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American Academy of Otolaryngology—Head and Neck Surgery

FEBRUARY 2015

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The AAO-HNS/F Leadership Forum, a new otolaryngology summit, and leading change 12

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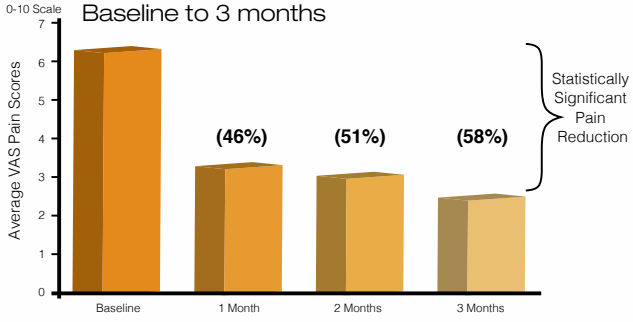

Visual Analog Scale (VAS) scores range from 0 (no pain) to 10 (worst) pain imaginable

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Initial JVA Summary before insertion of TMJ NextGeneration™

	Average Left	Average Right
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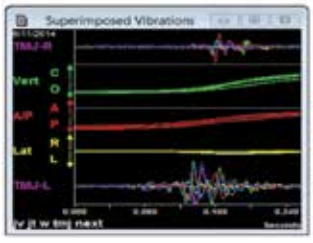
Integral <300Hz	37.6	10.0
Integral >300Hz	1.8	1.7
>300/<300 Ratio	0.05	0.17
Peak Amplitude	5.1	1.3
Peak Frequency	64	37
Med. Frequency	82	59
Distance to CO	41.8	35.0



JVA Summary after insertion of TMJ NextGeneration™

	Average Left	Average Right
Total Integral	28.2	11.4
Integral <300Hz	22.8	9.7
Integral >300Hz	1.8	1.7
>300/<300 Ratio	0.06	0.17
Peak Amplitude	3.4	0.9
Peak Frequency	60	33
Med. Frequency	76	107
Distance to CO	42.2	35.0

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*Tavera A, et al: Approaching Temporomandibular Disorders From a New Direction. A Randomized Controlled Clinical Trial of the TMDes Ear System. J Craniomandibular Practice July 2012; Vol 30, No 3, 172-181.
**This was a single-patient study using JVA to measure the before and after effects with TMJ NextGeneration™ devices; individual results may vary.

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President
Gayle E. Woodson, MD
Executive Vice President, CEO, and Editor of the Bulletin
James C. Denneny III, MD
Managing Editor
Jeanne McIntyre, CAE
bulletin@entnet.org

INQUIRIES AND SUBMISSIONS
bulletin@entnet.org

MAILING INFORMATION
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Ascend Integrated Media, LLC
Suzee Dittberner
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Fax: 1-913-344-1492
sdittberner@ascendintegratedmedia.com

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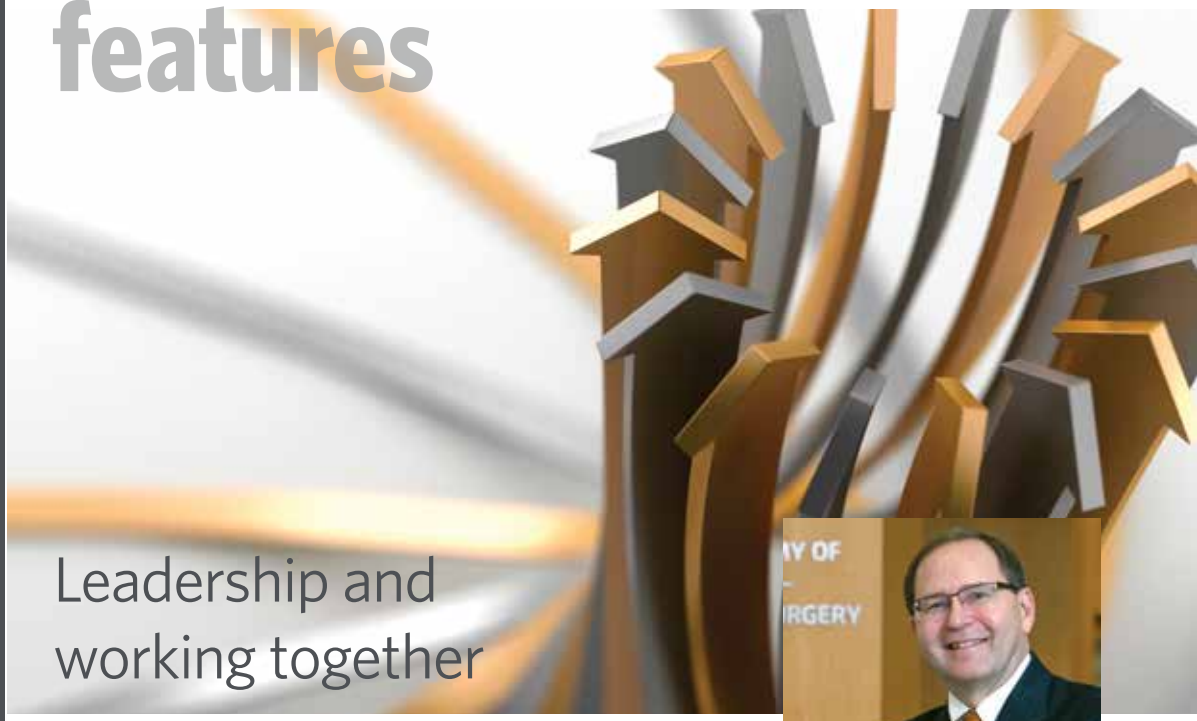

Leadership and working together

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Innovation at its best

Gayle E. Woodson, MD
AAO-HNS/F President

I wish I could say I am a savvy early adopter of innovation. In 1972, I won a microwave oven as a door prize and wondered what I would ever do with such a thing. When endoscopic sinus surgery appeared on the scene, I was skeptical. And electronic mail? I initially thought it would never be an adequate means of communication.

So when ENTConnect emerged, I dutifully signed on as a "beta tester," but did not expect much. I figured this was just one more information stream.

In recent months, however, I have been amazed with how rapidly Member concerns posted on ENTConnect can reach all of us—and how quick the response can be. For example, a physician despairs over the need for quality measures to submit to Medicare. This physician could have taken valuable time from his or her practice to search the Internet, call the Academy office, pore over old issues of the *Bulletin*, or craft an email to AAO-HNS staff.

This physician would have eventually learned that AAO-HNSF has been hard at work developing two performance measure groups (one for external otitis and one for adult sinusitis), which have already been accepted in the 2015 Medicare Physician Fee Schedule. Appropriate use of these measure groups can substantially reduce the reporting burden for physicians, since only 20 patients are required in an annual period as opposed to the requirement for reports on 80 percent of patients when individual measures are used.

So if this physician invested sufficient time and effort, all information would be obtained.

Instead, this physician posted a "distress call" on ENTConnect and a targeted response was promptly posted. Not only did this physician get the prompt feedback with minimal hassle, anyone who had similar concerns about quality reporting and happened to check ENTConnect received the same valuable information—and also could provide concerned colleagues with the latest update.

ENTConnect is a vibrant bulletin board of the hot-button issues in our field: legislative alerts, insurance company challenges, coding alerts, educational opportunities, etc.

If you have not yet used ENTConnect, explore it today. ■

> "Not only did this physician get the prompt feedback with minimal hassle, anyone who had similar concerns about quality reporting and happened to check ENTConnect received the same valuable information."

entconnect.entnet.org/home

A blueprint for the future

I am excited to be assuming the role as your EVP/CEO. During the last five years, I have experienced the barriers, distractions, and aggravations that take away from physicians' ability to deliver the best care possible both from the private and academic perspectives. The ongoing and accelerating process that represents "healthcare reform" affects us all—and our patients.

Before I review what I expect to be an active winter and spring, I want to personally, and on behalf of our Members and patients, thank **David R. Nielsen, MD**, for the exceptional job he did as our Academy's executive vice president/CEO for the last 13 years. His commitment to improving patient care through quality programs initiated during his tenure and his leadership in the "quality arena" have positioned otolaryngologists to participate in the new payment system as high quality, high value providers. The planning process that Dr. Nielsen put in place has resulted in a strategically focused operation that has produced a synergy between the Boards of Directors and the incredible Academy staff that he assembled. He has been a clear and unwavering voice for our Members and patients throughout his tenure as the CEO.

There are many forces, acting both in concert and independently, that are shaping a healthcare delivery model that will be significantly different for our Members and their patients. Legislative, regulatory, and market forces will each affect the way we will need to adapt to provide the best care for our patients. While it is not clear what model or models will emerge or the timeframe during which this will take place, it is certain that predictable elements will be a part of the resultant system. All iterations of "reform" will hold providers responsible for "quality, evidence-based care" that is measureable. "Value," as determined by both quality and cost, will be demanded by both patients and payers. Patient-centered "team-based" care will flourish and be the norm for common disease processes. It is likely that there will not be a single methodology of reimbursement for providers, but rather a menu of options, many of which we are unfamiliar with today.

Forces, both from within medicine and otolaryngology as well as external influences, will present challenges and opportunities that we will need to address on both a short- and long-term basis. Issues such as pediatric otolaryngology subcertification, the change in the Medicare payment system to all 0-day global procedures, changes to the continuing education system that affect MOC (maintenance of certification) and MOL (maintenance of licensure), and the ongoing scope of practice challenges will need collaborative discussion and solutions.

Among the great strengths of otolaryngology are the diversity of our Members and their skill sets. We have specialties that contribute to advances in patient care and educational efforts based on their work. This, however, also adds difficulty in serving this membership based on both identifying issues and assembling the resources to deal with them. This puts a premium on strategic planning and budgeting based on accurate prioritization of needs within our specialty and the ability to work together as a team for the good of all.

Otolaryngology needs all otolaryngologists to work together collaboratively when possible. This will allow us to maximize resources, avoid duplication, and generate a blueprint for the future of the specialty while maintaining the identity and relevance of each organization. To that end, the AAO-HNS will convene a summit in March 2015, prior to the AAO-HNS/F strategic planning retreat and the Leadership Forum. We have invited the specialty societies within otolaryngology as well as representatives from the American Board of Otolaryngology, the Society of University Otolaryngologists, and The Triological Society to a facilitated strategic meeting designed to understand the needs and concerns across the specialty and determine how we can best work together. I hope this will be the beginning of regular meaningful dialogue. A unified specialty will allow us to serve our patients and Members most completely.

AAO-HNS/F will work with all appropriate groups to produce educational opportunities that we hope will satisfy continuing education, MOC, MOL, and quality reporting requirements as a one-stop option to make things easier for our Members.

Finally, I want you to know how honored and humbled I am to take over as your executive vice president/CEO. I assure you I will do everything possible to work for you and your patients. ■

James C. Denneny III, MD
AAO-HNS/F EVP/CEO

> "Legislative, regulatory, and market forces will each affect the way we will need to adapt to provide the best care for our patients."

New AcademyU® *Learning Opportunities* delivers ease and access

The new AcademyU® *Learning Opportunities* booklet can be found with this issue of the *Bulletin*. As we continue to enhance the effectiveness of our education portfolio, Members will see new Education and Knowledge products. These include the AcademyQ™ Knowledge Assessment app now available for Apple and Android with 800 assessment questions ideal for exam preparation; 25 Online Lectures from the 2014 Annual Meeting & OTO EXPO,℠ including two new Clinical Practice Guidelines lectures on Tinnitus and Allergic Rhinitis; updated eBooks on Head and Neck Cancer, Geriatric Otolaryngology, and Otolaryngology Lifelong Learning; and the fourth Annual *ENT for the PA-c* Conference to take place in March.

The AcademyU® *Learning Opportunities* booklet highlights the AAO-HNS/F education portfolio.

Education Member-volunteers are hard at work on a number of new projects in 2015, such as the implementation of an AcademyU® Education Platform, a nonphysician clinician initiative, faculty development courses, and education marketing strategies.

And last but not least, the Education Steering Committee is launching an Innovation Group that will become an integral component to the ongoing development of the AAO-HNSF's new education platform. This group will determine learning opportunities for the education platform; assessing and recommending activity formats and design; and keeping apprised of emerging technological trends in professional education. This group, chaired by **Richard V. Smith, MD**, includes representatives from the eight education committees, young physicians, residents, and fellows.

"2015 promises to be an exciting year for education at the Foundation," said **Sonya Malekzadeh, MD**, coordinator for education with the Foundation. "Stay tuned for updates on all the efforts of the education committees throughout the year." ■

The practice of otolaryngology circa 1900

■ **Eugene N. Myers, MD, FRCS Edin (Hon)**, Distinguished Professor Emeritus, Department of Otolaryngology, University of Pittsburgh School of Medicine

Looking back on the practice of otolaryngology in 1900, it seemed rather primitive. It's amazing that anyone survived. The most important indicator of survival of cancer of the head and neck is the extent of the cancer in the neck. Therefore, management of the neck is one of the most significant aspects of cancer control.

Metastasis to the neck is treated by surgery and radiation therapy, depending on the site and stage of the primary as well as the clinical pathological staging of the neck. The neck dissection was first described in 1847 by Dr. Chilious and then by other famous surgeons such as Drs. Kocher, Butlin, Jawdynski, Solis-Cohen, and Crile. Metastasis to the lymph nodes was largely untreated until the medical profession was aroused by Dr. George Crile's paper systematically describing the radical neck dissection published in the *Journal of the American Medical Association (JAMA)* in 1906.

Cancer of the head and neck was relatively rare until the advent of factories that could produce cigarettes cheaply—then people started to smoke in the mid- to late 19th century. This led to a dramatic rise in the incidence of squamous cell carcinoma of the head and neck.

Sir Henry Trentham Butlin was a clever surgeon on the faculty of St. Bartholomew's Hospital in London. He transformed the department at St. Bart's into a center of excellence. He was the first to connect smoking and syphilis as etiologic factors in carcinoma of the tongue. He advocated surgical treatment of chronic suspicious ulcers of the tongue by excision with wide margins.

He began to speculate that subclinical malignant disease of the neck might be cured by elective neck dissection, and in 1895, he stated that every malignancy should be operated on radically and immediately. We've now come to use the selective neck dissection much as Dr. Butlin did in the management of cancer of the neck both in the N0 and N+ neck.

Dr. Codreanu, a native of Romania, performed the first total parotidectomy with facial nerve dissection in 1892. However, it wasn't until 1921 when Walter Ellis Sistrunk, MD, published a paper on surgery for tumors of the parotid gland that he actually recognized that the key to successful parotid surgery was the preservation of the facial nerve. His technique was to identify the cervical branch of the facial nerve and to dissect proximal to the

OTOLOGIC OUTREACH IN JINOTEGA, NICARAGUA

■ **Rosemary B. Ojo, MD**, Humanitarian Travel Grant Awardee

Back row from left: Rosemary Ojo, MD; Allison Kerr, a pre-audiology student; Lindsey Ratkiewicz, a prenursing student; Whitney Skidmore, a premedical student; and Kelsey Ambrose, an audiology student, worked on complex cases at the Hospital Victoria Motta in the rural hills of Nicaragua.

➲ READ MORE ONLINE

bifurcation of the facial nerve into the upper and lower divisions. This resulted in a great decrease in facial nerve paralysis and in the recurrence of the tumor.

The Mayo Clinic's experience with 1,360 primary parotid tumors compared the results of surgical treatment of parotid tumors during two consecutive periods, 1940-1954 and 1955-1969. The publication of their results in the *American Journal of Surgery* put the Mayo Clinic surgeons in a position to change the destiny of parotid surgery in the future.

In the early series, local resection was used, while in the later period a superficial or total parotidectomy with identification and preservation of facial nerve was used, which became the treatment of choice due to the decreased recurrence and facial nerve injury.

James E. Newcomb, MD, in his textbook published in 1901 by J.B. Lippincott, Philadelphia, stated that "tumors of the oropharynx were rare and the malignant growths were classified as lymphoma, sarcoma, or carcinoma." It was thought that primary

Sir Henry Trentham Butlin

malignant lymphoma was rare in the pharynx and that carcinoma of the soft palate was incurable. They describe carcinoma of the oropharynx, which metastasizes quickly to the cervical glands and death usually results in 16 to 18 months.

It is a marked difference in the management of this cancer of the oropharynx now with either chemoradiation or transoral robotic surgery (TORS), which has saved many lives and certainly has changed dramatically the outcome of treatment since this publication in 1901. ■

Physician, groom thyself

■ **Mina N. Le, MD**, Women in Otolaryngology Section

Attributed to Hippocrates is this description of how a physician should appear: "clean in person, well-dressed, and anointed with sweet-smelling unguents." The first is a given, the third is outmoded, but the second point proves difficult to pin down: What constitutes appropriate physician attire?

The most distinctive article of physician dress, the white coat, isn't going away any time soon. Originally adopted for its evocations of cleanliness and of scientific rigor, the white coat is consistently preferred whenever patients are surveyed on how they would like their doctor to dress.[1-4] Survey respondents state that a doctor looks "unclean," "sloppy," and "unprofessional" without a white coat, "more like a salesman."[2] Despite a "myth" that white coats intimidate, this preference even holds among the pediatric population, with 69 percent of children aged four to eight preferring a doctor in a white coat.[5]

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Longer article and reference list available
Continue the discussion on ENTconnect.

What footwear is acceptable? Four hundred ninety-six patients surveyed at two Tennessee family practice clinics, using a Likert scale from 1 (desirable) to 5 (undesirable), objected to sandals (3.9 for male physicians, 3.6 for female physicians) as well as to clogs (3.8 for male physicians, 3.5 for female physicians).[4] Patients of surgeons, in contrast, appear to give them more leeway. Of 570 patients who were asked at a Texas general surgery clinic, 60 percent to 70 percent thought that tennis shoes were OK for their surgeon to wear, and 72 percent to 80 percent felt that clogs were acceptable.[6] ➲

Annual Meeting: A transformative experience

Kibwei A. McKinney, MD, Harry Barnes Endowment Travel Grantee, University of North Carolina–Chapel Hill

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Longer article available

The 2014 AAO-HNSF Annual Meeting & OTO EXPO℠ was an enlightening and transformative experience because of the tremendous clinical and research opportunities it offered me as I enter the field of otolaryngology–head and neck surgery. I am extremely grateful for being selected as the recipient of the Harry Barnes Endowment Travel Grant.

Ready to participate

I have now had three opportunities to attend the AAO-HNSF Annual Meeting. My first two experiences were as a medical student, and during my second-year research block, as a resident. At those stages of my education, I found the meeting both overwhelming and daunting, because I had little clinical experience through which to understand the complex research questions being addressed or the topics being discussed in the Instruction Courses. The 2014 Annual Meeting was different for me; I used this as an opportunity to bolster my understanding of topics relating to my eventual career in rhinology and anterior skull base surgery.

I arrived in Orlando on Saturday to attend the Harry Barnes Society meeting. I was impressed by the diligence and leadership demonstrated by Lisa Perry-Gilkes, MD, and other committee members. This meeting underscored the importance of my involvement with the society, personally, and the need to recruit others in the pursuit of its goals. I joined a subcommittee that focuses on increasing the applicant pool for the visiting clerkship endowment, because I believe the best way to eliminate disparities within our field is by providing the opportunity to medical students considering this discipline.

The importance of the SRF section

On Sunday, the turnout for the General Assembly of the Section for Residents and Fellows-in-Training was tremendous, reflecting its leaders' efforts. As a seventh-year trainee, I have witnessed the immense transformation of the residency training experience, specifically with respect to the implementation of residency work hours, the logging of key indicator cases, and the evolution of the core curriculum during the last decade. Many of these changes are attributable to this section.

Absorbing the Instruction Course and community experience

The various Instruction Courses that I attended provided key insights into clinical, surgical, and practice management tools that I will need upon completion of my fellowship. Many of these lectures focused on surgical techniques, and I learned a great deal about the nuances of frontal sinus anatomy and approaches, including the modified Lothrop technique. I further enhanced my understanding of the management of surgical complications, including the management of CSF fistulas and intra-operative hemorrhage. Finally, I received a crash course in coding, in general, in a talk geared toward trainees, and in rhinology-specific coding, that will invariably equip me well for years to come.

More than anything, attending the 2014 AAO-HNSF Annual Meeting & OTO EXPO℠ has made me feel part of a larger community. This is both an honor and a great responsibility, and I look forward to contributing to the Academy throughout my career. ➲

Experience the new *Bulletin* and get more

Yes, this is a new *Bulletin*, designed to better serve your needs—keeping you up-to-date and in touch. This important member benefit now extends the news and information you have received monthly to strengthen accessibility, speed of delivery, and ease of discussion.

Designed for how you read

Informed by your own responses to member surveys and focus groups, the new print design offers three easy-to-navigate sections for your reading style:

Upfront, **"The Leading Edge"** delivers leadership views on top specialty concerns. Following these pages, the **"At the Forefront"** section quickly updates you on strategic specialty activities and alerts you to important dates, practice tools, trends, and regulatory issues with more informational graphics.

The **"Features"** section spotlights three or four in-depth looks at timely topics such as new guidelines and practice coding issues.

New elements in the print *Bulletin* point

Connect with leadership opportunities in your state

Most state legislative sessions have convened and some states are still vulnerable to ill-advised proposals. We are seeking volunteers for "state trackers" in Alaska, Idaho, Mississippi, Oregon, South Dakota, and Wyoming. The time it takes to be a state tracker is minimal, but the influence is immense!

In addition, to supplement our state tracker program, we are creating a database of AAO-HNS Members serving on state hearing and/or speech language pathology licensing boards. We need your help to identify Academy Members serving in this capacity. To provide feedback on these initiatives or to volunteer, email govtaffairs@entnet.org. ■

to additional content throughout the book that is exclusive or expanded online.

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As each print issue is published, Members will receive the online edition via a special email.

The *Bulletin* changes mentioned above and this "special delivery" help you to navigate to more information more easily. From the online *Bulletin*, dynamic links connect you directly to all the content on the AAO-HNS/F website and to the protected community of ENTConnect. Express your thoughts immediately to specialty leaders and each other.

Get more from your membership — read the *Bulletin*. ■

114th Congress: Impetus for change or more stalemate?

In January, incumbent and newly elected lawmakers converged on Capitol Hill to convene the 114th Congress. Most notable for this year's new Congress is the gaveling in of an expanded Republican majority in the U.S. House of Representatives, as well as a slim majority in the U.S. Senate. While it may be too soon to determine whether GOP control in both chambers of Congress will help, or further hurt, the legislative and political gridlock that has been plaguing Washington, one thing is certain—it should be interesting. Below are a couple things we know, and a few we don't.

Things we know

1. **The President is in "legacy" mode.** As a result, his administration may be more willing to seek compromise in order to protect its marquee achievements.
2. **Healthcare remains a hot topic.** In post-election press briefings, leaders from both parties discussed the Affordable Care Act (ACA) and made it clear that many health-related topics remain high on their respective priority lists.
3. **With more than 60 new legislators, the AAO-HNS and others in the physician community will be busy educating Members of Congress and their staffs** on key priorities, including repeal of Medicare's Sustainable Growth Rate payment formula.

Things we don't know

1. **Will the GOP majorities be able to "function?"** All eyes are on the U.S. House of Representatives, with many pundits speculating on whether or not Speaker John Boehner's expanded majority will give him some much-needed breathing room to maneuver more easily around the ultra-conservative faction of his caucus. Furthermore, will the newly minted Senate Majority Leader Mitch McConnell succeed in bringing the Senate back to "regular order?"
2. **Will further implementation of the ACA, as well as legal challenges of the law, improve or harm patient care?** And, how will the GOP-controlled Congress respond?
3. **Will the political posturing surrounding the start of the Presidential election cycle derail everything?**

For more information about the 114th Congress and specific AAO-HNS legislative priorities, email govtaffairs@entnet.org or visit www.entnet.org/advocacy. ■

Leadership and working together

Leadership and working together are two emerging themes in 2015. The new Clinical Practice Guideline: Allergic Rhinitis and the forthcoming otolaryngology summit are but two examples featured in this edition of the *Bulletin*.

This particular section focuses on the upcoming AAO-HNS/F Leadership Forum, March 14-16, in Arlington, VA; ideas for creating change; and a notable example of how much can be achieved—working together.

The Leadership Forum weekend is key to helping prepare the next generation of leaders for the Academy and is designed, in part, to help provide many diverse leadership opportunities especially for residents, young physicians, and women.

It is one of many Academy benefits, allowing Members opportunities to network and engage in peer-to-peer interaction while attending the Board of Governors' sessions, related advocacy sessions, and more.

The forum weekend also includes many invitation-only leadership activities, including the *Boards of Directors (BODs)* and *Executive Committee* meetings and the *BODs' Strategic Planning session*.

Beginning on Saturday, March 14, special leadership development content specifically designed for residents, women, and young physicians will be offered. The Board of Governors and advocacy sessions are open to all and begin on Sunday morning, March 15, and continue through mid-day on Monday, March 16.

This year's program includes: Advocacy, Leadership Development and Mentoring, the BOG General Assembly including the President-elect Candidates Forum, and an ENT PAC Reception exclusively for PAC Leadership Club members.

Some specific program highlights include:

- "How Did Otolaryngology—Head and Neck Surgery Become the Essential Discipline for the 21st Century?" Speaker: Robert J. Ruben, MD
- "Pathways to Leadership in Your Academy" Moderator: Stacey L. Ishman, MD, MPH
- "What's New in the ICD-10 Transition?" Speakers: Robert R. Lorenz, MD, and Spencer C. Payne, MD
- "A Primer for the Otolaryngologist: Quality Measurement and Reporting Process" Moderator: Emily F. Boss, MD, MPH
- "Healthcare Policy in the 114th Congress" Speaker: Julius W. Hobson, Jr.

In the coming pages, "Ensuring Meaningful Reporting Options in PQRS" illustrates a significant collaboration by the AAO-HNSF and the American Board of Otolaryngology (ABOto). Stacey L. Ishman, MD, MPH, chair of the BOG Rules and Regulations Committee, offers ideas on how to create the change "we want to see"—a topic that speaks to both leadership and working together. ■

REGISTER TODAY
Visit **entnet.org/content/aao-hnsf-leadership-forum** to register.

New this year: an Otolaryngology Summit

The summit will take place on Friday, March 13, just before the Leadership Forum Weekend.

"This is an important gathering for leaders from our specialty areas as well as the American Board of Otolaryngology and The Triological Society. I would hope that frank discussions can be conducted that allow us to ascertain areas where we can work well together and synergize our resources and goals," said James C. Denneny III, MD, EVP/CEO. "It is important that a small specialty, such as otolaryngology, work together whenever possible to maximize its effectiveness in education, research, advocacy, and member services. I would hope that this type of meeting would become a regular event for our specialty leaders in the future. Establishing a good working dialogue would be an essential step for these opportunities to come to fruition."

The response to the summit invitation has been very positive. The following organizations, in alphabetical order, have indicated that they plan to attend:

- American Academy of Facial Plastic and Reconstructive Surgery (AAFPRS)
- American Academy of Otolaryngic Allergy (AAOA)
- American Board of Otolaryngology (ABOto)
- American Broncho-Esophagological Association (ABEA)
- American Head and Neck Society (AHNS)
- American Laryngological Association (ALA)
- American Neurotology Society (ANS)
- American Otological Society (AOS)
- American Rhinologic Society (ARS)
- American Society of Geriatric Otolaryngology (ASGO)
- American Society of Pediatric Otolaryngology (ASPO)
- Association of Otolaryngic Administrators (AOA)
- Otolaryngology Program Directors Organization (OPDO)
- Society of University Otolaryngologists (SUO)
- The Triological Society (TRIO) ■

WORKING TOGETHER

Ensuring meaningful reporting options in PQRS

The AAO-HNSF recently engaged in a project working collaboratively with our specialty's certifying board, the American Board of Otolaryngology (ABOto), and on behalf of our Members and their diplomates to create relevant, meaningful reporting options that will help ensure quality care, improve patient outcomes, and ease the burden of reporting significantly. The AAO-HNSF strongly believes otolaryngologist-head and neck surgeons should be able to report on measures that are meaningful to their specialty. With this goal in mind, after identifying a gap in the current measures groups offered in the Physician Quality Reporting System (PQRS), the Academy convened a group of experts to create additional measures groups for both acute otitis externa (AOE) and adult sinusitis to be proposed for inclusion in PQRS in 2015 and beyond.

Requirements for successful reporting (and penalties for unsuccessful reporting) under PQRS have increased for eligible professionals (EPs). Beginning in 2015, EPs who do not successfully report for PQRS will be subject to a -1.5 percent payment adjustment based on the 2013 reporting period (January 1, 2013-December 31, 2013). In 2016, that payment adjustment increases to -2 percent, based on last year's reporting period (January 1, 2014-December 31, 2014). In 2014, EPs must report on a total of nine measures across three National Quality Strategy domains for at least 50 percent of the EP's Medicare Part B FFS patients seen during the reporting year to which the measure applies. Using the PQRS*wizard*® to report for PQRS via a measures group is an attractive option to physicians, as it significantly reduces the reporting burden to one measures group for only 20 applicable patients.

The Academy and relevant stakeholders agreed that inclusion of new measures groups for sinusitis and AOE would not only help address a reporting gap for otolaryngologists and offer a streamlined and less burdensome reporting option, but also help accomplish the aim of improving the quality of care provided to patients suffering from these and related conditions.

Your AAO-HNS/F in action: Convening measures stakeholders

In May 2014, with representation from the American Board of Otolaryngology, and the American Medical Association—Physician Consortium for Performance Improvement (AMA-PCPI), the AAO-HNSF convened a group of experts, including **David R. Nielsen, MD**, then AAO-HNSF executive vice president/CEO; **James C. Denneny III, MD**, current AAO-HNSF executive vice president/CEO and former coordinator, Socioeconomic Affairs; **Robert H. Miller, MD, MBA**, executive director, American Board of Otolaryngology; **Randal S. Weber, MD**, ABOto president-elect; **Richard M. Rosenfeld, MD, MPH**, AAO-HNSF senior consultant for Quality and Guidelines; **Lisa E. Ishii, MD, MHS**, AAO-HNSF coordinator, Research and Quality Improvement; **Jane T. Dillon, MD, MBA**, AAO-HNSF coordinator, Socioeconomic Affairs; Samantha Tierney, MPH, project manager II, Performance Improvement, American Medical Association; and AAO-HNSF staff. These stakeholders deliberated over the critical measures to include in the sinusitis and AOE measures groups, while reviewing measure specifications and relevant diagnosis, procedure, and encounter codes. After extensive discussion, this group agreed that the measures included in the two proposed measures groups are important and relevant to treating sinusitis and AOE.

New measures group options

After the expert group concluded its work to assemble and finalize the proposed measures groups, the AAO-HNSF submitted a letter to the Centers for Medicare & Medicaid Services (CMS) officially requesting inclusion of the sinusitis and AOE measures groups in the PQRS program. Additionally, the AAO-HNSF met with CMS representatives in June 2014 to further detail the collaborative process for creating the measures groups and to offer a supporting rationale for inclusion of the two new reporting options.

As a result of the collaborative efforts of the AAO-HNSF, ABOto, and AMA-PCPI, the Academy is pleased to announce that CMS has finalized both the sinusitis and AOE measures groups for inclusion in PQRS in 2015 and beyond, as detailed in the recently released Medicare Physician Fee Schedule Final Rule.

The new sinusitis measures group features six individual measures, including documentation of current medications in the medical record (PQRS #130), pain assessment and follow-up (PQRS #131), preventive care and screening for tobacco (PQRS #226), antibiotic prescribed for acute sinusitis (PQRS #331), appropriate choice of antibiotic (PQRS #332), and CT for acute sinusitis (PQRS #333).

The new AOE measures group features eight individual measures, including use of topical therapy for AOE (PQRS #91), avoidance of systemic therapy for AOE (PQRS #93), documentation of current medications

in the medical record (PQRS #130), pain assessment and follow up (PQRS #131), risk assessment for falls (PQRS #154), plan of care for falls (PQRS #155), preventive care and screening for tobacco (PQRS #226), and preventive care and screening for high blood pressure (PQRS #317).

The Academy remains committed to continued partnership with ABOto in efforts to assist our Members with quality improvement initiatives, including developing and maintaining clinical quality measures, and ensuring meaningful reporting options are available in PQRS and other reporting programs. In fact, AAO-HNSF recently formed a Performance Measures Task Force to proactively address the ongoing need to develop new measures and measures groups, assume stewardship of existing measures, and pursue meaningful reporting solutions applicable to our otolaryngologist Members. The Academy is confident that the creation and inclusion of the sinusitis and AOE measures groups will be more relevant to otolaryngologists and encourage greater PQRS participation within the otolaryngology community, and we look forward to continued collaboration with other measures stakeholders such as the ABOto, AMA-PCPI, and CMS, to ensure robust participation by otolaryngologists in PQRS and other reporting programs. ■

BOARD OF GOVERNORS

Leading change

Stacey L. Ishman, MD, MPH, Chair, BOG Rules and Regulations Committee

During the most recent Board of Governors (BOG) audit of state and local societies, we found that member organizations enjoy varying degrees of involvement. And, as a former state society president and a current representative to my local organization, I have come to appreciate the energy and effort necessary to create and maintain a healthy society. Whether we are reinvigorating an otolaryngology society or reenergizing our hospital boards, there is often a need for us to create the change that we want to see.

I turned to the book *The Heart of Change*, by John Kotter and Dan Cohen, which suggests that creating change is best accomplished by:

- Creating a sense of urgency to "do something"
- Building a guiding team with the characteristics and power to drive change
- Communicating to maximize buy-in
- Empowering action by removing barriers
- Creating short-term wins
- Continuing to drive the need for change and make it stick

Create urgency

The need to create a change needs to be appreciated by the people who can effect change and result in a sentiment that it has to happen right now. Although this may be accomplished by listing facts and figures, personal stories and appeals to our emotion can be the most powerful tools to create a call to "do something."

Build a guiding team

In addition, the leadership must include individuals who listen, work together, create a plan, and remain energized to effect change. At the local society level, there may be a history of nominating the person who skipped the meeting, but the recruitment of individuals who are excited and regular participants will serve the organization better and engender greater trust in your members.

Communication

Dissemination of your new vision or work plan (or commitment to better dinner meetings) is also critical to engage members and recruit like-minded peers to leadership. It may be as simple as an email, phone call, or *Bulletin* article, but make sure that your words and actions match your goals.

Removing barriers

As you begin to work your way through the impediments to participation, active elimination of barriers is critical to empowering action. This may require rotating meeting locations or finding dinner sponsorship or negotiating with staff to facilitate the work plan.

Creating short-term wins

Once the decision is made to make a change, creating some quick, visible changes to the areas that matter most to members will keep the momentum going and assist with motivation. This may mean that you take the lead on the achievable and most obvious areas needing change to build excitement.

Don't let up

Keep necessary changes coming and eliminate needless work that does not add value.

2015 AAO-HNS/F Leadership Forum March 14-16

We will be addressing BOG issues such as these on Sunday, March 15, and Monday, March 16. The BOG Rules and Regulations Committee is also working to maximize society engagement in the BOG and assure that we are providing the tools that are most useful to our Members. Please join us or send your ideas and questions (bog@entnet.org). I hope to see you there. ■

> The Academy's greatest strength lies in the extraordinary support it gets from its dedicated and loyal membership and staff. The efforts these groups give on behalf of our specialty and patients enable our education, research, and advocacy efforts.
>
> **James C. Denneny III, MD**
> *AAO-HNS/F EVP/CEO*

This year began with a new executive vice president/CEO at the American Academy of Otolaryngology—Head and Neck Surgery and its Foundation. James C. Denneny III, MD, has assumed the leadership role after years of experience in both academic and private practice.

An active member of the Academy since 1984, Dr. Denneny served as president of the AAO-HNS/F (2007-2008). He has held a series of leadership positions including 11 years on the Boards of Directors, 22 on the Board of Governors with a term as BOG chairman (1998-1999) as well as positions on numerous committees, coalitions, and workgroups.

Before serving in the Knoxville, TN, community for 24 years as a private practitioner, he held academic appointments in Houston and Indianapolis. In 2011, he joined the Department of Otolaryngology—Head and Neck Surgery at the University of Missouri as professor of clinical otolaryngology. Dr. Denneny shares his thoughts as he begins his new role.

Why were you interested in becoming the executive vice president/CEO of the AAO-HNS/F?

I have been involved in the Academy for more than 20 years. I am excited to help lead otolaryngology through the ongoing transition in the healthcare delivery system. As we develop the tools for our Members to actively participate in the evolving paradigm shift in the way medicine is practiced, it will be essential that we produce the implements necessary for them to improve upon and report patient outcomes. This will become essential for our Members to be able to continue to practice the quality of medicine they are accustomed to.

What do you most want Academy Members to know about you?

I want to assure our Members that I have the energy, innovation, passion, and skills to continue to move forward the mission of the Academy to provide our Members with the tools necessary to deliver the best patient care. Times of change, like we are experiencing now, give us the opportunity to adapt and improve things that we have been doing well for some time. I am committed to continuing our core services of education, research, and advocacy to produce the products and services our Members need as their practice environment changes.

What are you most looking forward to in your new role?

I am looking forward to being able to commit my full-time efforts to working with all of otolaryngology to best position the specialty for continued success in the future. I am looking forward also to working with my many friends and colleagues within the broad spectrum of otolaryngology to accomplish

Meet your new EVP

James C. Denneny III, MD, on his first action items, the Academy's greatest challenges and strengths, and why he became an otolaryngologist

this as a team. I have never had the opportunity to work with such a dedicated and skilled staff such as the one I have inherited in my new job. The collaboration between the staff and the component Members represented by the diverse field of otolaryngology will be essential to all of our success.

What are the first actions you will take as executive vice president/CEO?

I have attended several meetings with **David R. Nielsen, MD**, including the ASAE (American Society of Association Executives), the AMA interim meeting, and the CMSS (Council of Medical Specialty Societies), met with the staff of the Academy, and planned our inaugural otolaryngology specialty summit to coincide with the Academy's strategic planning meeting. **Robert H. Miller, MD**, and I have met and will continue to meet to explore ways the American Board of Otolaryngology and the Academy can work together for our Members' and patients' benefit.

What do you see as some of the biggest challenges?

The changes in the healthcare delivery system create a great challenge for the Academy. We are trying to provide our Members with the tools they need to provide the best patient care as well as maintain viable practice settings. We are trying to produce educational and quality materials based on a system that has not yet been defined. The political climate has changed following the last election and will affect our advocacy positions, too. Specifically, it will make repeal of the Sustainable Growth Rate payment formula more difficult.

What are the greatest strengths of the Academy and the Foundation?

The Academy's greatest strength lies in the extraordinary support it gets from its dedicated and loyal membership and staff. The efforts these groups give on behalf of our specialty and patients enable our education, research, and advocacy efforts. The breadth and depth of their skill and knowledge directly relate to the Academy's ability to be a leader in these areas. The scientific innovation within the field of otolaryngology itself over our broad range of specialty groups gives great strength to our efforts as well.

What are your hopes for the March Otolaryngology Summit?

This is an important gathering for leaders from our specialty areas as well as the American Board of Otolaryngology and The Triological Society. I would hope that frank discussions

can be conducted that would allow us to ascertain areas where we can work well together and synergize our resources and goals. It is important that a small specialty such as otolaryngology work together whenever possible to maximize our effectiveness in education, research, advocacy, and Member services. I would hope this type of meeting would become a regular event for our specialty leaders in the future. Establishing a good working dialogue would be an essential step for these opportunities to come to fruition.

Who has influenced you as a leader?

I have had the opportunity to observe and work with a number of great leaders and observe different styles that they used. I have incorporated valuable insights from many including **Harold C. Pillsbury III, MD**; **C. Ron Cannon, MD**; **Jonas T. Johnson, MD**; **KJ Lee, MD**; and Dr. Nielsen. However, the person who started me out in Academy activities and most influenced my leadership style was **M. Eugene Tardy, MD**. In addition to being a premier facial plastic surgeon, Dr. Tardy was also a unifying leader in the specialty.

Why did you become an otolaryngologist?

When I was growing up as a child I had extensive problems with my tonsils, allergies, and sinuses. My experiences related to diagnosis and treatment of these problems led me to medicine in general. When I was in high school, my friendship with **Willard B. Moran, MD**, helped me to finalize my decision to go into otolaryngology as a specialty. Interestingly enough, in my first job at The University of Texas-Houston, I took over the office of Herbert H. Harris, MD, who had taken my tonsils out 20 years earlier.

What would members be most surprised to learn about you?

I like operating heavy equipment and driving classic "muscle" cars.

What do you like to do when you aren't working?

I like being outdoors in almost any activity. I enjoy working on my family farm that has been in the family since 1819. I also enjoy hunting, fishing, and watching baseball. Some of my most memorable times have been on family trips both within the United States and abroad. I try to exercise on a nightly basis, which is relaxing for me. ■

What the final CY 2015 Medicare Physician Fee Schedule means for you

On October 31, 2014, the Centers for Medicare & Medicaid Services (CMS) posted the final Medicare physician fee schedule (MPFS) for calendar year (CY) 2015. Several key provisions of the MPFS positively affect otolaryngologists. While the final rule included several positive provisions, the Academy remains concerned regarding CMS' decision to affirm policies that have the potential to negatively influence the specialty. Some of the key provisions Members should be aware of from the final rule include:

Medicare Sustainable Growth Rate (SGR)

Within the final rule, CMS projects that the conversion factor (CF) for the first three months of CY 2015 would be $35.8013 (compared to the 2014 CF of $35.8228). This estimate is based on a zero percent update (through March 31, 2015, as provided under the Protecting Access to Medicare Act of 2014 [PAMA]) and the adjustments necessary to maintain budget neutrality for the policies adopted in this final rule. CMS applies this CF to all of CY 2015 for purposes of completing its regulatory impact analysis, however, absent further Congressional action, a Medicare Sustainable Growth Rate (SGR)-induced reduction of more than 20 percent would occur on April 1, 2015 (CF of $28.2239).

As in previous years, we are hopeful that Congress will take action to avoid the impending cut due to the SGR before the March 31, 2015, deadline.

Estimated overall influence on total allowed charges for ENT services

The overall influence of the CY 2015 final rule for otolaryngology–head and neck surgery is zero percent. *It is important to note that the estimate* ***does not include*** *the proposed reduction attributable to the SGR absent a Congressional fix prior to March 31, 2015, and is not necessarily reflective of changes that may occur among families of codes within any given specialty designation.*

Establishing RVUs for 2015

While the overall impact is zero percent, the Academy is pleased to announce that as a result of our advocacy and comments on the 2014 final MPFS rule, **we were**

able to obtain increases for eight ENT services for CY 2015, including increased values for rigid esophagoscopy, TNE, and some flexible esophagoscopy codes. Additionally, for all services the RUC surveyed in the CY 2014 cycle, CMS affirmed the RUC valuation. More specifically, CMS affirmed the RUC recommended value for Endoscopic Zenker's Diverticulum and VNG codes. For additional payment policy and RVU details, view our RUC summary at **http://www.entnet.org/sites/default/files/ruc_summary_of_2015_final_mpfs.pdf**.

Practice expense

CMS revisited its CY 2014 proposed policy to limit the nonfacility PE RVUs for individual codes so the total nonfacility PFS payment amount would not exceed the total combined amount that Medicare would pay for the same code in the facility setting. CMS continues to believe there are various possibilities for leveraging the use of available hospital cost data in the PE RVU methodology to ensure that the relative costs for PFS services are developed using data that is auditable and comprehensively and regularly updated. Although CMS include details about this policy in final rule, agency representatives have indicated to specialty society staff that it is likely to be included in the CY 2016 MPFS proposed rule.

> "The Academy is pleased with our success rate in obtaining fair and appropriate valuation for otolaryngology services. This success is due, in large part, to our ability to integrate clinical input from specialty societies within otolaryngology via appointed liaisons on the CPT/RVU committee, as well as feedback from relevant subject matter experts on other Academy committees."
>
> **Jane Dillon, MD, MBA**
> *Coordinator for Practice Affairs*

Table 1. 2015 PQRS changes

NEW INDIVIDUAL MEASURES	INDIVIDUAL CROSS-CUTTING MEASURES	MEASURES WITH NQS DOMAIN CHANGES	MEASURES REMOVED IN 2015	CHANGES TO HOW MEASURES CAN BE REPORTED	CHANGES TO MEASURE GROUPS	CHANGES TO GPRO MEASURES
CMS has **added** 20 measures in CY 2015.	CMS has finalized the inclusion of 19 measures in the cross- cutting measures set.	CMS has changed the NQS domain for 23 measures.	CMS has **removed** 50 measures.	CMS has changed the way 33 measures are reported.	CMS has increased the required minimum number of measures in measures groups from 4 to 6. As a result of Academy Advocacy, CMS has **added 2 new measures groups: Sinusitis and AOE**. CMS has removed 6 measures groups, including perioperative care.	CMS has added 4 measures to GPRO and removed 4 measures.

Valuation of the global surgical package

Members should be aware that within the 2015 final rule there is a major change to reporting global surgical procedures. CMS finalized a two-year transition of all 010 (by 2017) and 090 (by 2018) global services to a 000 global. CMS is scheduled to begin this transition by February 2016, but does not have a methodology for operationalizing the transition. In the rule, CMS encourages stakeholders to provide input and/or recommendations for the best method. This policy, coupled with the aggressive timeline, has a number of potential consequences, and because of such the Academy is advocating for rescission or at least a delay. As part of the surgical coalition, we sent a letter (dated December 2, 2014) to Congress urging repeal of this policy and in our final comments (submitted December 30, 2014) we reiterated our concerns. The Academy then attended the Surgical Coalition meeting on January 12, 2015. We will continue to advocate on this issue and will keep members apprised of all pertinent information.

Potentially misvalued services

CMS identified 10 additional potentially misvalued codes relevant to otolaryngology, using a new screening process that targets codes the typical identification process overlooks. *However, within the final rule, CMS rescinded this screen as a result of their decision to finalize the transition of all codes to 000 globals by 2018. Rather, they directed that the RUC should focus their efforts on how to operationalize that policy change, and delayed this screen and review of associated codes to a time uncertain.*

Physician Quality Reporting System (PQRS)

Within the final rule, CMS addressed proposals regarding PQRS measures for 2015 and beyond. More specifically, the perioperative measures group has been removed as a reporting option, although CMS has retained several of the individual perioperative measures, which will continue to be available for PQRS in 2015 via claims and registry reporting options. Further, CMS has included additional measures groups that directly benefit otolaryngologists. The Academy is pleased that, as a direct result of its advocacy efforts, measures groups for sinusitis and acute otitis externa (AOE) have

Table 2. 2015 VM changes

PERFORMANCE YEAR /VM YEAR	SIZE OF PRACTICE	PARTICIPATE IN PQRS	VM OUTCOME
2015 /2017	Solo practitioners and groups with 2-9 EPs	Yes (Category 2)	Neutral or incentive* (+2.0%) (Depending on quality tiering)
	Solo practitioners and groups with 2-9 EPs	No (Category 1)	-2.0% penalty
	10+	Yes (Category 1)	-2.0% to -4.0% penalty neutral or incentive* (+2.0% to +4.0%) (Depending on quality tiering)
	10+	No (Category 2)	-4.0% penalty

**Groups and solo practitioners receiving an upward adjustment are eligible for an additional +1.0 percent if their average beneficiary risk score is in the top 25 percent of all beneficiary risk scores nationwide.*

been newly added for PQRS reporting. In 2015, members may report via the Asthma, Sleep Apnea, Sinusitis, or AOE measures groups. Members should consider reporting via the PQRS*wizard*. Information is available at http://www.entnet.org/content/pqrswizard. See **Table 1** for a brief synopsis of some of the changes made.

CMS also finalized several other proposals, including changes to the 2017 payment adjustment, criteria for individual reporting, changes to individual reporting requirements, and changes to group practice reporting requirements. Members are encouraged to review the Academy's final rule summary to ensure they are prepared for these important adjustments.

Value Based Payment Modifier (VM)

The VM assesses both quality of care furnished and the cost of care under the MPFS. CMS began with a phase-in of the VM in 2015 and will apply to all physicians by January 1, 2017. Implementation of the VM is based on participation in PQRS. In 2015, CMS is expanding the application to groups between two and nine EPs groups and solo practitioners, but will hold harmless from a VM penalty if they participate in PQRS even if they do not meet reporting requirements. See **Table 2**. For specifics on 2015 VM requirements, additional information is available on the Academy website at http://bit.ly/entVBPM.

Physician compare

As Members know, CMS was required to develop a Physician Compare website with information on physicians enrolled in the Medicare program. Using a phased-in approach, CMS also publicly posts information on EPs and their participation with the PQRS program. Within the CY 2015 MPFS final rule, CMS finalized several proposals, including, but not limited to: 1. Publicly reporting all 2015 PQRS measures for individual EPs collected through a registry, EHR, or claims; and 2. Publicly report all 2015 PQRS Group Practice Reporting (GPRO) measures reported via the web interface, EHR, and registry for group practices of two or more EPs and all measures reported by ACOs with a minimum sample size of 20 patients. Additional finalized proposals are outlined in detail in the Academy summary of the 2015 final MPFS rule.

More information

Members are encouraged to review the detailed summary of the final rule. Both the summary and final comments are located on the Academy's Regulatory Advocacy page at http://www.entnet.org/content/advocacy. Please contact the Health Policy unit with questions at http://www.entnet.org/content/practice-management-tool. ■

CLINICAL PRACTICE GUIDELINE

Allergic rhinitis

Adapted from the February 2015 Supplement to ***Otolaryngology–Head and Neck Surgery***. Read the guideline at **otojournal.org**.

EDITOR'S NOTE: This online article contains a revision that was too late to be included in the print edition of this *Bulletin*. The updated Guideline recommendation appears below under the sub-headline: **Chronic conditions and comorbidities**.

Allergic rhinitis (AR), estimated to affect nearly one in six Americans and generate $2 billion to $5 billion dollars in direct health expenditures annually, is the topic of the latest AAO-HNSF clinical practice guideline, released this month.

"The guideline makes clear and specific recommendations on what should be and should not be the first line of medication for allergic rhinitis," explained Sandra Y. Lin, MD, one of the guideline's authors. "That will be of great interest to clinicians, as well as the recommendation on immunotherapy as it expands the indicators to include patients who want therapy to modify their immune systems' responses to allergens."

What might surprise readers about the guideline's 14 recommendations? "Acupuncture," Lin said. "Some may not expect the recommendation regarding acupuncture as I think U.S. physicians may be less familiar with the literature that supports its use."

The guideline's 14 recommendations were developed to optimize patient care and address quality improvement opportunities for all clinicians, in any setting, who are managing patients with AR. The full guideline, as well as other resources, is available at www.entnet.org/AllergicRhinitisCPG.

Guideline recommendations

Patient history and physical examination

Clinicians should make the clinical diagnosis of allergic rhinitis when patients present with a history and physical exam consistent with an allergic cause and one or more of the following symptoms: nasal congestion, runny nose, itchy nose, or sneezing. Findings of AR consistent with an allergic cause include, but are not limited to, clear rhinorrhea, nasal congestion, pale discoloration of the nasal mucosa, and red and watery eyes.

Allergy testing

Clinicians **should** perform and interpret, or refer to a clinician who can perform and interpret, specific IgE (skin or blood) allergy testing for patients with a clinical diagnosis of allergic rhinitis who do not respond to empiric treatment, or when the diagnosis is uncertain, or when knowledge of the specific causative allergen is needed to target therapy.

Imaging

Clinicians **should not** routinely perform sinonasal imaging in patients presenting with symptoms consistent with a diagnosis of allergic rhinitis.

Environmental factors

Clinicians **may** advise avoidance of known allergens or may advise environmental controls (i.e. removal of pets, the use of air filtration systems, bed covers, and acaricides [chemical agents that kill dust mites]) in allergic rhinitis patients who have identified allergens that correlate with clinical symptoms.

Chronic conditions and comorbidities

Clinicians **should** assess patients with a clinical diagnosis of allergic rhinitis for, and document in the medical record, the presence of associated conditions such as asthma, atopic dermatitis, sleep disordered breathing, conjunctivitis, rhinosinusitis and otitis media.

Topical steroids

Clinicians **should** recommend intranasal steroids for patients with a clinical diagnosis of allergic rhinitis whose symptoms affect their quality of life (QOL).

Oral antihistamines

Clinicians **should** recommend oral second generation/less sedating antihistamines for patients with allergic rhinitis and primary complaints of sneezing and itching.

Intranasal antihistamines

Clinicians **may** offer intranasal antihistamines for patients with seasonal, perennial, or episodic allergic rhinitis.

Oral Leukotriene Receptor Antagonists (LTRAs)

Clinicians **should not** offer oral leukotriene receptor antagonists as primary therapy for patients with allergic rhinitis.

Combination therapy

Clinicians **may** offer combination pharmacologic therapy in patients with allergic rhinitis who have inadequate response to pharmacologic monotherapy.

Immunotherapy

Clinicians **should** offer or refer to a clinician who can offer immunotherapy (sublingual or subcutaneous) for patients with allergic rhinitis who have inadequate response to symptoms with pharmacologic therapy with or without environmental controls.

Inferior turbinate reduction

Clinicians **may** offer, or refer to a surgeon who can offer, inferior turbinate reduction in patients with allergic rhinitis with nasal airway obstruction and enlarged inferior turbinates who have failed medical management.

Acupuncture

Clinicians **may** offer acupuncture, or refer to a clinician who can offer acupuncture, for patients with allergic rhinitis who are interested in non-pharmacologic therapy.

Herbal therapy

No recommendation regarding the use of herbal therapy for patients with allergic rhinitis.

Guideline authors

Michael D. Seidman, MD; Richard K. Gurgel, MD; Sandra Y. Lin, MD; Seth R. Schwartz, MD, MPH; Fuad M. Baroody, MD; James R. Bonner, MD; Douglas E. Dawson, MD; Mark S. Dykewicz, MD; Jesse M. Hackell, MD; Joseph K. Han, MD; Stacey L. Ishman, MD, MPH; Helene J. Krouse, PhD, ANP-BC, CORLN; Sonya Malekzadeh, MD; James (Whit) W. Mims, MD; Folashade S. Omole, MD; William D. Reddy, L.Ac., Dipl.Ac.; Dana V. Wallace, MD; Sandra A. Walsh, BS (MdT); Barbara E. Warren, PsyD, MEd; Meghan N. Wilson, MD, and Lorraine C. Nnacheta, MPH ■

KIDS ENT HEALTH MONTH

Pediatric Chronic Rhinosinusitis in the practice

by **Maria T. Peña, MD**

The AAO-HNSF published a clinical consensus statement (CCS) on pediatric chronic rhinosinusitis (PCRS) in October 2014, which was designed to promote improved patient care, reduce inappropriate variations in care, and educate and empower clinicians and patients on the optimal management of PCRS.[1]

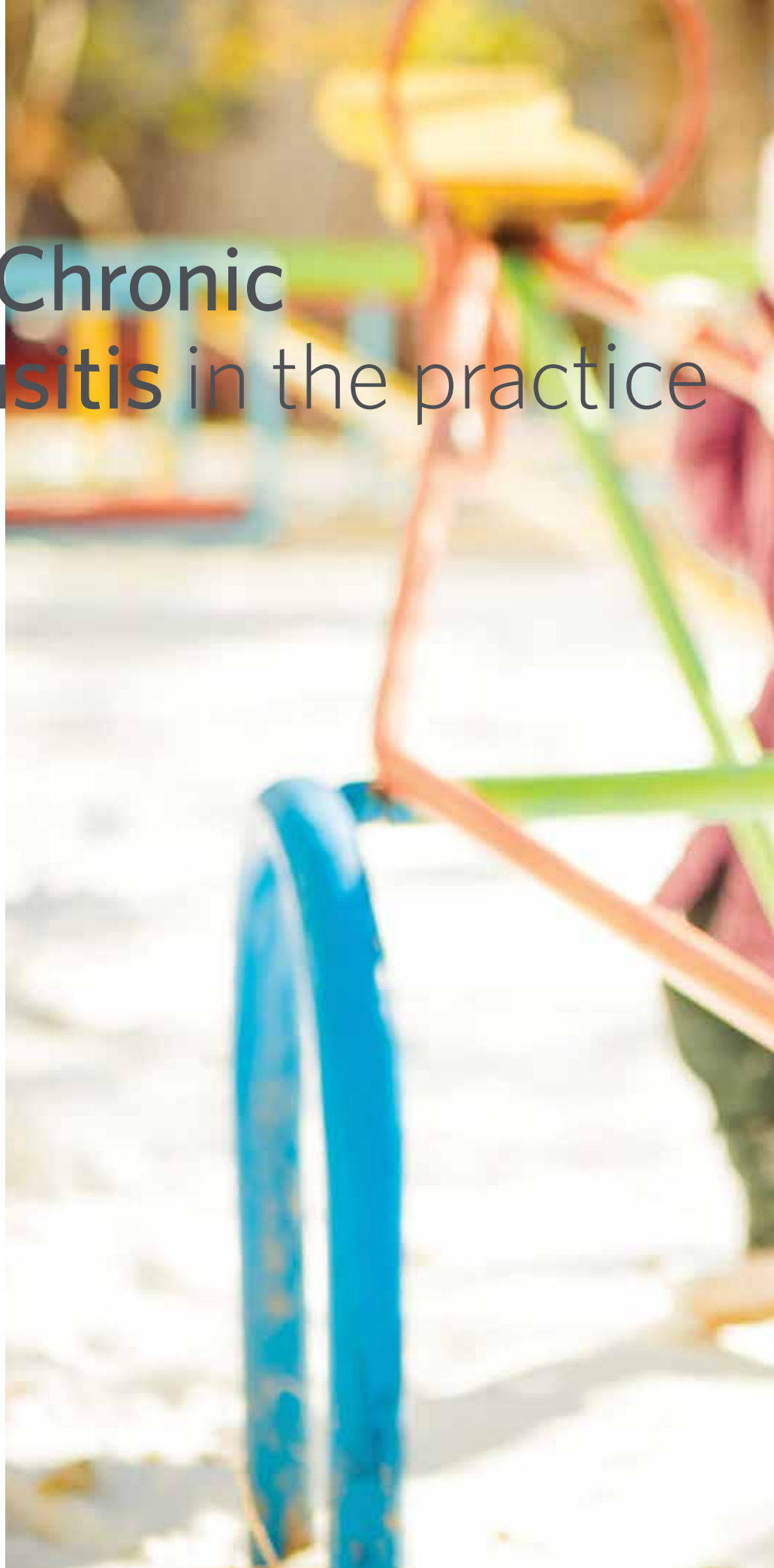
How and why was this CCS developed?

The AAO-HNSF Guidelines Task Force reviewed and selected PCRS for CCS development as PCRS is a clinical problem frequently encountered by otolaryngologists and is associated with a significant influence on quality of life, but with limited evidence-based research to guide clinical management.[2] An expert panel of nine fellowship-trained pediatric otolaryngologists and rhinologists was convened by the AAO-HNSF to create the CCS using a modified Delphi survey method. The latter is a systematic approach to achieving consensus among a panel of topic experts through multiple anonymous surveys.[3]

Panel members completed an initial qualitative survey on clinical aspects and definition of PCRS followed by two Delphi surveys. The survey results were discussed in detail with all the members of the panel via teleconference to determine which items reached consensus. The panel narrowed the scope of the target population to patients 6 months to 18 years of age without craniofacial syndromes or relative immunodeficiency. The target audience for the statement was otolaryngologists. The findings of this consensus group are stated as opinions or suggestions, not as recommendations.

What was the criterion for consensus?

The criterion for consensus is summarized



in the table below[1,4,5] and was established a priori with reference to previous CCSs.[4,5]

Strong consensus	Statements achieving a mean score of 8.0 or higher with no outliers*
Consensus	Statements achieving a mean score of 7.0 or higher and having no more than 1 outlier*
Near consensus	Statements achieving a mean score or 6.50 or higher and having no more than 2 outliers*
No consensus	Statements that did not meet the criteria of consensus or near consensus

**Outliers were defined as any rating two or more Likert points from the mean.[1,4,5]*

How was PCRS defined?

The consensus definition of PCRS is the presence of two or more of the following symptoms: purulent rhinorrhea, nasal obstruction, facial pressure/pain or cough for at least 90 days of continuous duration, and either endoscopic signs of mucosal edema, purulent drainage, or nasal polyposis and/or CT scan changes consistent with mucosal changes in the ostiomeatal complex and/or sinuses.[1]

What is maximal medical management for PCRS?

Extended courses of antibiotics have been recommended for PCRS compared with acute uncomplicated pediatric sinusitis, but the optimal duration of therapy remains unclear. The consensus panel agreed that 20 consecutive days of antibiotic management may produce a better response than 10 days of antibiotic therapy. In patients who do not respond initially, culture directed antibiotic therapy may improve outcomes.

The panel also agreed that daily nasal saline irrigations[6] and intranasal steroid use with or without antibiotic[7] are useful adjunctive therapies for PCRS. Nasal saline is effective at clearing the mucus and the nasal steroid spray is effective in relieving the congestion and rhinitis. Since the literature currently does not support a significant relationship between PCRS and gastroesophageal reflux (GERD), there was no consensus regarding the impact of GERD on the pathophysiology of PCRS.

There was consensus that empiric therapy for GERD is not beneficial.

What is the role of adenoidectomy in the management of PCRS?

Adenoidectomy has been shown to decrease the load of nasopharyngeal pathogens associated with PCRS.[8,9] Additionally, adenoidectomy is clinically effective in the treatment of children with PCRS based on a meta analysis of eight PCRS studies.[10] Given this evidence, there was consensus that adenoidectomy is an appropriate initial surgical intervention in children with CRS from 6 to 12 years of age and strong consensus for patients younger than six.

The panel also agreed that adenoidectomy can have a beneficial therapeutic effect independent of endoscopic sinus surgery (ESS). The ability of the adenoid to serve as a bacterial reservoir for the development of PCRS is not related to the size of the adenoid, so lateral plain films are not recommended to evaluate the adenoid in PCRS. Tonsillectomy without adenoidectomy is not useful in the treatment of PCRS.

What other surgical therapies may be considered after medical management, adenoidectomy, or both have failed?

Endoscopic Sinus Surgery (ESS) has been shown to be a safe and effective therapy for PCRS in patients who have failed maximal medical management[11,12] and patients undergoing ESS have more severe disease compared to those managed with antibiotics or adenoidectomy.[11] Due to this and other supporting evidence, there was consensus that ESS is effective for managing PCRS and is best performed when medical therapy, adenoidectomy, or both, have not been successful.

There was strong consensus that image-guided ESS was helpful for cases where anatomical landmarks may be distorted due to extensive nasal polyps or previous sinonasal surgery and that a CT scan of the paranasal sinuses is indicated prior to ESS. There was not convincing evidence that clinically relevant long-term facial growth is impaired after ESS.

Balloon catheter sinuplasty (BCS), performed endoscopically with a balloon over a guide-wire, recently has been developed and used for PCRS management and was reviewed by the panel. No consensus could be reached about the efficacy of BCS for PCRS with the current evidence.

In contrast to post-ESS treatment paradigm of CRS in adults, post-operative debridement after ESS for PCRS is not essential for treatment success in children. There was no consensus for turbinoplasty as there have been no clinical studies evaluating its benefit in PCRS.

READ MORE ONLINE
References available

ADVANCES IN RHINOPLASTY

Course Directors
Tom D. Wang, MD
David W. Kim, MD
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For additional information, please contact Allegheny General Hospital, Continuing Medical Education by e-mail to **cjackel@wpahs.org**, by phone at 412-359-4952, or by fax at 412-359-8218. To download a brochure or to register online, please visit our Web site at **www.aghcme.org**. Select Conference Schedule on the left, then scroll until you find the appropriate Temporal Bone Course.

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LSUHSC
Department of Otolaryngology – Head and Neck Surgery
Assistant Professor (non-tenure, full-time clinical track)

The Department of Otolaryngology-Head and Neck Surgery of LSU Health Sciences Center is actively seeking applicants for a full-time faculty position at the rank of Assistant Professor (non-tenure, clinical track). Qualified applicants must be BC/BE in Otolaryngology – Head and Neck Surgery, fellowship trained in Head and Neck Oncology - Microvascular / Reconstruction and licensed or eligible for licensure to practice medicine in Louisiana.

This is an excellent opportunity to join our growing practice. Responsibilities include patient care, resident and medical student education, and the pursuit of clinical research. Extensive collaborative research opportunities are available. Our faculty team members enjoy liberal cross-coverage for weekend and holiday on-call responsibilities and share the benefit of subspecialty support in otology, laryngology, head and neck oncology, pediatric otolaryngology, and plastic/reconstructive surgery.

Salary and rank will be commensurate with the knowledge, education and experience of the individual. Candidates interested in working within a dynamic and stimulating setting combined with a generous package of related benefits are encouraged to provide a cover letter and current Curriculum Vitae to: SOM-Jobs@lsuhsc.edu; reference ENT - Microvascular position.

The School of Medicine does not participate in sponsoring faculty candidates for the Department of Health and Hospitals' Conrad 30 Program.

LSUHSC-NO is an Equal Opportunity Employer for females, minorities, individuals with disabilities and protected veterans.

THE UNIVERSITY of TENNESSEE HEALTH SCIENCE CENTER

Head and Neck Surgeon – The Department of Otolaryngology Head and Neck Surgery of University of Tennessee Health Science Center, is recruiting a mid-career Head and Neck Cancer surgeon to lead its Division of Head and Neck Surgery. This individual must, have a proven record of collaborative multi-specialty clinical experience, an interest in clinical translational research, be well published, and nationally recognized. The position will be tenure-track at either the Associate/ Professor rank as appropriate. The individual will join another surgeon, and be a leader in a large established multi-specialty Cancer Treatment Team, The West Group, as well as be closely affiliated with Methodist University Hospital.

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Candidates must be able to obtain a Tennessee medical license.

Letters of inquiry and curriculum vitae should be sent to:

Jerome W. Thompson, M.D., MBA, Chairman
Department of Otolaryngology-Head and Neck Surgery
The University of Tennessee Health Science Center
910 Madison Avenue, Suite 408
Memphis, TN 38163

Or email to: jkeys@uthsc.edu

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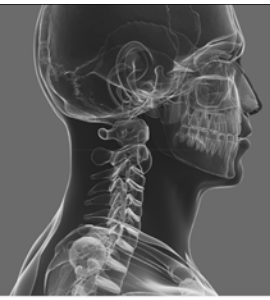

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Interested applicants should forward CV to:

Ellie Maghami, M.D., F.A.C.S.
Associate Professor and Chief, Division of Otolaryngology/Head and Neck Surgery
City of Hope
1500 E. Duarte Road, Duarte, CA 91010
Phone 1-626-471-7100
Fax 1-626-471-9212
emaghami@coh.org

MED-17453

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— Samuel Golter

OTOLARYNGOLOGY-DARTMOUTH-HITCHCOCK
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POSITION ANNOUNCEMENT
Academic Position – Rhinologist/Generalist
University of Washington
Otolaryngology-Head and Neck Surgery • Seattle, Washington

The University of Washington Department of Otolaryngology-Head and Neck Surgery seeks candidates for a full-time rhinologist/generalist position as Assistant Professor without tenure (0113). This position would be a multi-year appointment with a 12-month service period. Individuals for this outstanding opportunity should have interest and experience in rhinology and sinus surgery. This position will also have a high volume practice in all aspects of general otolaryngology. Candidates should have a background and interest in clinical research that focuses on these areas critical to our specialty.

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Minimum qualifications include an MD (or equivalent), certified or eligible for certification by the American Board of Otolaryngology, and eligible for a Washington State medical license. In order to be eligible for University sponsorship for an H-1B, graduates of foreign (non-US) medical schools must show successful completion of all three steps of the US Medical Licensing Exam (USMLE), or equivalent as determined by the Secretary of Health and Human Services.

Send letter of interest and CV to:
Neal D. Futran, MD, DMD
University of Washington
Oto-Head & Neck Surgery, Box 356515
Seattle, WA 98195-7923
nfutran@uw.edu

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Memorial Healthcare System

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To inquire or learn more about this opportunity, visit memorialphysician.com.

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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# 0824589. Please attach electronic copies of a current CV and a letter of interest to the application.

In addition, please submit three (3) letters of reference to the email address below. Applications will not be considered complete until all three (3) letters of reference are received. This position **will remain open until filled**. For more information and to submit letters of reference, please contact Erica Bennett, M.D., at ***EBennett@salud.unm.edu***.

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Due to increased patient demand and institutional support for expansion, the Division of Otology & Neurotology in the Department of Otolaryngology - Head and Neck Surgery at University Hospitals Case Medical Center in Cleveland, Ohio is seeking to add a fellowship trained otologist/neurotologist to our team. Our program currently averages over 13,000 wRVUs per cFTE and continues to grow. We have two providers in the division at this time and would like to expand with the addition of a junior faculty member. The propsective candidate will have clinical and teaching responsibilities.

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Candidates should forward a current CV to: Maroun.Semaan@UHhospitals.org

Candidates may also mail a current CV to:
Maroun T. Semaan, MD, FACS
Director, Division of Otology and Neurotology
Ear, Nose and Throat Institute
University Hospitals Case Medical Center
c/o Kim Kuivila
11100 Euclid Avenue
Mailstop LKS5045
Cleveland, OH 44106

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You'll join a highly skilled team making an extraordinary difference in the lives of patients across our entire state. Ours is a collaborative atmosphere that encourages you to grow and evolve as you practice advanced medicine in a highly satisfying academic setting.

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Otolaryngology

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Department of Otolaryngology – Head and Neck Surgery
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This is an excellent opportunity to join our growing practice. Responsibilities include patient care, resident and medical student education, and the pursuit of clinical research. Extensive collaborative research opportunities are available. Our faculty team members enjoy liberal cross-coverage for weekend and holiday on-call responsibilities and share the benefit of subspecialty support in otology, laryngology, head and neck oncology, pediatric otolaryngology, and plastic/reconstructive surgery.

Salary and rank will be commensurate with the knowledge, education and experience of the individual.

Interested candidates should provide a cover letter and current Curriculum Vitae to: **SOM-Jobs@lsuhsc.edu**; reference Otology/Neurotology position.

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

ENT / OTOLARYNGOLOGY

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For consideration and/or additional details, please submit your CV and Letter of Introduction to:

Daniel Kim MD
Department of Otalaryngology-Head and Neck Surgery
UmassMemorial Medical Center
c/o Jennifer Pappas,
Physician Recruiter
Email: jennifer.pappas@umassmemorial.org
Phone: 774-312-0483

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UAB MEDICINE
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Head and Neck Oncologist/Reconstructive

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This opening is an excellent opportunity for a head and neck oncologist/reconstructive surgeon with a strong interest in academic growth and excellent clinical experience. The successful candidate will receive access to state-of-the-art operating facilities and clinic space. The University of Alabama at Birmingham exhibits academic opportunities through its Otolaryngology Residency Program, its medical school, and active clinical and basic research. The successful candidate will receive salary and benefits commensurate with their experience.

Letters of inquiry and curriculum vitae should be sent to the Chair of the Search Committee:

William R. Carroll, MD, FACS
wcarroll@uabmc.edu
205.934.9767

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Join a Prestigious Otology & Neurotology Practice in Chicago!

The Ear Institute of Chicago is seeking a partner to join their busy practice, which specializes in Otology & Neurotology. The practice includes a team of Audiologists.

The Ear Institute of Chicago is a member of Adventist Health Partners and the Adventist Health System, a nationally integrated health system.

Such a system offers substantial income potential, a large referral network, and security in the changing healthcare environment.

BENEFITS
Health, Dental, and Vision Insurance along with 401(k) and 457(b) Retirement Savings.

Must be Board-Eligible or Board-Certified in Neurotology.

For more information contact Niki Conforti at Niki.Conforti@ahss.org

AdventistHealthPartners.com

Adventist Health Partners
Keeping you well

Pediatric Otolaryngologist
FULL-TIME BC/BE FACULTY

The Department of Otolaryngology at UTMB Health in Galveston, Texas is actively recruiting enthusiastic candidates for a full-time position. This job entails opportunities to participate in all aspects of clinical practice, as well as resident and medical student teaching. UTMB Health is undergoing rapid growth as exemplified by the building of two cutting-edge surgical hospitals and the acquisition of a third. With a light call schedule and generous benefits, this is an outstanding opportunity in one of the fastest growing geographic regions in the country. Clinical research is encouraged but not mandatory.

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 Health

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

Bulletin Content

AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY

AT YOUR FINGERTIPS

Read the *Bulletin* online or on your mobile device at
www.entnet.org/educationandresearch/bulletin.cfm

The Department of Otorhinolaryngology-Head & Neck Surgery is recruiting faculty members with interests in facial plastic & reconstructive surgery, head & neck surgery, pediatric ENT and rhinology.

This is a unique opportunity to join a growing, established academic practice at a large medical center in an urban setting. Fellowship training preferred, but not required. Academic appointment commensurate with experience. Great salary and benefits. Excellent opportunities for teaching and research.

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

Applicants should forward a CV and statement of interest to:
Martin J. Citardi, MD (chair)
The University of Texas Medical School at Houston
Department of Otorhinolaryngology-Head & Neck Surgery
866-205-6487 (fax)
martin.j.citardi@uth.tmc.edu
www.ent4.me/recruit

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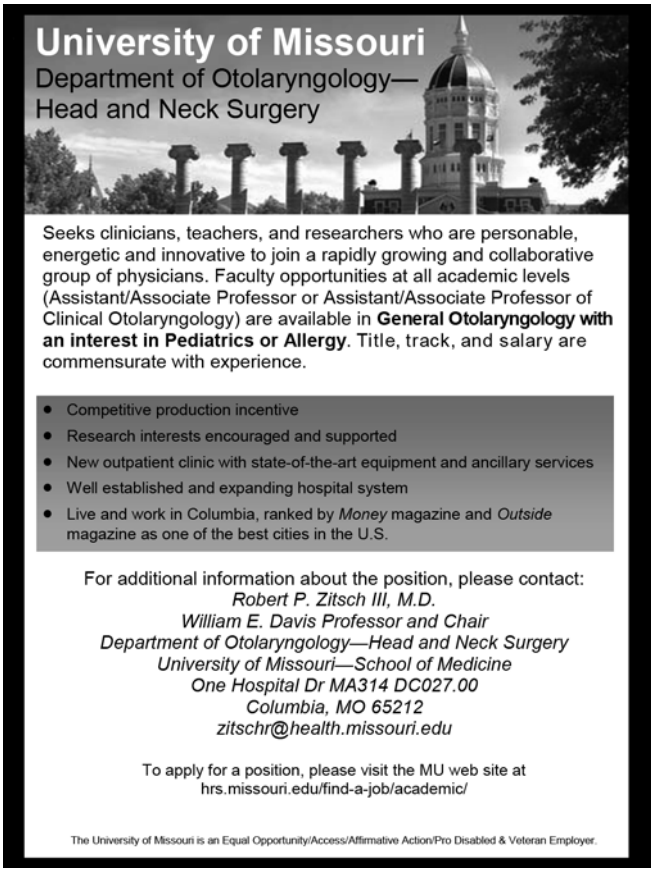

Seeks clinicians, teachers, and researchers who are personable, energetic and innovative to join a rapidly growing and collaborative group of physicians. Faculty opportunities at all academic levels (Assistant/Associate Professor or Assistant/Associate Professor of Clinical Otolaryngology) are available in **General Otolaryngology with an interest in Pediatrics or Allergy**. Title, track, and salary are commensurate with experience.

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

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

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

The University of Missouri is an Equal Opportunity/Access/Affirmative Action/Pro Disabled & Veteran Employer.

Leading South Florida Healthcare Systems Seeks

Pediatric Otolaryngologist

Joe DiMaggio Children's Hospital
AT MEMORIAL
1005 Joe DiMaggio Drive / Hollywood, Florida 33021

About the Opportunity:

The Division of Pediatric Otolaryngology-Head and Neck Surgery at Joe DiMaggio Children's Hospital seeks a motivated BC/BE fellowship-trained pediatric otolaryngologist interested in growing our rapidly expanding tertiary-care division. This is a robust outpatient and hospital-based program, with dedicated pediatric audiology, mid-level practitioners, and a diverse patient population. Our services include an established aerodigestive team, a Cochlear Implant Center, pediatric videostroboscopy, and the busiest Craniofacial Center in Florida. Qualified candidates should have an interest in head and neck surgery, airway, vascular malformations, or otology. Excellent opportunities exist for interdisciplinary collaboration, program development, research, and teaching. We also have a new affiliation with a four-year allopathic medical school. Emergency room call is 1:7. This is a full-time employed position within the multi-specialty Memorial Physician Group. The position offers competitive benefits, and a compensation package that is commensurate with training and experience. Professional malpractice and medical liability is covered under sovereign immunity.

About Joe DiMaggio Children's Hospital:

Joe DiMaggio Children's Hospital (JDCH) is a 204-bed facility with a 22-bed Pediatric Intensive Care Unit and a 64-bed Level III Neonatal Intensive Care Unit, which is expanding to 80+ beds in 2015. JDCH opened in 1992 and is located in Hollywood, Florida. As South Florida's newest freestanding children's hospital, Joe DiMaggio Children's Hospital is redefining the pediatric healthcare experience. We combine cutting-edge excellence with a commitment to patient- and family-centered care, and have the largest and most diverse group of board-certified pediatric specialists in the region. Thanks to exemplary medical expertise, advanced technology, and exclusive pediatric programs, JDCH has earned the distinction of being the leading children's hospital in Broward and Palm Beach counties. JDCH is the only Pediatric Trauma Center in south Broward County. We're continuing to pioneed revolutionary programs that define the standard in pediatric care. To learn more, please visit JDCH.com.

About South Florida:

South Florida offers quality of life, miles of pristine beaches, is rich in cultural and recreational amenities, top-rated golf courses, museums, and world-class dining. The greater Ft. Lauderdale area offers numerous communities in which to raise a family. In addition, Florida has no state income tax.

To inquire or learn more about this opportunity, visit memorialphysician.com.

The Center for Hearing and Balance Disorders

Neurotologist

The Center for Hearing and Balance Disorders is seeking a board certified/board eligible neurotologist to join a successful practice in the St. Louis area. The candidate will be joining a practice of two very busy neurotologists, one of whom is seeking to retire in the near future. This practice has a nationally recognized cochlear implant program, as well as an active emphasis on skull base surgery. Clinical research opportunities and resident teaching are available if desired.

The Center is offering a competitive salary with full benefits and a rapid pathway to partnership.

Interested Candidates should submit a cover letter and CV to:

Jacques A. Herzog, MD

Email Office Manager: sharonj@stlouisear.com
Address: The Center for Hearing and Balance Disorders
226 South Woods Mill Rd. Suite 58W
Chesterfield, MO 63017
www.stlouisear.com

DEPARTMENT OF OTORHINOLARYNGOLOGY
UNIVERSITY OF OKLAHOMA HEALTH SCIENCES

POSITION AVAILABLE: RHINOLOGIST
DATE AVAILABLE: IMMEDIATELY

The Department of Otorhinolaryngology of the University of Oklahoma Health Sciences Center has a position available for a full-time otolaryngologist at the Assistant or Associate Professor level. Specific expertise is required in rhinology.

Minimum requirements include: Doctoral degree (M.D. or equivalent), Board certification/eligibility, a demonstrable commitment to teaching and an interest in collaborative research.

Responsibilities will include program development and patient care, resident and medical student education, and research.

Letters of interest with accompanying CV should be directed to: Greg A. Krempl, M.D., F.A.C.S., Attn: Nancy Geiger, Department of Otorhinolaryngology, P.O. Box 26901, Williams Pavilion 1290, Oklahoma City, OK 73126-0901 or via email to nancy-geiger@ouhsc.edu.

The University of Oklahoma is an Affirmative Action and Equal Opportunity Employer. Individuals with disabilities and protected veterans are encouraged to apply.

SOUTHERN CALIFORNIA FELLOWSHIP

The Department of Otolaryngology at Loma Linda University is currently seeking a fellow in Advanced Head & Neck Oncologic Surgery and Microvascular Reconstruction beginning in July 2015. This is a recently restructured one-year program for residents having residency exposure to Head & Neck and Microvascular Surgery. Two-year commitments are also considered on a case-by-case basis respecting the resident's experience, future ambitions, and research interests. Exposure to international fellows is likely, and mission electives are strongly encouraged. This candidate will be the sixth fellow in our program—all of which still practice advanced Head & Neck / Microvascular Surgery.

Currently, 5 full-time fellowship trained Head & Neck surgical oncologists practice at Loma Linda, 3 performing microvascular reconstructions and the others focusing on endocrine and ablative surgery. Two additional Head & Neck oncologic surgeons practice at our VA facility. Two endoscopic skull base surgeons, and two facial plastic/reconstructive surgeons help augment the fellow's experience. Advanced cases will be covered by the fellow preferentially, including: major head and neck ablative cases, microvascular reconstructions, TOLMS/TORS, endoscopic skullbase surgery, open/craniofacial skullbase resections, advanced trauma, and advanced Moh's reconstructions. The fellowship also includes participation in approximately 130 thyroid/parathyroid surgeries, which includes minimally invasive techniques, reoperative surgery, and surgery for non-localizing disease.

The fellow works at Loma Linda University assisting faculty with cases. Fellows choose their cases with limited mentor over-site to ensure a balanced experience. Intraoperative resident teaching and research is expected. The fellow may also assist at the VA or county hospital as interesting cases dictate. No call or clinic responsibilities exist; this is a surgical fellowship, with a focus on operative experience. A California Medical License is required.

Please send a letter of interest and curriculum vitae to **cnoble@llu.edu** or to:
Jared Inman and Alfred Simental
Department of Otolaryngology-Head & Neck Surgery
11234 Anderson St. #2586A, Loma Linda, CA 92354.

LOMA LINDA UNIVERSITY HEALTH

Director of Pediatric Otolaryngology
Assistant Professor, Associate Professor, or Professor (Non-Tenure, Clinical Track)
Anticipated Vacancy

The Department of Otolaryngology-Head and Neck Surgery of the LSU Health Sciences Center is actively seeking an experienced, board certified Pediatric Otolaryngologist to serve as Director of its growing Pediatric Otolaryngology division. This position will carry a full-time university faculty appointment at the rank of Assistant Professor, Associate Professor, or Professor (non-tenure, clinical track); appointment rank will be made commensurate with academic achievements and experience.

This is an outstanding opportunity to join a growing practice in a thriving department and a wonderful city. Children's Hospital of New Orleans, the principal site of this practice, is a 247-bed, not-for-profit medical center offering the most advanced pediatric care; it is the only full-service hospital exclusively for children in Louisiana and it also maintains busy outpatient and community outreach clinics. Critical care is provided in the hospital's 36-bed NICU, 24-bed PICU, and 20-bed CICU. The medical staff includes 40 pediatric specialties and more than 400 physicians.

Responsibilities include serving as Director of a growing Pediatric Otolaryngology practice that is currently composed of three pediatric otolaryngologists, with an institutional commitment for hiring two more in the next two years. The Director's responsibilities include clinical and academic pediatric ENT program oversight, direction and mentorship of junior faculty, active patient care, and resident and medical student education. Extensive collaborative research opportunities are also available. Qualified applicants must be board certified in Pediatric Otolaryngology and licensed or eligible for licensure to practice medicine in Louisiana. A minimum of 7 years' experience in academic and/or clinical practice management is required. Compensation packages are competitive nationally.

Our pediatric faculty members share the benefit of subspecialist support from other department members in otology, laryngology, head and neck oncology, rhinology, skull base surgery, and plastic/reconstructive surgery.

The city of New Orleans is one of the most culturally diverse and fastest growing cities in the country, and residents enjoy outdoor activities and coastal access all year long. New Orleans offers many of the amenities of larger cities but continues to maintain a small town family oriented atmosphere.

Interested applicants should send a CV and cover letter to SOM-Jobs@lsuhsc.edu; reference Pediatric ENT Director.

LSUHSC – Department of Otolaryngology – Head and Neck Surgery
Assistant Professor or Associate Professor (non-tenure, full-time clinical track)

The Department of Otolaryngology-Head and Neck Surgery of LSU Health Sciences Center is actively seeking fellowship trained, BC/BE Pediatric Otolaryngologists for one or two full-time faculty positions at the rank of Assistant Professor or Associate Professor (non-tenure track). Qualified applicants must be licensed or eligible for licensure to practice medicine in Louisiana.

This is an excellent opportunity to join our growing academic practice. Responsibilities include patient care, resident and medical student education. Extensive collaborative research opportunities are also available. The selected candidate will assume a dedicated pediatric otolaryngologist position in a busy clinical practice in a state of the art, free standing Children's Hospital; we are particularly interested in those candidates with special expertise in airway reconstruction and/or sinus surgery.

Children's Hospital is a 247-bed, not-for-profit medical center offering the most advanced pediatric care for children from birth to 21 years. It is the only full-service hospital exclusively for children in Louisiana and the Gulf South. Critical care is provided in the hospital's 36-bed NICU, 24-bed PICU, and 20-bed CICU.

Our faculty members benefit from cross-coverage arrangements for weekend and holiday on-call responsibilities and share the benefit of subspecialty support in otology, laryngology, head and neck oncology, and plastic/reconstructive surgery for complex patients.

New Orleans offers many of the amenities of larger cities but continues to maintain a small town family oriented atmosphere. New Orleans is also one of the most culturally diverse and fastest growing cities in the country, and residents can easily enjoy either an urban or outdoor and coastal lifestyle.

Salary and rank will be commensurate with the knowledge, education and experience of the individual. Candidates interested in working within a dynamic and stimulating setting combined with a generous package of related benefits are encouraged to provide a cover letter with clinical and research interests and current Curriculum Vitae to: SOM-Jobs@lsuhsc.edu;
reference Pediatric Otolaryngologist.

LSUHealthNewOrleans
School of Medicine

The School of Medicine does not participate in sponsoring faculty candidates for the Department of Health and Hospitals' Conrad 30 Program. LSUHSC-NO is an Equal Opportunity Employer for females, minorities, individuals with disabilities and protected veterans. LSUHSC is an AA/EEO employer.


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