especially influential in his/her career. This year, President **James L. Netterville, MD**, has selected six talented individuals to receive the 2013 Presidential Citations and be recognized during the meeting's opening ceremony in Vancouver, BC, Canada.

Roland D. Eavey, MD, SM
In recognition of his selfless dedication to create opportunity and advance the careers of those under his wing.

Dr. Eavey is the director of the Vanderbilt Bill Wilkerson Center for Otolaryngology and Communication Sciences in Nashville, and the Guy M. Maness Professor and chair of the Department of Otolaryngology. He obtained a master's degree in healthcare management from the Harvard School of Public Health. He trained as a pediatric otolaryngologist and evolved into a pediatric otologist with contributions such as becoming (probably) the first otolaryngology microtia surgeon, inventing the butterfly inlay graft myringoplasty, and serving as the clinical trial site PI of the first widely used pneumococcal vaccine.

His collaborative research foci on the pediatric ear, which has received NIH funding, include tissue engineering of an auricle for microtia, the molecular genetics of hearing loss, and hearing loss epidemiology. Dr. Eavey has contributed more than 200 publications, including the *New England Journal of Medicine, JAMA*, and *Nature Genetics*.

His educational initiatives include creating a novel didactic Vanderbilt resident training program that promotes interactive learning and removes traditional lectures; additionally, he has created a unique four-year resident leadership training program. His service and outreach activity includes serving as the American ear representative of the World Health Organization, making about 30 trips to Latin America to teach primary care providers about otitis media for which Dr. Eavey was honored with the 1997 AAO-HNS Jerome C. Goldstein Public Service Award.

Michael E. Glasscock III, MD
In recognition of his gifts as a surgeon, consummate clinical investigator, excellence in teaching, and training legions of leaders in our field.

Dr. Glasscock earned his medical degree from the University of Tennessee in 1958. He completed residencies at Methodist Hospital-Dallas, Kennedy Veterans Administration Hospital-Memphis, John Gaston Hospital-University of Tennessee, and The Memphis Eye, Ear, Nose and Throat Hospital. His fellowships were in otology and neurotology at the Otologic Medical Group (House Ear Clinic) and the University of Southern California, Los Angeles, CA.

Nashville, TN, was the site of his otology/neurotology practice, where he was associated with Vanderbilt University. At Vanderbilt, Dr. Glasscock served as a clinical professor of surgery (otology and neurotology) from 1981-1997, associate clinical professor of neurosurgery from 1985-1997, and adjunct professor division of hearing & speech from 1986-1997. He has recently returned to The Otology Group at Vanderbilt to work with residents and otologic fellows in the mining of data from the practice and preparation of scientific articles for publication in peer-reviewed journals.

Michael D. Maves, MD, MBA
In recognition of his exceptional abilities and remarkable gifts as a mentor, teacher, and surgeon.

Michael D. Maves, MD, is a leader. Recently, he has served as senior vice president of Development and Global Health Impact Programs for U.S. Pharmacopeia (USP). Before that, he was executive vice president of Project HOPE, with programs in more than 35 countries. Dr. Maves served from 2001-2011 as executive vice president and chief executive officer of the American Medical Association. During his tenure, he provided a stable platform of consistent executive presence through personal leadership and stability that allowed the AMA to concentrate on moving critical national health policy forward.

Dr. Maves served as professor and chairman, Department of Otolaryngology–Head and Neck Surgery at Saint Louis University College of Medicine from 1988-1994. He also held faculty appointments at the University of Iowa Hospitals and Clinics, Indiana University School of Medicine, and Georgetown University School of Medicine. He currently is adjunct professor of otolaryngology at the Saint Louis University School of Medicine.

From 1994-1999 he was the executive vice president of the AAO-HNS. Under his leadership, AAO-HNS increased visibility in Washington, DC, with its first political action committee.

Raised in Toledo, OH, Dr. Maves received his undergraduate degree from the University of Toledo and his medical degree and residency in otolaryngology from Ohio State University. He received an MBA from the University of Iowa College of Business Administration.

Dr. Maves has a passion for the people and culture of India. Dr. Maves, his wife Elizabeth, and his youngest son Christopher, support the Chinmaya Vijaya Orphanage and NRI Academy of Sciences in Vijayawada, Andhra Pradesh, India.

J. David Netterville, MD
In recognition of his remarkable talent, gained from the practice of cardiothoracic anesthesiology, and heavenly gifted wisdom.

Dr. Netterville has served as president and founding director of Third World Medical Missions and co-director of African Medical Mission outreach since 1999. These two organizations oversee, organize, and fund otolaryngology–head and neck surgical medical mission trips to Aba, Nigeria, and Malindi, Kenya. As director, he oversees the anesthetic services for each trip, which provides surgical care in underserved rural regions. During each mission, he and his team manage difficult anesthetic care for more than 100 advanced head and neck tumors and congenital malformations, with limited equipment and resources. Hundreds of otolaryngology head and neck surgery attendings, fellows, residents, and medical students have benefited from his wisdom, generosity, and his example of unselfish service. In recognition of his service outside of our U.S. borders, Dr. Netterville was awarded the George Burrus M.D. Humanitarian Service Award by his peers at St. Thomas Medical Center of Ascension Health. He has also served on the board of Wayne Reed Inner City ministries of Nashville, TN.

After graduating with highest honors from Lipscomb University, he attended medical school at the University of Tennessee Medical Center. He completed his residency in anesthesiology at Vanderbilt University Medical Center, followed by advanced training in cardiovascular anesthesiology. He was invited to join Cardiovascular Anesthesiologists P.C., based at St. Thomas Health Care in Nashville, where he has served as both president and senior partner. From 1989–2000, he served as adjunct assistant professor of anesthesiology at Vanderbilt Medical Center. After many years as lecturer and clinical faculty, he was elected to the Board of Trustees of Middle Tennessee School of Anesthesia.

Robert H. Ossoff, PMD, MD
In recognition of his role as mentor, motivator, and lifelong friend.

Dr. Ossoff is the Maness Professor of Laryngology and executive medical director of the Vanderbilt Voice Center. After completing his residency training at Northwestern in Chicago in 1980 and fellowship training in 1981, he became the first Maness Professor and chairman of the department of otolaryngology at Vanderbilt University Medical Center (VUMC) in 1986. In 1991, he established the Voice Center as the first modern advanced training program in laryngology and voice care where more than 44 fellows have been trained. Dr. Ossoff was also a founding director of the Vanderbilt Bill Wilkerson Center for Otolaryngology and Communication Sciences. After 22 years as department chairman, was appointed assistant vice chancellor of compliance in 2008. In 2013, he was appointed as special assistant to vice-chancellor for health affairs at VUMC.

Dr. Ossoff is a AAO-HNS former director. He served on numerous committees, including a five-year term as the development coordinator. He is a member of numerous otolaryngology societies and has served as past president of several. In April 2012, he completed his term as president of the Triological Society. He is certified in healthcare compliance by the Compliance Certification Board. Dr. Ossoff has lecturered at numerous local, regional, and national otolaryngological and compliance meetings. Dr. Ossoff serves on the editorial and advisory boards for several otolaryngology professional and compliance journals.

Robert A. Sofferman, MD
In recognition of his uniting diverse medical and surgical specialties to work and learn together, enhancing our understanding, and our stature in the treatment of thyroid and parathyroid disease.

Dr. Sofferman is emeritus professor of surgery at the University of Vermont School of Medicine/Fletcher Allen Health Care, and in 2006, he retired as chairman of division of otolaryngology. He graduated *magna cum laude* from the University of Maryland School of Medicine and trained in general surgery at the University of Colorado, which was interrupted by a military stint. He completed his residency at the Massachusetts Eye and Ear Infirmary/Harvard Medical School and joined the University of Vermont Faculty in 1975.

He became chairman of the division of otolaryngology in 1978, a position he had for 28 years. He received the Harris B. Mosher Award from the Triological Society for his work on "Recovery of the Optic Nerve," and has published more than 70 manuscripts and book chapters on topics including head and neck oncology, and thyroid and parathyroid surgery.

His 2012 textbook, *Thyroid and Parathyroid Ultrasound*, is the culmination of immersion in the clinical application of ultrasound. He established Vermont's first cochlear implant program in 1986, which remains the state's only clinically active site.

In conjunction with the neurosurgical skull base team he performed all of the division's neurotologic surgery from 1975 to 2006. He has been chairman of the Endocrine Surgery Committee of the American Academy of Otolaryngology—Head and Neck Surgery and chair of the post-graduate course in head and neck ultrasound of the American College of Surgeons and its National Ultrasound Faculty for the past five years. His focus now is on the application of ultrasound to the diagnosis and management of a variety of head and neck conditions, ultrasound education, and his position on the Admissions Committee of the University of Vermont School of Medicine.

OTO EXPO℠ Open Invitation

The doors of the Vancouver Convention Centre will open soon for the AAO-HNSF 2013 Annual Meeting & OTO EXPO℠. Following up on the feature article in the August *Bulletin*, we want you to view the OTO EXPO℠ as an open invitation to experience first-hand nearly 300 exhibiting companies presenting hundreds of products and services.

One new area in particular is the new AAO-HNSF Product Showcase. This venue is designed to enhance Annual Meeting attendees' product awareness. Don't miss presentations of innovative and cutting edge ENT products from leading companies like ArthroCare, Olympus, NeilMed Medical PENTAX Pharmaceuticals, and Siemens Hearing Instruments. Our sponsors are eager to share their industry products to help you in your quest to provide the best patient care. Seating is limited to the first 200 people so be sure to include the Product Showcase, Booth 1146, in your plans when completing your Annual Meeting schedule. Look for the schedule of presenting companies in the Final Program and on our Annual Meeting website.

We want to be certain that you have the most updated list of exhibitors. Following this piece is a list of the companies we have added since the last issue. At any time we invite you to view the current list and floorplan on our new OTO EXPO℠ webpage tailored just for you: **www.entannualmeeting.org/13.**

The excitement continues to build and we are looking forward to welcoming all of our valued attendees to this great event. Vancouver is set to be a gracious host and our team is ready to provide you with what you will need for a terrific experience. Don't forget, September 29-October 2!

More than 250 companies will exhibit in the 2013 OTO EXPO℠.

New Exhibitors (as of August 1, 2013)	Booth
1st Line Medical	2339
Beijing Fanxing Guangdian Medical Treatment Equip	1241
BIOLASE + Valam	1750
Biomet Microfixation	744
Dr. Kim Co	518
ELMED Incorporated	524
European Laryngological Society—ELS 2014	2310
ENTrigue Surgical—**new location**	2013
GlaxoSmithKline	2240
Healthcare Research Analytics	742
Hospital Information Services (Canada)	436
Immco Diagnostics	526
ImThera Medical Inc	1944
Insightra Medical	2335
KLS Martin—**new location**	1118
Laser Engineering	1550
Lippincott Williams & Wilkins	509
Lumenis—**Additional for Show Floor Meeting Room**	1734-M
Magnolia Regional Health Center	2411
Newport Surgical Instruments Inc.	2322
Olive Medical Corporation	542
OtoSim	2236
Passy-Muir Inc	952
Phacon GmbH	1443
QED Medical	2404
RG Medical	1050
Sidra Medical and Research Center	505
Stryker—**Additional for Show Floor Meeting Room**	2050-M
The Oral Cancer Foundation	1946
Theravent Inc.	503
Toshiba Ultrasound	2326
Veracte Inc.	1140
Visionsense	1749
Vivosonic Inc	520
Waiting Room Solutions EMR	2409

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

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SEPTEMBER 29–OCTOBER 2, 2013

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Why Attend?

1

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More than 500 experts lead education sessions to attend while earning up to 27.5 CME credit hours. This year's program offers the latest evidence based information and updates on practical applications affecting operative procedures, drugs and medical devices.

2

Connect

Network with peers from all over the globe at receptions and events occurring each day.

3

Explore

The OTO EXPO℠ features products and services that will help you provide the best patient care.

4

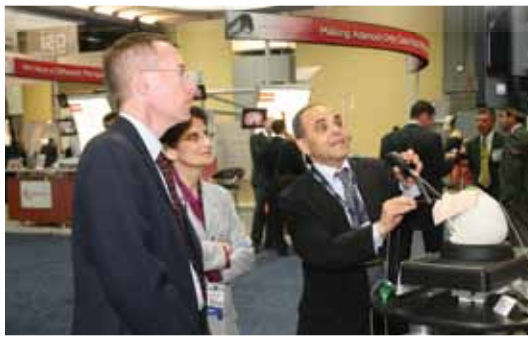
Experience

Create an experience that will be memorable for generations. With its breathtaking landscape and abundant activities to enjoy, Vancouver, BC is the ideal location to visit and experience everything the AAO-HNSF has to offer.

NEW this Year!!

AAO-HNSF Clinical Practice Guidelines Minseminars:

Bell's Palsy	Tympanostomy Tubes
SEPTEMBER 29 10:30-11:50AM West 304-305	SEPTEMBER 30 8:00-9:20AM West 301



AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY FOUNDATION

EMPOWERING PHYSICIANS TO DELIVER THE BEST PATIENT CARE

Exclusive Events for ENT PAC Members during Annual Meeting*

ENT PAC, the political action committee of the AAO-HNS, financially supports incumbent Members of Congress and viable candidates—regardless of their party affiliation—who champion the specialty's legislative priorities. Please mark your calendars to join the ENT PAC Board of Advisors and staff for the following 2013 events:

- **The annual ENT PAC Investors "thank-you" reception.** This popular event will take place on Monday, September 30, at the Rogue Kitchens. U.S. AAO-HNS members who make donations to ENT PAC prior to or during the meeting are invited to the event!
- **A special "thank-you" luncheon for members of the ENT PAC Chairman's Club ($1,000+ donors).** The luncheon, hosted by members of the ENT PAC Board of Advisors, is a unique opportunity to learn about the Academy's political strategy and decision-making process. This year's luncheon will feature an exciting guest speaker from the Canadian Parliament and will take place on Tuesday, October 1.

For more information on becoming an ENT PAC Investor, please visit www.entpac.org (log-in using your AAO-HNS user ID & password) or email ENT PAC staff at entpac@entnet.org.

**Contributions to ENT PAC are not deductible as charitable contributions for federal income tax purposes. Contributions are voluntary, and all members of the American Academy of Otolaryngology-Head and Neck Surgery have the right to refuse to contribute without reprisal. Federal law prohibits ENT PAC from accepting contributions from foreign nationals. By law, if your contributions are made using a personal check or credit card, ENT PAC may use your contribution only to support candidates in federal elections. All corporate contributions to ENT PAC will be used for educational and administrative fees of ENT PAC, and other activities permissible under federal law. Federal law requires ENT PAC to use its best efforts to collect and report the name, mailing address, occupation, and the name of the employer of individuals whose contributions exceed $200 in a calendar year.*

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.

Annual Meeting Preview

Get to Know AAO-HNS Advocacy Programs in Vancouver!

With the AAO-HNSF 2013 Annual Meeting & OTO EXPO℠ fast approaching, now is the time to learn more about the advocacy-related programming available at this year's meeting. As in past years, the ENT PAC and Grassroots Advocacy Booth will serve as the Government Affairs "hub" in Vancouver. AAO-HNS members are encouraged to visit the booth to learn more about easy ways to support the Academy's various legislative, political, and grassroots advocacy programs. Be sure to visit to:

- Obtain information on becoming a 2013 ENT PAC Investor;*
- See who is "investing" in ENT PAC, and at what level, by viewing the renowned ENT PAC "Wall of Investors" for 2013;
- Hear about ENT PAC's exciting new resident outreach campaign;
- Join the ENT Advocacy Network to receive timely updates on political and legislative issues impacting the specialty and a free subscription to a biweekly e-Newsletter, The ENT Advocate;
- Learn more about the Academy's new localized grassroots program, "I-GO"; and
- Receive the latest updates on legislation affecting your practice and your patients.

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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Proposed CY 2014 Medicare Physician Fee Schedule (MPFS): What Does It Mean for You?

On July 8, the Centers for Medicare & Medicaid Services (CMS) posted the proposed Medicare physician fee schedule (MPFS) for calendar year (CY) 2014. In addition to payment policy and payment rate updates, the MPFS addresses a number of quality initiatives. The Academy will submit comments to CMS on the proposed rule by the September 6 deadline. The Academy also developed a member summary, which can be accessed here http://bit.ly/CMSregs. Key provisions Members should be aware of from the proposed rule include:

Medicare Sustainable Growth Rate (SGR) Formula

The overall ***estimated*** impact of the policy changes within the proposed rule for CY 2014 MPFS on otolaryngology is -2 percent. [Note: This amount does not include the possible 24 percent reduction to the conversion factor (CF) that could result if Congress does not take action to prevent the annual cuts from the SGR]. As in years prior, it is expected that Congress will take action to avoid the impending cut before the January 1, 2014 deadline. ***The Academy continues to campaign for a permanent repeal and replacement of the SGR formula, and has submitted comments on the recent SGR repeal and payment reform legislation.***

Practice Expense

One of the biggest changes in the proposed rule is CMS' suggestion to change to the methodology for setting practice expense RVUs for services under the PFS. Specifically, they propose that for PFS services provided in the physician offices whose payment rates exceed payment for the same procedure when performed in a facility (hospital outpatient department (HOPD) or Ambulatory Surgical Center (ASC)), CMS would use current year OPPS or ASC rates as a point of comparison in establishing PE RVUs for services in the office under the PFS. For services on the ASC list, they would make the same comparison except they would use the ASC rate as the point of comparison instead of the OPPS rate. ***In these cases, CMS proposes to limit the office PE RVUs for individual codes so that the total office PFS payment amount would not exceed the total combined amount Medicare pays for the same code in the facility (hospital or ASC) setting. Of note, this policy will severely affect several key Otolaryngology services and the Academy plans to submit comments to CMS on this issue. See the Academy's summary for a full analysis of impact on ENT service here http://bit.ly/entPEchart.***

Requirements for Billing "Incident To" Services

CMS proposes to revise its regulations to require that individuals performing "incident to" services meet any applicable requirements to provide the services, including licensure imposed by the state in which the services are being furnished. CMS says this will not only provide health and safety benefits to the Medicare patient population, but also assure that federal dollars are not expended for services that do not meet the standards of the states in which they are being furnished. This change will also allow CMS to recover federal government funds paid where services and supplies are not furnished in accordance with state law. ***This will affect Otolaryngology offices providing incident to services, thus we encourage all practices to ensure their non-physician providers are in compliance with state licensure requirements, to allow for appropriate Medicare reimbursement for the services they provide.***

Physician Quality Reporting System (PQRS)

CMS proposes many overarching changes to the PQRS system, highlights of those affecting otolaryngology are below:

- ***As a direct result of Academy advocacy during the past several years, CMS proposes inclusion of four of the Academy Sinusitis Measures for reporting in 2014.***
- CMS proposes eliminating two measures applicable to otolaryngology and eliminating the claims based reporting option for two additional measures applicable to otolaryngology.
- CMS proposes increasing the number of measures Eligible Professionals (EPs) must report on to qualify for an incentive payment in CY 2014, from three to nine measures.
- CMS proposes to remove the option of reporting via administrative claims for CY 2014 reporting.
- CMS proposes to reduce the percentage of patients EPs must report on using a registry from the previous 80 percent down to 50 percent for CY 2014.

As indicated below, physicians are eligible

Reporting Period	2014	2016 (based on 2014 reporting)
Incentive Amount	0.5%	
Penalty Amount		-2.0%

to receive a .5 percent incentive payment, or could be subject to a two percent penalty, assessed in 2016, based upon PQRS reporting in 2014. It is important to note these penalties and incentives are separate from other programs such as the EHR Meaningful Use, Electronic Prescribing, and Value Based Payment Modifier programs.

Physician Compare Website

Recently, CMS released a redesigned Physician Compare website that includes a physician's address, education and ABMS board certification information, hospital affiliations, and EPs' language skills. CMS is required to post the names of EPs who satisfactorily report under PQRS and those who are successful e-prescribers under the Medicare eRx Incentive Program. CMS intends to place a check mark moving forward for any individual who has earned a Maintenance of Certification additional Incentives starting with data reported for CY 2013. CMS also plans to post 2014 PQRS GPRO performance data and data from the CG-CAHPS surveys for group practices of 100 or more EPs reporting data

under the GPRO in 2013, and for ACOs participating in the MSSP in 2014.

For future years CMS proposes to post adding performance rates on measures and patient experience survey measures such as Clinicians and Group Consumer Assessment of Health Providers and Systems (CG-CAHPS) for groups participating in the and Accountable Care Organization (ACO) programs. ***These proposed changes will likely affect otolaryngology-head and neck surgeons as more information regarding the public's opinion of the quality of care they received will be posted. The information available on the website is populated automatically from CMS' PECOS system, so it is critical that members verify their information is accurate. Visit the Physician Compare website at http://www.medicare.gov/physiciancompare.***

For additional information on what CMS intends to post in future years, access the full Academy summary at http://bit.ly/CMSregs.

Electronic Health Record (EHR) Incentive Program

CMS proposes that EPs may use the new qualified clinical data registry (QCDR) mechanism to report clinical quality measures that meet both EHR Meaningful Use and PQRS reporting specifications. The measures included in a QCDR are not required to be approved by the National Quality Forum (NQF). Aligning with proposed changes to PQRS reporting, EPs would report nine Clinical Quality Measures (CQMs) included in the Stage 2 final rule covering at least three domains. ***The Academy is reviewing the requirements to determine if this may be a feasible avenue for otolaryngologists use in the future and will be commenting on the proposal.***

Value Based Payment Modifier & Physician Feedback Program

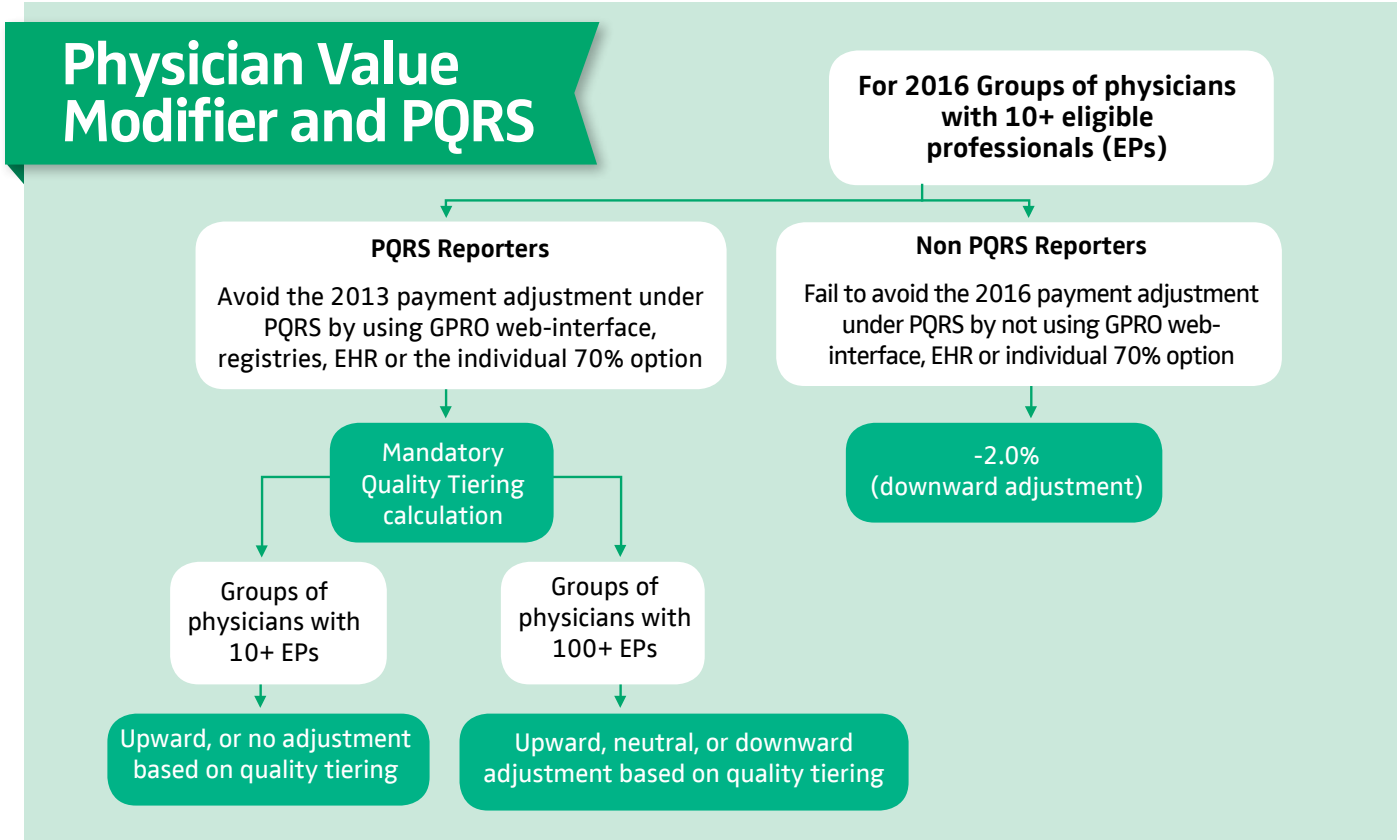
CMS proposes expanding the Value Based Payment Modifier (VBPM) to groups of 10+ EPs in CY 2014. The VBPM is based on PQRS participation. Groups would report via GPRO-web interface, qualified registries, EHRs, or individually if 70 percent of all EPs in the group report successfully. ***2014 reporting will be used to determine whether a payment penalty will apply in CY 2016. CMS plans on expanding the VBPM to all EPs by 2017.***

Value Modifier Components	2015 Finalized Policies	2016 Proposed Policies
Performance Year	2013	2014
Group Size	100+	**10+**
Payment at Risk	-1.0%	**-2.0**

An outline of how the program will coincide with PQRS, and how payment adjustments or incentives will be allocated, is below. Members should also know that as of September 16, groups of 25+ will receive physician feedback reports based on their 2012 PQRS performance.

For a more detailed explanation, view the Academy's Value Based Payment Modifier webpage at http://bit.ly/entVBPM.

For a more detailed summary on the proposed requirements for the programs highlighted above, visit the Academy's CMS Regulations page at www.bitly/CMSregs or email questions to Academy health policy staff at HealthPolicy@entnet.org.



Imaging Committee Update

Gavin Setzen, MD, chair
Jenna Kappel, MPH, MA, director, Health Policy and Staff Liaison, Imaging Committee

On behalf of the Imaging Committee, we want to share some of the recent efforts with members, including involvement in the new head and neck ultrasound accreditation program, updates on the joint survey with the American Rhinologic Society on CT imaging, participation in the Academy's Clinical Practice Guideline on Bell's palsy, comments on the Milliman Care Guidelines regarding their requirement for a CT scan for stapedectomy, and review of AcademyU® courses to develop a CME resource for members to help them meet accreditation requirements.

"The Academy's Imaging Committee continues to educate members on CT imaging policy and regulation. During the past year the committee has also assumed a more proactive role in ultrasound imaging in the head and neck region as this modality has become an integral part of contemporary management of patients with a variety of head and neck conditions."

New Opportunity for Academy Members: AIUM Head and Neck Ultrasound Accreditation

The Academy's Imaging Committee continues to educate members on CT imaging policy and regulation. During the past year the committee has also assumed a more proactive role in ultrasound imaging in the head and neck region as this modality has become an integral part of contemporary management of patients with a variety of head and neck conditions. The Imaging Committee and the Head and Neck Surgery Education Committee facilitated a course in thyroid and parathyroid ultrasound at its Annual Congress Meetings, and Head and Neck Ultrasound Exported Courses, provided by the American College of Surgeons, were available via a variety of selected venues to include the American Academy of Otolaryngology—Head and Neck Surgery. Individuals who attended these courses and took the online post-test completed the first step in developing the opportunity to provide point-of-care ultrasound in their practice. However, until now there was no way of accrediting a subsequent experience and documented expertise in ultrasound of the head and neck.

The American Institute of Ultrasound in Medicine (AIUM) and our Academy have merged their interests in head and neck ultrasound to provide a comprehensive accreditation process, which should be available for application by the time of the Annual Meeting in Vancouver. This will require successful completion of an ACS-sponsored course, a waiting period of a minimum of six months to accrue adequate experience, submission, and examination by an appointed Review Board of a requisite number of cases to include documentation of guided FNA, and maintenance of *AMA PRA Category 1 Credits℠*. This is a preliminary notice that will be followed by formal details and means of applying in a subsequent issue of the *Bulletin*.

The ultrasound workshop, led by **Robert Sofferman, MD**, with **Russell Smith, MD, Lisa Orloff, MD**, and **Merry Sebelik, MD**, worked diligently with AIUM and ALS to develop this opportunity, and we thank them.

AAO-HNS/ARS CT Imaging Survey

The Academy's Imaging Committee joined with the American Rhinologic Society (ARS) to develop a questionnaire to jointly survey Academy and ARS members, including residents and fellows in training, regarding practice patterns and other aspects of CT imaging in patients with paranasal sinus disease. The response rate to the survey was tremendous with more than 300 surveys completed. The Imaging Committee and the ARS are currently analyzing the data to assess potential areas to improve care provision, safety, and quality, as well as address potential issues relating to knowledge gaps and educational opportunities. These data, together with the Clinical Consensus Statement on Appropriate Use of Computed Tomography for Paranasal Sinus Disease, will be

helpful to members and payers and policy makers alike. A subsequent issue of the *Bulletin* will include a summary of the results of the survey.

Bell's Palsy Clinical Practice Guideline

The Imaging Committee was asked to participate in the external peer review process for the newly developed clinical practice guideline (CPG) on Bell's Palsy, chaired by **Reginald Baugh, MD**. Members who participated in the external peer review process for the guideline included **Joseph Scharpf, MD**, and **David Friedmann, MD**. This multidisciplinary guideline addresses the management of acute idiopathic unilateral facial nerve paresis or paralysis, and is intended for any clinician involved in the care of a patient presenting with Bell's palsy. The primary purpose of this guideline is to improve the quality of and reduce variation in the care Bell's palsy patients receive.

Review of Milliman Care Guidelines on Requirement of Use of CT Scan for Stapedectomy

The Academy sent a letter on May 14 to leaders at Milliman Care Guidelines (MCG) regarding their guideline requiring a CT scan prior to a stapedectomy procedure. Many health plans utilize MCGs as the basis for coverage determinations. After thoroughly researching the issue, we received approval from **Gavin Setzen, MD**, and the Academy's Physician Payment Policy (3P) workgroup to request that MCG provide a copy of the guideline and work with the Academy to align it with current clinical care, which does not require a CT scan. Early in August, the MCG Medical director responded that he had received our letter and found the information most helpful, noting it is under consideration along with the rest of the medical evidence base that might help inform improvements to the MCG guidelines as part of their current cycle of research and guideline updating. Any additional updates received on the outcome of this effort will be provided to members via the *News*, HP Update, and a future *Bulletin* issue.

Review of 100-plus Online Courses

The Imaging Committee is also in the process of reviewing more than 100 online courses to determine whether they are imaging-related or not. This is an important activity because the new CME library will provide members who perform CT Imaging with CME resources to meet accreditation, particularly if they cannot wait to attend the annual meeting. Accreditation for CT imaging is a requirement by the Centers for Medicare & Medicaid Services (CMS) for practices to receive payment for Medicare patients. The link to the online courses that are imaging-related will be available by the end of 2013.

3P Update: Academy Advocacy Efforts with United Healthcare and Aetna Coverage Policies

James C. Denneny III, MD,
Michael Setzen, MD, MPh, MA
Jenna Kappel, AAO-HNS Health Policy Director
Harrison Peery, AAO-HNS Health Policy Analyst

> For more information on the Academy's guidance in addressing local and state private payer denials, see http://bit.ly/payerdenials. "Persistence beats resistance" in most cases, according to Dr. Setzen.

During the last year, several Academy members have experienced reimbursement issues with larger insurers for procedures associated with rhinoplasty, septoplasty, and repair of vestibular stenosis. In response, the Physician Payment Policy (3P) workgroup, supported by Health Policy staff and Academy committees, have been working with Aetna and United Healthcare (UHC) to revise their medical policies.

The Academy has written several letters during the past four years to UHC requesting changes to its clinical policy and has gradually received positive revisions from UHC. Many changes have been made to the policy on rhinoplasty, septoplasty, and repair of vestibular stenosis in response to our recommendations. In recent efforts, the Academy wrote another letter requesting that UHC make several modifications to the policy based on outstanding issues. Below is a table indicating how UHC has responded to the most recent Academy requests.

The Academy, similarly, has initiated advocacy efforts with Aetna to change its rhinoplasty and septoplasty policy due to specific reimbursement issues members have reported to Health Policy. In April, 3P and Health Policy staff worked with the Rhinology and Paranasal Sinus Committee and the Facial Plastic and Reconstructive Surgery Committee to assimilate comments into a letter sent to Aetna. Notably, **Russell W. H. Kridel, MD**, and Steve Duffy of the American Academy of Facial Plastic and Reconstructive Surgery Association assisted with advocacy and along with 3P, participated on a recent conference call with Aetna executives. The Academy anticipates positive changes to Aetna's policy and potential future collaborations with Aetna policy executives.

These policy changes show how important it is for Academy members to advocate at the local level and keep Health Policy staff informed about reimbursement issues. It is important to nurture good relationships with medical directors and decision makers, get involved in the committee structures and be well prepared to present a cogent argument supported by clinical data. For more information on the Academy's guidance in addressing local and state private payer denials, see http://bit.ly/payerdenials. "Persistence beats resistance" in most cases, according to Dr. Setzen.

Regarding policy changes requested, but not accepted by UHC, the Academy continues to advocate for necessary revisions and sent a follow up letter to UHC in early August revisiting those concerns.

If you receive an inappropriately denied rhinoplasty or septoplasty claim from an insurer, email healthpolicy@entnet.org so that we may track the issue.

Academy's Letter Dated 3/4/13	UHC Changes 5/1/13
We requested that UHC remove its statement about septal spurs from its policy.	ACCEPT: Under Criteria for a Coverage Determination to be Reconstructive: UHC Deleted Criteria C: "Septal spur: Isolated septal spurs generally do not cause a physiologic functional impairment"
We recommended UHC modify the policy to clarify the requirements based on our recommendations so that the policy is more uniformly interpreted across the country.	PARTIAL ACCEPTANCE: UHC made documentation requirements more specific and rearranged the documentation section. For instance, there are now separate requirements for Rhinoplasty for Vestibular Stenosis/ALAR Collapse and Rhinoplasty for Congenital Anomalies
We recommended that UHC clarify indications in the policy by specifically noting that it is covered for septoplasty or septoplasty in addition to/without rhinoplasty rather than septorhinoplasty.	PARTIAL ACCEPTANCE: UHC clarified documentation section and UHC deleted septorhinoplasty from the list of exclusions

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Pediatric OSAS: Guidelines, Evidence, and Nuance

Ron B. Mitchell, MD
Scott E. Brietzke, MD, MPH
Peter D. O'Connor, MD, OD
Steve Maturo, MD

Sunday, September 29
10:30 am-11:50 am
Miniseminar: Pediatric OSAS: Guidelines, Evidence, and Nuance
Moderator: Steve Maturo, MD
Presenters: Scott Brietzke, MD, MPH, Stacey L. Ishman, MD, Ron B. Mitchell, MD

Guideline evaluation and peri-operative management of Pediatric OSAS will be a few of the topics discussed by an experienced panel during a miniseminar at the upcoming AAO-HNS Annual Meeting in Vancouver, BC, Canada. Scott Brietzke, MD, a pediatric otolaryngologist and sleep surgeon will analyze the guidelines and discuss their differences. Ron Mitchell, MD, professor and chair of UT Southwestern in Dallas, will be discussing peri-operative management strategies and focusing on children with obesity. Stacey Ishman, MD, also a pediatric otolaryngologist and sleep surgeon will discuss subtleties of sleep studies, to include home sleep studies, and persistent OSAS after tonsillectomy.

Pediatric Obstructive Sleep Apnea Syndrome (OSAS) is frequently a result of adenotonsillar hypertrophy and is one of the most common referrals to otolaryngologists. Nearly 500,000 tonsillectomies are performed annually for OSAS in the United States. During the past three years, the AAO-HNSF, American Academy of Pediatrics (AAP), and the American Academy of Sleep Medicine (AASM) have published clinical practice guidelines regarding the diagnosis and management of OSAS. Although the three guidelines are targeted at somewhat different audiences who evaluate slightly different patient populations, these documents have conflicting information about indications for polysomnography and perioperative management of children with OSAS. This has led to some confusion among practicing physicians in how to appropriately manage children with clinical symptoms of sleep-disordered breathing in such areas as pre-operative evaluation, post-operative management, and long-term follow up.

One key source of variability among the three published guidelines is in the use of polysomnography (PSG) for the diagnosis of pediatric OSAS. The use of clinical parameters in the form of the history and physical exam is limited in specific ways in the reliable diagnosis of OSAS and in the determination of OSAS severity. The three guidelines have different recommendations regarding the utilization of PSG ranging from obtaining PSG in all children prior to adenotonsillectomy to limiting its use to high-risk patients (e.g., obesity, Trisomy 21) and in situations when there is significant doubt about the diagnosis. Unfortunately, universal use of PSG for the diagnosis of pediatric OSAS is not feasible due to high costs and limited access in many areas. The situation is further complicated by an incomplete understanding of the morbidity of primary snoring and mild OSAS. Careful examination of the three guidelines and the basis behind them is a useful endeavor to fully understand this complicated issue and to improve clinical diagnosis and the judicious use of pediatric PSG.

With increasing pressure to maintain health costs and the inability to obtain laboratory PSG in a reasonable time, one recurring question is the availability and accuracy of home sleep studies. Improved technology, accessability, and cost containment have driven the change toward out-of-center testing for adult patients where a growing body of data showing that outcomes following home studies are comparable to in-lab testing. However, there is a considerable knowledge gap in the use of home sleep monitoring technology for the evaluation of pediatric sleep disorder as recognized in the recent AAO-HNS guideline. Research of portable testing in pediatric patients typically includes a measure of oxygen saturation, and cardiac activity, along with respiratory effort and oronasal flow. Paramount to any evaluation of pediatric patients is that the testing should be interpreted in the context of the history and physical. If the patient is suspected of having SDB despite negative in-home testing, consideration for overnight laboratory testing should be considered. If there is a positive test, strong consideration for treatment should be made. Any portable testing should be done along with a comprehensive evaluation. Additional research on portable testing in pediatric patients is needed in such areas as relevant health and functional outcomes, along with reliability, acceptance, and the impact on time to treatment (for patients recommended to have PSG testing).

Once the determination has been made to proceed with adenotonsillectomy for OSAS, there is wide variation as to the peri-operative management of children. The majority of surgeries are carried out as an outpatient procedure, but there continues to be wide variation regarding which children require admission. Recently studies have demonstrated that certain populations have increased perioperative risk. The rise in overweight/obese children in the United States has resulted in more children presenting with OSAS. Often OSAS in obese children is more severe, leads to more per-operative morbidity, and is more likely to result in persistent OSAS after surgery.

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What is Partners for Progress?

AAO-HNSF Partners for Progress is a group of physician practices that provide philanthropic support to the mission of AAO-HNSF.

Partners for Progress members provide leadership level philanthropy annually to the Academy and its Foundation to ensure vital programs are administered to:

- Inform patients and the public of the need to seek otolaryngologists' care;
- Fund the research of promising young investigators;
- Disseminate specialty news and science;
- Develop practice management tools for today's otolaryngology practices; and
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AAO-HNS p4p partners for progress

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Patient Safety and Quality Improvement: What is the Next Goal?

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

A start of a new academic year is ahead of us and I am preparing to orient new residents and fellows to our hospital's safety culture. As I reflect on the lecture, I recall my orientation to internship, which lasted just long enough to sign my paperwork (without reading it) and get an ID badge. Orientations for current residents and fellows now take three to four days! Why? What are they learning that is so crucial that we attendings are left alone to care for our patients this first week of July?

At our hospital, one of the first things trainees learn about is our safety culture. Interestingly, the boring parts of orientation were pushed back onto days three and four. Yes—days three and four. These poor residents and fellows have a week of orientation (excluding July 4th) prior to being set free in the hospitals. The first words many of the trainees hear are about the safety culture and the safety transformation.

The last decade has brought about significant advancements and strides in improving

Learn about Clinical Practice Guidelines at Annual Meeting

Each year, the AAO-HNSF looks to the annual meeting as the premier venue to present its most recently published Clinical Practice Guidelines to the otolaryngology community. This year, those guidelines will include tympanostomy tubes and Bell's palsy.

In 2012, annual meeting attendees listed guidelines as the No. 1 topic they wanted to learn more about in 2013. In response, there also will be a miniseminar that presents the American Academy of Pediatrics' Clinical Practice Guideline on the Diagnosis and Management of Obstructive Sleep Apnea Syndrome and an instruction course that revisits the AAO-HNSF Clinical Practice Guideline: Polysomnography for Sleep Disordered Breathing.

At this year's meeting we will have two opportunities to learn about the methodology behind clinical practice guidelines. First, an instruction course will teach attendees how to interpret and prepare a systematic review that clinical practice guideline developers use to inform guidelines. A second course will focus on the methodology behind the AAO-HNSF clinical practice guidelines.

Sunday, September 29
10:30 am-11:50 am

NEW Miniseminar: AAO-HNSF Clinical Practice Guideline: Bell's Palsy

Moderator: Reginald F. Baugh, MD

Presenters: Gregory J. Basura, MD, PhD; Lisa Ishii, MD, MHS; Seth R. Schwartz, MD, MPH

10:30 am-11:50 am

Miniseminar: Pediatric OSAS: Guidelines, Evidence, and Nuance

Moderator: Steve Maturo, MD

Presenters: Scott Brietzke, MD, MPH; Stacey L. Ishman, MD; Ron B. Mitchell, MD

3:00 pm-4:00 pm

Instruction Course: How to Interpret and Prepare a High Quality Systematic Review

Instructors: Martin J. Burton, MD, and Richard M. Rosenfeld, MD, MPH

Monday, September 30
8:00 am-9:20 am

NEW Miniseminar: AAO-HNS Clinical Practice Guideline on Tympanostomy Tubes

Moderator: Richard M. Rosenfeld, MD, MPH

Presenters: Melissa Pynnonen, MD, MS; David E Tunkel, MD; Seth R. Schwartz, MD, MPH

Tuesday, October 1
3:00 pm-4:00 pm

Instruction Course: Review of Pediatric Polysomnography Guidelines

Instructor: Norman R. Friedman, MD

Wednesday, October 2
1:45 pm-2:45 pm

Instruction Course: Understanding Clinical Practice Guidelines

Instructor: Richard M. Rosenfeld, MD, MPH

patient safety and quality improvement. If you are dubious, simply look at our academy. Much of what we talk about, what we are concerned about being measured upon, and what our payment ultimately will depend upon are the quality of care we provide and how we demonstrate that the care is on par with the standard.

Indeed, the orientation for the incoming residents and fellows made me ponder what are the next goals for the patient safety and quality improvement initiatives especially vis a vis our Academy membership. There is myriad data showing that quality improvement is needed in American healthcare and that such improvements have demonstrable improvement in the overall quality patients receive.

My thoughts (and only mine, not the Academy's or others) are that there will be three areas that much attention will be devoted toward as we embark upon a new year of interns, residents, and fellows. The use of big data to drive quality improvement will begin to take form. Indeed, the Global Tracheostomy Collaborative (see: http://globaltracheostomycollaborative.org/, which I am honored to be a part of) is one such example of using institutional datasets to improve the care of a specific condition on a macro-level (in a collaborative). There will be an emphasis on the role of the smaller group practices and the private physicians and how they can drive quality improvements (and measure such interventions). The majority of initiatives and studies in the last decade have disproportionally focused on inpatients. There are more studies and quality improvement measures emerging about surgical quality improvement in the latter half of the last decade. The next frontier will be affecting where the majority of patients receive their care—out of the hospital. Finally, my thoughts on the last macro level trend would be focused attention on "getting to zero." I do not know whom to attribute this classic quotation to, but it has been garnering significant attention in the patient safety and quality improvement world. The basic concept is even one child harmed is one too many, etc. The concept of "getting to zero" is to completely eliminate medical error as a source of patient harm. Of course, this is a lofty goal and perhaps not even attainable, but it is nevertheless worth striving for. In the past decade, major institutions have noted a marked decrease in serious safety events by more than 80 percent. Just as in most business and operations, the next 20 percent will take most of the effort and time.

It will be interesting to see the path that the patient safety and quality improvement initiatives take in the coming years, but I believe the next goals will focus on collaborative initiatives to drive improved outcomes, an increased focus on outpatients (where most patients receive care), and finally there will be significant efforts geared toward "getting to zero."

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.

Education Evaluations: Why Your Answers Matter

As we approach the 2013 Annual Meeting & OTO EXPO℠ in Vancouver, it is important to look at the value of education activity evaluations and the role they play in the overall education program of the Foundation. At the end of each Annual Meeting miniseminar and instruction course, attendees line up at the onsite computer stations to answer a series of questions pertaining to the session they just attended. This is also true for everyone who participates in our more than 150 online courses and lectures, as well as Patient Management Perspectives in Otolaryngology and Home Study Course subscribers. The responses to these questions represent an integral part of what the education leadership considers as they plan education activities that will benefit both our members and their patients.

First and foremost, the evaluation process is a requirement for awarding *AMA PRA Category 1 Credit*™ for the education activity. One of the AMA PRA core requirements for certifying activities specifically states "the activity must evaluate the effectiveness in achieving its educational purpose and/or objectives." This effectiveness is measured in three ways: knowledge, competence, and performance. A change in knowledge answers the question, "Did I learn new information about the topic at hand?" A change in competence answers, "Did I learn how to apply the new information I learned?" A change in performance answers, "Did I master the new skills I acquired through practice?"

With the current emphasis on improving patient outcomes, it is critical that physicians are educated on specific skills that will lead to improved practice and quality of care. All education activity objectives are written as outcome objectives that assess whether the participant has learned a new concept, learned a new skill, or perfected a new technique. The Foundation's focus is always on measuring not just knowledge, but, more importantly, competence and performance. Other questions found on a typical education activity evaluation include an assessment of the content and format of the activity, the resource materials accompanying the activity, the quality and expertise of the faculty, and if there was any appearance of commercial bias associated with the activity. Annually, staff compiles this evaluation data from all the education activities conducted in a given year in order to get a sense of the overall perceptions of activity participants regarding the quality of our offerings and faculties and whether they are influencing patient care outcomes. The summaries from all this data are used by the eight education committees, who serve as content experts and activity planners, to determine future education resources that will be of value to our members.

Recently the Foundation acquired a new education data management system to assist in the reporting and assessment process within education. This database helps us to summarize the evaluation responses from participants in all of our education activities. We are currently inputting evaluation data for all activities conducted during the last three years. This information will be valuable to determine which of our products are succeeding at improving the knowledge, competence, and performance of our members. This new tool will help us better access and utilize this data during future education planning.

Needs Assessment

Evaluations are just a part of the process of determining the education needs of our members. As mentioned throughout the year, the Foundation has been involved in a membership-wide education needs assessment initiative. One of the components of this initiative has been to perform a gap analysis within the discipline of otolaryngology-head and neck surgery. A gap analysis is a formal study of what the profession is doing currently and where it needs to be in the future. In relation to the practice of otolaryngology-head and neck surgery, this analysis will provide evidence where physician knowledge, competence, and practice may be lacking or best practices are not being utilized. The results of this analysis will help the Foundation determine where best to allocate its time and resources to address these gaps through education and knowledge products.

Another component of this initiative was the education needs assessment survey sent to members in August. This survey was another important tool to help paint the overall picture of where the Foundation currently stands in providing valuable education to our members and where it should be going in improving these efforts. While individual education activity evaluations provide insight into one specific education activity, the member-wide survey targets the needs of the entire membership. Results of this initiative will be shared and discussed in a future *Bulletin*.

Combined, all of this evaluation data is critical to help the Foundation create a quality and effective education portfolio that will provide the best service to our members. So the next time you hear "be sure to complete your evaluation," do so knowing your input is vital to the success of the education program at the Academy.

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2013 Annual Dinner Meeting of the Otolaryngologists of Indian Heritage

The 36th Annual Meeting of the American Association of Otolaryngologists of Indian Heritage (AAOIH) will take place 6:45 pm-11:00 pm Monday, September 30, at Maurya Indian Cuisine, 1643 West Broadway, Vancouver, BC, Canada. The featured speaker will be **Manohar Bance, MB, MSc**, FRCSC, of Dalhousie University, Halifax, NS, Canada.

For charges and details about the upcoming meeting, please contact **Pete Batra, MD**, secretary (pete.batra@utsouthwestern.edu), or **Satish Govindaraj, MD**, president-elect (satish.govindaraj@mountsinai.org). *Attendance at the Annual Dinner meeting is anticipated to be large and an RSVP is strongly encouraged.*

Otolaryngology residents of Indian heritage are encouraged to present their scientific work at the meeting. Three prizes will be announced. Residents who would like to present are urged to email **Kevin D. Pereira, MD,** at kevindpereira@gmail.com.

Those desiring to join the organization are encouraged to contact **Ameet Singh, MD**, membership secretary. Email dr.ameetsingh.ent@gmail.com or visit www.aaoih.com.

Manohar Bance, MB, MSc

In addition, **Arun K. Gadre, MD,** AAOIH president, will convene a meeting of the Executive Board 4:30 pm-6:00 pm on Sunday, September 29, in the Vancouver Convention Centre, ICS room (Room 111). Board members are requested to RSVP Dr. Gadre at akgadr01@exchange.louisville.edu.

Congratulations to 2013 International Visiting Scholars

Please welcome the following scholars at our Annual Meeting & OTO EXPO℠ in Vancouver. They will be recognized and receive their certificates and scholarship grants during the International Assembly from 2:00 pm-4:00 pm Tuesday, October 1.

- Ahmed Hassan Allam, MD, MRCS, MSc, Mansoura University School of Medicine, Egypt (University of British Columbia)
- John W. Ayugi, MBChB, MMED ENT, University of Nairobi, Kenya (University of Kentucky)
- Tripti Kaur Brar, MS ENT, DNB, MBBS, Maulana Azad Medical College, India (University of Miami)
- Angela Maria Campos, MD, Fundacion Universitaria de Ciências de la Salud, Colombia (University of Iowa)
- Guyan A. Channer, MD, Kingston Public Hospital, Jamaica (Johns Hopkins University)
- Wakisa Katepala Mulwafu, MBBS, FCORL (SA), University of Malawi College of Medicine, Malawi (Vanderbilt University)
- Christian Gomez Quiroz, Universidad San Martin de Porres, Peru (House Research Institute)
- Doreen Nakku, MBChB, Mbarara University of Science and Technology, Uganda (University of British Columbia)
- Sunita Chhapola Shukla, MS, DNB, FCPS, DORL, Mumbai Port Trust Hospital, India (Columbia Cochlear Implant Center)
- Kapil Sikka, MBBS, MS, DNB, All India Institute of Medical Sciences, New Delhi, India (Stanford University)
- Myrton Smith, MBBS, DM (ORL), University Hospital of the West Indies, Jamaica
- Basim Metwally Wahba, MD, DOHNS, MRCS, Cairo University Faculty of Medicine, Egypt (Yale University)

Dr. Campos is the Antonio de la Cruz Scholar. Dr. Nakku is the Nancy L. Snyderman Scholar. Dr. Mulwafu is the Gelot Scholar.

Changing Lives in Rwanda, the Land of a Thousand Hills

Yi-Hsuan E. Wu, MD
Tufts Medical Center
Boston, MA

▲ Meeting a patient during morning rounds.

▲ Liliane before and after her thyroid lobectomy.

Inspiring. Refreshed. Energizing. Humbled.

Those are some of the words my fellow team members and I use when describing our mission experience. With the help of a grant from the AAO-HNSF Humanitarian Efforts Committee, I had the privilege of joining Medical Missions for Children (MMFC) on its annual trip to Gitwe, Rwanda, in March to treat patients with endemic goiter due to iodine deficiency. **Jagdish K. Dhingra, MD**, has led the team, made up of 15 healthcare professionals and volunteers from the United States and Rwanda, for the past seven years.

We arrived with 44 pieces of luggage in tow, including instruments, electrosurgical generators, and medications. The first day was spent turning two nearly empty rooms of the hospital into a functional operating room and recovery unit. With the help of Vianney Ruhumuliza, our in-country partner, prescreened patients were already at the hospital awaiting our evaluation and hopefully, surgical intervention. One woman had walked for three days for her chance to meet us. Unfortunately, not everyone with an operable goiter was able to be treated during our short time in Gitwe. These patients were given follow-up instructions and asked to return next year.

Throughout the week, we took note to be thankful for the amenities taken for granted back home. Power went out unpredictably and frequently during surgeries, often leaving the surgeons without the ability to use electrocautery and the anesthesiologists with the task of keeping patients ventilated with an Ambu bag. Without a sterile processing unit (only a small autoclave), the surgical technologists diligently cleaned and packed the instruments between operations and rationed the use of clean towels, drapes, and sponges.

Despite these hurdles, the team completed 25 subtotal thyroidectomies in six days. Everyone will remember Liliane, a friendly and attractive young woman with a contagious smile and an enormous goiter that involved her entire neck and extended to her left ear. Her surgery was the longest and most challenging. It was particularly rainy that day, and we lost power a few times during her seven-hour procedure to remove the two-pound mass from her neck. She had lost a fair amount of blood and also required nasogastric tube feeds for a few days. The team celebrated each step in her recovery, from drain and staple removals to finally being able to tolerate a regular diet. Despite being away from her children for nearly two weeks while recuperating in the hospital, Liliane smiled every day.

Our last day in Gitwe was filled with hugs and "murakoze" ("thank you" in Kinyarwanda). In return, we are thankful for the opportunity to change lives and to "return to the essence of the profession," as well expressed by David Gregg, MD, one of the attending surgeons on the team.

I remain touched by every patient's gratitude and positive attitudes and look forward to my next medical mission trip.

International Resident Exchange

In the fall of 2012, **Gregory W. Randolph, MD**, international coordinator and chair, International Steering Committee, commissioned a task force to investigate the possibility of an international resident exchange program as a collaborative effort between the committee and Latin American International Corresponding Societies. Members of this task force are **Hilary A. Brodie, MD, PhD, Juan Manuel Garcia, MD,** Dr. Randolph**, J. Pablo Stolovitzky, MD,** and **Mark E. Zafereo, MD, PhD.**

Goals of the exchange include providing U.S. residents and international residents an opportunity to experience unique aspects of otolaryngology-head and neck surgery training and patient care at an international academic institution, and to foster relationships between U.S. and international training programs.

The task force extended invitations to six American and five international residency programs to take part in a resident exchange program. The six American institutions include programs from five states, and the international institutions include programs from Mexico and Central and South America.

Residents from these programs will be invited to visit an international OTO-HNS training program.

Any U.S. or international programs that wish to participate in this international resident exchange program can email Dr. Zafereo (mzafereo@mdanderson.org) for details.

Meet Us in Vancouver!

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

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

Monday, September 30 and Tuesday, October 1, 2013

5:30 – 7:30 PM each evening

Cocktails and hors d'oeuvres at The Fairmont Waterfront, 900 Canada Place Way, Princess Louisa Suite.

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

Seeking board certified, fellowship trained Pediatric Otolaryngologist

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

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

Opportunities for Otolaryngologists

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

Send CV to:
Dan Mui, Department Administrator
The New York Eye and Ear Infirmary
310 East 14th Street
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Tom D. Wang, MD
Edwin F. Williams, MD

Plastic Surgery
J. William Little, MD
Timothy J. Marten, MD
Foad Nahai, MD
Jason Pozner, MD
Renato Saltz, MD
Edward O. Terino, MD

Oculoplastic Surgery
Robert A. Goldberg, MD
Don O. Kikkawa, MD
Tanuj Nakra, MD

Dermatology
Rebecca Fitzgerald, MD
Mitchell Goldman, MD
Raynella Hirsch, MD
Vic Narukar, MD
E. Victor Ross, MD

Tuesday morning, choose between Fundamental Learning Part 1: The Basic Principles of the Aging Face or The Facial Volumization Workshop with live demonstration.

Tuesday afternoon features Lasers, IPL and Resurfacing Workshop with live demonstrations or an afternoon Practice Management Workshop

Wednesday, you can sign up for Fundamentals Learning Part 2: Aging Face Laboratory or continue with Part 2 of the Practice Management Workshop in the morning followed by Facial Volumization, Part 2 in the afternoon.

Thursday, Friday, and Saturday sessions address brows/upper lids, followed by lower lids and midface, midface to jawline and new horizons, with interactive panel discussions.

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Office- 717-843-9089
Email- yorkent@comcast.net

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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

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Susan Scott
800-678-7858 x 64414
sscott@cejkasearch.com

ID#149241AD cejkasearch.com

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

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

GENERAL OTOLARYNGOLOGIST

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

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

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

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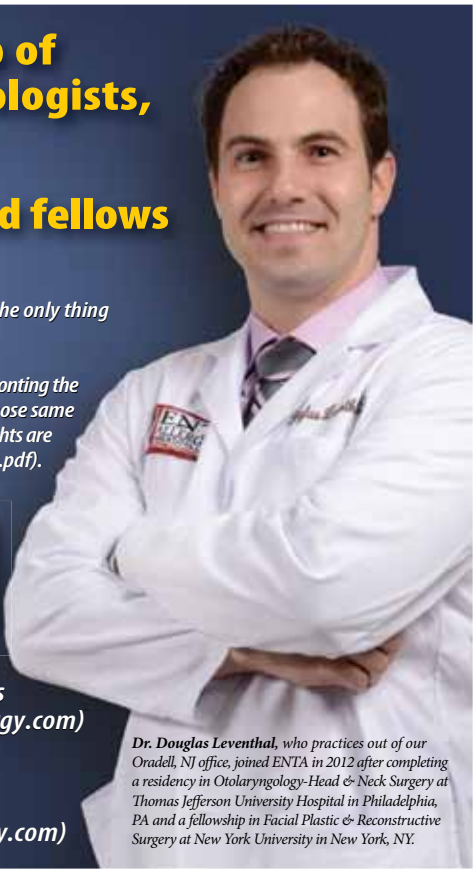

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Wayne Eisman, MD, FACS
President, ENT and Allergy Associates
(914-333 5809/weisman@entandallergy.com)

Bob Glazer
CEO, ENT and Allergy Associates
(914-490-8880/rglazer@entandallergy.com)

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

Cooper University Health Care

Cooper Medical School of Rowan University

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.

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 with expertise in cochlear implantation, airway reconstruction, and vascular malformations are preferred. The otolaryngologists truly welcome all advanced skill sets and will work as a group to facilitate the clinical and academic growth of the candidate.

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

Academic appointment and compensation is commensurate with training and experience. Interested applicants in either position should contact:

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

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Pediatric Otolaryngologists
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Nemours is seeking two Pediatric Otolaryngologists to join our team in Orlando, Florida. Physician candidates must have completed a Pediatric Otolaryngology fellowship or have ten or more years in practice with a concentration on Pediatric ENT.

Practice call is one week in five. Our department services include endoscopic neck surgery, sinuplasty surgery, cochlear implants and otology. Our Division of Audiology provides a full range of audiology services on site. A clinical interest in head and neck surgery or airway issues is preferred.

Interested candidates should forward their formal CV to Julie L. Wei, M.D., Division Chief of Otolaryngology, Julie.wei@nemours.org or submit CV online: http://careers.nemours.org/jobs/39760/

In the fall of 2012, Nemours opened an unprecedented health campus located in the Lake Nona Medical City. Anchored by a children's hospital like no other in Florida, NCH also features a new Nemours Children's Clinic location, an ambulatory diagnostic center, and extensive research and education facilities. Designed with the help of patient-families and health care professionals, the initial phase consists of a 95-bed children's hospital that is part of a 60-acre, fully integrated health campus.

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Department of Health and Human Services
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National Institute on Deafness and Other Communication Disorders
Otolaryngology Surgeon-Scientist Position

NIDCD Otolaryngology Surgeon-Scientist Career Development Program (OSCDP) is a mentored, early career faculty development program within the NIDCD Intramural Research Program. The OSCDP aims to promote training and research opportunities for otolaryngologists committed to pursuing translational research by providing an optimal environment in which to develop the skills necessary for cutting-edge, translational research on human communication processes in health and disease.

The Otolaryngologist designs and implements a career development plan that ideally integrates basic scientific and clinical research. The key elements of support for the program are: (1) prospective and stable funding, typically for 2-5 years; (2) defined research and career mentorship; and (3) the research environment of the National Institutes of Health (NIH), the National Institute on Deafness and Other Communication Disorders (NIDCD) and the NIH Clinical Research Center, the 2011 recipient of the Lasker-Bloomberg Public Service Award.

The NIH Clinical Research Center

We seek ambitious, creative and insightful clinicians with the drive and vision to lead the global community of Otolaryngology-Head and Neck Surgery and leverage advances in basic science toward better care for patients. Candidates should demonstrate outstanding scholarly achievement and accomplishment throughout their career, and be able to identify a relevant research topic and plan. Interested candidates may apply to the program either before completing their Otolaryngology residency or subspecialty fellowship, or at any time up to five years after completing their postgraduate training. Applicants will be American Board of Otolaryngology-certified or -eligible in Otolaryngology-Head and Neck Surgery or an affiliated subspecialty from ACGME-accredited programs. Participants will have the opportunity to work with a wide range of talented and creative scientists within NIDCD (http://www.nidcd.nih.gov/research/faculty/pages/alpha.aspx) and NIH (http://irp.nih.gov/our-research/principal-investigators). Opportunities to integrate activities and resources with nearby academic otolaryngology programs are also available.

Interested applicants should submit a curriculum vita, a brief letter of interest, a letter of recommendation from the director of their most recent clinical training program (usually the residency or fellowship program director), and names and contact information for 3 former research and/or clinical mentors who can serve as references. Questions and applications should be addressed by phone, email, fax, or mail to Carter Van Waes, M.D., Ph.D., Clinical Director, NIDCD/NIH, CRC 4-2732, 10 Center Drive, Bethesda, MD 20892; Phone: 301-402-4216, Fax 301-402-1140; Email: vanwaesc@nidcd.nih.gov. The deadline for applications is **October 31** of the year preceding the typical July 1 starting date. The OSCDP is described at: http://www.nidcd.nih.gov/research/training/pages/training.aspx

DHHS and NIH are Equal Opportunity Employers and encourage applications from women and minorities.

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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

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

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

UCSF

Otolaryngology

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Featured 9th in Money Magazine's "Best Places to Live", Ames, Iowa is recognized as an active, friendly community with plenty to do. Ames is a vibrant university town with one of the highest-rated public school systems in the nation. Having close access to several major metropolitan cities means that this versatile community provides small-town serenity and charm plus big-city amenities and culture.

EOE/AA Employer

Contact Doug Kenner
866.670.0334 or dkenner@mountainmed.net

University of Missouri
Department of Otolaryngology—
Head and Neck Surgery

Seeks clinicians, teachers, and researchers who are personable, energetic and innovative to join a rapidly growing and collaborative group of physicians. 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.

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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.

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

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

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

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

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

This position will remain open until filled; however, for best consideration, application materials should be received by December 31, 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

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

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.

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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.

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**

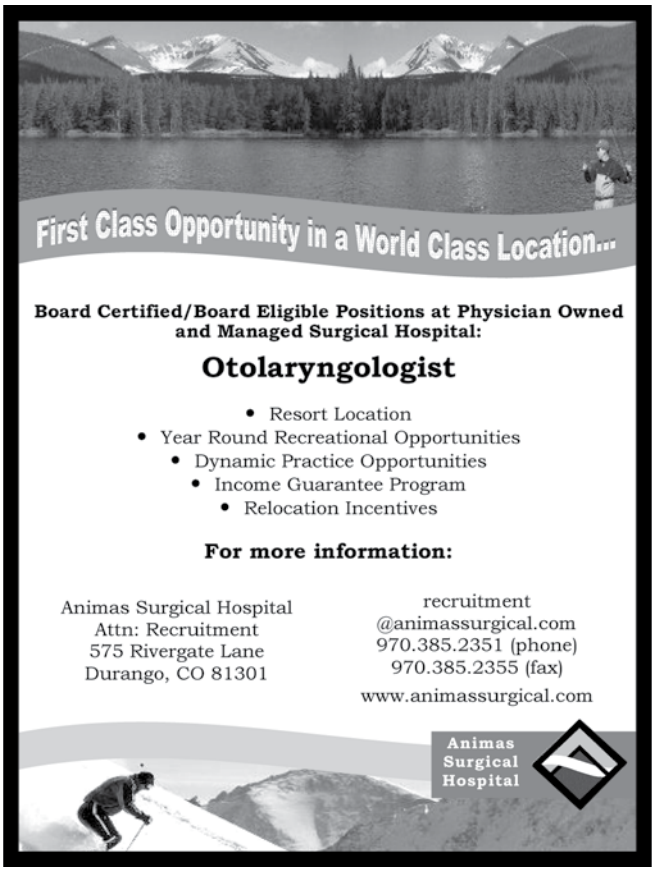
THE UNIVERSITY OF UTAH

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



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

UIC UNIVERSITY OF ILLINOIS AT CHICAGO

Department of Otolaryngology–Head and Neck Surgery


Aspen at Night Photo: Hal Williams


Photo: Paul Morrison

38th Midwinter Symposium on Practical Surgical Challenges in Otolaryngology

February 17-20, 2014
Snowmass Village, Colorado

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- Head and Neck Surgery
- Nasal and Sinus Surgery
- Otology
- Pediatric Otolaryngology
- Facial Plastic and Reconstructive Surgery
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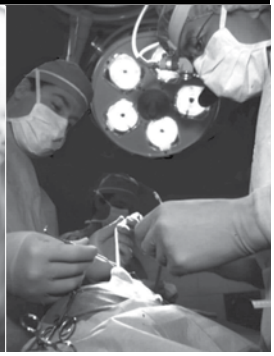

MICHIGAN

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 an Neurotologist, 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

The Ear, Nose, Throat & Plastic Surgery Associates

OTOLARYNGOLOGIST

The largest otolaryngology group in Central Florida, offering a full array of subspecialty care including emphasis in general otolaryngology, pediatric and head and neck focus, is seeking several partners. We offer the best of private practice with opportunities for academic pursuits. Integrity, quality and camaraderie are our core values.

We offer an excellent salary, benefits, and partnership and the opportunity to teach residents and medical students.

Orlando is the home of Disney World, Universal Studios, and Sea World. It offers a variety of large city amenities and is a short drive to both the East and West Coasts of sunny Florida.

To learn more, visit us online at www.entorlando.com

Direct Contact Information:
Interested candidates should contact Debbie Byron, Practice Administrator, online at dbyron@entorlando.com or by fax at 407-644-3697

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

SAINT LOUIS UNIVERSITY

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.

Training for Clinical Research in Hearing, Balance, and Other Communication Disorders
Duke University Medical Center

The Division of Otolaryngology–Head and Neck Surgery and Duke Clinical Research Institute are looking for exceptional candidates for an NIH-funded training program in hearing, balance and other communication disorders.

This new research training opportunity is for otolaryngologists interested in clinical research, including outcomes research, clinical trials, and translational research. The NIDCD-sponsored T32 program will enroll post-residency otolaryngologists with a desire to enter academic practice with a research focus in clinical research. Each trainee will be mentored by a team that includes both experts in research methodology and content experts. A clinical and surgical practice opportunity is also provided (1/2 to one day per week), as is the opportunity to mentor OHNS residents and participate in leadership development programs. Collaboration with the Duke Institute of Global Health and the opportunity to participate in research at Duke programs in developing countries is also available. Our goal is to train tomorrow's leaders in OHNS-related clinical research.

This program is the ONLY clinical research training program in the field and offers practical research application through the national Creating Healthcare Excellence through Education and Research (CHEER) practice-based research network. Trainees will earn a Master of Health Sciences in Clinical Research or related degree.

Openings for July 2014 (2 year program)

- One postdoctoral, post-residency OHNS MD graduated from any accredited U.S. Otolaryngology training program
- One postdoctoral PhD with a desire for clinical research training and experience in OHNS-related fields

Please direct inquiries to Debara L. Tucci, MD, MS, MBA, Professor of Surgery, Duke University Medical Center at debara.tucci@duke.edu, or 919-684-6968.

http://www.entnet.org/EducationAndResearch/Duke-T32-Training-Program.cfm

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

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

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.

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.

THE UNIVERSITY OF NORTH CAROLINA
SCHOOL OF MEDICINE
CLINICAL FACULTY
FULL-TIME FACULTY POSITION

OTOLARYNGOLOGY/HEAD AND NECK SURGEON-
The Division of Head and Neck Oncology, Department of Otolaryngology/Head and Neck Surgery, University of North Carolina at Chapel Hill School of Medicine is seeking a board-certified or eligible Otolaryngologist for a full time position at the Clinical Assistant or Clinical Associate Professor Level. Applicants should be fellowship trained in head and neck surgical oncology and have a strong interest in clinical as well as translational research. The successful applicant should be able to work in a multidisciplinary environment and be knowledgeable about modern therapy of a wide variety of head and neck neoplasms and disorders. Projected start date is January-July of 2014.

Apply online http://unc.peopleadmin.com/postings/29223.
Address cover letter to:
Harold C. Pillsbury, MD
Professor and Chair
Otolaryngology/Head and Neck Surgery
170 Manning Drive, Physician Office Building, CB# 7070
University of North Carolina School of Medicine
Chapel Hill, NC 27599-7070
(919) 966-3342
Fax (919) 966-7941

The University of North Carolina at Chapel Hill is an equal opportunity/ADA employer.

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

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.

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