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American Academy of Otolaryngology—Head and Neck Surgery February 2014—Vol.33 No.02

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American Academy of Otolaryngology—Head and Neck Surgery February 2014—Vol.33 No.02

Kids ENT Health Month: Child Health Disparities

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AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY

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

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- Leadership Development Opportunities
- Submissions to the *Otolaryngology – Head and Neck Surgery*, the scientific journal as well as the Academy's monthly news magazine, the *Bulletin*.

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- Practice management
- Clinical Practice Guidelines
- Advocacy session
- Health Policy
- ENT PAC networking reception
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Reconnecting

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

Sometimes we get stuck. We get lost in the process—the details—the sticking points and we forget to keep our sights on the end goal. We suddenly realize that we are involved in an issue so complex that it obfuscates passage, that we do not know where we are and cannot see the "markers" that may help us find our way.

We all from time to time share this predicament, but our responses to it vary greatly. Do we continue on, doggedly convinced of the ideal, despite finding ourselves isolated and unsure? Or do we look for signs, blazes on the trees, so to speak, that lead us to other seekers who work together to find the way?

When the sun shines along the way and the trails are clearly marked, we can sometimes be lucky enough to navigate alone. Often, however, this is not the case, and making progress becomes more time-consuming and frustrating. How we respond to our predicaments makes a difference.

Our practice environments today provide ample opportunity for us as individuals in either a community-based or academic setting, to veer off course, and be overwhelmed. It is just such a time when the Academy can help us reconnect by drawing upon its resources.

The Academy Board of Governors, for example, is well aware of the incredible challenges you, its members, face in finding your way through the ongoing requirements of change. Often local medical societies are the first to identify specific issues as they emerge in a community. To quote the AAO-HNS BOG Model Society Handbook, "…local societies have a significant advantage…because issues directly affect the local practitioner and the community. The result is a stronger desire for involvement." The society is small and agile and built on personal relationships between the medical community and governing agents. These society-built relationships then become an asset to the Academy and you.

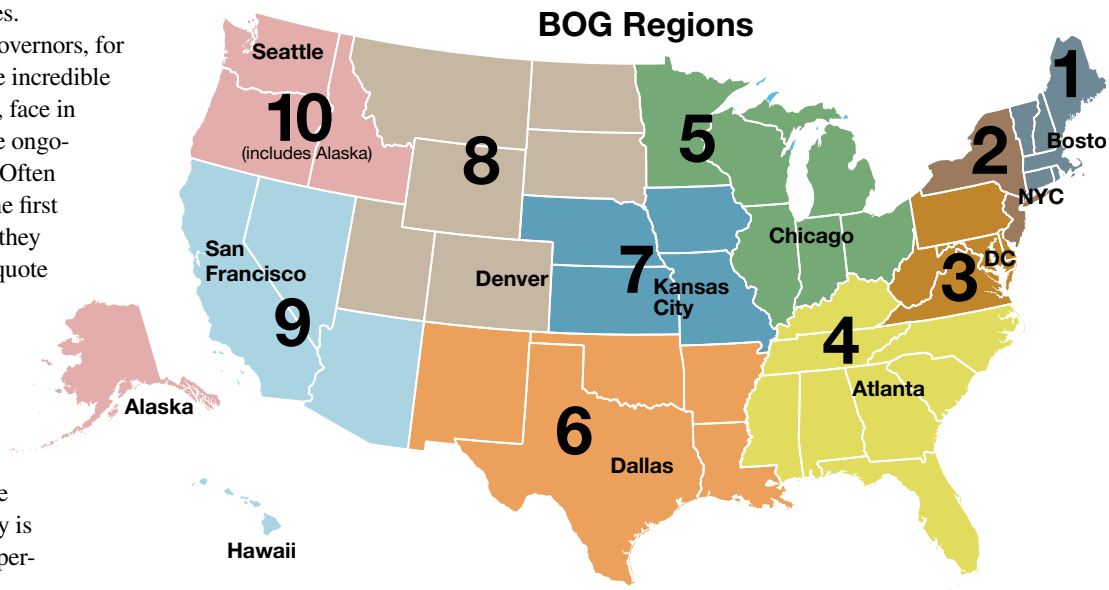
When local societies work with the AAO-HNS Board of Governors network, such as those awarded each year as model societies, they coalesce their resources and function as a high- performing team for the overall good of the state society and the specialty.

The BOG has a long history of leading our state societies to benefit the specialty at the national, regional, and state levels. They form an important legislative, socio-economic, and public relations force for the specialty at large. At the national level the BOG accesses its collective power and reach to lead and find solutions that individuals and smaller societies cannot.

I am reminded of our EVP and CEO David Nielsen's BOG leadership in the late '90s for the hugely successful AAO-HNS Through with Chew campaign. In this effort, the Academy's BOG developed a national message that received considerable attention.

Many such successes have occurred since then marking the effectiveness of this pathway. Last year, the New York State Society of Otolaryngology-Head and Neck Surgery (NYSSO) was able to organize around legislative challenges and leverage relationships with other state organizations and individuals to be heard in its legislature.

These resources help us all reconnect and find solutions together. Please see page 8 in this issue for a listing of the newly organized regional BOG groupings that may help you make the right connection.



*http://www.entnet.org/Community/public/upload/Model-Society-Handbook-Updates-6-12.pdf

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Developing Leadership

David R. Nielsen MD

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

Early in my undergraduate education, I was fortunate enough to take a course in business law taught by a judge who had previously been my father's law partner. His class was particularly memorable for me not only because I knew him personally, but also because I knew he actually practiced law and conducted his personal life according to the principles he taught. He was not content to just teach the law as it applied to business conduct, but taught the principles of living with integrity. He demanded of his students that each of us conduct our businesses with high standards of personal behavior. He asserted that every business man or woman should set personal standards of conduct that were so high, that when we achieved them, we had already exceeded the legal and professional standards required of us. He repeatedly taught that this was the essence of leadership, and that **no matter where we worked, or what our pay grade or job title was, leadership would be required of us**.

Throughout my life, whether in personal business ventures, managing finances, running my own solo medical practice, being employed in a large multispecialty internationally renowned clinic, volunteering, or serving as the CEO of the Academy and Foundation, I have found this to be true. I require of our staff here in Alexandria, VA, and Washington, DC, that everyone from the newest hire to the most tenured of the leaders in the C-suites demonstrate leadership in standards of personal behavior and professional conduct. I am grateful for the positive way in which your Academy staff model leadership skills and professional development. It is our desire, as well, to ensure that we provide every possible opportunity for our membership to advance their leadership through teaching opportunities (Annual Meeting; Education Committees; journal submissions; etc.); research, quality, and patient safety initiatives; health policy work (RUC; CPT; and appropriations, etc.) content committee work; BOG and BOD involvement; local community service; and international and humanitarian engagement.

As part of our offerings for you, our colleagues and members, to advance your leadership skills and involvement we have provided opportunities to learn about and engage in the necessary policy and political processes that influence the practice of medicine. We invite you to attend our Leadership Forum from February 28-March 3. Our programming combines many leadership activities, including the Boards of Directors (BODs) meetings and Strategic Planning sessions, Executive Committees, the Science and Education Committee, the Board of Governors sessions, related advocacy components, and more. We also offer special content designed for Residents and Young Physicians. You can access more information about this on our members-only web page at http://www.entnet.org/LeadershipForum.

> We invite you to attend the AAO-HNS/F Leadership Forum from February 28-March 3.

This meeting is one of many academy benefits; that is, registration is free, but you must register to attend. Participation allows members opportunities to network and engage with peers and Academy leaders, as well as political and professional experts in other fields. The Board of Governors and advocacy sessions are open to everyone and begin on Sunday morning, March 2, and continue through midday on Monday, March 3. New for this year, selected qualifying sessions will offer CME credit.

This year's program includes sessions addressing:

- Practice management
- Clinical Practice Guidelines
- Advocacy sessions
- Health Policy
- Academy 101
- Model Society Forum with best practices
- Sunshine Act: What you need to know
- BOG General Assembly and Candidates Forum
- National leaders and guest speakers, including leadership from the Centers for Medicare and Medicaid Service (CMS)
- ENT PAC Reception (ENT PAC Leadership Club members only)

As the healthcare delivery systems evolve, it is increasingly necessary for physicians to understand more of the formal language of leadership and business models to ensure that the clinical concerns of patients and their doctors remain the primary focus and do not take a secondary role to the "business of medicine." Our professionalism and Hippocratic Oath require us to continually put the interests of patients and their health ahead of our own financial or personal interests. Only through our leadership and modeling of this focus, and engagement in policy processes, can we ensure that business and financial fiduciaries (employers, purchasers, insurers, health plans and systems, and government) do the same.

Why a Frog?

Wendy B. Stern, MD,
BOG Chair-Elect

We want to jump out at you and catch your attention. The BOG Frog* and the Board of Governors are hoping that you will take a moment and think about how you can stay connected with the Academy, your local and regional ENT societies, and your fellow otolaryngologists. We want you to take the leap and become involved.

The Board of Governors is the grassroots organization that represents your interests and concerns and serves as the conduit of information and action between you and the Academy. In order for us and for you to be successful, we need you to be involved. Everyone is welcomed to attend our 2014 AAO-HNS/F Leadership Forum, March 2-3 in Alexandria, VA: www.entnet.org/leadershipforum.

Right now we need help finding you!

If you represent or know a colleague who represents your local or state BOG society or if you work in an area that does not have a society and need help being represented please reach out to us and give us your contact information (bog@entnet.org). We look forward to hearing from you soon and seeing you in early March.

* Frogs have large protruding eyes, giving them almost 360° vision, allowing them to look without moving, and many are nocturnal, with good night vision. A mirror layer (*tapetum lucidium*) in the back of their eyes allows them to reflect light at night, giving them a search light for hunting.

Newly Organized Regional BOG Groupings

Region 1—David Boisoneau, MD
Boston—Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont

Region 2—David R. Edelstein, MD
New York—New Jersey, and New York

Region 3—Soha N. Ghossaini, MD
Philadelphia—Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia

Region 4—Daniel L. Wohl, MD
Atlanta—Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee

Region 5—Robert J. Stachler, MD
Chicago—Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin

Region 6—Larry M. Simon, MD
Dallas—Arkansas, Louisiana, New Mexico, Oklahoma, and Texas

Region 7—Joseph E. Hart, MD
Kansas City—Iowa, Kansas, Missouri, and Nebraska

Region 8—Phyllis B. Bouvier, MD
Denver—Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming

Region 9—Eric J. Kezirian, MD, MPH
San Francisco—Arizona, California, Hawaii, Nevada

Region 10—Sanjay R. Parikh, MD
Seattle—Alaska, Idaho, Oregon, and Washington

Interested in Our History?

Join or renew your membership in the Otolaryngology Historical Society (OHS). Check the box on your Academy dues renewal or contact museum@entnet.org.

Save the date for the OHS annual meeting and reception, 6:30 pm-8:30 pm, September 22, in Orlando, FL.

Present a paper at the OHS meeting. Email museum@entnet.org. May 15 is the deadline.

The Otolaryngologist As Educator

When I became a physician, I did not realize I was signing on to a lifetime as an educator. While I knew I needed to remain up-to-date and participate in continuing medical education (CME), I did not realize I would spend a significant amount of my clinical time educating my patients and colleagues. As an academic physician, I understood I would be responsible for the training of medical students, residents, and fellows, and I have contributed to my fair share of book chapters and review lectures toward this endeavor. However, the more I learn, the more I realize I came unprepared for the job.

In medical school, there was no instruction on curriculum development, skill assessment, or giving honest and constructive feedback, and yet I am expected to do all of these things. To address this gap in my knowledge, I have found courses, workshops, and articles (often in a piecemeal fashion) on giving feedback, curriculum development, and skill assessment to be the beginning of my educator education.

> "In medical school, there was no instruction on curriculum development [for patients and colleagues], skill assessment, or giving honest and constructive feedback, and yet I am expected to do all of these things."

Education Resources

I am also assisted by an Academy that focuses many resources on education so I don't have to do all the work myself. A quick look at Academy educational resources includes myriad educational formats that apply to learners at every level. Many are well-known such as the Home Study Course and Annual Meeting courses. However, there are a number of lesser-known products like the case-based Patient Management Perspectives (PMP) and AcademyQ™ App, which includes 400 study questions that are useful for exam preparation. There are also products geared to the residents like COCLIA℠ (Comprehensive Otolaryngologic Curriculum, Learning through Interactive Approach), products geared toward mid-level providers such as case-based COOL℠ (Clinical Otolaryngology OnLine), and the ENT for the PA-C course, as well as resources for medical students (and future referrers) including the ENT Exam Video Series and PA-C Primary Care for Otolaryngology eBook.

Kids E.N.T. Health Month

In addition, the Academy assists us in our educational efforts through public education campaigns like the Kids E.N.T. Health Month being observed this month. This serves as an opportunity to educate our colleagues and patients about the appropriate diagnosis and management of pediatric ear, nose, and throat disorders. This is especially important as we reach out to our primary care partners, where more than 40 percent of their visits involve a pediatric ENT complaint. This campaign is also an opportunity to market our services and the Academy provides numerous resources (http://www.entnet.org/kidsent), including sample outreach letters to the media, fact sheets on common disorders, and links to pediatric otolaryngology organizations.

While the Academy develops and promotes tools to treat and educate patients, none of them are effective unless they are used. Kids E.N.T. Health Month is an established occasion for us to promote both children's health and our specialty, and the best part is, the Academy has really done most of the work.

2014 AAO-HNS/F Leadership Forum

In addition to the Kids E.N.T. campaign, the Academy continues to provide education to members and our legislators on state and federal legislative issues. We accomplish this through our excellent legislative staff, ENT Advocacy Network, and the I-GO Program (designed to promote interactions with legislators in their home districts). In addition, the new AAO-HNS/F Leadership Forum (March 2-3 in Alexandria, VA) replaces the traditional advocacy day with a focus on both advocacy training for otolaryngologists and practice management education, which is offered with some free CME this year. This forum is designed to educate us on the topics such as clinical practice guidelines, current federal legislation, alternative payment models, and transition to ICD-10 coding.

As in previous years, the candidates for AAO-HNS president-elect will be speaking at the candidates' forum during the Board of Governors meeting that will occur during that event, giving us an opportunity to ask questions of the candidates directly. Unlike in previous years, we will not be visiting the Hill to meet our legislators and their staff, but will be equipped with the tools to conduct meetings in our home districts. (For more information see: www.entnet.org/LeadershipForum.)

Whether you are in a private practice, a multispecialty group, or academic practice, each of us is an educator. I, for one, appreciate the plethora of educational opportunities and tools that are offered by the Academy and hope that you will join me to educate ourselves and our peers through the Kids E.N.T. campaign and the Academy's Leadership Forum.

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

Impact of Chevalier Jackson and Gosta Dohlman on Endoscopic Surgical Therapy for Zenker's Diverticulum*

Alexander T. Hillel, MD

Zenker's diverticulum, or hypopharyngeal diverticulum, develops in a triangular area of weakness between the oblique muscle fibers of the inferior pharyngeal constrictor muscle and the horizontally oriented fibers of the cricopharyngeus muscle. Its location at the interface of the pharynx, neck, and mediastinum makes surgical access difficult and risks severe morbidity.

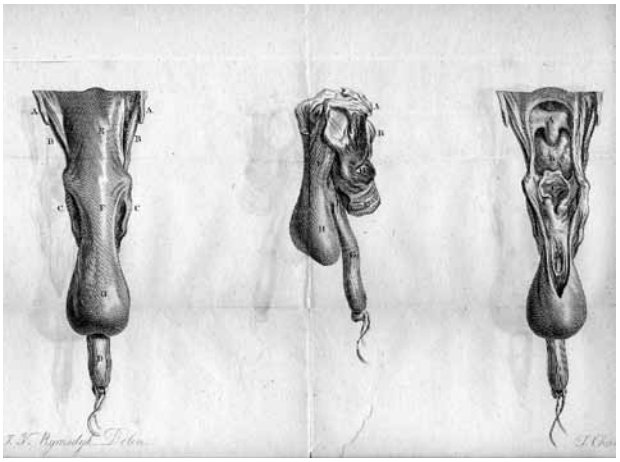
The history of endoscopic treatment of Zenker's diverticulum demonstrates the process of transition to new surgical therapies based on the sequential efforts of many pioneers. Two otolaryngologists of great renown, Chevalier Jackson and Gosta Dohlman, were critical in advancing the surgical technique and reducing morbidity in the endoscopic treatment of Zenker's diverticulum.

Jackson proposed an esophagoscope-assisted, one-stage, transcervical diverticulectomy with the aim of decreasing morbidity and improving recovery time as compared to the two-stage operation. Jackson's use of contemporary endoscopic technology advanced the surgical treatment of Zenker's diverticulum, lowering morbidity in a variety of ways.

First, the esophagoscope emptied the diverticulum's contents, which decreased the risk of aspiration pneumonia and mediastinitis. Second, its distal illumination facilitated identification of the diverticular sac, which in turn cut operative time. Jackson's use of the esophagoscope represented a vital step in evolution of surgical treatment for Zenker's diverticulum from an external diverticulectomy to the endoscopic esophagodiverticulostomy.

Dohlman attributed cricopharyngeal spasm as the key cause of hypopharyngeal diverticulum, after comparing barium swallow studies of Zenker's patients to those of controls. His utilization of the cricopharyngeal myotomy directly addressed this key component of disease pathogenesis.

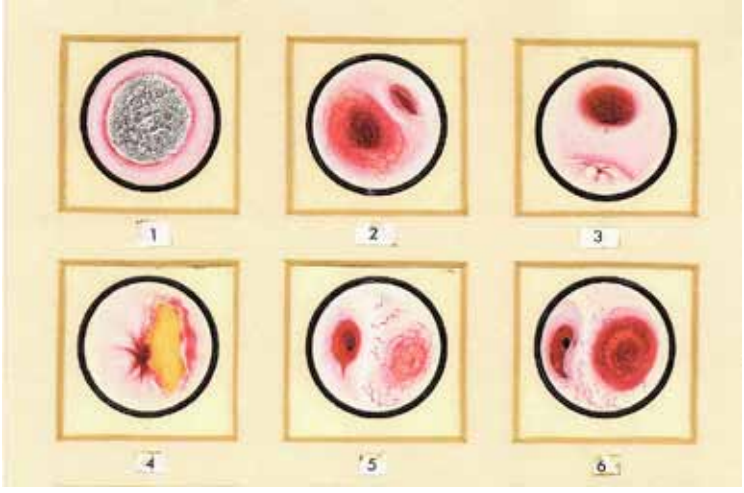
In 1960, Dohlman published his case series of 100 patients treated with the endoscopic esophagodiverticulostomy. He reported no cases of low morbidity and recurrence rate, along with much more rapid recovery times, supporting the role of cricopharyngeal myotomy as a key step in the evolution of endoscopic esophago-diverticulotomy.



First known published drawings of Zenker's diverticulum from an autopsy performed by Mr. Abraham Ludlow, surgeon, at Bristol, England in 1764. A) Anterior; B) lateral; and C) open anterior views. (Reproduced with permission from the Institute of the History of Medicine, Johns Hopkins University.)

The great leap forward in the general acceptance of endolaryngeal repair of Zenker's diverticulum can be attributed to the endoscopic stapler, introduced separately in 1993 by Martin-Hirsch *et al.* and Collard *et al.* The ability to simultaneously divide and staple the mucosal edges relieved concern about suture-less division of the esophagodiverticular wall.

More importantly, the results achieved with the endoscopic stapler technique were more easily reproduced by other otolaryngologists, resulting in more patients treated endoscopically. Endoscopic stapler-assisted diverticulostomy now represents the first line surgical treatment for Zenker's diverticulum, due to reduced morbidity and shortened operative and recovery times compared with external approaches.



Endoscopic views as sketched by Chevalier Jackson: 1) Zenker's diverticulum with food bolus; 2) Zenker's diverticulum following endoscopic removal of the food bolus; and 3) esophagus following diverticulectomy. (Reprinted from *Bronchoesophagology* and endoscopic plates illustrated by Chevalier Jackson.)

*Abridged from: Evolution of endoscopic surgical therapy for Zenker's Diverticulum. *Laryngoscope* 2009; 119:39-44.)

Clinical Practice Guideline: Acute Otitis Externa

Executive Summary

Richard M. Rosenfeld, MD, MPH; Seth R. Schwartz, MD, MPH; C. Ron Cannon, MD; Peter S. Roland, MD; Geoffrey R. Simon, MD; Kaparaboyna Ashok Kumar, MD, FRCS, FAAFP; William W. Huang, MD, MPH; Helen W. Haskell, MA; Peter J. Robertson, MPA. Corresponding author: Richard M. Rosenfeld, MD, MPH, Department of Otolaryngology, SUNY Downstate Medical Center and Long Island College Hospital, 339 Hicks Street, Brooklyn, NY 11201-5514. Email: richrosenfeld@msn.com.

This month, the American Academy of Otolaryngology—Head and Neck Surgery Foundation (AAO-HNSF) published its first clinical practice guideline update, "Acute Otitis Externa," as a supplement to *Otolaryngology–Head and Neck Surgery*. Recommendations developed address appropriate diagnosis of acute otitis externa (AOE) and the use of oral and topical antimicrobials and highlight the need for adequate pain relief. The guideline was developed using the a priori protocol for guideline updates outlined in the AAO-HNS Clinical Practice Guideline Development Manual.[1] The complete guideline is available at http://oto.sagepub.com.

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

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

Differences from Prior Guideline

This clinical practice guideline is an update and replacement for an earlier guideline published in 2006 by the American Academy of Otolaryngology—Head and Neck Surgery Foundation.[1] Changes in content and methodology from the prior guideline include:

- Addition of a dermatologist and consumer advocate to the guideline development group
- Expanded action statement profiles to explicitly state confidence in the evidence, intentional vagueness, and differences of opinion
- Enhanced external review process to include public comment and journal peer review
- New evidence from 12 randomized, controlled trials and two systematic reviews
- Review and update of all supporting text
- Emphasis on patient education and counseling with new tables that list common questions with clear, simple answers and provide instructions for properly administering ear drops

Introduction

Acute otitis externa (AOE) as discussed in this guideline is defined as diffuse inflammation of the external ear canal, which may also involve the pinna or tympanic membrane. A diagnosis of diffuse AOE requires rapid onset (generally within 48 hours) in the past three weeks of symptoms and signs of ear canal inflammation as detailed in **Table 1**. A hallmark sign of diffuse AOE is tenderness of the tragus, pinna, or both that is often intense and disproportionate to what might be expected based on visual inspection.

AOE is a cellulitis of the ear canal skin and subdermis, with acute inflammation and variable edema. Nearly all (98 percent) AOE in North America is bacterial.[2] The most common pathogens are *Pseudomonas aeruginosa* (20-60 percent prevalence) and *Staphylococcus aureus* (10-70 percent prevalence), often occurring as a polymicrobial infection. Other pathogens are principally Gram negative organisms (other than *P. aeruginosa*), any one of which cause no more than 2-3 percent of cases in large clinical series.[3-10] Fungal involvement is distinctly uncommon in primary AOE, but may be more common in chronic otitis externa or after treatment of AOE with topical, or less often systemic, antibiotics.[11]

The primary outcome considered in this guideline is clinical resolution of AOE, which implies resolution of all presenting signs and symptoms (e.g., pain, fever, otorrhea). Additional outcomes considered include minimizing the use of ineffective treatments; eradicating pathogens; minimizing recurrence, cost, complications, and adverse events; maximizing the health-related quality of life of individuals afflicted with AOE; increasing patient satisfaction;[40] and permitting the continued use of necessary hearing aids. The relatively high incidence of AOE and the diversity of interventions in practice make AOE an important condition for the use of an up-to-date, evidence-based practice guideline.

Purpose

The primary purpose of the original guideline was to promote appropriate use of oral and topical antimicrobials for AOE and to highlight the need for adequate pain relief. An updated guideline is needed because of new clinical trials, new systematic reviews, and the lack of consumer participation in the initial guideline development group. The target patient is aged 2 years or older with diffuse AOE, defined as generalized inflammation of the external ear canal, with or without involvement of the pinna or tympanic membrane. This guideline does not apply to children younger than 2 years or to patients of any age with chronic or malignant (progressive necrotizing) otitis externa. AOE is uncommon before age 2 years, and very limited evidence exists regarding treatment or outcomes in this age group.[41] Although the differential diagnosis of the "draining ear" will be discussed, recommendations for management will be

limited to diffuse AOE, which is almost exclusively a bacterial infection. The following conditions will be briefly discussed, but not considered in detail: furunculosis (localized AOE), otomycosis, herpes zoster oticus (Ramsay Hunt syndrome), and contact dermatitis.

The guideline is intended for primary care and specialist clinicians, including otolaryngologists-head and neck surgeons, pediatricians, family physicians, emergency physicians, internists, nurse-practitioners, and physician assistants. The guideline is applicable to any setting in which children, adolescents, or adults with diffuse AOE would be identified, monitored, or managed.

Key Action Statements

STATEMENT 1. DIFFERENTIAL DIAGNOSIS:

Clinicians should distinguish diffuse AOE from other causes of otalgia, otorrhea, and inflammation of the external ear canal. *Recommendation based on observational studies with a preponderance of benefit over risk.*

Action Statement Profile

- Aggregate evidence quality: Grade C, observational studies and Grade D, reasoning from first principles
- Level of confidence in evidence: High
- Benefit: Improved diagnostic accuracy
- Risks, harms, costs: None in following the recommended action
- Benefits-harm assessment: Preponderance of benefit over harm
- Value judgments: Importance of accurate diagnosis
- Intentional vagueness: None
- Role of patient preferences: None, regarding the need for a proper diagnosis
- Exceptions: None
- Policy level: Recommendation
- Differences of opinion: None

STATEMENT 2. MODIFYING FACTORS:

Clinicians should assess the patient with diffuse AOE for factors that modify management (non-intact tympanic membrane, tympanostomy tube, diabetes, immunocompromised state, prior radiotherapy). *Recommendation based on observational studies with a preponderance of benefit over risk.*

Action Statement Profile

- Aggregate evidence quality: Grade C, observational studies
- Level of confidence in evidence: High
- Benefit: Optimizing treatment of AOE through appropriate diagnosis and recognition of factors or co-morbid conditions that might alter management
- Risks, harms, costs: None from following the recommendation; additional expense of diagnostic tests or imaging studies to identify modifying factors
- Benefits-harm assessment: Preponderance of benefits over harm
- Value judgments: Avoiding complications that could potentially be prevented by modifying the management approach based on the specific factors identified
- Intentional vagueness: None
- Role of patient preferences: None
- Exceptions: None
- Policy level: Recommendation
- Differences of opinion: None

STATEMENT 3. PAIN MANAGEMENT:

The clinician should assess patients with AOE for pain and recommend analgesic treatment based on the severity of pain. *Strong recommendation based on well-designed randomized trials with a preponderance of benefit over harm.*

Action Statement Profile

- Aggregate evidence quality: Grade B, one randomized controlled trial limited to AOE; consistent, well-designed randomized trials of analgesics for pain relief in general
- Level of confidence in evidence: High
- Benefit: Increase patient satisfaction, allow faster return to normal activities
- Risks, harms, costs: Adverse effects of analgesics; direct cost of medication
- Benefits-harms assessment: Preponderance of benefit over harm
- Value judgments: Consensus among guideline development group that the severity of pain associated with AOE is under-recognized; preeminent role of pain relief as an outcome when managing AOE
- Intentional vagueness: None
- Role of patient preferences: Moderate, choice of analgesic and degree of pain tolerance
- Exceptions: None
- Policy level: Strong recommendation
- Differences of opinion: None

STATEMENT 4. SYSTEMIC ANTIMICROBIALS:

Clinicians should not prescribe systemic antimicrobials as initial therapy for diffuse, uncomplicated AOE unless there is extension outside the ear canal or the presence of specific host factors that would indicate a need for systemic therapy. *Strong recommendation based on randomized controlled trials with minor limitations and a preponderance of benefit over harm.*

Action Statement Profile

- Aggregate evidence quality: Grade B, randomized controlled trials with minor limitations; no direct comparisons of topical vs. systemic therapy
- Level of confidence in evidence: High
- Benefit: Avoid side effects from ineffective therapy, reduce antibiotic resistance by avoiding systemic antibiotics
- Risks, harms, costs: None
- Benefits-harms assessment: Preponderance of benefit over harm
- Value judgments: Desire to decrease the use of ineffective treatments, societal benefit from avoiding the development of antibiotic resistance
- Intentional vagueness: None

Acute Otitis Externa: Danger of Using Ototoxic Topical Drops

Adapted from Key Action Statement 7 of the CPG on Acute Otitis Externa
Sujana S. Chandrasekhar, MD

In the patient with acute otitis externa, if the tympanic membrane is known or suspected to be non-intact (including with the presence of a tympanostomy tube), topical drops that contain alcohol, have a low pH, or both should be AVOIDED because of pain and potential ototoxicity. Substances with ototoxic potential (e.g., aminoglycosides, alcohol) should NOT be utilized when the tympanic membrane is perforated and the middle ear space is open, because the risk of ototoxic injury outweighs the benefits compared to non-ototoxic antimicrobials with equal efficacy.

The potential danger from administering an ototopical drop into the middle ear is the risk of its components reaching, and then crossing through, the round window membrane to affect the inner ear. Ototoxic antibiotics are used appropriately, for example, in Meniere's disease, for their ability to cross the RWM and enter the cochlea and vestibule. The potential ototoxicity of such agents includes permanent SNHL and disequilibrium, and informed consent precedes that intervention.

Clinical experience with topical ototoxic antibiotics in patients with tympanic membrane perforation suggests that hearing loss does not occur after a single short course of therapy; however, severe hearing loss has been observed after prolonged or repetitive administration of topical drops. There may be middle ear mucosal inflammation during the initial phase of AOE treatment in the case of the non-intact TM; as that swelling diminishes, the round window membrane actually becomes more accessible, and therefore the inner ear becomes potentially more susceptible to the deleterious effects of the ototoxic agents.

Clinicians are advised to carefully evaluate the patient with AOE for presence of non-intact tympanic membrane by obtaining a thorough history and performing a comprehensive ear examination, including tympanometry as needed. Most tympanostomy tubes remain in the tympanic membrane for at least six to 12 months; therefore a patent tube should be assumed in that time frame, unless documented otherwise. Tubes may, of course, remain functional for three years or longer. Individuals who taste medicines placed into their ear, or who can expel air out of their ear canal by pinched nose blowing, can be assumed to have a perforation.

The only topical antimicrobials approved by the FDA (December 2005) for middle ear use are quinolone drops. Additionally, there is an explicit warning by the manufacturer that neomycin/polymyxin B/hydrocortisone should NOT be used with a non-intact tympanic membrane, and that warning cites explicitly the risk of permanent SNHL with its use.

It is reiterated, therefore: when treating a patient with acute otitis externa, obtain a focused history and perform an otological examination that will, in addition to defining the AOE, determine the status of the tympanic membrane. If you know or suspect that there is a TM perforation or PE tube, do NOT use ototoxic eardrops.

The evidence supporting this is level D with a moderate level of confidence in the evidence.

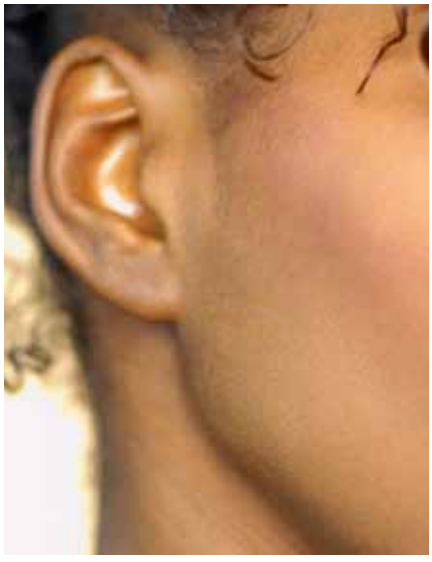
- Role of patient preferences: None
- Exceptions: None
- Policy level: Strong recommendation
- Differences of opinion: None

STATEMENT 5. TOPICAL THERAPY:

Clinicians should prescribe topical preparations for initial therapy of diffuse, uncomplicated AOE.
Recommendation based on randomized trials with some heterogeneity and a preponderance of benefit over harm.

Action Statement Profile

- Aggregate evidence quality: Grade B, meta-analyses of randomized controlled trials with significant limitations and heterogeneity
- Level of confidence in evidence: High for the efficacy of topical therapy as initial management, but low regarding comparative benefits of different classes of drugs or combinations of ototopical drugs
- Benefit: Effective therapy, low incidence of adverse events
- Risks, harms, costs: Direct cost of medication (varies greatly depending on drug class and selection), risk of secondary fungal infection (otomycosis) with prolonged use of topical antibiotics
- Benefits-harms assessment: Preponderance of benefit over harm
- Value judgments: Randomized clinical trials results from largely specialty settings may not be generalizable to patients seen in primary care settings, where the ability to perform effective aural toilet may be limited
- Intentional vagueness: No specific recommendations regarding the choice of ototopical agent
- Role of patient preferences: Substantial role for patient preference in choice of topical therapeutic agent
- Exceptions: Patients with a non-intact tympanic membrane (see Statement No. 7, Non-intact tympanic membrane)
- Policy level: Recommendation
- Differences of opinion: None



STATEMENT 6. DRUG DELIVERY:

The clinician should enhance the delivery of topical drops by informing the patient how to administer topical drops and by performing aural toilet, placing a wick, or both, when the ear canal is obstructed.
Recommendation based on observational studies with a preponderance of benefit over harm.

Action Statement Profile

- Aggregate evidence quality: Grade C, observational studies and Grade D, first principles
- Level of confidence in evidence: High
- Benefit: Improved adherence to therapy and drug delivery
- Risks, harms, costs: Pain and local trauma caused by inappropriate aural toilet or wick insertion; direct cost of wick (inexpensive)
- Benefits-harms assessment: Preponderance of benefit over harm
- Value judgments: Despite an absence of RCTs demonstrating a benefit of aural toilet, the guideline development group agreed that cleaning was appropriate, when necessary, to improve penetration of the drops into the ear canal
- Intentional vagueness: None
- Role of patient preferences: Choice of self-administering drops vs. using assistant
- Exceptions: None
- Policy level: Recommendation
- Differences of opinion: None

STATEMENT 7. NON-INTACT TYMPANIC MEMBRANE:

When the patient has a known or suspected perforation of the tympanic membrane, including a tympanostomy tube, the clinician should prescribe a non-ototoxic topical preparation.
Recommendation based on reasoning from first principles and on exceptional circumstances where validating studies cannot be performed with a preponderance of benefit over harm.

Action Statement Profile

- Aggregate evidence quality: Grade D, reasoning from first principles, and Grade X, exceptional situations where validating studies cannot be performed
- Level of confidence in evidence: Moderate, because of extrapolation of data from animal studies and little direct evidence in patients with AOE
- Benefit: Reduce the possibility of hearing loss and balance disturbance
- Risk, harm, cost: Eardrops without ototoxicity may be more costly
- Benefits-harms assessment: Preponderance of benefit over harm
- Value judgments: Importance of avoiding iatrogenic hearing loss from a potentially ototoxic topical preparation when non-ototoxic alternatives are available; placing safety above direct cost
- Intentional vagueness: None
- Role of patient preferences: None
- Exceptions: None
- Policy level: Recommendation
- Differences of opinion: None

STATEMENT 8. OUTCOME ASSESSMENT:

The clinician should reassess the patient who fails to respond to the initial therapeutic option within 48-72 hours to confirm the diagnosis of diffuse AOE and to exclude other causes of illness.
Recommendation based on observational studies and a preponderance of benefit over harm.

Action Statement Profile

- Aggregate evidence quality: Grade C, outcomes from individual treatment arms of randomized controlled trials of efficacy of topical therapy for AOE

- Level of confidence in evidence: Medium, because most randomized trials have been conducted in specialist settings and the generalizability to primary care settings is unknown
- Benefit: Identify misdiagnosis and potential complications from delayed management; reduce pain
- Risks, harms, costs: Cost of reevaluation by clinician
- Benefits-harms assessment: Preponderance of benefit over harm
- Value judgments: None
- Intentional vagueness: Time frame of 48 to 72 hours is specified since there are no data to substantiate a more precise estimate of time to improvement
- Role of patient preferences: None
- Exceptions: None
- Policy level: Recommendation
- Differences of opinion: None

Disclaimer

This clinical practice guideline is provided for information and education purposes only. It is not intended as a sole source of guidance in managing patients with acute otitis externa. Rather, it is designed to assist clinicians by providing an evidence-based framework for decision-making strategies. This guideline is not intended to replace clinical judgment or establish a protocol for all individuals with this condition and may not provide the only appropriate approach to diagnosis and management.

As medical knowledge expands and technology advances, clinical indicators and guidelines are promoted as conditional and provisional proposals of what is recommended under specific conditions, but they are not absolute. Guidelines are not mandates; these do not and should not purport to be a legal standard of care. The responsible physician, in light of all the circumstances presented by the individual patient, must determine the appropriate treatment. Adherence to these guidelines will not ensure successful patient outcomes in every situation. The AAO-HNS, Inc. emphasizes that these clinical guidelines should not be deemed inclusive of all proper treatment decisions or methods of care, nor exclusive of other treatment decisions or methods of care reasonably directed to obtaining the same results.

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Table 1. Elements of the diagnosis of diffuse acute otitis externa

1. Rapid onset (generally within 48 hours) in the past 3 weeks, AND…
2. Symptoms of ear canal inflammation, which include: otalgia (often severe), itching, or fullness, WITH OR WITHOUT hearing loss or jaw pain*, AND…
3. Signs of ear canal inflammation, which include: tenderness of the tragus, pinna, or both OR diffuse ear canal edema, erythema, or both WITH OR WITHOUT otorrhea, regional lymphadenitis, tympanic membrane erythema, or cellulitis of the pinna and adjacent skin

*Pain in the ear canal and temporomandibular joint region intensified by jaw motion.

Table 2. Summary of Evidence-Based Statements.

Statement	Action	Strength
1. Differential Diagnosis	Clinicians should distinguish diffuse AOE from other causes of otalgia, otorrhea, and inflammation of the external ear canal.	Recommendation
2. Modifying Factors	Clinicians should assess the patient with diffuse AOE for factors that modify management (non-intact tympanic membrane, tympanostomy tube, diabetes, immunocompromised state, prior radiotherapy)	Recommendation
3. Pain Management	The clinician should assess patients with AOE for pain and recommend analgesic treatment based on the severity of pain.	Strong recommendation
4. Systemic Antimicrobials	Clinicians should not prescribe systemic antimicrobials as initial therapy for diffuse, uncomplicated AOE unless there is extension outside the ear canal or the presence of specific host factors that would indicate a need for systemic therapy.	Strong recommendation
5. Topical Therapy	Clinicians should use topical preparations for initial therapy of diffuse, uncomplicated AOE.	Recommendation
6. Drug Delivery	The clinician should inform patients how to administer topical drops and should enhance delivery of topical drops when the ear canal is obstructed by performing aural toilet, placing a wick, or both.	Recommendation
7. Non-intact Tympanic Membrane	When the patient has a known or suspected perforation of the tympanic membrane, including a tympanostomy tube, the clinician should recommend a non-ototoxic topical preparation.	Recommendation
8. Outcome Assessment	If the patient fails to respond to the initial therapeutic option within 48-72 hours the clinician should reassess the patient to confirm the diagnosis of diffuse AOE and to exclude other causes of illness.	Recommendation

Table 3. Common topical otic preparations approved by the FDA for treating diffuse AOE

Active drug(s)	Name	Bottle size, ml	Cost, US$* Trade	Cost, US$* Generic
acetic acid 2.0% solution	Acetic acid otic (generic)	15.0	—	33
acetic acid 2.0%, hydrocortisone 1.0%	Acetasol HC (generic)	10.0	—	23
ciprofloxacin 0.2%, hydrocortisone 1.0%	Cipro HC (trade)	10.0	170	—
ciprofloxacin 0.3%, dexamethasone 0.1%	Ciprodex (trade)	7.5	144	—
neomycin, polymyxin B, hydrocortisone	Cortisporin Otic (trade)	10.0	85	30
ofloxacin 0.3%	Floxin Otic (trade)	5.0	76	18

*Approximate price in New York metropolitan region

Table 4. Patient information for topical therapy of acute otitis externa (AOE)

Frequently asked question	Answer
Are eardrops alone sufficient to treat my infection or do I also need to take an antibiotic by mouth?	Eardrops alone are the most effective treatment for AOE and may contain antibiotics, antiseptics, steroids, or a combination. Antibiotics taken by mouth do not kill most germs that cause AOE and should be used only when infection spreads beyond the ear canal, eardrops cannot get into the ear, or the immune system is weak.
Which eardrop is best for treating my ear infection?	All eardrops approved for treating AOE (Table 5) are highly effective with no consistent advantage shown for any one specific drug.
If all eardrops are equally effective why do doctors prescribe different ones?	Your doctor will discuss with you the reasoning behind his or her eardrop recommendation, but some of the factors considered include cost, dosing frequency, status of the eardrum, and the doctor's experience. Your opinion and preferences should also factor into this decision.
Is there anything I should be sure to tell my doctor that might help in deciding which eardrop is best?	Let your doctor know if you had any prior ear surgery, if there is an opening (hole or perforation) of the eardrum, or if an ear tube is in place. If one or more of these conditions apply then your doctor will need to use an eardrop that is approved for use in the middle ear, just in case some of it gets past the eardrum. Also let your doctor know if you have recently used other ear products or medications, or if you have had a reaction in the past to a particular eardrop or antibiotic. Last, tell your doctor if you have, or are suspected to have, diabetes, since this could alter management.
Once I start using the eardrops how long should it take until I feel better?	Most people feel better within 48 to 72 hours and have minimal or no symptoms by seven days. Notify your doctor if your pain or other symptoms fail to respond within this time frame.
If it usually takes at least 48 hours to feel better from the eardrops what should I do for earlier relief?	Pain medicine is especially important to use for relief in the first few days, until the eardrops begin working. Discuss with your doctor which pain medicines are best for you. Pain-relieving (anesthetic) eardrops are not recommended because they are not intended for use during an active ear canal infection and can mask symptoms of a delayed response to therapy.
For how long will I need to use the eardrops?	Eardrops should be used for at least 7 days, even if you feel better sooner, to prevent relapse of infection. If symptoms persist beyond 7 days you should notify your doctor and continue the drops until the symptoms resolve for a maximum of 7 additional days.
Are there any activity restrictions or special precautions that will help my ear recover faster?	Avoid scratching or touching the ear and do not insert anything into the ear canal, including cotton-tipped swabs. Cover the opening of the ear canal with an earplug or cotton (with petroleum jelly) prior to showering or hair washing to minimize water entry. Check with your doctor regarding swimming or other water activities that may take place during, or soon after, your infection.
Do eardrops have side effects that I should be aware of?	Eardrops are, in general, very safe and well tolerated. Some people report local rash, itching, irritation, or discomfort, but it is rarely bad enough to require stopping the medication. If you taste the eardrops it means there is likely a hole or perforation of the eardrum, so inform your doctor (if you have not already done so). Also call your doctor if the drops become painful or you develop unexpected symptoms.

(See Table 5 on page 18)

David R. Nielsen, MD, Embarks on a Robust Final Year as EVP/CEO

David R. Nielsen, MD, will complete his tenure as Executive Vice President and CEO of the American Academy of Otolaryngology—Head and Neck Surgery and its Foundation, as planned, at the end of his contract in January 2015.

"Even though I have remained in this position a little longer than I originally intended, I am continually impressed by the wealth of leadership within our membership that rises each year to the challenges of an evolving and often uncertain health care environment," Dr. Nielsen said.

"My goal is to ensure that we keep up the pace of improvement and leadership in the federation of medicine this year and to continue to help our members do what they care most about—providing the finest patient care possible."

Dr. Nielsen has served as the EVP and CEO for 12 years, completing two contract terms and agreeing in 2011 to a third and final three-year extension.

"The vision David brought to AAO-HNS/F, early in his tenure shifting its culture to one more responsive to current challenges, now increasingly emphasizes research and quality improvement. This focus is preparing our organization for the critical challenges and opportunities that face us including healthcare reform, with its attendant quality-driven changes in physician payment, and the critical need for the integration of education and research," said Richard W. Waguespack, MD, AAO-HNS/F president.

"We are fortunate to have benefitted from his prescient leadership and look forward to working with him this year as we prepare for a transition in the EVP/CEO position."

The research and quality agenda over the past decade has focused on empowering physicians to provide the best patient care through the development of evidence-based guidance, identifying tools, services, and processes that contribute to the advancement of the field of otolaryngology-head and neck surgery and fundamentally to improved patient outcomes. "Our transition will be smooth and positive, and members and their patients will experience continued exceptional value," Dr. Nielsen said.

A search task force has been formed and an announcement of the search for a new Executive Vice President/CEO will be made in March 2014.

(Continued from "Guideline" page 17)

Table 5: Instructions for Patients

• If possible get someone to put the drops in the ear canal for you.
• Lie down with the affected ear up. Put enough drops in the ear canal to fill it up.
• Once the drops are in place, stay in this position for three to five minutes. Use a timer to help measure the time. It is important to allow adequate time for the drops to penetrate into the ear canal.
• A gentle to-and-fro movement of the ear will sometimes help in getting the drops to their intended destination. An alternate method is to press with an in/out movement on the small piece of cartilage (tragus) in front of the ear.
• You may then get up and resume your normal activities. Wipe off any excess drops.
• Keeping the ear dry is generally a good idea while using eardrops.
• Try not to clean the ear yourself as the ear is very tender and you could possibly damage the ear canal or even the eardrum.
• If the drops do not easily run into the ear canal you may need to have the ear canal cleaned by your clinician or have a wick placed in the ear canal to help in getting the drops into the ear canal.
• If you do have a wick placed, it may fall out on its own. This is a good sign as it means the inflammation is clearing and the infection subsiding.
• Do not remove the wick yourself unless instructed to do so.

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Kids E.N.T. Health Month: Child Health Disparities

Emily F. Boss, MD, MPH
Assistant Professor, Otolaryngology - Head and Neck Surgery
Johns Hopkins University School of Medicine

Introduction: Focus on Health Disparities

A health disparity may be defined as "an inequitable difference between groups in health, healthcare, and developmental outcomes that are potentially systematic and avoidable." Every year in the United States, thousands of children experience disparities in healthcare access and utilization resulting in worse overall health status and outcomes. While many factors contribute to these disparities, socioeconomic status, race, and ethnicity are key influential social determinants. Disparities related to socioeconomic status include factors such as parental education, health literacy, insurance status, household income, access to transportation, and availability of social/familial support structures such as childcare. Disparities related to race and ethnicity may arise from cultural beliefs about disease and doctors, language differences, and historical discrimination. Provider factors may create further barriers to care of children, including issues with qualifications and experience with the care of medically complex children, or non-acceptance of certain insurance programs such as Medicaid. In general, children from low-income families and racial or ethnic minorities experience increased morbidity and disability compared to children who are white or more affluent. Moreover, parents of children from lower income environments are more likely to report poor communication with health providers.

Case Studies in Pediatric Otolaryngology: Sleep and Hearing

Because ear, nose, and throat conditions are so common in children, it is no surprise that a number of disease-specific disparities have been demonstrated in the care of children with otolaryngologic disease. One key example considers variation related to diagnosis and treatment of sleep-disordered breathing (SDB) in children. SDB affects 5 percent to 20 percent of U.S. children and occurs even more frequently in children with co-morbid conditions such as Trisomy 21 and obesity. Race and ethnicity may influence the risk of SDB in children. Indeed, SDB has been found to be more common in African-American children and Hispanic children compared with white children. Likewise, children in families of low socioeconomic status appear to be at increased risk for SDB. Some proposed explanations for these differences include factors such as household crowding in low-income homes, dietary influences, increased prevalence of obesity among certain racial and ethnic subgroups, higher exposure to secondhand smoke, or increased risk of upper respiratory infections.

Prompt diagnosis and treatment of SDB in vulnerable children is extremely important, particularly with the increased risk for minority children to suffer comorbid conditions such as obesity, neurocognitive delays, and behavioral problems such as Attention Deficit Hyperactivity Disorder. Although one might anticipate higher rates of adenotonsillectomy to treat SDB, which is often seen in at-risk or minority children, this trend has not been observed, perhaps because vulnerable subgroups of children may experience barriers to

otolaryngic care, even with insurance coverage. Moreover, the wide variation in tonsillectomy rates across U.S. geographic regions calls into question the effects of differences in healthcare delivery systems and insurance plans across the country. Efforts to reduce disparities related to evaluation and treatment of pediatric SDB may potentially include standardization of clinical protocols across regions, expanded coverage and access for children with public or no insurance, and application of shared decision-making to reduce unwarranted variation and promote appropriate use of adenotonsillectomy.

Health disparities are also evident for children with hearing loss, where hearing services are limited for children from racial, ethnic, and socioeconomic minorities. For example, proportionately higher rates of cochlear implantation are observed in children who live in areas with high median income and in children who are white or Asian compared to other minority counterparts. Children from low socioeconomic strata display poorer speech and language outcomes following implantation. Families of hearing-impaired children live closer to the poverty level and more frequently are insured by Medicaid. Additionally, low socioeconomic status is a risk factor for otitis media with effusion. Multiple barriers may contribute to these health disparities experienced by children with hearing loss, including communication hurdles, medical costs for diagnosis, medical visits for audiologic evaluation, fitting of hearing aids, care of associated external and middle ear problems, and costs of assistive devices. Both monetary costs and time commitments related to special education services, speech and language pathologists, and interpreters may also augment health disparities related to hearing loss.

The Role of Access

The presence of health insurance is a key factor for promotion of improved health status and access to routine healthcare. Children of racial minorities and children from low socioeconomic strata are more likely to experience reduced healthcare coverage and access to care. In 2011, about 16.1 million (22 percent) of U.S. children younger than 17 years old lived in poverty, 39 percent of children were covered by public health insurance, and 7 million children were uninsured. Hispanic children were less likely to have health insurance (85 percent insured) compared to non-Hispanic white (93 percent insured) or black (90 percent insured) children. Even when children do have health insurance coverage, true access may limit referrals to otolaryngologic care. Research on access to specialty care found that in one community 31 percent of patients with public insurance were not offered otolaryngology appointments, and for clinics that accepted all insurance types, children with public insurance waited on average 53 days for an appointment compared with an average of six days for privately-insured children. In another community, less than 20 percent of otolaryngologists were willing to perform tonsillectomy on children with publicly funded insurance due to administrative and financial burdens placed on their practices. Although the Affordable Care Act will expand Medicaid coverage for children, it remains to be seen whether improved access to otolaryngologic and other specialty care will follow.

Working to Reduce Disparities

Although tracking and establishing the variations in healthcare access and utilization across child subgroups in otolaryngology is important, reducing these disparities in care and improving outcomes for vulnerable children is a separate challenge. The Department of Health and Human Services "Healthy People" program has made reducing disparities and achieving health equity a major goal during the past two decades. Our specialty is charged with studying the unique characteristics of our specific patient population, our specialty disease patterns and variation, and local practice/health system limitations in order to best design strategies to promote equitable otolaryngic healthcare for children of all backgrounds. Some potentially fruitful interventions may include construction of innovative educational programs targeting rural and inner city pediatricians, which focus on common conditions such as SDB and hearing loss; creation of policies which improve reimbursement to otolaryngologists serving areas where access for at-risk children is limited; development of outreach programs initiated by larger health organizations to provide greater regional otolaryngic care; design of health educational materials which are applicable to parents of all levels of health literacy; and conception of formalized programs educating otolaryngology providers on use of culturally-competent communication strategies with patients.

Pediatric Patient Resources

Go to http://www.entnet.org/HealthInformation/pediatric.cfm to link to these topics

Children face many of the same health problems that adults do, however symptoms may show themselves differently and treatment methods that work well in adults may not be appropriate for children. This topic listing identifies common pediatric ENT, head, and neck ailments and what you may offer patients.

Bell's Palsy
Children's Hearing Health
Child's Hearing Loss
Choking Campaign
El Humo del Tabaco Ambiental y los Niños
Facial Sports Injuries
Fact Sheet: Allergic Rhinitis (Hay Fever)
Fact Sheet: Child Screening
Fact Sheet: Children and Facial Trauma
Fact Sheet: Cochlear-Meningitis Vaccination
Fact Sheet: How Allergies Affect your Child's Ears, Nose, and Throat
Fact Sheet: Laryngopharyngeal Reflux and Children
Fact Sheet: Noise-Induced Hearing Loss in Children
Fact Sheet: Pediatric Food Allergies
Fact Sheet: Pediatric GERD (Gastro-Esophageal Reflux Disease)
Fact Sheet: Pediatric Obesity and Ear, Nose, and Throat Disorders
Fact Sheet: Pediatric Sleep Disordered Breathing/Obstructive Sleep Apnea
Fact Sheet: Pediatric Thyroid Cancer
Fact Sheet: The Necessity of Early Intervention in Hearing
Fact Sheet: When Your Child Has Tinnitus
Hearing Loss and Ear Infection
Pediatric Sinusitis
Post-Tonsillectomy Analgesia Article
Post-Tonsillectomy Analgesia, an Old Problem Revisited
Reduced Choking Risks fact sheet
Research Gaps-Pediatrics
Second Hand Smoke and Children
Spotlight on Patient Safety

Social Network

Get social for Kid's ENT Month and help raise awareness! Visit www.entnet.org/facebook andwww.entnet.org/twitter for special Kid's ENT Month posts that you can share with your patients.

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Otitis Media, Tympanostomy Tubes, and Clinical Practice Guidelines from 2013

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In 2013, both the American Academy of Pediatrics (AAP) and the American Academy of Otolaryngology—Head and Neck Surgery Foundation (AAO-HNSF) published clinical practice guidelines (CPGs) that address the management of recurrent acute otitis media (AOM) and otitis media with effusion (OME), including treatment with tympanostomy tubes. In the table below we compare and contrast the different CPGs so clinicians can better understand the recommendations made by these two organizations.

Condition	CPG	Key Action Statement	Discussion Points
RECURRENT ACUTE OTITIS MEDIA (AOM)	**AAP** Clinical Practice Guideline on Acute Otitis Media1	Clinicians MAY offer tympanostomy tubes for recurrent AOM (three episodes in six months or four episodes in one year with one episode in the preceding six months).	This is considered an "option" for treatment of recurrent AOM. Most AOM guidelines before 2013 did not contain statements about tympanostomy tubes for recurrent AOM.
	AAO-HNSF Clinical Practice Guideline on Tympanostomy Tubes in Children[2]	Clinicians SHOULD NOT perform tympanostomy tube insertion in children with a history of recurrent acute otitis media who do not have a middle ear effusion in at least one ear at the time of evaluation.	Children in the control groups of antibiotic prophylaxis trials for prevention of AOM did not have middle ear effusions at trial entry and did have a favorable natural history, with most children experiencing less than two infections during the study period. Children with a history of recurrent AOM and a normal examination at presentation perhaps are "over-diagnosed," given the known difficulties of diagnosis of AOM in young children.
		Clinicians SHOULD offer tympanostomy tube insertion in children with history of recurrent AOM who have middle ear effusion in one or both ears at the time of evaluation.	Trials that did not exclude children with middle ear effusion suggest a modest reduction in number of episodes of AOM after tympanostomy tubes. While reduction of episodes of AOM is the primary goal, tympanostomy tubes may reduce pain during episodes of acute otitis media and can allow treatment of otorrhea with ototopical antibiotics.
OTITIS MEDIA WITH EFFUSION (OME)	**AAO-HNSF** Clinical Practice Guideline on Tympanostomy Tubes in Children[2]	Clinicians SHOULD NOT perform tympanostomy tube insertion in children with a single episode of OME of less than three months' duration, from the date of onset (if known) or from the date of diagnosis (if onset is unknown).	Short-term effusions can occur after viral infection or AOM and often resolve without therapy.
		Clinicians SHOULD offer tympanostomy bilateral tube insertion to children with bilateral OME for three months or longer AND documented hearing difficulties.	Hearing difficulties may include abnormal audiometry and other functional assessments of hearing status.
		Clinicians MAY perform tympanostomy tube insertion in children with unilateral or bilateral OME for three months or longer (chronic OME) AND symptoms that are likely attributable to OME that include, but are not limited to, balance (vestibular) problems, poor school performance, behavioral problems, ear discomfort, or reduced quality of life.	Otitis media with effusion can be associated with symptoms and conditions such as dysequilibrium, behavioral problems, and otalgia. Placement of tympanostomy tubes has been shown to improve disease-specific quality of life measures.
		Clinicians MAY perform tympanostomy tube insertion in at-risk children with unilateral or bilateral OME that is unlikely to resolve quickly as reflected by a type B (flat) tympanogram or persistence of effusion for three months or longer.	Tubes are an option for "at risk" children with OME and type B tympanograms. Who are these "at risk" children? 1) Children who likely will have increased consequence of the hearing and other effects of otitis media, and those where otitis media is unlikely to resolve. 2) "At risk" group includes children with: underlying hearing loss not from OME, speech-language delays, autism and other pervasive developmental disorders, craniofacial syndromes that include cognitive and communication delays, visual impairment, cleft palate, other developmental delays. "At risk" children are rarely included in otitis media trials, yet they may have greater need for interventions such as tympanostomy tubes.
CARE ISSUES FOR CHILDREN WITH TYMPANOSTOMY TUBES	**AAO-HNSF** Clinical Practice Guideline on Tympanostomy Tubes in Children[2]	Clinicians SHOULD prescribe topical antibiotic eardrops only, without oral antibiotics, for children with uncomplicated acute tympanostomy tube otorrhea.	This strong recommendation is made as ototopical drops have increased efficacy, treat organisms such as Pseudomonas aeruginosa and Staphylococcus aureus, and have few side effects. Children with complicated otorrhea, cellulitis of the ear, other bacterial infection such as sinusitis or pharyngitis, and children with impaired immune status may require systemic antibiotics when otorrhea occurs after tympanostomy tubes.
		Routine, prophylactic water precautions SHOULD NOT be encouraged for children with tympanostomy tubes.	Evidence from clinical trials shows no benefit or trivial clinical benefit from routine water precautions. Some children with tubes may benefit from water precautions in specific situations (lake swimming, deep diving, history of recurrent otorrhea, head dunking during bathing, or otalgia with water entry into the ear canal).

Hot Topics and Slow (or No) Action: An Election Year Federal Legislative Update

The mid-term election year is upon us. So, what does that mean for our federal legislative priorities? Most election years promise to deliver a lighter-than-usual legislative schedule for lawmakers, and a general downtick in activity on the issues important to the specialty. While we already know the scheduling of fewer legislative days will remain true, the amount of activity and/or issue-specific dialogue for this year remains somewhat of a wildcard. Why, you ask? The bumpy rollout of Healthcare.gov during the last several months of 2013 has left a lasting spotlight on the ongoing implementation of the Affordable Care Act (ACA) and health-related issues in general. As a result, these issues are likely to remain prominent, if not the most critical issues discussed leading up to November's mid-term elections. Read on for a brief overview of where our key legislative priorities may "register" in the ongoing dialogue.

Medicare Physician Payment

Repeal of the flawed Sustainable Growth Rate (SGR) formula used to determine payments to physicians in the Medicare system acted as a vacuum in 2013, dominating much of the legislative focus for the year. Despite these efforts, the fate of SGR-related legislation remained in flux as late as mid-December. However, hurried action by the Senate Finance and the House Ways & Means Committees resulted in the advancement of SGR repeal legislation prior to Congress adjourning for the holidays. In addition, language was included in the year-end budget agreement to temporarily (for three months) halt the scheduled SGR cuts and instead replace the payment reduction with a .5 percent increase. This payment "bridge" was largely put in place to provide additional time for lawmakers to further refine permanent SGR repeal/replacement legislation and identify the necessary offsets. Therefore, the SGR will remain a key policy issue this year. If Congress succeeds in repealing the SGR formula, the implementation of a new payment policy program will trigger a flurry of activity regarding the implementation of the new programs that many physicians—particularly surgeons—may have difficulty participating in. On the other hand, failure to repeal the SGR formula will "punt" a major—and costly—issue into an election year where fiscal policy will draw increased scrutiny.

Audiology Direct Access

Expect to hear a lot about "direct access" and general audiology-related issues this year. As reported in 2013, each of the respective audiology groups has been pursuing their own specific legislative initiatives. Based on current "intel," it is highly likely that each group's proposal will be introduced as legislation by early spring, at the latest. Notwithstanding the issue's importance to our particular organization, we generally expect discussion regarding scope-of-practice issues to increase in the coming months/year. As more Americans obtain health insurance via the mandate in the ACA, some lawmakers view the expansion of services (by various non-physician providers) as a key means to mitigate assumed access-to-care issues. The AAO-HNS continues to support a physician-led, team-based approach to patient care.

IPAB Repeal

Repeal of the Independent Payment Advisory Board (IPAB) remains a top legislative priority for the AAO-HNS. In the last several months of 2013, Rep. Phil Roe, MD (R-TN), the lead sponsor of a bill to repeal the IPAB (H.R. 351), doubled efforts to obtain cosponsors on his legislation. As part of this push, various physician organizations, including the AAO-HNS, will be reaching out to past cosponsors and "newer" Members of Congress. The ultimate goal is to garner more than 218 cosponsors of H.R. 351, and to continue urging Congressional leaders to allow a "clean" vote on the legislation.

Truth-in-Advertising

While the "TIA" issue may not emerge as prominently as the SGR or scope-of-practice issues, the efforts of the AAO-HNS and others in the TIA coalition will increase this year to garner support for H.R. 1427, the "Truth in Healthcare Marketing Act of 2013." Our goal is to further expand the cosponsor list and elevate the general awareness in Congress of this important legislation, as well as seek the introduction of a Senate "companion" bill.

Medical Liability Reform

The AAO-HNS continues to advocate for the implementation of substantive medical liability reforms. However, in the current hyper-partisan (and political) environment on Capitol Hill, it remains difficult to gain traction on broad liability legislation. However, the appetite for more targeted liability efforts may be increasing, and the potential cost-savings available through these efforts could be included in the election-year rhetoric.

Funding for Graduate Medical Education

The protection (and hoped for) increase in funding for GME remains a legislative quandary. Lawmakers tend to agree that the pipeline of physicians in training should be as robust as possible. However, that fact has not prevented cuts to existing GME funds from being regularly included in "offset" packages for various large legislative proposals. This year, it is possible that dialogue regarding the general funding mechanisms for GME will become woven into larger conversations about the overall healthcare delivery system.

The bottom line is that while 2014 may not be a rich legislative year, it could become an action-packed discussion year, with many AAO-HNS priorities addressed and/or referenced in the context of broader healthcare-related election year dialogue. For more information regarding AAO-HNS federal legislative priorities, email legfederal@entnet.org.

On the Frontlines: State Legislative Tracking

The 2014 state legislative sessions are in high gear, and a number of the specialty's priorities are being debated by state lawmakers. AAO-HNS members are a key resource for tracking state legislation and communicating to policymakers its influence on the specialty, physician practices, and patients. Join the growing team of AAO-HNS state trackers by emailing 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 (TIA) initiatives, and efforts to repeal the Independent Payment Advisory Board (IPAB). Not a fan of Twitter? You can also check the Government Affairs webpage for updates at http://www.entnet.org/Advocacy.

ENT PAC

2014 is an election year for Congress. ENT PAC, the political action committee of the AAO-HNS, financially supports federal Congressional candidates and incumbents who help and/or 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).

www.entnet.org/Practice/Position-Statements.cfm

UPDATED

Take Advantage of Academy Position Statements

Need help responding to payer denials or providing supporting documentation for procedures? Need help with advocacy efforts? Want clarification on Academy positions within the specialty? If you answered yes to any of these questions, consider our Position Statements housed on the Academy website. These useful tools outline a statement, policy or declaration of the Academy on a particular issue or topic. For example:

- Allergy
- Point-of-Care Imaging in Otolaryngology
- Laryngopharyngeal Reflux

Visit our website for a full list of the available Position Statements.

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When Do I-GO?

With the release of the 2014 Congressional calendar, it is clear Members of Congress will have plenty of time at home to interact with their constituents and potential voters. Act now to schedule an in-district legislative meeting or host a lawmaker at your practice, and help make the AAO-HNS In-district Grassroots Outreach (I-GO) program a success in the New Year! For more information, email the AAO-HNS Government Affairs team at govtaffairs@entnet.org.

2014 House Calendar

January

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Federal Holidays 2014

Jan .1st	New Year's Day	May 26th	Memorial Day	Oct. 13th	Columbus Day	Dec. 25th	Christmas Day
Jan. 20th	Martin Luther King Day	July 4th	Independence Day	Nov. 11th	Veterans Day		
Feb. 17th	President's Day	Sept. 1st	Labor Day	Nov. 27th	Thanksgiving Day		

Highlighted areas denote Congressional recess dates

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"Just because you do not take an interest in politics doesn't mean politics won't take an interest in you."
—Pericles (430 B.C.)

In an effort to assist AAO-HNS members in the voting process, the Academy has compiled a few helpful voting resources for 2014. If you have any questions about an election in your area, please email govtaffairs@entnet.org.

www.canivote.org
- Am I registered to vote?
- Where do I vote?
- When is the next election?
- Do I need identification to vote?

www.entnet.org/elections
- Where can I find more information on candidates?
- How are these candidates on physician issues, particularly legislation important to the specialty?
- Who are my Members of Congress?

www.entpac.org
- How can I support physician-friendly candidates?
- How can my political contribution have a greater impact?

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The Art of Balance

Rahul K. Shah, MD
George Washington University School of Medicine
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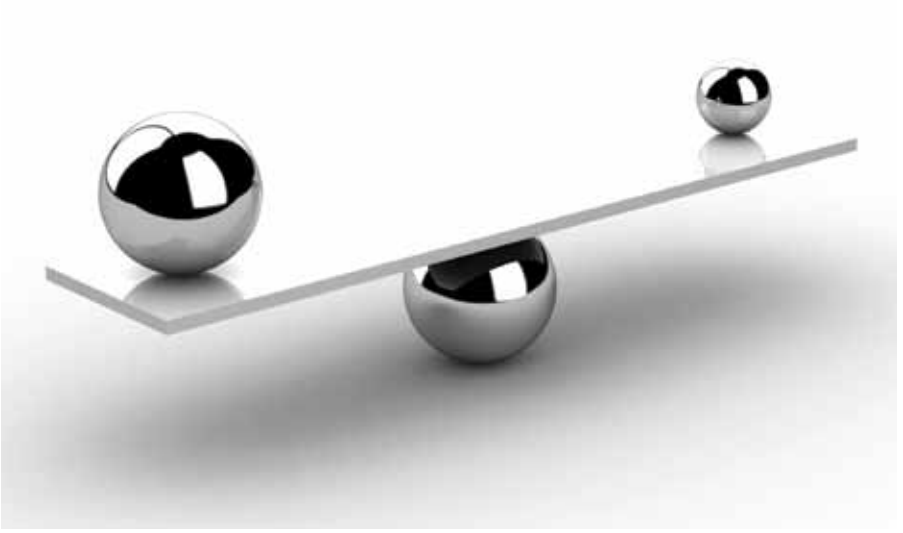


My hospital is making me see more patients and is going to penalize me financially for not achieving a patient satisfaction goal of more than 90 percent where patients rate me as "very good"! —AAO-HNS member

The email I received from the Academy member above succinctly juxtaposes the competing demands that clinicians are currently facing: increasing volumes (in the face of declining reimbursement) and improving patient satisfaction. Many AAO-HNS members have implored me to write this month's column to demonstrate that this dual aim is simply not possible.

Since when did a monthly column dedicated to improving safety, quality, and outcomes for our patients start discussing the satisfaction of our patients? As you may have noticed, over the past five years, this column has tried to keep AAO-HNS members abreast of the latest trends in patient safety and quality improvement. We have discussed myriad topics such as zones of risk, pitfalls, strategies to ameliorate problems, reporting systems. Recently, probably in the last 18 months, we have started discussing the issue of patient satisfaction and how payers and others are using this as a pure quality measure and linking reimbursement and even at-risk compensation to ensure our patient's experiences are the "top box."

The literature certainly supports that an optimized patient experience drives overall quality and is a surrogate for safety within an organization. However, operationalizing this is difficult.

For example, I could guarantee that I would run/manage the safest and most efficient operating room in the world. It is easy to do this: I would simply operate on one patient a month. We would ensure that we spent millions of dollars and resources to keep that patient safe. If you ask me to do this for a thousand patients a month, it becomes difficult. Similarly, as the AAO-HNS member writes above, it is becoming difficult for physicians to increase their clinical volumes to achieve Relative Value Unit (RVU) targets while optimizing patient satisfaction. On many levels the paradox becomes apparent—the waiting room is swamped, your staff is exhausted, your phone line pick-up times are extended, etc.

Elements Are Not Equal

The problem is that external forces are driving hospitals to include the experience of care in their metrics and eventually will tie this to reimbursement. Organizational scorecards have started emphasizing and reporting on patient experience and satisfaction. The end result of such is that these organizational priorities have trickled down to the providers. The stress that organizations are feeling from external agencies is now being transferred to the providers and the competing demands emerge.

I am secretly worried that piggybacking patient satisfaction to quality and safety will *de facto* erode the huge gains the industry has made in improving the overall outcomes of our patients. I have had the pleasure of hearing James Merlino, MD, the chief experience officer of the Cleveland Clinic, speak many times. One of his excellent analogies on these competing demands uses the airline industry as an example. He states that when we fly, our absolute priority is to not crash (safety), we really want to take-off and arrive on time (quality/efficiency), and if the first two criteria are met, it would be great to have a nice experience (satisfaction). How does this relate to the hospital and how do we prioritize patient safety, quality, and satisfaction? We can use Dr. Merlino's airline analogy to help us prioritize these demands in our realms of care.

I wish I had an easy answer or a crystal ball to assuage our AAO-HNS members' concerns. What I can guarantee is that for the short-term, there is no solution in sight and I eagerly look toward our exceptionally intelligent, passionate, and motivated membership for innovative solutions to this apparent paradox.

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

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

On November 27, 2013, the Centers for Medicare & Medicaid Services (CMS) posted the final rule for payments in the Medicare physician fee schedule (MPFS) for CY 2014. In addition to payment policy and payment rate updates, the MPFS addresses a number of quality initiatives. The Academy submitted comments to CMS on the final rule prior to the January 27, 2014, deadline (see www.bit.ly/CMSregs).

Medicare Sustainable Growth Rate (SGR)

The Medicare law includes the standard statutory formula that required (absent Congressional intervention) a 20.1 percent reduction to the CY 2014 conversion factor (CF) under the 2014 Medicare PFS. This would have resulted in a CY 2014 CF of $27.006, as compared to the CY 2013 CF of $34.0230. Congress acted, however, prior to the January 1 deadline to pass a three month patch that provided a .5% update to Medicare Payments through March 2014.

Estimated Impact on Total Allowed Charges for ENT Services

The overall impact of the CY 2014 final rule for otolaryngology-head and neck surgery is -2 percent. It is important to note that these estimates DO NOT INCLUDE the proposed reduction attributable to the SGR absent a Congressional fix prior to January 1, 2014. To fully understand the -2 percent impact to otolaryngology for CY 2014, members should be aware of the changes CMS is making to PE RVUs as it relates to the Medicare Economic Index formula. The MEI is an index that measures the price change of the inputs used to furnish physician services. CMS believes that the MEI is the best measure available of the relative weights of the three components in payments under the PFS—work, PE, and malpractice. CMS plans to hold the work RVUs constant and adjust the PE RVUs, the malpractice RVUs and the CF to produce the appropriate balance in RVUs among components and payments for CY 2014. ***The overall result of this policy change is that practitioners who furnish services with a higher proportion of PE RVUs (such as ENTs) will be most directly affected and should expect to see reductions across the board to PE RVUs for their services.***

Practice Expense

Within the proposed rule, CMS proposed a major change to the methodology for setting practice expense RVUs for services under the PFS. They proposed to limit the office PE RVUs for individual codes so that the total office MPFS payment amount would not exceed the total combined amount Medicare pays for the same code in the facility (hospital or ASC) setting. As members recall, this policy would have significantly impacted 13 otolaryngology services by reducing their payment 6-60 percent for CY 2014, if finalized.

Thanks to extensive advocacy efforts by the Academy, Congress, AMA, industry partners, and other specialty societies; CMS has chosen to retract this policy proposal within the 2014 Final rule. CMS expects to develop a revised proposal for using OPPS and ASC rates in developing PE RVUs that they will propose through future notice and comment rulemaking. They further clarify that they do not believe that the standard process for evaluating potentially misvalued codes, including the use of the AMA RUC, is an effective means of addressing these codes. Specifically, CMS believes the current review process for direct PE inputs only accommodates incomplete, small sample, and potentially biased or inaccurate resource input costs that may distort the resources used to develop non-facility (office) PE RVUs used in calculating PFS payment rates for individual services, and therefore, CMS plans to revisit this issue in future rulemaking.

Potentially Misvalued Services Under the Fee Schedule

CMS is also exploring new ways to broaden the process of identifying potentially misvalued codes. For the CY 2014 they proposed, and are now finalizing, a new process whereby they will solicit feedback from Medicare Contractor Medical Directors (CMDs) in developing a list of potentially misvalued codes.

> "Thanks to extensive advocacy efforts by the Academy, Congress, AMA, industry partners, and other specialty societies; CMS has chosen to retract this policy [OPPS PE CAP] proposal within the 2014 Final rule."

Improving Valuation of the Global Surgical Package

In the CY 2013 proposed rule, CMS sought comments on methods of obtaining accurate and current data on E/M services furnished as part of a global surgical package. Commenters provided a variety of suggestions including comments from the AMA RUC noting that the hospital and discharge day management services included in the global period for many surgical procedures may have been inadvertently removed from the time file in 2007. CMS said in the CY 2013 final rule with comment period that they would review this file and, if appropriate, propose modifications to the physician time file in the CY 2014 PFS proposed rule. After extensive review, ***CMS agrees that the data were deleted from the time file due to an inadvertent error, as noted by the AMA RUC. Thus,***

they are replacing the missing post-operative hospital E/M visit information and time for the 117 codes that were identified by the AMA-RUC. Nine of the 117 CPT codes noted by the AMA RUC are provided by otolaryngology, and will be adjusted for CY 2014 accordingly.

Physician Quality Reporting System (PQRS)

For CY 2014, CMS finalized several changes to the PQRS program. Notable changes are outlined below: For 2014, CMS sets the incentive payment for satisfactory participation in PQRS at .05 percent of all Medicare Part B charges. For 2014 and beyond, CMS has set the penalty for unsatisfactory participation in PQRS at -2 percent of all Medicare Part B charges. Incentives are awarded in the performance year and penalties are applied to the reporting year, which is 2 years after the reporting year (e.g., 2014 reporting penalties would be applied to 2016 payments).

CMS Changes to PQRS Measures and Measure Groups for CY 2014 Reporting

- CMS finalized 285 individual measures for inclusion in the 2014 PQRS program, including four of the Academy's Sinusitis Measures for inclusion in 2014 and beyond.
- **CMS did not finalize the proposed increase in the minimum number of measures in a measures group from four to six for CY 2014**. They do state, however, that they plan to increase this minimum number in the future. As a result, CMS also does not finalize the proposed addition of measures to measures groups with less than six measures. CMS adds that it will work with the measure developers and owners of these measures groups to appropriately add measures to measures groups that only contain four measures.

CMS Changes to PQRS Reporting Methods for CY 2014

- CMS eliminated the option to report measure groups via claims for individual EPs in CY 2014. Individuals may now only report measure groups via registry.
- CMS reduced the percentage of patients EPs must report on using Registry reporting from the previous 80 percent to 50 percent for CY 2014 reporting. This is now consistent with the patient threshold requirements for reporting via claims.

Changes to Individual PQRS Reporting in CY 2014

- **Reporting via Claims**—CMS has increased the number of measures individual EPs must report on from the prior three to nine measures (across three quality domains, for 50 percent of beneficiaries) for CY 2014 reporting. EPs who report on less than nine measures will be subject to the Measure Applicability Validation (MAV) process.
- **Reporting via Registry**—CMS has increased the number of measures individual EPs must report on from the prior three to nine measures (across three quality domains, for 50 percent of beneficiaries) for CY 2014 reporting. EPs who report on less than nine measures will be subject to the MAV process.
- **Reporting via Qualified Clinical Data Registry (NEW)—**CMS finalized the new QCDR reporting option for individual reporting in CY 2014.
- **CMS finalizes exceptions for individuals reporting via Claims and Registries for CY 2014 to avoid 2016 payment penalty.** These EPs will not be eligible for the 2014 bonus payment, however.

Changes to PQRS Group Reporting in CY 2014

- CMS revised the deadline by which Group Practices choosing to report for PQRS via the Group Practice Reporting Option (GPRO) must self-nominate from the previous October 15 of the reporting year, to a new deadline of September 30 of the reporting year.
- CMS finalized a new group reporting option for groups of 25-99 EPs to report, via a CMS-certified survey vendor, on the CG-CAHPS survey measures. Groups selecting this reporting option will need to report using additional reporting methods in order to report on additional measures to meet the criteria for satisfactory reporting for CY 2014.
- CMS added the requirement for CY 2014 that groups of 25+ who wish to report the CG-CAHPS patient satisfaction survey measures must indicate their intent to do so when they register for the PQRS program. CMS also finalized a change to utilize a single website for Groups to self-nominate to use the GPRO reporting option as well as indicate they would like to report on CG-CAHPS measures for CY 2014.
- CMS added the requirement that groups of 100+ must report on all CG-CAHPS measures as well as the GPRO measures in the web interface.

Physician Compare Website

Under the ACA, CMS is required to develop a Physician Compare website with information on physicians enrolled in the Medicare program, as well as information on other EPs who participate in PQRS. In 2013, CMS released a redesigned Physician Compare website, which can be found at www.medicare.gov/physiciancompare. The primary source of administrative information on Physician Compare is from the Provider Enrollment, Chain, and Ownership System (PECOS), with the use of Medicare claims information to verify the information in PECOS. Providers must ensure information is up-to-date and accurate in the national PECOS database. To update information not found in PECOS, such as hospital affiliation and foreign language, providers should contact the Physician Compare team directly at physiciancompare@westat.com.

Within the final rule, CMS finalized several new proposals for CY 2014 and beyond which are outlined in detail in the Academy summary of the 2014 final MPFS rule found at http://bit.ly/CMSregs. Members interested in more information on Physician Compare should also stay tuned for a Physician Compare specific article in the March edition of the *Bulletin*.

Value Based Payment Modifier and Physician Feedback Reporting Program

The VBM assesses both quality of care furnished and the cost of care under the MPFS. CMS has begun with a phase-in of the VBM in 2015, which will apply to all physicians by January 1, 2017. Implementation of the VBM is based on participation in PQRS. For CY 2013, the VBM applies to groups of physicians with 100 or more EPs. In 2014, CMS is expanding this to groups with 10+ EPs. For specifics on 2014 VBM requirements, additional information is available on the Academy website at http://bit.ly/entVBPM.

CMS also issued regulations in several other areas affecting the otolaryngology community such as EHR Meaningful Use, e-Prescribing, ACOs, and more. We encourage members to view the more detailed summary on the finalized requirements for the programs highlighted above, at the Academy's **CMS Regulations and Comment letter page at http://bit.ly/CMSregs. Additionally, should you have any questions, please email the Health Policy staff at HealthPolicy@entnet.org.**

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

Physician Payment Policy (3P) Workgroup Update

James C. Denneny III, MD
Coordinator for Socioeconomic Affairs
Jane T. Dillon, MD
Coordinator for Practice Affairs and Co-chairs of 3P

The Physician Payment Policy Workgroup (3P), co-chaired by James C. Denneny III, MD, and Jane T. Dillon, MD, is the senior advisory body to Academy leadership and staff on issues related to socioeconomic advocacy, regulatory activity, coding or reimbursement, and practice services or management. 3P and the Health Policy staff were busy in the last quarter of 2013 with a continued high level of activity, constant emails, and monthly calls, working diligently and tirelessly on behalf of all members.

Key 3P Accomplishments Included: Face-to-Face Meeting with CMS/CMMI Representatives in November 2013

In early November, Academy leaders James C. Denneny, III, MD, **Lisa E. Ishii, MD, MHS**, (coordinator-elect for Research and Quality Improvement) and David Nielsen, MD, along with Health Policy and Research/Quality Improvement staff, Jean Brereton, MBA, senior director, Research, Quality and Health Policy, and Jenna Kappel, MPH, MA, director, Health Policy, met with Patrick Conway, MD, chief medical officer for Centers for Medicare & Medicaid Services and acting director for Center for Medicare & Medicaid Innovation (CMMI), along with other top officials at CMS to discuss payment reform efforts and the need for development of additional clinical quality measures to ensure successful participation in the PQRS and Value Based Modifier programs by otolaryngologists. The Academy representatives inquired as to why five of the nine sinusitis measures were not accepted within the 2014 proposed fee schedule, and outlined our continued concerns regarding CMS' proposed Outpatient Prospective Payment System cap policy, which, if finalized in 2014, would reduce practice expense relative value units for 13 otolaryngology services when performed in the office setting. This meeting was yet another effort by the Academy to ensure CMS understands the critical role otolaryngologists play in the healthcare system and the influence these programs and policies have on our specialty.

> "P and the Health Policy staff were busy in the last quarter of 2013 with a continued high level of activity, constant emails, and monthly calls, working diligently and tirelessly on behalf of all members."

Direct Impact: Our meeting with Dr. Conway was instrumental in acceptance of four adult sinusitis measures for 2014 PQRS reporting. Continued dialogue also maintains the Academy's high-level visibility with CMS. As a result of numerous advocacy efforts, including these face-to-face meetings, and comment letters, CMS decided not to move forward with the OPPS cap policy and finalized the four adult sinusitis measures for PQRS reporting in 2014. For more details on the Medicare Physician Fee Schedule final rule's influence on otolaryngology, see page 31.

Regulatory Issues: Academy Advocates on Behalf of Members

Meaningful Use Stage 3

- In November, the Academy submitted a comment letter to CMS regarding Proposed Clinical Quality Measures (CQMs) for Use in Stage 3 of the EHR Meaningful Use Incentive Program. Specifically, the proposed Stage 3 measure on Overuse of Diagnostic Imaging for Uncomplicated Headache. The letter also reiterated the Academy's concerns regarding Stage 2 timing requirements and Stage 3 thresholds and penalties. Input was based on feedback from the Imaging Committee, PSQI, and 3P.

Colorado Clean Claims Act

- The Academy has been active in providing comments to the Colorado Clean Claims Act Task Force, an effort to develop a standardized set of payment rules and claim edits to be used by payers and healthcare providers. This is being closely monitored as it could be used in many other parts of the nation. In the summer, we submitted a formal letter on the first round of rules released for comment. These comments were reviewed and vetted through the CPT team, **Richard Waguespack, MD, Bradley F. Marple, MD, and Lawrence M. Simon, MD**. During the second round of review, the task force liaison reached out to the Academy directly, seeking our input on a few of the rules, and we provided input on the multiple procedure payment rule and the modifier -50 draft rule. Finally, the task force liaison sent us an early preview of the third round proposed rule on multiple endoscopies, which the CPT team reviewed in October and submitted comment on.

ICD-10

Also in November, the Academy submitted comments to the Centers for Disease Control and Prevention regarding the new ICD-10 Codes for Unilateral Hearing Loss in support of the Conductive and Sensorineural Hearing Loss proposal presented during the ICD-10-CM/PCS Coordination and Maintenance Committee Meeting on September 18, 2013. The comments

oppose the removal of references of contra-laterality and instead state that the codes are unilateral and retain language referencing which ear the diagnosis relates to. This will facilitate the fact that different types of hearing loss conditions can exist in each ear.

RUC and CPT Update

- The Academy is surveying new CPT code 4319X in preparation for the January 2014 AMA Relative Value Scale Update Committee (RUC) meeting. After only a week and a half, the Academy obtained an impressive 146 responses. The minimum requirement by AMA is 30 surveys so this response rate is excellent and is helpful to the Academy's RUC team, who must base the recommendations for relative value units (RVUs) on the data received. The survey closed early December and was sent to our practicing members specializing in head and neck and laryngology/bronchoesophagology with the support/assistance of AHNS, ALA, and ABEA. Many thanks to the physician leadership of these subspecialties who made the large survey response possible.
- **AMA CPT/RBVS Symposium** At the AMA CPT/RBVS Symposium in Chicago, Dr. Waguespack presented on new, and modified, CPT codes for otolaryngology for 2014, including flexible and rigid transnasal esophagoscopy (otherwise known as TNE) and chemodenervation of the larynx for spasmodic dysphonia, which were RUC surveyed by the Academy. Jenna Minton, Esq, senior manager, Health Policy, also represented the Academy at this meeting.
- **Academy Releases New CPT for ENT Coding Guidance**
  You may have noticed that your 2014 CPT Code Books include several modifications and additions to CPT codes used to report otolaryngology services. To assist members in understanding these changes and achieving correct coding, the Academy has revised our CPT for ENT articles on CPT 69210 Removal Impacted Cerumen and CPT 64617 Chemodenervation of Larynx (formerly reported by CPT 64613). These articles can be found in our Coding Corner of the website at www.bit.ly/CPT4ENT.

Academy Collaborates with UHC on Septoplasty Coverage Policy and Provides Feedback on Premier Designation Program

In November, Academy physician leaders, Drs. James Denneny and **Richard M. Rosenfeld, MD, MPH** participated in a conference call with United Healthcare National Medical Director Richard Justman, MD, and other physician leaders at UHC, to discuss and provide feedback on United's Premier Designation program. This program recognizes physicians who meet certain cost/quality parameters and highlights them with a "Premier" designation in the UHC physician networks. During the call, we were able to get confirmation from UHC leadership to work in partnership with otolaryngology to develop future models for reimbursement.

The Academy has also been collaborating with UHC to provide comments regarding their Rhinoplasty, Septoplasty, Vestibular Stenosis policy and are working with them to address issues we've continued to hear from members related to receiving a septoplasty review that was approved prior to surgery, but denied coverage following surgery. UHC is working to correct these issues. Also, the Academy is providing UHC with recommendations about patient criteria for septoplasty for UHC to consider including in their coverage policy.

New HP Team Member

The Health Policy team welcomes Danielle Jarchow, Esq, to the staff as a health policy analyst. Danielle comes from a family of otolaryngology-head and neck surgeons with her father and sister, who practice in academic and private practice, members of the Academy.

"HP Update" Archives

Missed the last edition of the "HP Update"? Access the monthly newsletter: http://www.entnet.org/Practice/HP-Update.cfm.

For questions on the above Health Policy issues, please send an email to HealthPolicy@entnet.org.

Clarification of Position Statements: What Are They and How Can They be Used?

In an effort to provide clarification about the differences among the quality knowledge products the Academy provides, the Ad Hoc Payment Model Workgroup has summarized the products including the Clinical Practice Guidelines (CPG) and Clinical Consensus Statements (CCS)s as compared to other Academy documents such as Clinical Indicators (CI)s, and Position Statements (PS)s, providing members with descriptions of the documents and how to use them. These documents can be viewed at http://www.entnet.org/Practice/loader.cfm?csModule=security/getfile&pageID=175934.

The Health Policy unit and the Physician Payment Policy (3P) Workgroup oversee the process for the development, review, and update of the position statements. Below are more details about the definition of a position statement, the process to create a position statement, and a summary of the recent review of all position statements.

Position Statements Defined

A position statement (formerly known as "policy statement") is used to designate a statement, policy, or declaration of the American Academy of Otolaryngology—Head and Neck Surgery, and Foundation (AAO-HNS/F) on a particular topic or topics. Statements are created to formalize the AAO-HNS/F position on a clinical procedure or medical service with third party payers, for use in state and federal regulatory or advocacy efforts, or to clarify the AAO-HNS/F approval or disapproval of certain practices in medicine.

Creating a Position Statement

Position statements are generated from within AAO-HNS/F committees. However, an individual member may request consideration of a topic for position statement development. If a member would like to propose the Academy consider developing a position statement on a particular topic, or revisions to an existing position statement, the details about the topic and concerns should be emailed to healthpolicy@entnet.org. The next steps in the process include:

- Academy staff will route the request to the Academy's 3P workgroup for review and determination of which committee(s) should receive the draft position statement for consideration.
- The Chair of the committee(s) receives the request, examines the need for a statement, and works to draft the necessary position statement language.
- Academy staff will present it to 3P for review. If 3P has questions related to the draft position statements, they are relayed back to the committee(s) for further clarification, and then sent back to 3P for review.
- The position statement is then submitted to the Board of Directors (BOD) for review and approval. If the Executive Committee (EC) or BOD has any requests for clarification, they ask 3P, or related committee, to re-review and re-submit. **Once the EC has approved, the request for a new or revised position statement is submitted to the Board of Directors during their biennial meetings for final approval.** After that, the position statement is posted to the website. The same process is followed for any updates to the position statements.

2012–2013 Review Position Statements

3P and the Health Policy team are committed to ensuring the position statements are updated and useful for members.

In August 2012, a process was initiated to review all of the position statements since they had not been reviewed for several years. At the commencement of the review process, there were 74 position statements. The position statement update process was reviewed and approved by the 3P.

3P initially divided the position statements into three tiers for three separate

rounds of review during the course of a year (September 2012-September 2013) taking multiple factors into account for priority including how outdated each statement was, concurrent ongoing research and guideline development, and utilization of each.

After prioritization, 3P assigned each of the statements to the clinical committee(s) of corresponding expertise for review and update. The committee(s) then made recommendations to reaffirm, revise, or delete assigned Position Statements.

Round 3: In September 2013, after an extensive third-round review process by AAO-HNS committees, the EC, and Board of Directors, the Academy reaffirmed eight position statements and revised 10. The third-round updates can be found on the Academy website at www.bit.ly/PositionStatements.

Several existing and new position statements are undergoing further committee review in an effort to reach a consensus on suitable language prior to Board approval.

The Academy currently reviews all position statements on a rolling four-year basis. The first round of review began in September 2012 and we continue to ensure that Position Statement content is up to date.

Position Statements	Revised or Reaffirmed on 9/28/2013
Delineation of Hospital Privileges	Revised
Evidence-Based Medicine	Revised
Flexible Endoscopic Examinations of Swallowing	Revised
Laryngoscopy and Bronchoscopy	Reaffirmed
Laryngopharyngeal Reflux	Reaffirmed
Midline Glossectomy for OSA	Revised
Patient Physician Covenant	Reaffirmed
Pay for Performance	Reaffirmed
Performance Measures	Revised
Plastic Surgery	Reaffirmed
Point of Care Imaging in Otolaryngology	Revised
Reimbursement for Taking Hospital Call	Revised
Scope of Otolaryngology Head and Neck Surgery	Revised
Thyroid and Parathyroid Diseases	Revised
Tobacco Use and Secondhand Smoke	Reaffirmed
Use of Animals in Research	Revised
Use of the Term "Doctor" in Advertising and Patient Communications	Reaffirmed
Utilization Review	Reaffirmed

Academy Launches 2014 Socioeconomic Survey

Since 1997, the Academy, through its Health Policy Team, has disseminated a Socioeconomic Survey every three years to all members (excluding military, retirees, and those in training). The survey is an important tool for gathering information on members' practice patterns, the healthcare environment, and future trends in otolaryngology-head and neck surgery. This data enables the Academy to provide members with useful benchmarking tools.

The survey is the most recognized otolaryngology-specific member survey available and allows the Academy to identify key issues and policies affecting members, particularly as they relate to practice productivity, revenue, and operations. The Academy encourages all eligible members to get involved and lend their voice to this important survey.

Members will be able to complete the online survey February 18-March 31 after receiving a unique link to their designated email address.

Your participation is essential for strong, statistically meaningful results. The published aggregate results serve as an asset for members when measuring themselves against their peers.

Aggregate results will be published by an independent research firm in the November *Bulletin*, and will be on display at the 2014 Annual Meeting in Orlando, Florida, September 21-24. For more information on the AAO-HNS Socioeconomic Survey, please email the Health Policy Team at healthpolicy@entnet.org.

Education: Awareness, Engagement, and Value

Always seeking to improve education for members, the AAO-HNS Foundation embarked on a year-long education needs assessment in 2013. The recent member-wide survey provided enlightening and actionable data regarding member's perceptions of our education offerings. The five central themes that emerged were described in the January 2014 *Bulletin*: member awareness, engagement, and value; existing education products; technology and learning styles; collaboration; and ideal education platform. In the first of the series, this article presents findings from the survey regarding member awareness, engagement, and value in Foundation education and knowledge resources.

Member Awareness

Though a vast majority of members showed familiarity with the Annual Meeting & OTO EXPO℠ and the Home Study Course, the familiarity did not extend to the 15-plus other knowledge products provided by the foundation. More than half of members are not aware that the Foundation offers free education resources such as online courses and lectures, COOL, COCLIA, and eBooks as a member benefit. More than one-third of the members were unable to distinguish between free education resources and those that are fee-based.

Whether you are a long-time member or relatively new to the specialty, you may also be missing out on valuable resources. Take a look at the 2014 Educational Opportunities at www.entnet.org/EducationAndResearch/upload/2014_AcademyU_EduOpps_Final_Optimized.pdf or visit www.entnet.org/academyU to check your own knowledge of AAO-HNSF's education and knowledge resources.

Member Engagement

The survey provided some positive news about member engagement in education, but also showed some opportunity for improvement—particularly for longer-term members. According to the survey, two-thirds of the respondent's current continuing education needs are fulfilled by the Foundation. Half of those completing the survey plan to continue to or increase their engagement in education with the Foundation during the next three years. Newer members are particularly heavy users, indicating that they have accessed four or more education resources in the past three years. While this is all great news, we also learned that nearly one-third of long-term members have not used any Foundation education resources in the past three years. While one-third of members receive all of their education from the Foundation, many turn to other organizations as well. An additional one-third of respondents indicate that they rely on one other organization in addition to the AAO-HNSF for their education. Members list a variety of organizations they use for continuing education purposes with other otolaryngology specialty organizations making up the majority of other resources.

Value

The perceived value of the Foundation's education content is high among long-time members, but newer members rate the value significantly lower. This decline in value between long-term and short-term members may indicate there are gaps in quality content, learning formats, delivery of information, or some combination of all three in the minds of the short-term members.

In general, the Foundation has a positive reputation among its members in terms of education. More than half of members rate the value of education resources as very good and also indicate they are very likely to recommend them to others. However, both value and likelihood to recommend is lowest for younger members.

The most common reasons the Foundation education resources offer better value than other organizations include:

- Education content is more relevant to area of practice or interests
- Wider variety of topics covered
- Greater quantity of offerings / resources
- More advanced / in-depth content
- Accessibility / navigation / organization
- More online offerings
- Current / cutting edge

The most common reasons the Foundation education resources offer worse value than other organizations include:

- Education content is less relevant to my area of practice or interests
- Expense of education products
- Content is too broad / too focused on generalists
- Fewer offerings available
- Poor accessibility
- Not as current or up-to-date

Members do not see the Foundation as "providing one-stop-shopping" for all education needs." Significant work will be required on the part of our education leadership to determine whether that goal is achievable, and if so, how to raise the bar to that level.

The relationship between member **awareness**, **engagement**, and **value** of education and knowledge resources will be an overarching measure of success as we work to build a better education platform for members. Through improving the perceived value of its offerings, the Foundation will secure its spot as the primary source for otolaryngology education.

Kenya Relief at the Brase Clinic

Anya J. Miller, MD
Humanitarian Grant Awardee,
Resident, Henry Ford Hospital
Royal Oak, MI

Last September, I traveled with a team from Henry Ford Hospital and the University of Michigan to Migori, Kenya, with Kenya Relief. Under the supervision of **Lamont R. Jones, MD**, and **Greg Basura, MD, PhD**, we performed otologic surgery at the Brase Clinic. With the assistance of local nurses, scrub techs, and nurse practitioners, we were able to perform surgeries including hemithyroidectomies, tympanoplasties, cleft lips, and various lumps and bumps.

Although we operated out of a clinic and not a hospital, our patients were able to stay overnight for observation due to the support of local nurses. Despite the occasional fly in the operating room, we enjoyed many amenities such as air conditioning, OR tables that moved up and down, operating microscopes, and Neptune suction machines, to name a few. In fact, after touring the local district hospital, our clinic appeared much better equipped thanks to many generous donations throughout the years. Supplementing with some supplies from home such as an ear tray and LED headlights, we were able to safely provide surgical care to the people.

The majority of the surgical patients who arrived for ENT evaluation were women with goiters. While we were able to alleviate much of the compression and cosmetic deformity with a hemithyroidectomy, we were not able to provide them with a real long-term solution. For smaller goiters, we prescribed iodine drops and education on iodized salt. It was unfortunate that we had not brought with us any iodine drops to dispense to the patients, so how many people were actually able to get the medication is uncertain.

While I do believe our team made a difference and patients were happy to have the surgery, multiple ENT teams arrive at the Brase Clinic each year and perform many surgeries for goiters. Despite this, the patients lined up with goiters are endless each time. It seems that the people in Kenya could benefit from ENT mission groups joining efforts with public health specialists. Given all the resources invested in taking a team to Kenya, a multidisciplinary approach to this issue could be both cost effective and provide a more substantial benefit to the local people. Without this or a similar effort, it seems inevitable that the lines of people waiting to have their goiters removed will continue to be lengthy.

Preoperative photo of a 72-year-old woman with a goiter for more than 30 years.

Postoperative photo after hemithyroidectomy. Her thyroid was so large that her carotid was adherent to the capsule and her internal jugular vein had little to no flow.

Kenya Relief Brase Clinic
P.O. Box 1078
Suna, Migori
Kenya, Africa 40400
Contact:
Dominic, Clinical Officer
011-254-724-777-048
Keptembwa@yahoo.com

While we were there to serve the people of Kenya, from a resident's perspective, there was much personal benefit derived from this experience as well. I was able to give my undivided attention to each surgical case without pagers going off, heading off to complete other clinical duties, or anything else that might draw my attention away from the case at hand. We also performed similar cases often, so I was able to learn from each case and improve on those skills without having days or weeks between cases to forget what I had learned. Having consistency in attendings also meant that I could reliably anticipate the next move, which also seemed to accelerate my learning.

Medical missions are in general a huge undertaking for everyone involved, but patients are universally thankful and resident benefit is priceless. Because time and money committed to this endeavor is great, each mission group should look at the needs of the particular area and try to tailor their mission accordingly to maximize impact. Many thanks to the AAO-HNSF Humanitarian Efforts Committee for its grant that made my participation possible.

Healing the Children—Santa Marta Smiles Again

Neha A. Patel, MD
Third-year resident, otolaryngology-head and neck surgery
The New York Eye & Ear Infirmary
New York, NY

In September 2013, I joined a team of 25 other volunteers from the U.S.-based Healing the Children organization. After months of planning and packing, we arrived at the Hospital Universitario Fernando Troconis in Santa Marta, Colombia. Excitement was in the air as the local volunteers of the Colombia-based UNIMA organization and enthusiastic Colombian medical students greeted us at the airport. The travel grant I was awarded by the Humanitarian Efforts Committee of the American Academy of Otolaryngology—Head and Neck Surgery gave me the opportunity to help give life-altering care to Colombian families.

In Colombia, an ecologic paradise is juxtaposed with the extreme poverty of many indigenous children. We screened about 100 surgical candidates upon arrival. The patient population ranged from ages six-weeks to 38 years old. Many of these patients had waited years for their surgery and many families spent months to gather the funding to travel by bus and boat. We traveled with all our equipment from New York. This included the OR surgical masks and instruments, the anesthesia machines, the PACU pulse oximeters, and beverages for patients. We operated on 59 patients in five days. The majority of surgical patients were children who needed repair of cleft lip and palate. In addition, patients underwent tympanostomy tube placement, cleft rhinoplasty, and treatment for velopharyngeal insufficiency. Patients with disfiguring hemangiomas, burns, and microtias were also treated.

The team was led by **Andrew A. Jacono, MD**, a New York Facial Plastic Surgeon, who has led several mission trips throughout the world. Other members of the American Academy of Otolaryngology—Head and Neck Surgery also included attending surgeons **Joseph Rousso, MD**, and Augustine L. Moscatello, MD, facial plastic and reconstructive fellow **Benjamin Talei, MD**, and otolaryngology residents including myself and fourth-year resident **Michael Bassiri-Tehrani, MD**. Additionally, an amazing team of anesthesiologists, nurse anesthetists, pediatricians, nurses, surgical technicians, administrators, and local Colombian volunteers contributed an enormous amount of time and effort to help these young patients receive excellent care. Every day would start with a team meeting to optimize the flow of cases and make sure all patients were treated optimally.

The highlight of the week was seeing the tears of joy on the faces of the mothers when they saw the immediate difference surgery made on our patients. Day after day, I got the honor of helping treat children who no longer had to be ostracized by craniofacial malformations. Many children were able to get immediate improvement in their ability to eat, drink, and speak. I was blessed to share this amazing experience with the best team anyone could dream of. There are still many children who need our help and my week in Colombia helped me realize how lucky we are to have the ability to help make a difference in their lives.

"The highlight of the week was seeing the tears of joy on the faces of the mothers when they saw the immediate difference surgery made on our patients. ... There are still many children who need our help and my week in Colombia helped me realize how lucky we are to have the ability to help make a difference in their lives."

Facial Plastic Surgeon Joseph Rousso, MD, with a patient recovering post cleft lip repair. Here she is blowing bubbles for the first time.

Pediatric anesthesiologist Jairo Castillo, MD, (left) and otolaryngology resident Neha Patel, MD, with patient prior to cleft lip repair.

11th International Symposium of Facial Plastic Surgery

❖ *150 hours of CME activities to include lectures, debates, panel discussions and hands-on workshops in microtia reconstruction, lasers, face lifting, blepharoplasty, rhinoplasty and brow lifting*

❖ *world renowned experts in facial plastic surgery, plastic surgery, dermatology, oculoplastic surgery, and maxillofacial surgery*

❖ *fast-paced and comprehensive with multiple concurrent courses offering something of interest to all*

❖ *Commemorating the 50th Anniversary of the founding of the American Academy of Facial Plastic and Reconstructive Surgery*

AAFPRS 50 ANNIVERSARY

Symposium Chair: Jonathan M. Sykes, MD
Program Chair: Anthony P. Sclafani, MD

May 27-31, 2014
New York City, NY

www.aafprs.org
info@aafprs.org

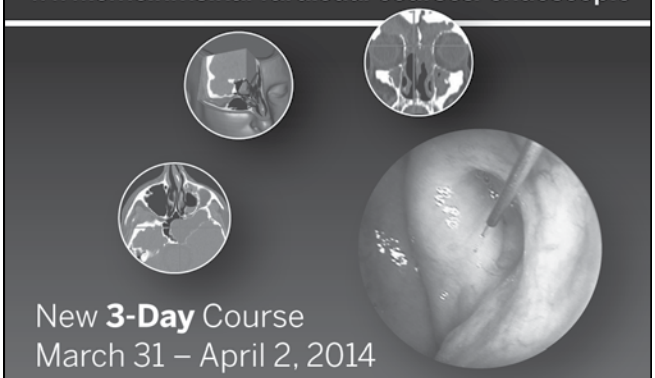
FACIAL PLASTIC SURGERY

IFFPSS
International Federation of Facial Plastic Surgery Societies

Endoscopic Surgery of the Sinuses, Eustachian Tube, and Ear

Course Directors: **Ralph Metson, MD and Dennis Poe, MD**
Co-Directors: **Stacey Gray, MD, Eric Holbrook, MD, Daniel Lee, MD**

Register online:
www.cme.hms.harvard.edu/courses/endoscopic



New **3-Day** Course
March 31 – April 2, 2014
Massachusetts Eye & Ear Infirmary | Boston, MA

Course videos can be previewed at **www.SinusVideos.com**

HARVARD MEDICAL SCHOOL

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.

ALBANY ENT & Allergy Services, PC

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

Fellowship Trained BC/BE Neuro-Otologist

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

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

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

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

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

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

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

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

HARVARD MEDICAL SCHOOL TEACHING HOSPITAL
BRIGHAM AND WOMEN'S HOSPITAL
Massachusetts Eye and Ear Infirmary

Neurotologist Faculty Position

The Department of Otology and Laryngology at Harvard Medical School with the Division of Otolaryngology and the Department of Neurosurgery at Brigham and Women's Hospital are jointly recruiting a full-time academic neurotologist clinician-scientist to support the clinical and research goals of the Brigham and Women's Hospital Skull Base Surgery Program.

The ideal applicant will have training and expertise in otology and neurotology, in particular acoustic neuromas, interest in cochlear implant programs, and be board eligible/board certified in Otolaryngology. The candidate should be qualified to be appointed at the Instructor, Assistant or Associate Professor level at Harvard Medical School. Salary and academic appointment will be commensurate with training and level of experience.

Brigham and Women's Hospital is a Top 10 ranked US News and World Report Academic Medical Center.

Interested applicants should submit curriculum vitae to:

Jo Shapiro, MD Chief, Division of Otolaryngology,
Department of Surgery, Brigham and Women's Hospital
through **aschwarzer@partners.org**.

Harvard Medical School and Brigham and Women's Hospital are equal opportunity/affirmative action employers with strong institutional commitments to diversity in their faculty. Women and minority candidates are particularly encouraged to apply.

UHealth
UNIVERSITY OF MIAMI HEALTH SYSTEM

UNIVERSITY OF MIAMI
MILLER SCHOOL
of MEDICINE

The University of Miami Miller School of Medicine's nationally ranked Department of Otolaryngology has immediate openings for fellowship trained.

Consult Attending/Hospitalist
We are seeking a board-certified or board-eligible otolaryngologist and will be hired on the clinical faculty track. They will staff inpatient consultation requests at UHealth and Jackson Memorial Hospitals. The consult patients may require operating room procedures which would be performed by this surgeon if appropriate, or they may be referred to sub-specialists in the department. They will also staff Emergency Room requests when available. Strong experience with airway management is preferred. Must have a record of successfully teaching residents and fellows. They may have a general ENT outpatient clinic. Must possess or eligible for Florida medical license. Please send Curriculum Vitae to: Mr. Tony Etzel Vice-Chair, Administration and Finance Department of Otolaryngology 1120 NW 14th Street, CRB Rm#571, Miami, Florida 33136.

Neurotologist
We are seeking a full-time fellowship-trained otologist/neurotologist. The applicant must be board-certified or board-eligible in Otolaryngology and in Neurotology. This is a position involving a mix of clinical practice, research and education of residents and fellows. The candidate will be expected to develop a clinical practice in all aspects of otology-neurotology and lateral skull base surgery, and lead research efforts in clinical and translational research. The candidate will participate in the University of Miami community as a faculty member where in our state-of-the art facility he/she will interact with institutional Otolaryngology residents, Neurotology fellows, audiologist, basic science researchers, neurologist, and neurosurgeons. Must possess or eligible for Florida medical license. Please send Curriculum Vitae to: Mr. Tony Etzel Vice-Chair, Administration and Finance Department of Otolaryngology 1120 NW 14th Street, CRB Rm# 571, Miami, Florida 33136.

Research Faculty
The Department of Otolaryngology Head & Neck Surgery is seeking applications for an open ranking professor (basic science) tenure-track faculty position. We are interested in applicants whose research relates to inner ear function, therapies and/or disease. A successful candidate will be a member of the vibrant and well-NIH funded Hearing Research Program within the department. The successful candidate should have a track record of NIH funded projects, a strong publication record, and the potential to secure/maintain extramural funding. Please send Curriculum Vitae to: Tony Etzel Vice-Chair, Administration and Finance Department of Otolaryngology 1120 NW 14th Street, CRB Rm#571, Miami, Florida 33136.

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, unmjobs. unm .edu/, Posting # 0819537. Please attach electronic copies of the CV, letter of interest, and three professional references to your application:

This position will remain **open until filled;** however, for best consideration, application materials should be received by January 29, 2014. For further information, interested applicants should contact Erica Bennett, M.D., at EBennett@salud.unm.edu.

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

University of Maryland Otorhinolaryngology

Otorhinolaryngology – Head and Neck Surgery is seeking up to two otologic researchers with genetic hearing loss experience and current funding to expand our research program.

Tenure and salary are commensurate with experience. Qualified applicants should submit their Curriculum Vitae and the names of three references to:

Scott Strome- M.D., Chair
Department of Otorhinolaryngology –
Head & Neck Surgery
University of Maryland
16 South Eutaw Street, Suite 500
Baltimore, Maryland 21201-1619

The University of Maryland, Baltimore is an Equal Opportunity, Affirmative Action employer. Minorities, women, veterans and individuals with disabilities are encouraged to apply.

Full Time Faculty Opportunities
University of Rochester Medical Center

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

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

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

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

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

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

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

Coastal
Ear, Nose & Throat

HIGHLY SUCCESSFUL ENT GROUP IN COASTAL NEW JERSEY - JUST AN HOUR FROM NYC!

Coastal Ear, Nose and Throat, a highly successful single-specialty group on the New Jersey shore, seeks well-trained Otolaryngologists to join their expanding practice.

Opportunities exist for the following:

- General Otolaryngology
- Neurotology
- Head & Neck
- Rhinology

Utilize your surgical skills in a modern practice with strong patient demand and an outstanding community reputation. Look forward to state-of-the-art surgical facilities both at Jersey Shore University Medical Center, a university teaching affiliate of the Rutgers Robert Wood Johnson School of Medicine, and the outpatient surgery center. Enjoy generous compensation and benefits while living in an attractive coastal community less than one hour from New York City.

Contact **Courtney Becker** at 800-678-7858 x64401
cbecker@cejkasearch.com

#151347AD www.cejkasearch.com

General Otolaryngology Physician, Maui, Hawaii

The Hawaii Permanente Medical Group in Honolulu, Hawaii is seeking a General Otolaryngology Physician for its Wailuku Specialty Care Clinic on the island of Maui.

Position Highlights

- An exceptional opportunity for an ENT physician with solid clinical skills who has a passion for care delivery as a part of a well-integrated team
- Practice full scope of otolaryngology including a wide range of general ENT procedures
- Shared call responsibilities
- Excellent work life balance in a tropical setting

Position Requirements

- **BC/BE in Otolaryngology-Head and Neck Surgery**
- **Experience preferred but not required**

Hawaii Permanente Medical Group is the state's largest and most experienced multi-specialty group comprised of over 400 physicians dedicated to providing the highest quality clinical care and building lifetime relationships with their peers and patients within Hawaii's richly diverse communities.

Many know Hawaii as an attractive tourist destination with beautiful scenery, mild weather, friendly people, and a host of cultural and recreational opportunities. These elements, and others, make Hawaii an excellent place to live.

HPMG offers an excellent benefit package which includes a moving allowance.

To apply, send cover letter and CV to: Janice Omori, Physician Recruiter, HPMG Professional Recruitment Services, 2828 Paa Street, Suite 2055, Honolulu, HI 96819
Email: Janice.Omori@kp.org
Fax: (808) 432-5827

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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**

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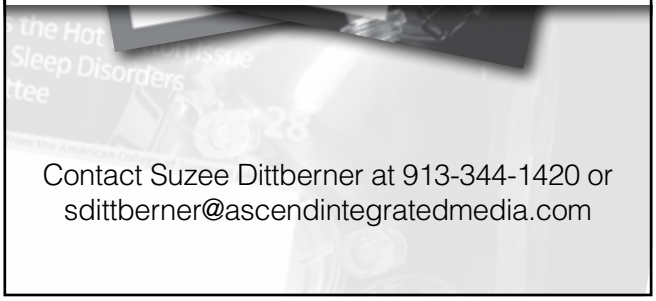

Contact Suzee Dittberner at 913-344-1420 or sdittberner@ascendintegratedmedia.com

Otolaryngologist Opportunity

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

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

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

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

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

For more information, please visit **Join-Geisinger.org** or contact: **Autum Ellis, Department of Professional Staffing, at 1-800-845-7112 or amellis1@geisinger.edu.**

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GEISINGER HEALTH SYSTEM

PROMEDICA

JOIN THE PROMEDICA FAMILY

Otolaryngologist Opportunity in Toledo, Ohio

ProMedica Physicians Ear, Nose and Throat is seeking highly motivated, personable BC/BE otolaryngologists to join their progressive and expanding practice. The practice consists of six ENT physicians and is the only ENT practice in Toledo with fellowship-trained otolaryngologists in head and neck surgical oncology and neurotology. We offer a full range of services including allergy testing and treatment, and complete audiology and vestibular services including ENG, rotary chair, posturography, and cochlear implantation and mapping.

We are seeking candidates who excel at general ENT or with advanced subspecialty interest and fellowship-trained in head and neck surgical oncology and laryngology.

- Full employment with ProMedica Physicians
- "Built in" referral base and high volume
- Call shared equally among all members (currently 1:6)
- Trauma call is optional and paid separately
- Opportunity for teaching residents and medical students
- All members participate in weekly board meetings
- Competitive compensation and generous benefits package
- Relocation paid up to $10K
- Perfect balance of work and lifestyle

Toledo, Ohio is home to an extensive Metropark system, Toledo Zoo, Toledo Museum of Art, and excellent institutions of higher education.

Contact: Denise Johnston, physician recruiter, at 419-824-7445, denise.johnston@promedica.org.

ProMedica is a tobacco-free employer. EOE

Northwestern University Feinberg Medical School
NEUROTOLOGIST

The Department of Otolaryngology – Head and Neck Surgery of the Northwestern University Feinberg Medical School is seeking a fellowship trained otologist-neurotologist. Track and rank will be dependent on the experience and qualifications of the applicant but they must possess an M.D. and be board certified (or eligible for certification) by the American Board of Otolaryngology. Candidates should also have the academic credentials and experience that will support an appointment to the full time medical school faculty as Assistant Professor. The candidate is expected to have the necessary interest and skills to collaborate with the extensive basic and translational auditory research program at Northwestern. Salary is negotiable. In order to ensure full consideration, applications must be received by February 28, 2014 for an expected starting date of July, 2014.

Candidates are requested to submit a letter of interest and a copy of a current curriculum vitae to Robert C. Kern, M.D., Chairman, Department of Otolaryngology – Head and Neck Surgery, 676 N. St. Clair, Suite 1325, Chicago, Illinois 60611.

Northwestern University is an Affirmative Action/Equal Opportunity Employer. Hiring is contingent upon eligibility to work in the United States and holding a medical license in the State of Illinois. Women and minorities are encouraged to apply. (Academic Search No. 22325).

PENNSTATE HERSHEY Surgery

Facial Plastic & Reconstructive Surgeon

The Division of Otolaryngology – Head & Neck Surgery at Penn State Milton S. Hershey Medical Center is seeking a full-time board certified Facial Plastic and Reconstructive Surgeon. Appointment will be at the Assistant/Associate Professor Level. Qualified candidates must have completed an approved residency program and be fellowship trained. Experience in a wide spectrum of aesthetic and reconstructive facial plastic surgery is desired. Training and interest in microvascular surgery is preferred. A strong commitment to patient care, resident education, and research is required.

The Penn State Milton S. Hershey Medical Center is a tertiary care facility that serves central Pennsylvania and northern Maryland. We are a part of a non-profit health organization that provides high-level patient services. Our division is part of a state-of-the-art, 551-bed medical center, a Children's Hospital, Cancer Center, research facilities, and outpatient office facilities. Penn State Hershey is the only Level I Trauma Center in Pennsylvania accredited for both adult and pediatric patients.

Join a growing team of clinical providers with the resources of one of the leading academic medical centers in the nation. Competitive salary and benefits.

For immediate consideration, please send curriculum vitae to:
David Goldenberg, M.D., F.A.C.S., Penn State Milton S. Hershey Medical Center, Division of Otolaryngology – Head & Neck Surgery, 500 University Drive, MCH091, Hershey, PA 17033
E-mail: jburchill@hmc.psu.edu

Penn State is committed to affirmative action, equal opportunity, and the diversity of its workforce. EOE-AA-M/F/H/V

Lahey Hospital & Medical Center

careers.lahey.org

At Lahey Hospital and Medical Center, as one of the world's premier health care organizations, we provide superior health care leading to the best possible outcome for every patient. We exceed our patients' high expectations for service each day. We also help advance medicine through research and the education of tomorrow's health care leaders. The Department of Otolaryngology & Head and Neck Surgery at Lahey Hospital and Medical Center is seeking applications for a **Fellowship Trained Microvascular Head and Neck Surgeon** to work with our team in **Burlington, MA**.

Appointment in Otolaryngology is available at the level of Assistant/Associate Professor through Boston University School of Medicine. In addition to being Board Certified in Otolaryngology & Head and Neck Surgery, the candidate must be a highly motivated team player with outstanding clinical and surgical skills. The candidate should also be dedicated to resident teaching and clinical research. Review of applications begins immediately and continues until the position is filled.

Lahey Clinic Hospital & Medical Center, now part of Lahey Health System, is a 317-bed tertiary care facility, outpatient clinic and Level II trauma center located in Burlington, MA, is a physician-led, multi-disciplinary group practice of 500 physicians. We maintain several accredited residency and fellowship programs and are an academic affiliate of Tufts Medical School. Burlington is located close to Boston and a short drive to the rest of the New England area.

Interested candidates must submit a cover letter and current curriculum vitae to the attention of:

Robert W. Dolan, M.D.
Chairman, Department of Otolaryngology – Head and Neck Surgery
Lahey Medical Center & Hospital, 41 Mall Rd., Burlington, MA 01805
Robert.W.Dolan@lahey.org

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utmb Health

General Otolaryngologist
with an interest in Allergy

FULL-TIME BC/BE FACULTY

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

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

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

NORTH ATLANTA EAR, NOSE & THROAT ASSOCIATES

We are seeking a BC/BE general Otolaryngologist to join our busy one physician, one Physician Assistant practice. The office is located in Cumming, GA, north of Atlanta, Ga. We are in south Forsyth County, one of the fasted growing counties in the US for the past several years. The area offers great cultural and recreational opportunities with excellent school systems.

We provide general ENT services for both Adult and Pediatrics. The practice is affiliated with Northside Hospital, one of the fastest growing and most respected hospital systems in the Atlanta area. The primary physician has been practicing in the area for over 20 years and has established a wide referral base.

We are offering a Competitive starting salary and excellent benefits (malpractice, pension plan, health insurance, dental, disability), Call is 1 in 4 with no trauma.

The candidate should have experience in General and Pediatric Otolaryngology but expertise in Otology, Head and Neck Surgery and Laryngology is a bonus. Seeking a motivated, hard working individual with excellent interpersonal skills and exceptional surgical training/experience.

Interested candidates should forward their CV and contact info to :
Joel Hoffman M.D.
hoff8811@gmail.com

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

Washington University in St. Louis
School of Medicine

Department of Otolaryngology-Head and Neck Surgery

Adult Comprehensive Otolaryngologist

The Department of Otolaryngology-Head and Neck Surgery invites applications for a full time faculty position at the Assistant Professor level on the Clinician/Educator track. This position carries a full academic appointment at Washington University School of Medicine. This faculty member will devote 100% time to clinical practice in the Otolaryngology clinics at the Center for Advanced Medicine and our West County Office. Clinical responsibilities will include inpatient and outpatient responsibilities within the Department of Otolaryngology at Barnes-Jewish Hospital and Barnes-Jewish West County Hospital, supervision of residents and medical students, as well as teaching and interdisciplinary collaborations in a very supportive and stimulating academic department. The position includes opportunities for innovation and discovery in education and clinical care. Candidates must be board certified or eligible for certification. Applicants may send their curriculum vitae to: Richard A. Chole, M.D., Ph.D., Lindburg Professor and Head, Department of Otolaryngology, Washington University School of Medicine, 660 South Euclid Avenue, Box 8115, St. Louis, MO 63110 or rchole@wustl.edu.

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