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bulletin

American Academy of Otolaryngology—Head and Neck Surgery

MAY 2015

You spoke, we listened

Discover exciting changes as we take the 2015 Annual Meeting & OTO EXPO℠ in Dallas to new heights. 12

Learn more about the Annual Meeting & OTO EXPO℠ with your Preliminary Program, included with this issue

tmj Next Generation™
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Ear Canal Inserts

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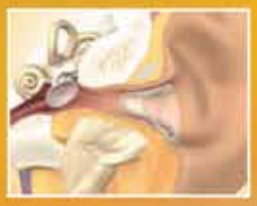
The TMJ NextGeneration™ device is FDA-cleared, safe and effective in reducing TMJ pain.



A New Approach

The TMJ NextGeneration™ device consists of custom ear canal inserts that support the temporomandibular joint and reduce pain. It also provides a "cognitive awareness" to the patient that discourages grinding, clenching and other para-functional behavior.

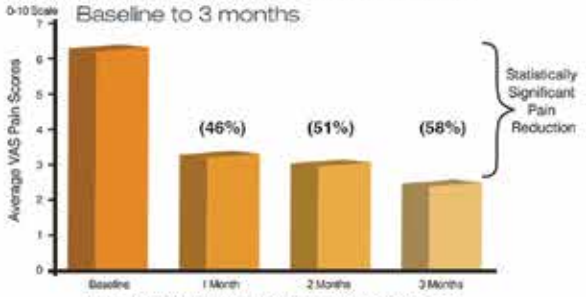
Patient Outcomes

In a clinical trial, subjects experienced statistically significant pain reduction while using TMJ NextGeneration™ devices. Visual Analog Scale scores showed a 58 percent pain reduction after three months of use. At the end of the trial, 100 percent of subjects reported good to excellent results.*

WARNINGS AND PRECAUTIONS: Do not wear devices while showering, swimming or during contact sports. Fluctuations in body weight may require a refitting. You may experience some discomfort when first using the devices. If discomfort worsens, please remove devices and contact your health care provider. Safety and effectiveness has not been established for people with arthritis, and those who have had jaw injuries or jaw or ear surgery. Go to tmjnextgen.com for a full list of risks and warnings.

VAS Pain Reduction Score*

Baseline to 3 months



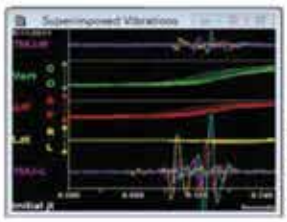
Visual Analog Scale (VAS) scores range from 0 (no pain) to 10 (worst) pain imaginable

TMJ NextGeneration™ Advantages

	TMJ NextGeneration™ Device
• Designed to be worn comfortably 24/7	✔
• No interference with eating or talking	✔
• Barely visible	✔
• No nighttime discomfort	✔
• No negative effect on your bite	✔

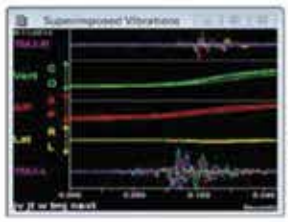
Informal Patient Case Study**

The TMJ NextGeneration™ device supports the jaw joint by preventing the ear canal diameter from collapsing while the jaw opens and closes. This Joint Vibration Analysis (JVA) illustrates the improvement in one patient immediately after insertion.



Initial JVA Summary before insertion of TMJ NextGeneration™

	Average Left	Average Right
Total Integral	28.6	11.7
Integral <200Hz	27.6	10.8
Integral >200Hz	1.0	1.2
>200/<300 Ratio	0.04	0.11
Peak Amplitude	6.1	1.2
Peak Frequency	84	31
Med. Frequency	84	84
Distance to CO	41.5	26.6



JVA Summary after insertion of TMJ NextGeneration™

	Average Left	Average Right
Total Integral	28.3	11.4
Integral <200Hz	23.8	9.7
Integral >200Hz	1.8	1.7
>200/<300 Ratio	0.06	0.17
Peak Amplitude	3.4	0.8
Peak Frequency	60	33
Med. Frequency	74	107
Distance to CO	42.2	28.6

Toll-free number: 855-303-4601

info@tmjnextgen.com • www.TMJNextGen.com

*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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UNRIVALED REWARDS

bulletin

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ONLINE ONLY: Is 'otosclerosis' a misnomer?

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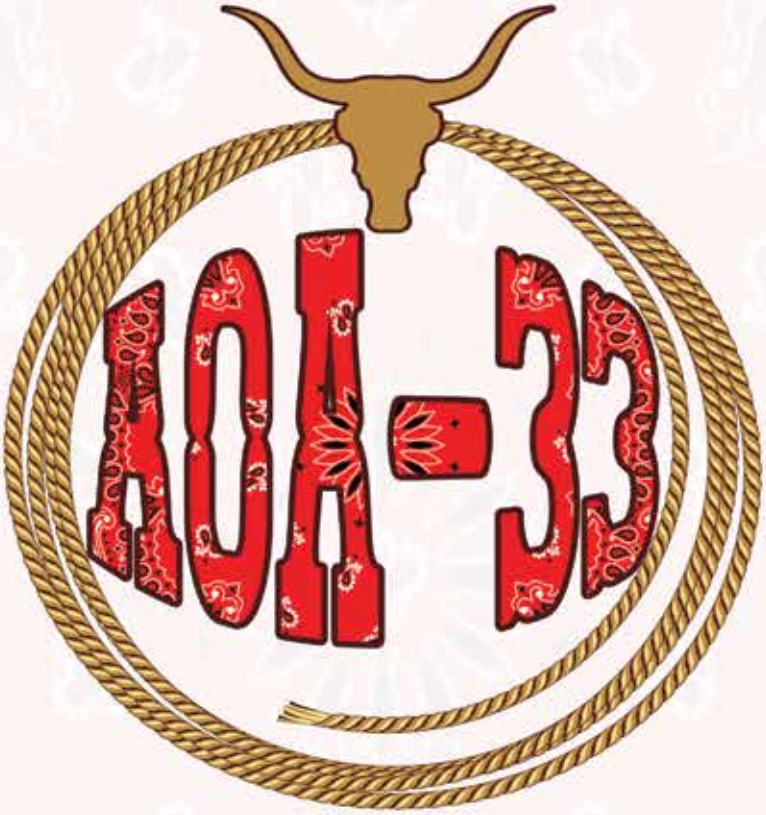

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No political gridlock here

It is election time again for the AAO-HNS! At a time when there is so much polarization in our nation's governance, it is comforting to know that our Academy does not suffer from political gridlock. The April issue of the *Bulletin* contained the statements of candidates who have agreed to stand for leadership positions in our Academy. The dedicated members of our Nominating Committee worked hard to identify Members who have demonstrated commitment to our mission, have agreed to serve, and who inspire confidence in their ability to move us forward. Thus we have an excellent slate of candidates.

Since the last Academy election, a task force, chaired by **Richard W. Waguespack, MD**, thoroughly reviewed our election process, tracing its evolution and comparing our practices to those of comparable organizations. In contrast to many societies, we do have an actual election rather than a presentation of a slate to be confirmed. And our Nominating Committee is structured and charged to consider a large cadre of nominees and volunteers to maximize inclusivity. Thus, we were surprised to learn that our organization is not significantly better than others in terms of voter participation. I would like to think that this is because of the confidence that Members have in the Nominating Committee, but there are undoubtedly other factors at play. The task force identified the time delay between the announcement of the candidates and the actual balloting as a potential suppressor of voter engagement. There seems to be no benefit from this time gap, but it could impair momentum.

You can look at last month's issue, then, for the candidate statements, and follow links to the video statements of the presidential candidates to see and hear them speak. And participate in setting the course of your Academy by voting.

So think about what the candidates have to say. Who comes closest to articulating your personal vision of what our Academy should be? And vote to have a voice in steering this organization. ■

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

> "Think about what the candidates have to say. Who comes closest to articulating your personal vision of what our Academy should be?"

Election dates

E-BALLOT **OPENS** MAY 6 (Wed morning)
E-BALLOT **CLOSES** JUNE 8 (Mon/midnight)

AAO-HNS has partnered with Survey & Ballot Systems (SBS) to administer the 2015 election of candidates for leadership positions. For technical support please call 952-974-2339 or email support@directvote.net. For all other ballot related questions, call Membership at 1-877-722-6467 or email Estella Laguna in Executive Operations at **ELaguna@entnet.org**. ■

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INFORMING THE VOTE

Workforce issues past and future

One of the key components when discussing what the evolving healthcare delivery system will look like relates to workforce issues. Attempts to incorporate all of the pertinent variables that will act as predictive markers for future needs have been fraught with difficulties. Questions arise such as how many providers will be needed to serve a future population, how can these providers be optimally distributed, what should be the demographics for the workforce, and what will be the scope of practice of these providers? There have been a number of studies done attempting to answer these questions. Despite the variety of studies undertaken, consensus has been difficult to reach—not only related to physicians in general—but otolaryngologists specifically. Currently, Congress is debating workforce issues as they tackle GME funding issues. We are rapidly approaching a situation where there will not be enough ACGME-certified post-graduate residency positions for all U.S. medical school graduates.

While working on an unrelated project, I came across the "Report on Manpower Resources and Needs in Otorhinolaryngology" produced by the American Council of Otolaryngology in July 1975. I thought it would be interesting to review its recommendations in light of current conditions and predictions of future needs for otolaryngology. This study and report were produced by the Otolaryngology Committee on Manpower Analysis, chaired by **John E. Bordley, MD**. The project was jointly supported by the American Council of Otolaryngology and the National Institute of Neurological Diseases and Stroke.

The group made recommendations in a number of areas. In 1975 they felt there was an unmet need for 500 otolaryngologists. At that time approximately 250 residents were being trained per year in otolaryngology programs. They predicted at that rate supply would meet the demand by 1985. This was based on the average otolaryngologist seeing 420 patients per month with a predicted increase of 11 percent over the ensuing 10 years. Currently, approximately 300 residents are being trained per year, but the program length has increased since 1975. Ideal ratios in today's world range from 2.8 otolaryngologists per 100,000 to 3.4 per 100,000 of population. Our most recent socioeconomic survey showed that the average otolaryngologist sees 28 new patients and 53 established patients per week, which represents a decline from 1975.

The 1975 study also recognized the serious need to increase the number of women and minorities who entered otolaryngology residency training programs. At that time there were 0.8 percent women, 1.3 percent African-Americans, and 7.9 percent Asians in otolaryngology residency programs. Currently, the ACGME database for 2013-2014 indicates that there are 33 percent women, 15 percent Asian, 2.8 percent Hispanic, 2.1 percent African-American, and 18 percent unknown. Many of these advances were directly related to the study recommendation that recruitment of a more diverse physician population would better serve the diversity of the population in general.

Another significant recommendation relating to residency training that changed the growth of otolaryngology was the recognition of the need to strengthen training programs to include teaching the specialties within otolaryngology residency programs. "Competent teachers in the specialty should be recruited for our faculties, rather than sending the trainees into other disciplines for experience." This particular directive resulted in many specialties flourishing and, in turn, significant advances in treatment of patients with these problems. The 1975 recommendations also mentioned that post residency fellowships should be increased, with the goal being the "support for the advanced research training of those otolaryngologists interested in a career of research." Fellowships have taken on a role of advanced clinical training as well as providing a framework for research in the current paradigm.

Additionally, the report touted the value of providing training "in the rudiments of office practice," and every effort should be made to establish required courses in medical school "designed to give practical instruction in diagnosis of the common disorders in our field." "Constant effort should be maintained to develop a strong and currently appropriate program for continuing education. Serious consideration should be given to the question of making it mandatory for maintaining board certification." A strong CME program including Practice Management offerings are among "anchor" services provided to our Members by the AAO-HNSF.

The wisdom of our predecessors is obvious after reading this thought-provoking document. The obvious value of selecting visionary leaders was clearly demonstrated in this endeavor. Hopefully, we will continue this tradition as we craft the future landscape for otolaryngology. I want to encourage everyone to vote in this year's AAO-HNS election. This year's elections will commence on May 6 online and close on June 8. We have an excellent slate of candidates. Please review the posted materials in last month's *Bulletin* and at entnet.org and choose your leaders. ■

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

> "We are rapidly approaching a situation where there will not be enough ACGME-certified post-graduate residency positions for all U.S. medical school graduates."

The SGR bill passes: Advocacy does work

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

The recent passage of H.R. 2, the Medicare Access and CHIP Reauthorization Act (MACRA), by Congress signaled the end of a 14-year journey that included 17 short-term "patches" for Medicare's flawed Sustainable Growth Rate (SGR) physician payment formula that was enacted in 1997. Not only did this landmark bipartisan bill address the yearly threat of significant decreases in Medicare physician payments, it also:

- **Consolidated the quality reporting requirements for Medicare providers.** Beginning in 2019, the Merit-Based Incentive Payment System (MIPS) will consolidate existing quality programs and focus on quality, resource use, meaningful use, and clinical practice improvement in a cohesive fashion. The quality measures chosen by CMS utilized by Qualified Clinical Data Registries (QCDR) will be automatically included. In addition, federal funding will be available to help physicians develop additional quality measures from 2015-2019.
- **Halted the CMS-mandated conversion away from 10- and 90-day global packages to 0-day billing parameters.** Pursuant to the provisions of H.R. 2, CMS is required to gather data related to the recommended changes to the global packages by the end of 2017, prior to initiation of any new policy.
- **Established positive payment updates for five years.** A .5 percent increase in Medicare physician payments will help provide stability as physicians transition to the new system.
- **Incentivized participation in an Alternative Payment Model (APM).** Physicians who partake in various APMs will receive a 5 percent bonus from 2019-2024.

During the debate, it was both amazing and rewarding to listen to both Democrat and Republican legislators articulate the same arguments that organized medicine had been putting forward for more than a decade as to why this proposal needed to be passed. The critical bipartisan interaction between Speaker of the U.S. House of Representatives, John Boehner, and the House Minority Leader, Nancy Pelosi, is an excellent example of how meaningful legislation can be passed when a spirit of compromise exists. Following their lead, the U.S. Senate and President Obama passed and signed the bill respectively. Overall, 484 legislators supported H.R. 2 – a rare demonstration of bipartisanship in the volatile political environment on Capitol Hill.

Why did this happen? The physician community had a unified message. What was different in 2014 and 2015 compared to previous years? For one, the price tag to repeal and replace the flawed SGR formula was the lowest it had been in some time. Also, an effective Congressional Doctors' Caucus partnered

with Committee leaders and the physician community to broker the historic compromise in early 2014. Despite the disappointment of not passing the bill last year, the physician community and its dedicated members persisted in bringing forth the rational arguments that eventually resulted in passage of this bill in April 2015. This was not an accident, but a result of years of work by multiple physician groups, including the AAO-HNS, to educate Members of Congress on the issues and the consequences of inaction. Personal relationships built and nurtured over many years, along with the consistency and appeal of the message, put this effort over the top.

> “Patience and perseverance have a magical effect before which difficulties disappear and obstacles vanish.”
>
> **John Quincy Adams**

Tens of thousands of physicians, along with their staffs, persisted with the same compelling message, despite year after year of failure to achieve permanent repeal. Members of Congress kept hearing the same message through advocacy outreach and grassroots efforts. These included Capitol Hill visits, political fundraisers, phone calls, emails, and tweets – all with the same message. This culminated in the passage of this landmark legislation and the subsequent signing into law by President Obama. Our message was heard. I would like to salute our legislative advocacy team headed by Joy Trimmer, JD, and thank all of you who contacted their personal representatives and senators.

The same strategy of building relationships and establishing trust while advocating for the best patient care has also demonstrated success in dealing with both CMS and private payers. Collaborative efforts within otolaryngology have recently been fruitful as demonstrated by the reversal of the ruling by CMS concerning implantable hearing devices (AAO-HNS, ANS, AOS), acceptance of group reporting measures by CMS (AAO-HNS, ABOto), and United Healthcare’s reversal of its policy that stated balloon ostial dilatation was experimental (AAO-HNS, ARS).

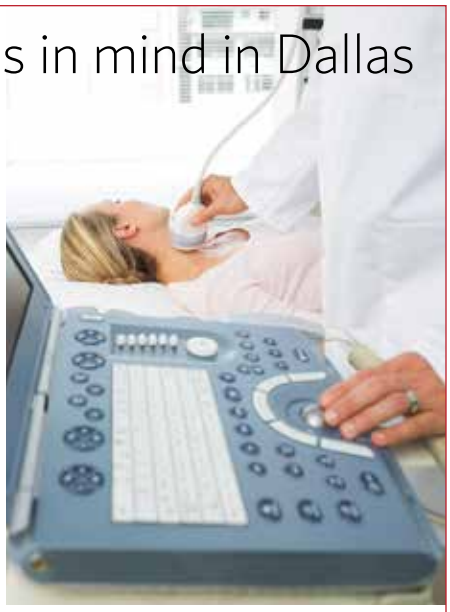
In today’s regulatory environment, and now with the implementation of H.R. 2, there is some concern among our Members about the ability for private practitioners, particularly those in small group practices, to participate in these quality-based programs, which on the surface seem quite complex. The Academy’s commitment to build an otolaryngology-specific Qualified Clinical Data Registry (QCDR) by 2016 will allow direct reporting of pertinent measures by participants to CMS, as well as provide additional quality and payment benefits to our Members. We feel this tool will allow otolaryngologists to continue to practice successfully in a variety of practice settings.

With SGR repeal finally a reality, what’s next? The AAO-HNS will continue to work to advance our specialty’s legislative priorities (liability reform, truth in advertising, patient safety/scope of practice, GME funding, etc.), minimize the increasing regulatory burdens on our members, and address private payer concerns such as network tiering, bundling of procedures, and payment denials. With your help and perseverance, we will continue to engage in all efforts to give our members the tools to provide the best care for their patients. ■

Imaging Committee has your course needs in mind in Dallas

The American Academy of Otolaryngology—Head and Neck Surgery recognizes the importance of quality standards and accreditation for medical imaging and knows that Members look to the Academy to provide leadership on this issue. To this end, the Academy created the Imaging Committee, currently chaired by **R. Christopher Miyamoto, MD**, to provide resources for Members’ use and to monitor legislative and reimbursement developments. The Foundation also ensures training for continuing medical education (CME) is provided in this area.

Each year at the AAO-HNSF Annual Meeting & OTO EXPO℠, the Foundation offers several courses related to head and neck imaging, with many courses specific to CT. These carefully crafted courses help Members learn about current best practices, coding changes, and potential reimbursement challenges as they pertain specifically to otolaryngologists providing head and neck imaging services. Further, participation in many of these expert-led courses qualifies for CME credit. As this year’s Annual Meeting draws closer, we will be sure to provide the specific lineup of imaging courses offered in Dallas. In the interim, if you would like to learn more, please visit our imaging page at **www.entnet.org/content/imaging-services**. ■



SEE PAGE 12 FOR MORE INFORMATION ABOUT THE AAO-HNSF ANNUAL MEETING & OTO EXPO℠

ICD-10: Where will you be when the switch flips October 1?

ICD-10 will likely not be delayed again. Last year's delay by itself was projected to cost the healthcare industry as a whole $6.8 billion. The House's Energy and Commerce Subcommittee on Health debated ICD-10 implementation in detail during its February ICD-10 hearing where seven witnesses testified on both the potential positive and negative effects of ICD-10. As full Committee Chairman Fred Upton (R-MI) said, "The United States is one of the few countries that has yet to adopt this most modern coding system. Australia was the first country to adopt ICD-10 in1998. Since then, Canada, China, France, Germany, Korea, South Africa, and Thailand—just to name a few—have all also implemented ICD-10. In the United States, Congress, through one vehicle or another, has prevented the adoption of ICD-10 for nearly a decade." While several delays have taken place in the past, consensus shows that the switch will finally be flipped on October 1 of this year.

Your Academy continues to work to facilitate the transition and help to make it as painless as possible. On the advocacy front, the Academy, along with numerous other organizations, signed onto a letter written to the Centers for Medicare and Medicaid Services (CMS), *not* urging for another delay of ICD-10, but rather urging CMS to publish further data on ICD-10 testing results, EHR vendor readiness, details on avoiding adverse impacts on quality measurement, risk mitigation plans, and more. (The letter is available online at **www.entnet.org/sites/default/files/uploads/icd-10-sign-on-letter.pdf**.) As for resources, the Academy has released an updated otolaryngology specific superbill (**bit.ly/1CV5LSH**) that has a more expansive list of ICD-10 codes that serve a larger variety of subspecialist practices. In addition, Academy partner Optum has worked to make an otolaryngology specific ICD-10 Fast Finder Tool (**www.optumcoding.com/product/41477/**). Slides from the 2014 ICD-10 Annual Meeting Miniseminar provide simple questions to ask vendors and payers with solid examples on how to assess your claims at risk with an impact analysis and more (**www.entnet.org/sites/default/files/uploads/practicemanagement/resources/_files/icd10_slides.pdf**).

For more Academy resources, visit the Academy's ICD-10 webpage at **www.entnet.org/node/740**. ■

Reference

1. http://energycommerce.house.gov/press-release/health-subcommittee-discusses-importance-and-readiness-icd-10-implementation

A legacy of service in Kijabe, Kenya

Bridget Leann Hopewell, MD,
University of Missouri, Humanitarian Travel Grant Awardee

"She's beautiful," her father said when we asked how her first night after the surgery had been. Even when we asked how well she was eating, or if she'd been in any pain, all he would answer was, "beautiful," as her mom quietly nodded.

READ MORE ONLINE

Boards of Directors approves registry, appropriate use criteria

Following extensive discussion during the strategic planning conference in March, the Boards of Directors took the bold step of authorizing the formation of a clinical data registry for our specialty. The Registry Task Force, chaired by **Lisa E. Ishii, MD, MHS**, has been directed to produce recommendations to the Boards of Directors regarding the type of registry as well as the vendor that we will select. The Foundation has been actively studying this project for the last 18 months and feels the time to act is now. The formation of a registry carries a multimillion dollar price tag.

This "game changing" action will provide many benefits for our Members. A registry will allow direct reporting of quality measures to CMS, thus simplifying this process greatly. In addition, registries can support measure development, inform alternative payment models, assist with maintenance of certification, and demonstrate clinical effectiveness. Participants will have access to their data, which they can use in negotiations with payers. The board also approved the creation of "appropriate use criteria," which are an additional guidance tool that can be used in payer negotiations and can be incorporated into a registry. This will help our advocacy efforts when we negotiate on our Members' behalf regarding national policies.

In the upcoming months we will be presenting more detailed information on registries in general and the type of registry that best meets the needs of our Members. We feel this is an exciting opportunity for our specialty that will enable our Members to practice under all changing paradigms of the healthcare delivery system. ■

BOARD OF GOVERNORS

Ben Franklin and the Annual Meeting

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

Like many of us, Ben Franklin was a busy man and in moments of self-reflection, recognized his deficiencies in a number of healthy habits, which he termed "virtues." As I get ready to attend our Annual Meeting and the fall meeting of the Board of Governors (BOG), I find that these virtues continue to ring true today.

These include:

- Set aside time for focused efforts.
- Always look for ways to do things better and faster.
- Set very few priorities and stick to them.
- Turn down things that are inconsistent with your priorities.
- Spot trouble ahead and solve problems immediately.
- Finish what's important and stop doing what is no longer worthwhile.

The Academy and its Annual Meeting provide us with options to address many of these virtues.

Time and efficiency

The Annual Meeting allows us to set aside time for education on myriad topics by national and international experts. As such, it often is a time when I am able to find ways to improve and optimize my practice. The scientific content and patient care pearls that I learn are the highlights of my meeting, but there is so much more to learn.

This is especially true as the business of medicine and compliance take up increasing amounts of mental energy and time. The BOG Hot Topics Miniseminar is designed to address the latest in practice management updates and perspectives, and I find it to be an extremely high-yield session. In addition, the BOG committee meetings on Saturday, September 26, are focused on the legislative, socioeconomic, and grassroots issues affecting our specialty. They are open to anyone and are a great way to understand the efforts that the Academy and the BOG are making on our behalf.

Prioritization

In addition to these education opportunities, the Opening Ceremony at the Annual Meeting allows us to more clearly understand the priorities of our Academy as it strives to do more with less. This has led to a streamlining of operations in order to focus efforts on the core values of education, advocacy, sustainability, research, and quality. Toward this end, a new, smarter learning management system is being introduced to allow for easier access to existing and new educational content.

Proactive focus

Our Academy has understood the need for a focus on quality and safety far before they were buzzwords in the media. This proactive stance has led to our recognition as national leaders in Clinical Practice Guideline development. This same focus has resulted in ongoing creation of CMS Measures groups to be used by our Members for simplified PQRS reporting. At the same time, the staff and physician volunteers are evaluating national and state legislation and addressing payment issues with insurers.

I continue to strive to master these virtues passed on by Ben Franklin and embraced by our Academy. Please join us as we witness them in action at the AAO-HNSF Annual Meeting & OTO EXPO℠ and BOG sessions. I hope to see you there. ■

You spoke, we listened

Discover exciting changes as we take the 2015 Annual Meeting & OTO EXPO℠ to new heights

The AAO-HNSF 2015 Annual Meeting & OTO EXPO℠ will be a meeting like no other you've ever attended. The AAO-HNSF Program Advisory Committee and Instruction Course Advisory Committee are pleased to announce a broad range of changes to this year's event. These changes will enhance your experience and better meet your professional needs. You'll experience even more of what you've come to expect at the world's premier event for otolaryngologist-head and neck surgeons at competitive rates.

Format

For starters, the **Scientific Program** (Oral Presentations and Miniseminars) **and Instruction Courses will now be blended**, with Miniseminars, Oral talks, and Instruction Courses running simultaneously Sunday through Wednesday. We've redesigned the program to allow attendees more uninterrupted time on the OTO EXPO℠ show floor to explore the latest products and technology. Committee members will delight in a new schedule for meeting times that no longer conflict with the Scientific Program or Instruction Courses. Similar to the committee meetings, the Women in Otolaryngology (WIO) Section will be meeting on a new date and time. The Young Physicians Section (YPS) will hold its inaugural event Tuesday afternoon.

Price

But, that is not all! Our new registration pricing now includes Instruction Courses in the regular registration fee, giving you access to more than 500 hours of education content presented by otolaryngology experts.

Now experience all aspects of the Annual Meeting at a single price point that brings a big bonus to early registrants.

The AAO-HNSF Annual Meeting & OTO EXPO℠ is *your* meeting. It's designed to deliver our Members and guests an incredible experience filled with world-class learning, networking, and inspiration. This year, you'll experience all this and more in a brand-new way. Keep reading this issue of the *Bulletin* to learn more about our exciting new program. ■

CATEGORY FOR INCLUSIVE RATES	EARLY (May 4-July 10)	ADVANCE (July 11-August 21)	REGULAR (August 22-September 30)
Member			
Physician/Nonphysician Clinician	$657	$986	$1,095
Resident/Fellow-in-Training/Medical Student	$231	$346	$385
Daily Physician/Non-Physician Clinician	$352	$397	$440
Daily Resident/Fellow-in-Training/Medical Student	$121	$135	$150
Non-Member			
Physician/Nonphysician Clinician	$987	$1,481	$1,645
Resident/Fellow-in-Training/Medical Student	$444	$666	$740
Daily Physician/Non-Physician Clinician	$528	$594	$660
Daily Resident/Fellow-in-Training/Medical Student	$236	$266	$295
Other			
OTO EXPO℠ Daily Pass	$100	$125	$150
Guest	$225	$255	$285

One easy fee + four days of world-class learning = **amazing value**

Attendee feedback told us you wanted a straightforward payment structure, so we're giving it to you. Now, pay one convenient and affordable price for four days of world-class learning. No more separate fees for add-ons*, no confusion about what's included. Your registration fee includes access to Miniseminars, Scientific Oral Presentations, Instruction Courses, Poster Presentations, and so much more!

Now it's easier than ever to experience all that the Annual Meeting has to offer, including:

- **Earn CME credit.** Earn up to 25.5 *AMA PRA Category 1 Credits™* with your choice of more than 500 continuing education sessions that arm you with new skills you can put into practice right away. Credit will be awarded to physicians when documented by the submission of the 2015 Annual Meeting & OTO EXPO℠ Evaluation.
- **Get the exact information you need.** Sessions are arranged according to tracks to provide the most beneficial information for your particular needs.
- **Get excited.** There's nothing like spending time with people who share your interests to re-energize and inspire you.
- **Tap the minds of leaders.** This is your chance to ask the best and brightest leaders in the otolaryngology community your most pressing questions.
- **See and touch the latest devices.** More than 300 exhibitors in the OTO EXPO℠ offer hands-on demonstrations and Q&A about innovative new products and technology.
- **Expand your network.** Share experiences, insights, and perspectives with talented professionals who can help you succeed.
- **Make your voice heard.** At the AAO-HNSF Annual Meeting, you can meet with Academy Advocacy staff to learn the latest legislative updates that impact the future of otolaryngology.
- **Become a stronger professional.** We promise you'll leave Dallas inspired, smarter, and better than ever.
- **Enjoy a fabulous destination.** Centrally located and easy to get to, Dallas offers a pleasing climate and endless sports, arts, entertainment, and dining options.
- **Save even more money** by registering before July 10 for the Early Registration Discount.

**Saturday workshops remain separate.* ■

All AAO-HNSF Annual Meeting and OTO EXPO℠ events will take place at the Kay Bailey Hutchison Convention Center in Dallas or the connecting Omni Dallas Hotel.

Meeting coordinators explain changes

We recently sat down with the Coordinator for the Instruction Course Program, **Sukgi S. Choi, MD**, and the Coordinator for the Scientific Program, **Eben L. Rosenthal, MD**, to talk about this year's Annual Meeting & OTO EXPO℠.

Sukgi S. Choi, MD

Eben L. Rosenthal, MD

Bulletin: What can you tell us about this year's event?

Dr. Choi: We have traditionally had a very distinct morning and afternoon program. This year, we have improved the entire program by offering content throughout the entire day. Miniseminars, Instruction Courses, and Oral Sessions now run simultaneously. This will allow for great variety in topics and content throughout the day, creating an individualized learning experience for each attendee. And even better, Instruction Courses are now included in the registration fee. The Annual Meeting is now an all-inclusive learning event with more choices for attendees to design a schedule that fits their needs. Our improved program offers significantly more value than ever before.

Dr. Rosenthal: Additionally, the program has been redesigned to give attendees unopposed time in the morning and afternoon for attending committee meetings and exploring the OTO EXPO℠. The early morning committee meetings made it very difficult for those with significant time zone changes and those who had morning lectures. We remain committed to creating all-day tracks that will bring the highest-quality material together in a way that the attendee can easily identify a series of talks that fit with the topics they are most interested in.

Bulletin: The Oral Presentations are always popular. Will there be any changes this year?

Dr. Rosenthal: The shorter Oral Presentations that were incorporated into the program two years ago improved the pace and interaction within the Oral Sessions. In addition to continuing that format, this year we are adding video presentations. These will focus on the technical aspects of surgical technique and will be an effective way for experienced surgeons to communicate novel techniques. We look forward to growing this aspect of the program. We will again offer the "Best of Orals" to recognize the best in original research being conducted by our Members. This was one of the best-attended lectures last year and demonstrates the quality of the work being presented at this unique forum.

Bulletin: How and why were these changes determined?

Dr. Choi: When Dr. Rosenthal and I first started in our roles as coordinators, we both knew we wanted to change the entire structure of the meeting. In fact, I think that's why we were chosen to work together. Feedback from evaluations and

honest, frank discussions with Members told us that attendees were looking for change, so we conducted an in-depth review of the meeting structure, analyzed three years' of attendee, exhibitor, and Member data, and benchmarked the meeting structure and education program of other medical societies. We then identified potential changes to the meeting, including the integration of the program, and discussed these options with the Boards of Directors and the Science and Education Committee. Various committees provided input, as well.

***Bulletin:* How do these changes add value?**

Dr. Rosenthal: By integrating the program and carefully scheduling committee meetings to not interfere with the Scientific Program, attendees can now enjoy education content for the entire 3 ½ days. And because there are no additional fees for Instruction Courses, attendees have access to more learning opportunities than ever before. It's truly a brand-new meeting and sure to please returning attendees and first-time attendees alike. ■

Clinical Fundamentals and MOC prep

Clinical Fundamentals, now included within the Maintenance of Certification track, are an extremely important offering during our meeting that allow Members to satisfy the ABOto's Clinical Fundamentals requirement for Part III of Maintenance of Certification.

In addition to participating in the Clinical Fundamental courses during the Annual Meeting, you may also satisfy the Clinical Fundamentals requirement for Part III of Maintenance of Certification by viewing online versions of the instruction courses of the same title that were presented during the Annual Meeting. The courses are available in AAO-HNSF's online library at www.entnet.org/content/clinical-fundamentals.

In addition to the seven Clinical Fundamental live courses, seven review courses will be presented, covering facial plastic surgery, general otolaryngology, rhinology and allergy, head and neck surgery, pediatric otolaryngology, laryngology/bronchoesophagology, and otology. ■

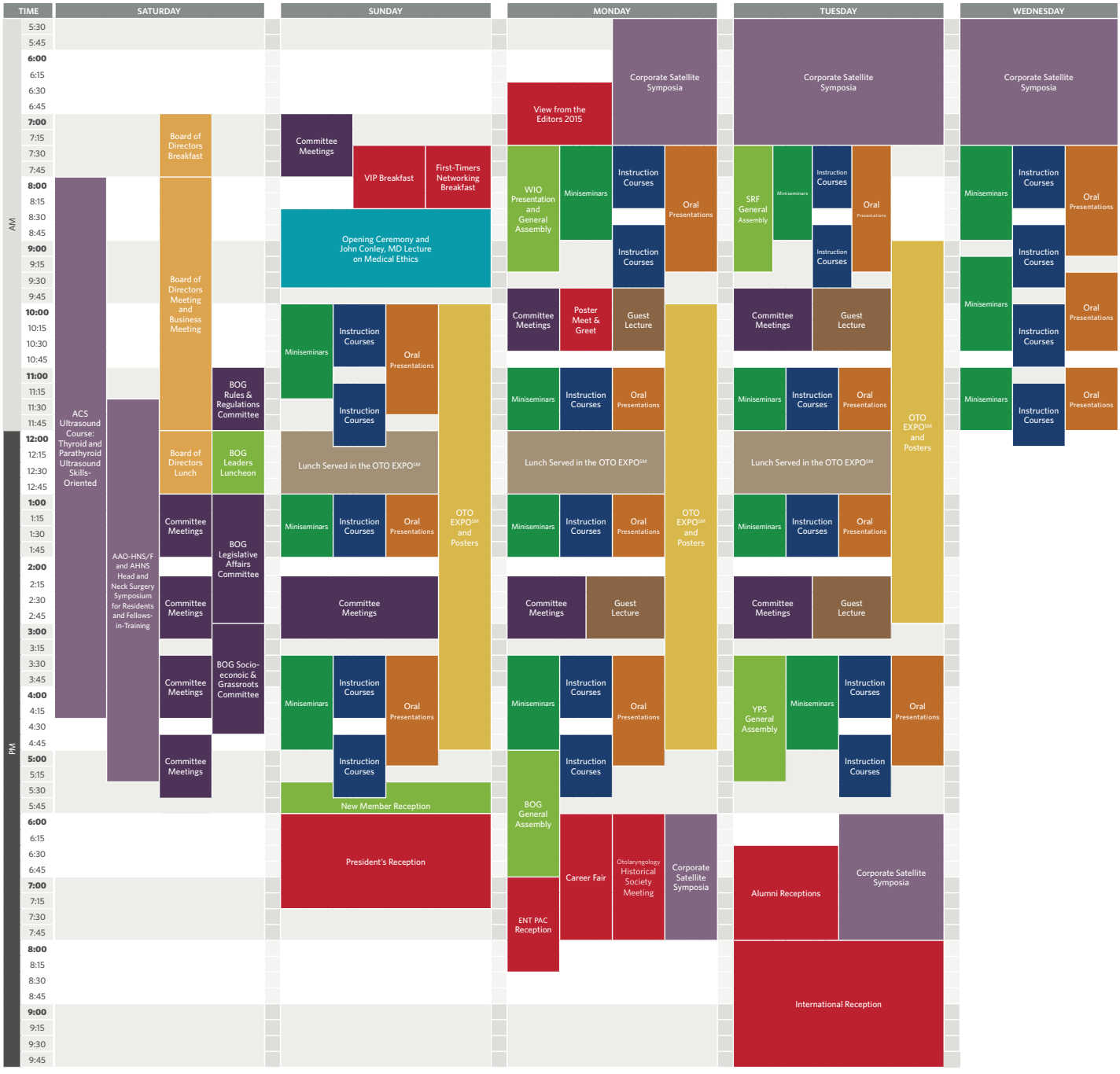
Poster presentations

The Poster Meet-and-Greet presentations will take place Monday from 9:45 to 10:45 am in the Poster Hall. While enjoying refreshments and a mid-morning break, learn about the latest advancements in research directly from the sources. Ask questions and share experiences with poster presenters for a truly interactive session. ■

FOR MORE INFORMATION, VISIT WWW.ENTNET.ORG/ANNUAL_MEETING

Schedule-at-a-glance

This schedule is available in different viewing options online and in the Preliminary Program.



★ FRIDAY AND SATURDAY

Academy-sponsored Coding and Practice Management Workshop

MORE DETAILS COMING SOON

Annual Meeting committee meetings

AAO-HNS Business Meeting
Saturday, September 26, 2015
11:30 AM - 11:45 AM

AAO-HNS/F Board of Directors Breakfast (by invitation only)
Saturday, September 26, 2015
7:00 AM - 8:00 AM

AAO-HNS/F Board of Directors Lunch (by invitation only)
Saturday, September 26, 2015
12:00 PM - 1:00 PM

AAO-HNS/F Board of Directors Meeting
Saturday, September 26, 2015
8:00 AM - 11:30 AM

AAO-HNS/F Executive Committee Meeting (by invitation only)
Friday, September 25, 2015
5:00 PM - 7:00 PM

Adhoc/Alternative Payment Model Workgroup
Monday, September 28, 2015
9:45 AM - 10:45 AM

Airway and Swallowing Committee
Monday, September 28, 2015
9:45 AM - 10:45 AM

Allergy, Asthma and Immunology Committee
Tuesday, September 29, 2015
9:45 AM - 10:45 AM

Board of Governors (BOG) Executive Committee (by invitation only)
Sunday, September 27, 2015
3:30 PM - 5:30 PM

Board of Governors (BOG) General Assembly
Monday, September 28, 2015
5:00 PM - 7:00 PM

Board of Governors (BOG) Leaders Training Luncheon
Saturday, September 26, 2015
12:00 PM - 1:00 PM

Board of Governors (BOG) Legislative Affairs Committee
Saturday, September 26, 2015
1:00 PM - 2:45 PM

Board of Governors (BOG) Rules and Regulations Committee
Saturday, September 26, 2015
11:00 AM - 11:55 AM

Board of Governors (BOG) Socioeconomic and Grassroots Committee
Saturday, September 26, 2015
3:00 PM - 4:45 PM

Complementary/Integrative Medicine Committee
Monday, September 28, 2015
2:15 PM - 3:15 PM

Core Otolaryngology and Practice Management Education Committee
Monday, September 28, 2015
2:15 PM - 3:15 PM

CORE Study Section
Saturday, September 26, 2015
3:30 PM - 4:30 PM

CPT and Relative Value Committee
Monday, September 28, 2015
2:15 PM - 3:15 PM

Credentials and Membership Committee
Saturday, September 26, 2015
1:00 PM - 2:00 PM

Development Committee
Saturday, September 26, 2015
1:00 PM - 2:00 PM

Diversity Committee
Sunday, September 27, 2015
2:15 PM - 3:15 PM

Education Steering Committee
Saturday, September 26, 2015
4:00 PM - 6:00 PM

Endocrine Surgery Committee
Tuesday, September 29, 2015
2:15 PM - 3:15 PM

ENT PAC Board of Advisors (by invitation only)
Sunday, September 27, 2015
2:00 PM - 4:00 PM

Equilibrium Committee
Monday, September 28, 2015
2:15 PM - 3:15 PM

Ethics Committee
Saturday, September 26, 2015
3:30 PM - 4:30 PM

Facial Plastic and Reconstructive Surgery Education Committee
Monday, September 28, 2015
2:15 PM - 3:15 PM

Finance and Investment Subcommittee (FISC)
Saturday, September 26, 2015
3:00 PM - 4:15 PM

General Otolaryngology Education Committee
Sunday, September 27, 2015
2:15 PM - 3:15 PM

Geriatric Otolaryngology Committee
Tuesday, September 29, 2015
9:45 AM - 10:45 AM

Head and Neck Surgery and Oncology Committee
Tuesday, September 29, 2015
2:15 PM - 3:15 PM

Head and Neck Surgery Education Committee
Tuesday, September 29, 2015
9:45 AM - 10:45 AM

Hearing Committee
Tuesday, September 29, 2015
9:45 AM - 10:45 AM

History and Archives Committee
Sunday, September 27, 2015
7:00 AM - 8:00 AM

Humanitarian Efforts Committee
Monday, September 28, 2015
2:15 PM - 3:15 PM

Humanitarian Efforts Committee Forum
Sunday, September 27, 2015
1:00 PM - 3:15 PM

Imaging Committee
Tuesday, September 29, 2015
9:45 AM - 10:45 AM

Implantable Hearing Devices Committee
Sunday, September 27, 2015
7:00 AM - 8:00 AM

Infectious Disease Committee
Sunday, September 27, 2015
7:00 AM - 8:00 AM

Instruction Course Advisory Committee
Tuesday, September 29, 2015
2:15 PM - 3:15 PM

International Assembly
Sunday, September 27, 2015
3:30 PM - 5:30 PM

International Otolaryngology Committee
Monday, September 28, 2015
9:45 AM - 10:45 AM

International Steering Committee
Tuesday, September 29, 2015
2:15 PM - 3:15 PM

Joint Education Committees Meeting
Sunday, September 27, 2015
7:00 AM - 8:00 AM

Journal Editoral Board Meeting
Tuesday, September 29, 2015
6:00 AM - 7:15 AM

Laryngology and Bronchoesophagology Education Committee
Sunday, September 27, 2015
2:15 PM - 3:15 PM

Media and Public Relations Committee
Monday, September 28, 2015
9:45 AM - 10:45 AM

Medical Devices and Drugs Committee
Sunday, September 27, 2015
7:00 AM - 8:00 AM

Medical Informatics Committee
Saturday, September 26, 2015
2:15 PM - 3:15 PM

Microvascular Committee
Tuesday, September 29, 2015
9:45 AM - 10:45 AM

Nominating Committee (by invitation only)
Saturday, September 26, 2015
1:00 PM - 2:00 PM

Otology and Neurotology Education Committee
Tuesday, September 29, 2015
9:30 AM - 10:30 AM

Outcomes Research and Evidence Based Medicine Committee
Saturday, September 26, 2015
1:00 PM - 2:00 PM

Panamerican Committee
Tuesday, September 29, 2015
9:45 AM - 10:45 AM

Patient Safety and Quality Improvement Committee
Sunday, September 27, 2015
7:00 AM - 8:00 AM

Pediatric Otolaryngology Committee
Sunday, September 27, 2015
7:00 AM - 8:00 AM

Pediatric Otolaryngology Education Committee
Monday, September 28, 2015
9:45 AM - 10:45 AM

Performance Measures Task Force
Saturday, September 26, 2015
5:30 PM - 6:30 PM

Physician Payment Policy Workgroup
Monday, September 28, 2015
3:30 PM - 5:30 PM

Physician Resource Committee
Saturday, September 26, 2015
3:30 PM - 4:30 PM

Plastic and Reconstructive Surgery Committee
Monday, September 28, 2015
9:45 AM - 10:45 AM

Program Advisory Committee
Saturday, September 26, 2015
1:00 PM - 2:00 PM

Meeting Advisory Committee
Monday, September 28, 2015
2:15 PM - 3:15 PM

Registry Task Force
Saturday, September 26, 2015
4:30 PM - 5:30 PM

Research and Quality Steering Committee
Sunday, September 27, 2015
2:15 PM - 3:15 PM

Rhinology and Allergy Education Committee
Monday, September 28, 2015
9:45 AM - 10:45 AM

Rhinology and Paranasal Sinus Committee
Sunday, September 27, 2015
7:00 AM - 8:00 AM

Robotic Surgery Task Force
Saturday, September 26, 2015
2:15 PM - 3:15 PM

Science and Education Committee
Saturday, September 26, 2015
2:15 PM - 3:15 PM

Section for Residents and Fellows-in-Training (SRF) Governing Council
Tuesday, September 29, 2015
2:15 PM - 3:15 PM

Section for Residents and Fellows-in-Training (SRF) General Assembly
Tuesday, September 29, 2015
7:00 AM - 9:00 AM

Skull Base Surgery Committee
Saturday, September 26, 2015
1:00 PM - 2:00 PM

Sleep Disorders Committee
Saturday, September 26, 2015
2:15 PM - 3:15 PM

Specialty Society Advisory Council
Tuesday, September 29, 2015
2:15 PM - 3:15 PM

Surgical Simulation Task Force
Tuesday, September 29, 2015
2:15 PM - 3:15 PM

Trauma Committee
Sunday, September 27, 2015
2:15 PM - 3:15 PM

Voice Committee
Sunday, September 27, 2015
2:15 PM - 3:15 PM

Women in Otolarnygology (WIO) Endowment Committee
Monday, September 28, 2015
9:45 AM - 10:45 AM

Women in Otolarnygology (WIO) General Assembly
Monday, September 28, 2015
7:00 AM - 9:00 AM

Women in Otolaryngology (WIO) Awards Committee
Monday, September 28, 2015
9:45 AM - 10:45 AM

Women in Otolaryngology (WIO) Communications Committee
Monday, September 28, 2015
2:15 PM - 3:15 PM

Women in Otolaryngology (WIO) Council on Committees
Tuesday, September 29, 2015
2:15 PM - 3:15 PM

Women in Otolaryngology (WIO) Governing Council Meeting
Tuesday, September 29, 2015
2:15 PM - 3:15 PM

Women in Otolaryngology (WIO) Leadership Development and Mentorship Committee
Sunday, September 27, 2015
2:15 PM - 3:15 PM

Women in Otolaryngology (WIO) Program Committee
Sunday, September 27, 2015
7:00 AM - 8:00 AM

Women in Otolaryngology (WIO) Research and Survey Committee
Saturday, September 26, 2015
3:30 PM - 4:30 PM

Young Physicians Section (YPS) General Assembly
Tuesday, September 29, 2015
4:30 PM - 6:30 PM

OTO EXPO℠: Happy trails to

Not only is the AAO-HNSF Annual Meeting & OTO EXPO℠ the premier event for our specialty, it's now an award-winning event! *Trade Show Executive* recently named the OTO EXPO℠ one of the 50 Fastest-Growing Shows of 2014, a testament to the increasing number of companies that exhibit at our show. For you, this means even more access to the latest technologies and products. If you attend only one trade show this year, make it the award-winning OTO EXPO℠, where more exhibitors mean more value.

Hours

This year allows attendees more opportunities to visit the OTO EXPO℠. We listened to our attendees requesting more time to be able to visit the OTO EXPO℠ and have responded. The OTO EXPO℠ will now be open Sunday and Monday, 10:00 am – 5:00 pm, and Tuesday, 9:00 am – 3:00 pm.

Food

Dallas is a world-renowned food destination that attendees and exhibitors can experience on the OTO EXPO℠ hall floor! The OTO EXPO℠ will host concession stands offering fresh and locally sourced food with high-quality ingredients to enjoy. Every full conference or daily registrant will receive meal voucher(s) with their registration materials to be redeemed at any of the concession stands in the exhibit hall during OTO EXPO℠ hours, Sunday through Tuesday. Some of the food destinations to enjoy include sushi, grab-and-go sandwiches, tacos, and carving stations featuring top round steak, roasted potatoes, and vegetables.

New products

Every year our exhibitors introduce new products in the OTO EXPO℠ and this year won't be any different. This year there will be new releases of laryngeal instruments, retractors, stapes prostheses, and needle holders.

The list of new-to-the-market medical devices includes septal plugs, strobolights, stroboscopes, touch audiometers, and a device designed to eliminate acid reflux into the throat and lungs. On the technical side there will be new virtual medical scribes, apps for education charts, and neurostimulation-based therapy for the treatment of tinnitus. All of these items are created to improve your practice and aid you in providing the very best in patient care. You have to see it to believe it.

Hands-On Training and the Product Theater

Returning is the highly successful Hands-On Training venue and our Product Theater.

Last year was the first time for our Hands-On Training venue and it was an amazing success. Hands-on Training on the OTO EXPO℠ floor provides you with the best product training opportunity in otolaryngology. These two-hour training sessions allow participants to preview the newest innovations in otolaryngology surgical tools on cadaveric specimens. Space is limited for this unique opportunity.

The AAO-HNSF Product Theater is your opportunity to extend your learning beyond the classroom with AAO-HNSF corporate sponsors. Review recent scientific studies and information or watch a live demonstration

Dallas!

The AAO-HNSF Annual Meeting & OTO EXPO℠ is one of *Trade Show Executive*'s 50 Fastest-Growing shows. The exhibit floor features many opportunities for hands-on learning.

performed by a leader in the field. Sessions are booked in conjunction with OTO EXPO℠ hours and will be prominently displayed around the Exhibit Hall.

Contact David Buckner at **dbuckner@entnet.org** or 703-535-3718 for more information on these two venues.

Ready to register? Visit **www.entannualmeeting.org** to register now and for the most current information on the 2015 Annual Meeting & OTO EXPO℠. ■

Why Dallas?

Dallas is the perfect choice for exceptional meetings, boasting the title of America's best sports city, the nation's largest urban arts district, the best shopping in the Southwest, 14 exciting entertainment districts, a vibrant dining scene, impressive accommodations, and stellar meeting spaces.

With more than $15 billion in new development, Dallas is destined to be a city of innovation, excitement, and success for years to come.

Easy accessibility

- Easily accessible from all major United States cities as well as Mexico, Latin America, and Canada.
- Less than four hours by air from any North American city.
- Dallas/Ft. Worth (DFW) International Airport services 38 international destinations with nonstop flights—nearly 2,000 flights daily.
- Major airline hub with locally-based American Airlines as its largest carrier in the world.
- Airports Council International survey ranks DFW "Best Airport in North America" for customer service.
- Dallas Love Field Airport, one of the finest general-purpose airports in the world, served by Southwest Airlines, the largest domestic carrier in the United States.

Not far from anywhere

Atlanta, GA	2 hours
Boston, MA	3 ½ hours
Chicago, IL	2 hours, 20 minutes
Cincinnati, OH	2 hours, 10 minutes
Grand Rapids, MI	2 hours, 20 minutes
Los Angeles, CA	3 hours, 20 minutes
Miami, FL	2 hours, 45 minutes
New Orleans, LA	1 hour, 20 minutes
New York, NY	3 hours, 30 minutes
Philadelphia, PA	3 hours
San Francisco, CA	4 hours
Seattle, WA	4 hours, 15 minutes

Destination appeal

- The Dallas-Fort Worth area is the No. 1 destination in Texas.
- DART—one of the nation's fastest-growing rail lines with the longest light rail system in the United States.
- Cosmopolitan, 14 entertainment districts, Western heritage culture, and more.

Nightlife and entertainment

- From clubs, pubs, lounges, and roof-top patios to the No. 1 shopping destination in the Southwest.
- Top-tier golf courses, public parks, lakes, and reservoirs within the Dallas area.
- Home to five professional sports teams.

World-class dining

- More than 9,000 restaurants in the DFW area.
- Famous celebrity chefs include Dean Fearing, Stephan Pyles, Wolfgang Puck, and Kent Rathbun.

Join us in Dallas for this world-class event! ■

Better hearing for **all**

May is Better Hearing and Speech Month, a time to raise public awareness about hearing and speech issues as well as available treatment options. This year we are focusing on the impact of hearing loss as related to age, from infants and children to working-age adults to the elderly. Otolaryngologists treat hearing loss in patients of all ages, helping to mitigate the impact hearing loss can have on one's quality of life. You can learn more about Better Hearing and Speech Month online at **www.entnet.org/BetterHearingSpeechMonth**. ■

The real cost of hearing loss on infants and children

By **Dale Tylor, MD, MPH**, Washington Hospital, Fremont, CA, Media and Public Relations Committee

In the United States, two to three of every 1,000 children born have a detectable hearing loss in at least one ear. Further, more than 1 million children ages 1 to 19 years have bilateral mild-to-severe hearing loss, and around 3 million children have unilateral mild-to-severe hearing loss.[1]

Hearing loss in children can cause significant language impairments. Because educational success is substantially impacted by a child's language and communications skills, those with hearing loss face significant academic challenges. The behavioral effects of hearing loss can mimic attention deficit disorders, cognitive or learning issues, or language processing problems. The lifetime educational cost per child of moderate or worse hearing loss in the absence of other disabilities is $115,600.[2]

Even children with unilateral hearing losses face significant language deficits, and have been found to have lower scores of language comprehension and oral expression than their normal hearing siblings.[3] Those with unilateral loss or mild bilateral hearing loss also face educational impacts, with up to 35 percent failing a grade and up to 41 percent receiving educational assistance.[4]

School-aged children with hearing loss report significantly more fatigue than their normal hearing peers, which also can have negative academic and psychosocial effects.[5] Parents of children with hearing impairment also are affected, and have been found to have impairment in almost all domains of health-related quality of life.[6]

Health disparities have been noted for children with hearing loss, with hearing services more limited for children from racial and socioeconomic minorities. Those in areas of lower median income and those of non-white or non-Asian minorities are less likely to receive cochlear implants, for example, and even when implanted can demonstrate worse speech and language outcomes.

It should be noted that universal neonatal hearing screening and school-related screening programs have significantly improved detection of pediatric hearing loss, allowing for earlier treatment. Rehabilitation of hearing loss, such as with hearing aid(s), cochlear implant(s), speech therapy, or with individualized education plans, can help to positively impact the quality of life of these children.

References are available at **entnet.org/bulletin**.

ages

The impact of hearing loss on working-aged individuals

The most common chronic sensory disorder in adults is hearing impairment, and it impacts about 16 percent of Americans aged 20-69 in at least one ear, totaling more than 29 million people in this country. Risk factors for hearing loss include male gender, Caucasian race, and history of smoking, diabetes, cardiovascular disease, and noise exposure, with increasing education being protective.[1]

The impact of hearing loss on employment and income is marked. Compared with peers with normal hearing, those with hearing loss are more likely to be unemployed or partially employed (adjusted odds ratio, 2.2), more likely to have no wage income whatsoever (adjusted odds ratio, 2.5), and have a lower annual wage by almost $8,000 ($23,481 vs. $31,272), but not be more likely to receive Supplemental Security Income.[2] Those with hearing loss may be looked over for a promotion or raise, and may be less comfortable with advocating for themselves at the workplace.

Psychomotor speed and executive function can be impaired with hearing loss in later middle age, to the extent that a drop of 25 dB in hearing was equivalent to an age difference of seven years. Hearing aids seem to improve cognitive function scores of those with hearing loss.[3] It can be difficult to remember something that wasn't heard correctly in the first place.

Hearing loss can have a dramatic negative impact on one's relationship with their significant other. It has been demonstrated that the hearing loss of a spouse can be predictive of poorer physical, psychological, and social well being in their partner, and this seems to be even more prominent when the male partner is the one with the hearing loss.[4] Men in their 20s to 50s with acquired bilateral sensorineural hearing loss, when compared to normal hearing men, have poorer sexual health in all domains examined including erectile function, orgasmic function, sexual desire, intercourse satisfaction, and overall satisfaction.[5]

Otolaryngologists should question patients about their hearing, even when it is not their presenting complaint. Diagnosing this problem, and treating it, can lead to dramatic improvements in the patient's (and their loved ones) socioeconomic status and quality of life.

References are available at **entnet.org/bulletin**.

SMART TALK TO SHARE WITH PATIENTS

Age-related hearing loss

By **Kourosh Parham, MD, PhD**, Department of Surgery, Division of Otolaryngology-Head and Neck Surgery, University of Connecticut Health, Farmington, CT/AAO-HNS Geriatric Otolaryngology Committee

Part of an occasional patient-focused series on geriatric otolaryngological care

Hearing loss is the most common sensory problem among older adults. Studies show that by 2060, 22 percent (92 million) of the population will be 85 or older, while 4 percent (18 million) of the population will be around 65 years old. Age-related hearing loss (ARHL, also known as presbycusis) is, by far, the leading cause of hearing loss in developed countries. Currently it affects 50 percent of 65-year-olds and more than 80 percent of those 85 years old and older.

Evaluation

The diagnosis of ARHL is based on patient history, physical examination, and a battery of audiologic tests, including an audiogram. ARHL is a progressive condition arising from changes in the inner ear (the cochlea) and the brain. Because of its deceptive nature, people frequently are less aware of their communication difficulties than the people around them and often discuss the hearing problem reluctantly with a physician at the insistence of family members.

Hearing loss specifics over time

Although early hearing loss is different for all and dependent on a number of factors, often the earliest sign of ARHL appears late in middle age. By this time, cochlear changes are advanced enough to affect hearing within the sound range that makes up our daily lives. Often the experience of loss causes a person to misidentify words that sound the same and then make up for this problem by using the situation to understand the meaning.

Age-related high-pitched hearing loss results in difficulty hearing consonants and makes hearing in noisy places more difficult. Often these high-pitched sounds work to separate syllables and words from one another. Without them, words tend to run together and sound "mumbled." As voices of children and women tend to have a higher pitch, the person with hearing loss may complain that women speak too softly or that "my grandchildren mumble."

Over the years, as a person's hearing loss increases to include lower-pitched sounds, the loss is a bigger problem. This may result in a person's lessening ability to understand difficult issues and to think and reason as quickly as would be normal. This means that hearing in noisy places and hearing accented or fast speech becomes more challenging. A common complaint from the person may be, "I can hear the words, but I can't understand them."

People find what work-arounds as they can to cope. Some ask others to speak louder or more slowly, while others avoid conversation and social activity. There are also social ramifications to this attribute of age-related hearing loss. Difficulties hearing on the telephone, particularly cell phones in which quality of sound

may fluctuate with the strength of the network signal, serve as a barrier to their effective use as an alternative to face-to-face communication.

Related problems with hearing loss

Besides speech sounds, other important high-frequency warning sounds (alarms, ringing tones, turn signals, etc.) also become more difficult to hear. Reduced ability to hear alarms raises concern about safety. For example, older individuals with hearing loss have been shown to be at increased risk of motor vehicle accidents while driving. Besides difficulty in hearing communication sounds and alarms, other auditory functions are also impaired such as the accuracy of detecting sound sources.

As hearing loss severity increases, overall function diminishes among older individuals. It has long been speculated that inability to communicate effectively, and potential decreased overall functional status, will lead to social isolation. This association was not affected by use of hearing aids. Social isolation has significant implications for the well-being of geriatric patients: lonely or isolated older adults are at greater risk for development and progression of cardiovascular disease and are more than twice as likely to develop Alzheimer's disease. Thus besides the insidious nature of the disorder, the isolation associated with hearing loss may be another factor that leads to delayed presentation and diagnosis, primarily because there is little pressure to seek care for communication difficulties.

Inherent difficulties in communication, which result in compounding psychosocial effects such as isolation, may precipitate psychiatric disorders such as depression, but whether hearing loss can contribute to depression remains a subject of debate.

Tinnitus

Another symptom that affects the well-being of patients with sensorineural hearing loss is tinnitus (intrinsic noises not heard by others). The incidence of tinnitus increases with age: Tinnitus affects 15 percent of the general population and 33 percent of geriatric persons. Presence of tinnitus by itself is not an independent risk factor for depression, but older individuals who perceive their tinnitus to be a problem or have problems with tinnitus when going to bed often display depression symptoms. In patients who also have ARHL, tinnitus can be a source of emotional and sleep disorders, difficulties in concentration, and social problems. In geriatric patients, it has been shown that tinnitus is associated with worse control of congestive heart failure in geriatric patients and may have important clinical implications for the early identification of patients who need more aggressive management of heart failure.

Managing hearing loss

Based on the results of medical evaluation, candidacy for different rehabilitation strategies is considered. Depending on the severity of hearing loss, interventions could include improved communication strategies and modification of listening environment, to personal assistive devices and hearing aids, to cochlear implantation. While these strategies are principally directed at compensating for peripheral hearing

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loss, our understanding of age-related changes in the brain, including cognitive changes, have significant impact on rehabilitation strategies.

Prevention

A number of factors have been recognized as contributing to the development of ARHL. These might be broadly classified into two categories: intrinsic and extrinsic. Intrinsic factors are host factors and are primarily genetic (including gender and race).

There are family genetics that we are born with and those we can help—health issues such as diabetes, hypertension, diabetes, and stroke. Managing these factors can have a critical role in prevention of ARHL. Because ARHL is a progressive condition, awareness of these factors is important not just to the older population, but also the young since their impact is not appreciated until decades later. Individuals with ARHL often report a family history of hearing loss among parents, siblings, and close relatives. Therefore, it has been presumed that ARHL has a genetic component that influences the age of onset and severity of the loss.

Challenges in separation of environmental from genetic factors have made it difficult to assess the contribution of genetics to ARHL. Overall, the heritability estimates suggest that up to 55 percent of the variance ARHL is attributable to genes. This means in a large group of biologically related people, hearing sensitivity is more similar than in a group in the same general environment, but who are unrelated.

Modifiable risk factors

The influence of genetics is likely to be modulated by a set of non-genetic factors. Cardiovascular disease, high blood pressure, and diabetes are well recognized as risk factors. Older persons with moderate-to-severe hearing loss have a significantly higher likelihood of reporting previous stroke, but it should be emphasized that ARHL is not predictive of increased risk of stroke. Chronic kidney disease and systemic inflammation may contribute to progression of ARHL. A common thread among these disorders is vascular disease/arteriosclerosis.

Environmental factors

There is also a set of modifiable environmental factors that have been identified. Noise exposure and cigarette smoking are the best established risk factors. Among older adults, history of exposure to workplace noise raises the risk of cardiovascular disease and angina, and severe exposure was associated with risk of stroke. There is much concern about recreational noise exposure, particularly given prevalence of personal listening devices among the younger population. Smoking-related worsening of hearing loss with age is likely mediated by vascular disease. Long-time smokers with occupational noise exposure tend to have higher risk of permanent sensorineural hearing loss.

Oxidative stress is one possible mechanism for the aging process, and cochlear oxidative stress has been implicated in ARHL. Diets rich in antioxidants have been suggested to reduce ARHL and there is some evidence that healthy diets tend to be associated with better high frequency thresholds in adults. ■

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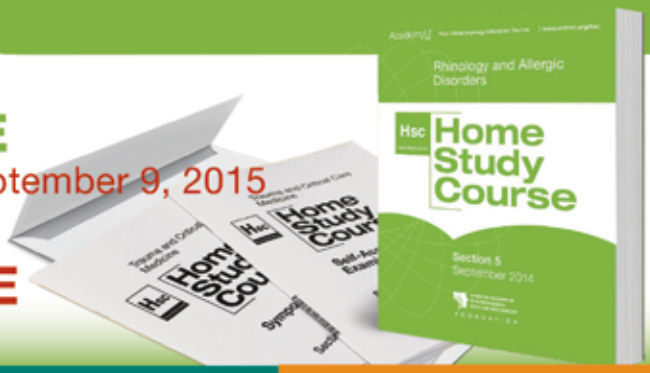

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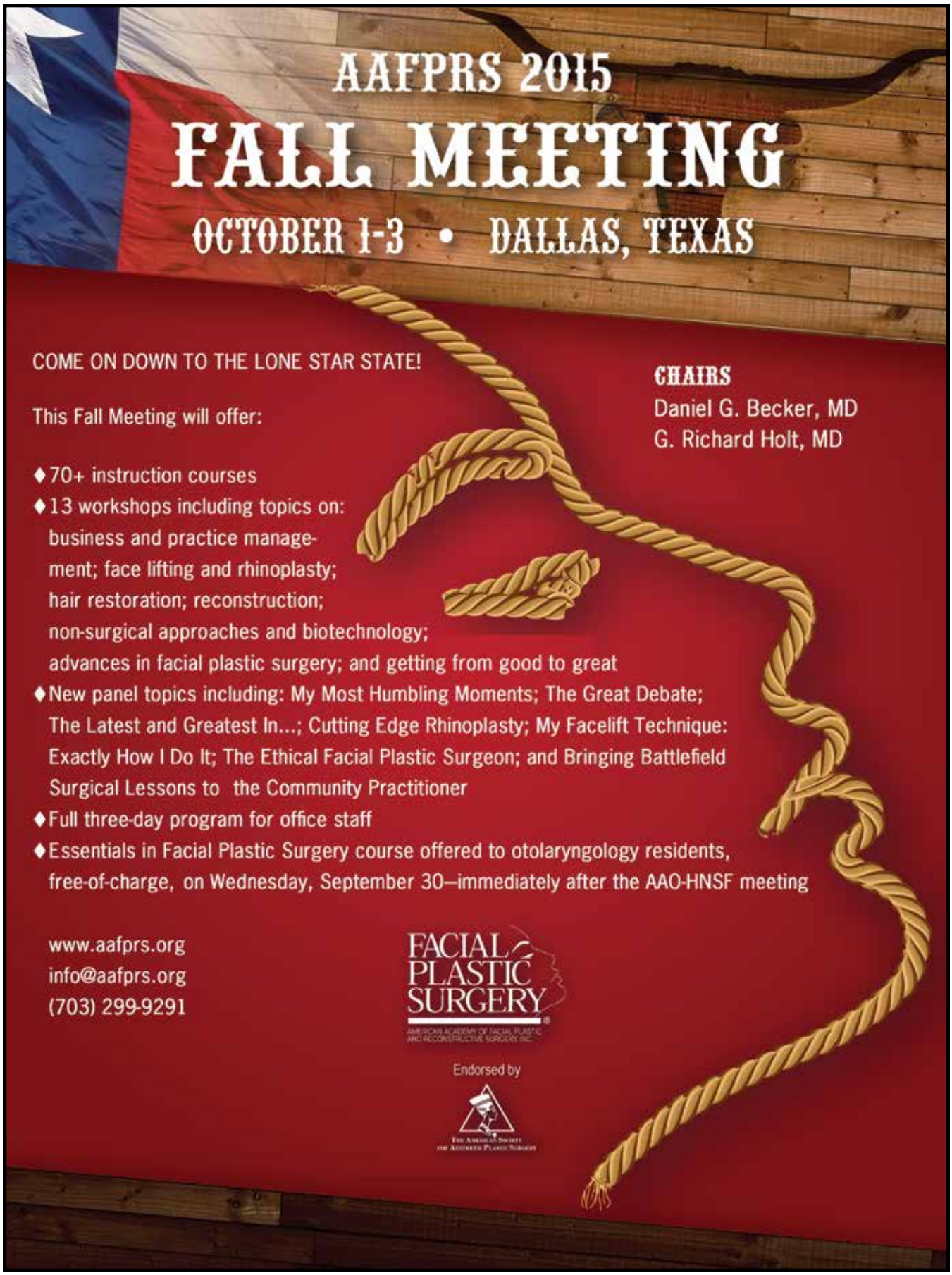
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Multiple Positions

Department of Otolaryngology-Head and Neck Surgery

Division of Pediatric Otolaryngology-Head and Neck Surgery

Pediatric Otolaryngologist-Peds Benioff SF

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Basic Qualifications:

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Minimum Qualifications: Medical doctor who is board certified/eligible in Otolaryngology-Head and Neck Surgery, eligible for licensure in New Mexico, and eligible to work in the U.S.

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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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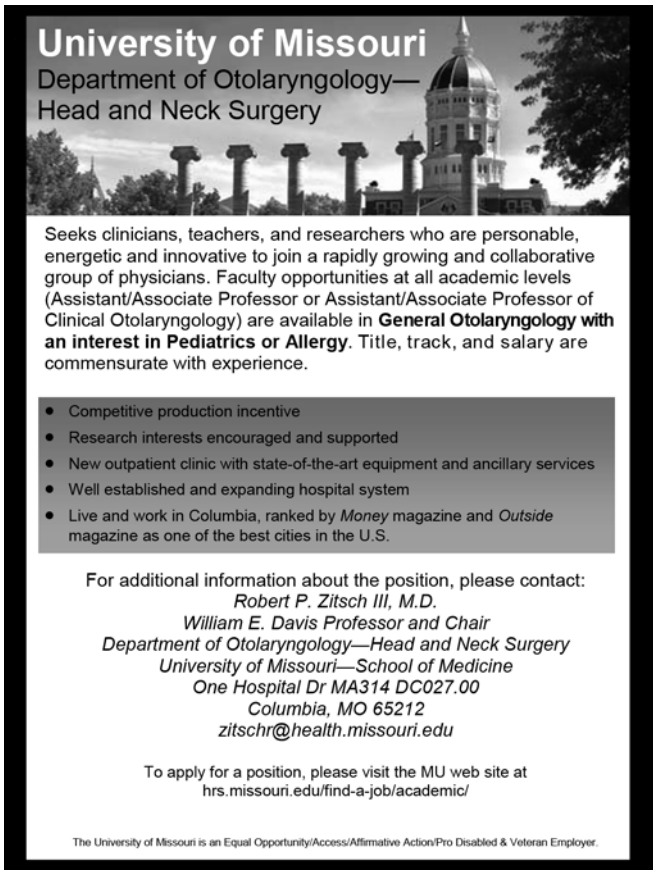

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Head & Neck Oncology and Microvascular Reconstructive Surgery ~ This fellowship will stress multidisciplinary management of head and neck malignancies with a primary clinical experience focused on oncologic resection and microvascular reconstruction. The fellow will also gain experience with transoral laser resection, robotic procedures, transnasal endoscopic resection, and anterior skull base surgery. The experience will offer both mentored and independent clinical responsibilities and protected research time.

Laryngology ~ This position provides a unique opportunity to interact with adult and pediatric Otolaryngologists, speech pathologists and voice researchers in a clinically active, high flow-through, multidisciplinary setting for treatment of voice, swallowing and airway disorders. Clinical experience will be comprehensive and include office evaluation, office-based procedures, and operative interventions. The applicant will learn surgical techniques for the treatment of benign and malignant vocal folds lesions, surgical and non-surgical management for neurologic, psychogenic and inflammatory disorders, swallowing dysfunction and airway stenosis. Training in video stroboscopy, high-speed video, Voice analysis, QOL, transnasal esophagoscopy, EMG, High Resolution manometry. Research participation and initiation are expected.

Applicants who will have completed a US or Canadian Otolaryngology residency should contact:

Delight Hensler
Division Otolaryngology Head & Neck Surgery
K4/719 CSC
600 Highland Avenue
Madison, WI 53792-7375
608-263-0192
Hensler@surgery.wisc.edu

For more information about the Department of Surgery, please visit our website:
http://www.surgery.wisc.edu

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.

Responsibilities include continued development of a strong clinical practice with other members of the Head and Neck Oncology Team, resident and medical student education, and clinical or basic science research.

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

The University of Tennessee is an EEO/AA/Title VI/Title IX/Section 504/ADA/ADEA/V institution in the provision of its education and employment program and services.

South Florida ENT Associates, P.A.

South Florida ENT Associates, a fifty-two physician group practice in Miami-Dade, Broward and Palm Beach has immediate openings for full-time ENT Physicians. South Florida ENT Associates is the second largest ENT group in the country and the largest in the state of Florida. We provide full service ENT including Audiology, Hearing Aid Sales, Allergy, Facial Plastics, Robotics and CT services.

We offer an excellent salary/bonus with partnership track, health insurance, paid vacation time, malpractice insurance and CME reimbursement, plus other benefits.

Candidate must have strong clinical knowledge, excellent communication skills, be highly motivated and hardworking.

This position will include both office and hospital settings.

Requirements:

Board Certified or Eligible preferred
MD/DO from approved medical/osteopathy school and graduation from accredited residency program in ENT
Current Florida license
Bilingual (English/Spanish) preferred
Excellent communication and interpersonal skills
F/T - M-F plus call

For more information about us, please visit www.sfenta.com.

Contact Information:

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

ENT Physician Opportunity – AtlantiCare

Geisinger Health System, on behalf of AtlantiCare, is seeking a board certified/board eligible Otolaryngologist to join AtlantiCare Physician Group (APG), our growing multi-specialty group located in southeastern New Jersey.

Join our team and share call with two highly skilled community Otolaryngologists who provide specialty support for head/neck functional and reconstructive surgery as well as allergy diagnosis and treatment.

Perform a wide range of general ENT procedures and help to grow a patient base. Take advantage of strong institutional support as you carve out a unique niche of your own, within the community and the AtlantiCare organization. You'll also have access to AtlantiCare's hospitals and facilities and its highly regarded network of referring physicians.

About AtlantiCare

AtlantiCare, a Baldridge Award-winning healthcare system, is renowned for medical innovation and performance excellence, that values and rewards your contributions, and that respects your need for work/life balance and your desire to make a difference. You'll have it all, here in beautiful southeastern New Jersey, with its pristine beaches, welcoming neighborhoods, and abundance of history, culture, arts, entertainment and recreation.

Join AtlantiCare and make a contribution that could change healthcare. To learn more, please visit atlanticarecareers.org or contact Frank Gallagher, Director of Provider Recruitment, at 609.441.8960, or francis.gallagher@atlanticare.org

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

Head and Neck Fellowship

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

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

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

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

FULL-TIME FACULTY POSITION

SCHOOL OF MEDICINE
UT HEALTH SCIENCE CENTER®
DEPARTMENT OF OTOLARYNGOLOGY•HEAD & NECK SURGERY

The Department of Otolaryngology at UT Health Science Center San Antonio is actively recruiting a qualified candidate for a full-time academic position. We are seeking faculty with interests in General Otolaryngology with a subspecialty in Laryngology for a non-tenure track position. Competitive salary will be commensurate with academic rank.

Qualifications include board certification, Texas licensure and a commitment to pursue resident education, patient care and research. Research experience and/or fellowship training are highly desirable.

Interested applicants should send inquiries, CV, and 3 to 5 references to:

Randal A. Otto, M.D.
Professor and Chairman
Department of Otolaryngology-Head and Neck Surgery
The University of Texas Health Science Center
8300 Floyd Curl Drive, MS 7777
San Antonio, T X 78229
Email: **cowartk@uthscsa.edu**

Applications will be accepted until the position is filled. The University of Texas Health Science Center at San Antonio is an Equal Employment Opportunity/Affirmative Action Employer including protected veterans and persons with disabilities. All faculty appointments are designated as security sensitive positions.

UHealth UNIVERSITY OF MIAMI HEALTH SYSTEM | UNIVERSITY OF MIAMI MILLER SCHOOL of MEDICINE

The University of Miami, Department of Otolaryngology, is searching for a recent BC/BE fellowship trained head and neck surgeon-scientist who is interested in developing an independent translational laboratory in collaboration with our established academic head and neck group. We have developed a competitive support package in collaboration with the Sylvester Comprehensive Cancer Center and the Miami VA hospital that will provide significant protected research time, mentorship, as well as equipment, supplies, and lab space to ensure that the candidate will have every opportunity to develop an independent laboratory over the course of 5 years.

We are specifically interested in individuals with a focus on head and neck cancer genomics, human papillomavirus (HPV), cancer stem cells, immunology, or early detection/disparities who work well with others and have the potential to become leaders in their field. Must possess or be eligible for Florida medical license.

Please send Curriculum Vitae to:

Mr. Tony Etzel, Vice Chair for Administration
Department of Otolaryngology
1120 NW 14th Street, CRB #571
Miami, FL 33136

UNIVERSITY OF Cincinnati

UNIVERSITY OF CINCINNATI COLLEGE OF MEDICINE
Department of Otolaryngology-Head & Neck Surgery

The Department of Otolaryngology-Head & Neck Surgery and Myles L. Pensak, MD, FACS, H.B. Broidy Professor and Chairman, are expanding its clinical/academic programs and recruiting a full-time board certified Neurotologist. Candidates interested in pursuit of a combination clinical/research track are preferred.

This position requires a strong interest and commitment to the education of residents, fellows and medical students. This position includes an academic appointment as an Assistant/Associate Professor of Otolaryngology-Head and Neck Surgery. Academic appointment will be commensurate with experience/qualifications. MD degree and the obtainment of a permanent Ohio medical licensure required.

Interested candidates should send letter of interest and curriculum vitae for review by Myles L. Pensak, MD to:
barbarag.huber@uc.edu

The University of Cincinnati is an equal opportunity and affirmative action employer. UC is a smoke-free work environment.

Otolaryngology

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Featured 8th in Money Magazine's "Best Places to Live", Ames, Iowa is recognized as an active, friendly community with plenty to do. Ames is a vibrant university town with one of the highest-rated public school systems in the nation. Having close access to several major metropolitan cities means that this versatile community provides small-town serenity and charm plus big-city amenities and culture.

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Contact Doug Kenner
866.670.0334 or dkenner@mountainmed.net

WestVirginiaUniversity.
SCHOOL OF MEDICINE

The Department of Otolaryngology at West Virginia University is seeking a fellowship-trained head and neck surgeon to join a well-established head and neck oncology service in the summer of 2015 or later. Applicants will have expertise with both ablative and reconstructive procedures. In addition to providing excellent patient care, the successful candidate will be actively involved in the teaching of medical students and otolaryngology residents. Opportunities are available for those interested in clinical/basic research. The department currently has thirteen physician faculty members and fifteen residents in addition to an active NIH-funded research division with three PhD members.

Successful candidates must have an MD, MD/PhD or DO degree (the employer accepts foreign educational equivalent) and be eligible to obtain an unrestricted West Virginia medical license. Candidates must be board certified/eligible by the American Board of Otolaryngology and have completed a fellowship in head and neck surgery. Faculty rank and salary will be commensurate with credentials.

U.S. News & World Report ranked West Virginia University Hospitals in Morgantown #1 in the state for the last three years. WVU Healthcare is a 645 bed hospital system, providing tertiary referral services and the most advanced level of care available to the citizens of West Virginia and bordering states. Major expansion is underway to Ruby Memorial Hospital, adding a 10-story tower and an additional 114 licensed beds. A new three story, 110,000 square foot ambulatory care facility is set to open in Spring 2015 to help address the growing demand for services. The Robert C. Byrd Health Sciences Center has a full complement of academic programs in the clinical and basic sciences.

Forbes recently ranked Morgantown as one of the Best Small Metros in America. Our area offers the cultural diversity and amenities of a large city in a safe, family-friendly environment. There is also an excellent school system and an abundance of beautiful homes and recreational activities.

To learn more, visit **http://www.hsc.wvu.edu/som/otolaryngology/** or submit your CV directly to Laura Blake, Director of Physician Recruitment, at **blakel@wvuhealthcare.com**.

WVU is an AA/EO employer - Minority/Female/Disability/Veteran - and is the recipient of an NSF ADVANCE award for gender equity.

The Ohio State University

Department of Otolaryngology – Head and Neck Surgery

The Ohio State University Department of Otolaryngology is accepting applications for the following faculty positions:

General Otolaryngologists to work in Community Practices

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Applicants must demonstrate excellence in patient care, research, teaching, and clinical leadership. This is an outstanding opportunity to join one of the top ranked programs in the country. Located in the heart of Ohio, Columbus offers a population of over 1.5 million people and excellent cultural, sporting, and family activities.

Send letter of interest and CV to:

Ted Teknos, MD
Professor and Chair
The Ohio State University
Department of Otolaryngology
915 Olentangy River Rd. Suite 4000
Columbus, Ohio 43212
E-mail: mark.inman@osumc.edu
Department Administrator
Or fax to: 614-293-7292
Phone: 614-293-3470

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The Ohio State University is an Equal Opportunity Affirmative Action Employer. Women, minorities, Vietnam-era veterans, and individuals with disabilities are encouraged to apply

Children's Hospital of San Antonio™
CHRISTUS SANTA ROSA HEALTH SYSTEM

Baylor College of Medicine

The Division of Pediatric Otolaryngology at the Children's Hospital of San Antonio-Baylor College of Medicine seeks an energetic, fellowship-trained **Pediatric Otolaryngologist** interested in building an academic program in a community-hospital setting. The qualified applicant will join three fellowship-trained Pediatric Otolarygologists at the only free standing children's hospital in San Antonio and will serve an intregal role in developing clinical programs, teaching residents, and providing exceptional care to the children of South Texas.
Assistant and Associate Professor levels preferred, and any area of pediatric otolaryngology subspecialty interests are encouraged.

Interested applicants should send CV and letter of intent to:

Lisa Buckmiller MD, Chief Pediatric Otolaryngology
Children's Hospital of San Antonio
315 N. San Sabe, Suite 1003
San Antonio, TX. 78207
(210) 704-3391
Lisa.Buckmiller@christushealth.org

The Division of Pediatric Otolaryngology at Miami Children's Hospital ("MCH") is seeking a third, hospital-employed, fellowship-trained

Pediatric Otolaryngologist

with a particular interest in complex airway disorders to join a multi-specialty pediatric hospital in Miami, FL.

About the Opportunity:

The Division of Pediatric Otolaryngology specializes in the treatment of routine and complex conditions of the ear, nose and throat, including the evaluation and management of sleep apnea, otologic and sinonasal disease, head and neck tumors and complex airway disorders. The practice is one of the busiest at Miami Children's Hospital with over 25,000 visits and more than 4,000 surgeries per year.

The Miami Children's Health System has recently partnered with Jupiter Medical Center to expand our brand of outstanding pediatric specialty care to Jupiter, Florida and its surrounding areas. Pediatric Otolaryngology has been identified and targeted by the community as an area of particular need. Working out of the Nicklaus Outpatient Center, the perspective candidate should have several years of experience to enable them to establish and grow MCHS's Pediatric Otolaryngology practice in this attractive location. In addition, there is potential to invest and operate at an existing outpatient surgery center in Jupiter. This represents a truly unique and exciting opportunity for a motivated individual to flourish in one of the most sought after locations to live in Florida.

Interested applicants should submit their curriculum vitae and letter of interest to:

Sandeep Dave, MD
Division of Pediatric Otolaryngology, Miami Children's Hospital, through joyce.berger@mch.com.

Advanced Head and Neck Surgery Fellowship

Head & Neck Surgery Center of Florida

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Fellowship Director: J. Scott Magnuson, MD
Beginning July 1st, 2015 (Duration 12-24 months)

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A limited (training) or unrestricted Florida medical license is required.

Those interested in careers in head and neck surgery should contact:

J. Scott Magnuson, MD
Head & Neck Surgery Center of Florida
410 Celebration Place, Suite 305 | Celebration, FL 34747
Scott.Magnuson@FLHosp.org

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UNIVERSITY OF CALIFORNIA, LOS ANGELES

The Department of Head and Neck Surgery at UCLA is seeking a fellowship-trained Skull Base and Microvascular Head and Neck Surgeon for a full-time academic position.

Academic rank and salary are open and are commensurate with qualifications. The successful candidate should possess a background in Skull Base and Microvascular H&N reconstruction and a demonstrated record of research and teaching.

Send letter of inquiry & curriculum vitae to:

Gerald S. Berke, M.D., Professor and Chair
UCLA Department of Head and Neck Surgery
10833 Le Conte Ave., CHS 62-132
Los Angeles, CA 90095-1624

Pediatric Otolaryngology

Joe DiMaggio Children's Hospital AT MEMORIAL

OPPORTUNITY IN SOUTH FLORIDA

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 are covered under sovereign immunity.

ABOUT JOE DIMAGGIO CHILDREN'S HOSPITAL

Joe DiMaggio Children's Hospital, a 204-bed facility, opened in 1992 and is located in Hollywood, Florida. This premier provider of tertiary-level pediatric care has a 64-bed Level II & III NICU, 22-bed PICU and 12-bed intermediate care unit. As South Florida's newest freestanding children's hospital, we are redefining the pediatric healthcare experience. The only Level 1 Pediatric Trauma Center in South Broward County, JDCH combines cutting-edge excellence with a commitment to patient- and family-centered care. JDCH has earned the distinction of being the leading children's hospital in Broward and Palm Beach Counties. Further, our South Florida location is known for its high quality of life. In addition, Florida has no state income tax. To learn more, please visit JDCH.com.

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